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# World Medical Journal



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- WMA General Assembly, Montevideo
- The World Conference on the Social Determinants of Health

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## Editorial

As the year is coming to a close, it is time to look back at the achievements and outline new tasks and new directions. The World Medical Journal wishes to thank all the authors and readers for the successful co-operation.

First of all, I want to thank the President of the WMA, Dr. Wonchat Subhachaturas, for the support and interest in the journal. The President made trips to all the continents, visited the medical associations and congresses of many countries and participated in important meetings, as well as found time to write articles and show interest in the journal. Many thanks to the WMA Council which provided themes for the articles; this year, Council worked harder than ever, it could be best seen in Sydney when the Australian government aligned its anti-smoking activities with the work of the WMA Council and Dr. Mukesh Haikerwal became the Chair of Council.

Thanks to Dr. Otmar Kloiber for his tireless support for creating the journal and forming its trend of development. In 2011, the World Medical Journal was and, in 2012, it will be the main mouthpiece of the World Medical Association's ideas that publishes the documents, declarations and statements of our organisation. Today, the

General Assemblies of the World Medical Association and the Executive Committee meetings are so versatile and highly topical that at least two of the six annual issues of the journal are filled with WMA information. Thanks for this to Nigel Duncan, who documents everything precisely. Of course, the entire WMJ effectiveness comes from the successful work of the staff, from which this time I wish to mark out Joelle Balfe; parallel with her own work, she edited many articles for the journal.

I wish to touch upon one, in my opinion, very significant turn of events. With Professor Sir Michael Marmot joining the WMA Council, the WMA has turned its face to the WHO activities, even more so – the WMA stands at the head of the WHO ideas, especially regarding issues relating to socially determined medicine.

And many thanks to my teachers and friends – co-editors Alan J. Rowe and Elmar Doppelfeld, who perused the journal by correspondence this year, gave good advice and moral support. Let me wish you good health, ALAN, so that we could meet face to face at meetings next year!

*Dr. Pēteris Apinis,  
Editor-in-Chief of the World Medical Journal*



*Wonchat Subhachaturas*



*Jose Luiz  
Gomes do Amaral*



*Dana Hanson*



*Otmar Kloiber*



*Frank Ulrich  
Montgomery*

## WMA General Assembly 12–15 October, Montevideo

Delegates from almost 50 national medical associations met in Montevideo, Uruguay for the 62<sup>nd</sup> annual General Assembly of the World Medical Association from 12 to 15 October. The meeting, which coincided with celebrations for the 200<sup>th</sup> anniversary of Uruguay's independence, was held in the Grand Ballroom of the Radisson Plaza Hotel, the venue of the last WMA meeting held in Montevideo in 1998.

Dr. Mukesh Haikerwal, Chair of the WMA, opened the proceedings on Wednesday with the 189<sup>th</sup> Council session.

The President, Dr. Wonchat Subhachaturas, reported on his visits during the year to 19 medical associations and forums in every continent except Africa.

The Secretary General, Dr. Otmar Kloiber, in his report, said the issue of non communicable diseases had been an important recent issue for the WMA. But it had been an uphill task, both in ensuring the WMA's attendance at the recent United Nations meeting in New York and in arguing for a more horizontal approach to the diseases included, beyond the four favoured by the World Health Organisation – cardiovascular and lung diseases, cancer and diabetes. In the end the WMA achieved its aims and was quite happy with the final results of the meeting, although it would still have liked a stronger policy.

On another subject, Dr. Kloiber spoke about the threat of attack which physicians were facing in various parts of the world, especially in Bahrain, where a number of physicians and other health professionals had been tried in a para military court and were facing lengthy prison sentences. This was a concern which the meeting would want to discuss.

## SOCIO-MEDICAL AFFAIRS COMMITTEE

The Socio-Medical Affairs Committee convened under the chairmanship of Sir Michael Marmot (UK).

### Armed Conflicts

Two papers relating to armed conflicts were considered. The committee agreed that against the background of alarming attacks on health professionals worldwide the first paper, a Statement on Protection and Integrity of Medical Personnel in Armed Conflicts, should be sent to the Assembly for adoption. The second paper, the WMA Regulations in Times of Armed Conflict, was mainly about physicians' duties and conduct during an armed conflict. It was agreed to circulate this to NMAs for comment.

### Violence in the Health Sector

The committee considered a proposed Statement on Violence in the Health Sector, put forward by the Israel Medical Association. This suggested a zero-tolerance attitude to threats and acts of violence in the health sector, including the right to refuse to treat violent offenders, except in emergency situations.

Dr. Yoram Blachar (Israel) said there was a growing problem of violence against health personnel and it was important NMAs were aware of this problem and worked to reduce such occurrences. But Dr. Vivienne Nathanson (UK) said the paper did not really deal with the patient who was violent because of an illness, such as somebody with a serious mental health problem where



*Cecil B. Wilson*



*Mukesh Haikerwal*



*Masami Ishii*



*Yoram Blachar*



*Sir Michael Marmot*



*Torunn Janbu*

violence was a part of that and where physicians in psychiatry had to manage that.

Dr. Heikki Pälve (Finland) said the same trend of violence was being experienced in Finland. He said all attacks should be publicised and made known to the police and possibly to the courts. The proposed Statement should mention such a procedure.



*Xavier Deau*

After further suggested amendments, it was agreed to refer the document to an ad hoc working group to report back to Council later in the meeting.

### Pain Relief

A proposed Resolution from the British Medical Association on Access to Adequate Pain Treatment was discussed, setting out a series of proposals to improve patients' access to pain treatment.



*Ajay Kumar*

It was agreed that the Resolution should be forwarded to Council and the Assembly for adoption.

### Tobacco-Derived Products (Protect Children)

The committee considered a proposed revision to the Statement on Health Hazards of Tobacco and Tobacco-Derived Products suggested by the American Medical Association, outlining measures to protect children from tobacco. After discussion, it was amended to include advice to NMAs to refuse to invest in companies or firms producing or promoting the use or sale of tobacco. It was agreed to forward the document as amended to the Assembly for adoption.



*Robert Ouellet*

### Ethical Implications of Physician Strikes

A proposed Statement on new guidelines for physicians about taking strike action



*Jón Snædal*

was put forward by the Israel Medical Association.

Dr. Blachar introduced the document, saying his Association had been involved in several months of negotiations and industrial action. Strikes were becoming more common and it was important that clear ethical guidelines were available. Dr. Peter Carmel (USA) said the document would be met with huge controversy, as in each country there were separate laws about physician strikes. It was agreed that the document should be circulated to NMAs for comment.

### Electronic Cigarettes

The American Medical Association introduced a proposed Statement on Electronic Cigarettes calling for a ban on the manufacture and sale of e-cigarettes until they had been fully researched, tested and regulated as either a new form of a tobacco product or as a drug delivery device.

It was agreed that the document should be circulated to NMAs for comment.

### Leprosy

The committee received a proposal from the charity, the Nippon Foundation, for the WMA to support its Global Appeal on leprosy. The committee first considered a proposed WMA Declaration on Leprosy Control Around the World and Elimination of Discrimination Against Persons Affected by Leprosy. The Declaration from the Brazilian Medical Association called on physicians to lead the way in combating all forms of prejudice and discrimination against people affected by leprosy and members of their families.

It was agreed that both the new WMA policy and the Global Appeal should be



*Roberto Luiz d'Avila*



*Jeremy A. Lazarus*



*A.C. Nieuwenhuijzen Kruseman*



*Alarico Rodriguez de Leon*



*A. Hallmayr*



*Jeff Blackmer*

sent to Council and to the Assembly for adoption.

## Advocacy

An oral report on the Advocacy Workgroup was given by its chair, Dr. Dana Hanson (Canada). The group had reviewed the effectiveness of the WMA's relationship with outside organisations. It said that advocacy should be a key element of the Association's strategic plan in reaching out to NMAs.



*Peter W. Carmel*

## COUNCIL

Council then reconvened to consider two emergency resolutions relating to the recent trial of physicians and other health professionals in Bahrain.



*Dongchun Shin*

## Bahrain trial of health professionals

The first resolution declared that Bahrain must prove to the watching world that the retrial of 20 physicians, nurses and other health professionals sentenced to prison in September followed fair process.



*Vinay Aggarwal*

Dr. Vivienne Nathanson, introducing the resolution, said that those tried included 13 physicians, all of them senior doctors. They had been found guilty and sentenced to five, 10 or 15 years imprisonment and the more senior the person the longer the sentence. The accusations against them included helping enemies of the state who were seeking regime change, stockpiling guns in the hospital and making political statements. Their lawyers said the physicians had been abused during the time of arrest and tortured while in detention. During the trial, they were not allowed to give evidence in their own defence, nor were their lawyers allowed to question the state's witnesses, all contrary to international rules. The final hearing had lasted just seven minutes.



*Vivienne Nathanson*

The court was held under special powers with a military judge. The doctors said the only thing they did was to treat people who came to their hospital, fulfilling their ethical obligations to treat all those who presented to them regardless of whether they were friends or enemies of the government.

## Independence of National Medical Associations

The second resolution related to the independence of medical associations and denounced attempts by some governments to silence medical associations. Council approved both emergency resolutions.

## FINANCE AND PLANNING COMMITTEE

In the absence of the committee Chair Dr. Leonid Eidelman (Israel), the Finance and Planning Committee convened under the chairmanship of Dr. Mukesh Haikerwal, Chair of Council.

The Financial Advisor, Mr Adi Hällmayr, presented the Audited Financial Statement for 2010 and the Budget for 2012, both of which were approved by the committee for adoption by the Assembly.

The committee also received a report on Membership Dues Payments for 2011 and Dues Categories for 2012.

The Secretary General thanked those members who had paid their dues promptly despite the difficult situations in some countries. He explained the necessity of adopting a new dues baseline for members.

## Strategic Planning

Dr. Robert Ouellet (Canada), Chair of the Workgroup on the WMA Strategic Plan, reported on the group's progress and in-



*Ramin Parsa-Parsi*



*Joshitake Yokokura*



*Florentino Cardoso*



*Daniel Johnson*



*Martin Rebella*

roduced Ms Emmanuel Morin from the Canadian Medical Association, who presented the results of a survey carried out among NMAs and key stakeholders.

Following a discussion on the findings, there was general agreement that:

- resource capacity and implications must be carefully considered in developing the strategic objectives and the strategic plan;
- the needs of junior physicians should be represented in the new plan as a priority area specific to networking and advocacy, and the WMA should collaborate with existing stakeholders such as the Junior Doctors Network;
- the WMA must take a proactive position in developing its new objectives in order to solidify its role as the foremost international leader in physician ethics and guidance, and in advocacy and representation;
- given the regulatory role of many NMAs, the WMA needed to continue its support and work in the area of quality and regulation. However, this should not be a new core area, but rather be integrated into the three existing core areas as a priority in the new strategic plan;
- the focus on members, individual physicians and their patients needed to be highlighted as this was critical to the unique value the WMA provided globally;
- the strategic plan must continue to include goals that worked to engage existing and new NMA members in order to build awareness and capacity, and to strengthen the international voice of physicians.

The committee recommended to Council that the workgroup should draft a strategic plan for presentation to the Council meeting in Prague in 2012.

## MEDICAL ETHICS COMMITTEE

The Medical Ethics Committee convened under the chairmanship of Dr. Torunn Janbu (Norway).

### Organ Procurement

Dr. Nathanson, chair of the WMA's workgroup on ethical organ procurement, reported to the committee about its work on a new draft document. She said it still needed major revision. Dr. Carmel said this issue represented a Pandora's Box of troubles with the moral, ethical and legal complexities surrounding this issue.

The committee recommended to Council that the workgroup be authorised to continue work on a draft document.





## Ethics in Palliative Sedation

A proposed Statement was considered on the Ethics in Palliative Sedation submitted by the Spanish Medical Association.

Dr. Janbu said as a result of the many comments received from NMAs on the document, it was clear that they would not be able to approve a new policy at the meeting. Some NMAs said there should be no separate document on this topic because it was already covered by existing policy statements. But only a few NMAs had actually suggested changes to the proposed Statement.

Following a debate, the committee recommended the setting up of a workgroup to review the proposed Statement alongside the three existing WMA policies on euthanasia, terminal illness and end of life medical care.

## Use of Placebo in Medical Research

Dr. Ramin Parsa Parsi (Germany), chair of the workgroup on placebo in medical research, reported on the activities of the past year. The WMA's Ethics Adviser, Prof. Urban Wiesing, then presented a summary of the discussion and the results of a conference held in São Paulo, Brazil in July. He said the conference discussed new wording for the placebo paragraph (par. 32) of the Declaration of Helsinki and suggested that the wording should be broadened. It had also discussed the issue of international clinical research and the use of interventions less effective than the best proven one in resource poor settings. Although there were disagreements about how to address this issue in the Declaration, the discussion helped to identify common ground among participants.

The committee recommended to Council that there should be a complete revision of the Declaration of Helsinki and that the workgroup's mandate should be extended to begin the process of revision. Council was also asked to consider organising a satellite conference on the Declaration of Helsinki in conjunction with the biannual conference of the International Association on Bioethics in Rotterdam in June 2012.

## Professional and Ethical Usage of Social Media

Dr. Jon Snaedal (Iceland), chair of the workgroup on social media, reported to the committee on the development of a white paper by the Junior Doctors Network examining the professional and ethical challenges of the increasing usage of social media by physicians,



medical students and patients. Dr. Xaviour Walker, representing the Junior Doctors Network, said the juniors had done a literature review on the topic to produce the white paper.

The committee then considered a proposed Statement urging NMA's to establish guidelines for their physicians on the use of social media. There was a debate about whether physicians should ever post identifiable patient information in any social media and the meeting concluded that they should not.

Following a discussion, the committee agreed that the document should be forwarded to Council and the Assembly for adoption. It was also decided that the workgroup should review the white paper and that the Executive Committee should decide if it should be published on the WMA website.

## Capital Punishment

Dr. Poul Jaszczak (Denmark), Chair of the workgroup on capital punishment, reported that the group had decided to develop a white paper on the ethical and societal implications of capital punishment. Whether a policy based on the white paper could be drafted would be subject to a separate decision in the future.

The committee authorised the workgroup to continue its deliberations and recommended to Council that the Executive Committee should decide if the white paper would be published on the WMA website.

## Human Rights

Ms Clarisse Delorme, the WMA's Advocacy Adviser, gave an oral report on the WMA's human rights activities during the year, including its many efforts to address the growing number of assaults on health personnel and health facilities in areas of armed conflict and civil unrest. She said the WMA had joined other health organisations in signing a joint letter requesting the UN Security Council to adopt a new resolution to include attacks on schools and hospitals in the existing monitoring and reporting mechanism that protected children in armed conflicts. This resolution had been passed.

The WMA was also in discussion with the International Committee of the Red Cross about a possible partnership with the ICRC's





campaign to improve the security and delivery of healthcare in situations of armed conflict.

## ASSOCIATE MEMBERS MEETING

Dr. Guy Dumont (Belgium) was re-elected Chair of the meeting on Thursday.

### Organ Procurement in China

A Resolution on Human Organ Procurement in the People's Republic of China was proposed on behalf of Dr. A. L. Halpern by Dr. Alejandro Centurion. He explained that in China organs were removed from prisoners, which was allowed by law. However, in line with WMA policy on transplantation, prisoners were not in a position to give free and informed consent. There was strong evidence that organs were still being removed not only from executed prisoners but also from individuals in detention centres, work camps and hospitals.

Dr. Guoming Qi, Vice President of the Chinese Medical Association, explained that the Chinese Medical Association and the Chinese Government were trying to change the situation. The Chinese Vice Health Minister agreed with the Chinese Medical Association that removing organs from executed prisoners was not acceptable. As the law was revised, the medical association would advocate for changes. He said the Chinese Government was about to establish allocation as well as data collection systems to ensure fair organ transplantation. Together with the medical association, the government had started investigating hospitals and other venues in 18 provinces. Originally 600 hospitals were enabled to carry out organ transplantations. That number had been reduced to 100 hospitals. Hospitals were about to be subject to sanctions if they violated medical ethics. Also, organ tourism was to be prohibited by the government. Dr. Qi said the

Chinese Medical Association and the government would use their best efforts to meet the standards of the WMA.

Dr. Daniel Johnson (USA), a Past President of the WMA, commended the Chinese Medical Association for its work in trying to tackle this issue and suggested that the meeting should adopt a less confrontational statement. Dr. Nathanson said that there were many countries where practices on organ procurement were far from ideal. The WMA had a workgroup revising policy on ethical organ procurement and she hoped its work would be finished in time for the next Assembly.

Following further discussion, the meeting amended the Resolution reiterating its opposition to any involuntary organ removal, not only from executed prisoners but also from all individuals in detention centres, work camps, hospitals and other places of confinement.

### Past Presidents

Dr. Dana Hanson (Canada), a Past President of the WMA, proposed setting up a Past Presidents and Past Chairs Network along the lines of the Junior Doctors Network. It was agreed to recommend this to the Assembly.

### Junior Doctors Network

Dr. Xaviour Walker, Chair of the Junior Doctors Network, reported on the inaugural meeting of the newly established Network and its work on a white paper on social media.

## SCIENTIFIC SESSION

The theme of the all-day session was 'Tobacco Cessation', with speakers addressing the issue of tobacco control policies.

The session was introduced by Dr. Martín Rebella, President of the Uruguyuan Medical Association, who spoke about the health and economic damage caused by tobacco smoking. This hindered economic development, particularly of poorer countries. But anti tobacco activities in his country had achieved successful health effects and were supported by public opinion.

The first speaker, Dr. Tom Glynn, Director, Cancer Science and Trends and Director, International Cancer Control at the American Cancer Society, gave a brief overview of the tobacco pandemic and spoke about what might be done to start to address it. He said Asia and Australia had more than half of the smokers in the world and tobacco was now moving from being a disease of the industrialised western countries to one of the middle and low income countries. But the good news was that the pandemic was preventable and reversible and he referred to the actions proposed by the WHO, including better monitoring and protection, good treatment, more warnings, the enforcement of advertising bans and higher taxes.

Dr. Tabaré Vázquez, former President of Uruguay, spoke about tobacco control in Uruguay and the progress that had been made. But a lot more needed to be done and he referred to his country's fight against the multinational tobacco industry and vowed that the companies would not triumph. Dr. Suthat Rungruangkitanya, Assistant Professor at the Medical Faculty of Srinakharinith University in Bangkok, said that in Thailand they had successfully implemented tobacco control measures over 20 years, reducing the prevalence rate from 32 per cent to 21 per cent. Now they were trying to deal with changes in taxation, more graphic warnings on cigarette packets, tougher law enforcement and a greater focus on teenage smokers.

During the session on tobacco dependence and treatment, Professor Richard Hurt

from the Mayo Clinic in Minnesota, USA, spoke about the neurobiology of tobacco dependence, while Dr. Glynn, in his second speech, explained article 14 of the Tobacco Framework Convention which mandated the development of treatment guidelines for parties to the treaty.

Speakers from Uruguay and Australia reported on actions being taken in their countries against Philip Morris International about cigarette package designs. Dr. Andrew Pesce from Australia referred to the progress in his country to legislate for plain packaging and Philip Morris's response in suing the Australian Government. He urged all governments to continue to act to decrease smoking and to introduce whatever legislation was possible. Dr. Eduardo Cazap from Argentina, President of the Oncology Association of Latin America and the Caribbean, said the UN Non Communicable Diseases High Level Meeting in New York presented challenges to all national medical associations.

In the final session, Uruguay's anti-tobacco activities were outlined by several speakers. Dr. Eduardo Bianco, a member of the Tobacco Commission of the Sindicato Médico del Uruguay, said that among his association's aims was to reduce the prevalence of smoking among physicians in the country to less than five per cent by 2015, a goal he thought was achievable. The session ended with a speech from Uruguay's Minister of Public Health, who spoke optimistically about his country's fight against the tobacco industry, likening it to the struggle between David and Goliath. But it was not an isolated struggle. It included all of civil society and he said the ethics were with them.

## COUNCIL

When the Council reconvened on Friday to approve the reports from the committees, it discussed a Statement on Disaster





Preparedness and Medical Response and agreed to send it to the Assembly for adoption.

It debated possible venues for future meetings and recommended meeting in Brazil for the 2013 Assembly. For the Council meetings in the spring of 2013 and 2014, both Japan and the UK were suggested, although this remained to be decided.

The meeting heard a report from Dr. Mads Hansen (Denmark) about the greening of activities at the Assembly to reduce the WMA's environmental impact. This included the move to organising a paperless meeting and he said there had been a reduction of two thirds in the use of paper at this Assembly.

An oral report was received from Mr Tony Bourne (UK), Chair of the Business Development Group, outlining its work to strengthen and diversify WMA revenue sources and it was agreed that this work should continue.

Following a workgroup report to Council, further debate took place on amendments to the proposed Statement on Violence in the Health Sector and it was decided that further work was needed on the document.

## CEREMONIAL SESSION OF THE GENERAL ASSEMBLY

At the ceremonial opening of the Assembly, participants were welcomed by Dr. Leonel Briozzo, Vice Minister for Health in Uruguay. He spoke about the substantial reform of the health system going on in his country and the autonomy of the medical profession. He also thanked the WMA for its support on anti-tobacco activities.

His Excellency João Carlos de Souza-Gomes, Brazil's ambassador to Uruguay, welcomed the election as WMA President

for 2011/12 of Dr. Gomes do Amaral and spoke about his work to improve the quality of health in Brazil. He congratulated Uruguay on its reforming health policies and spoke about the importance of international co-operation and the exchange of ideas and experiences.

Dr. Wonchat Subhachaturas, in his valedictory address as WMA President for 2010/11, referred to the various natural and manmade disasters that had happened during his year of office, as well as the many attacks on physicians around the world who were simply carrying out their job caring for the sick and injured.

During the past year, he had visited 19 medical associations and forums in every continent except Africa. The three challenges he identified were the political conflicts among countries, which were impacting on health provision, the economic crisis which was proving to be a great barrier to the development of medical care in many countries and the manmade disasters especially around the Mediterranean. He listed those factors which were essential to the provision of healthcare – among them professional unity, ethical practice, equitable provision of health, global collaboration and independence from politics.

Dr. José Gomes do Amaral, President of the Brazilian Medical Association, was then installed as the 62<sup>nd</sup> WMA President for 2011/12. He said it was time for physicians to reaffirm their leadership of the healthcare process and to stand up for medicine. He said physicians had to decide if they wanted to be the key players in the healthcare process or simply 'mere spectators'.

'This is no time to be vague. We cannot be supporting actors in a play where the people expect us to be protagonists. It is time for us to reaffirm our leadership of the healthcare process. This is what we were educated to do. We were given the privilege and responsibility to take care of

the lives of our patients. This is our duty and society trusts us to behave up to their expectations.'

Dr. Gomes do Amaral said this was a period of uncertainty and indecision for physicians around the world and he was taking over the Presidency as the medical profession was facing formidable challenges. Physicians found themselves surrounded by a complex healthcare network, the primary purpose of which was to broaden access to care. But the role of physicians in this network was often misrepresented and the medical profession could not accept that. Under no circumstances could physicians contemplate a retreat from their role and responsibilities.

He said that in the field of health, immense possibilities of diagnosis and treatment had been brought about by science and technological development, unimaginable a few decades ago. Physicians had played their part in this and they would certainly do more in this field. Specialisation and specialists were more necessary than ever and doctors, who had helped to build and integrate the health system, should not now be disregarded. It was time for doctors to stand up for medicine.

## PLENARY SESSION OF THE ASSEMBLY

When the Assembly reconvened on Saturday, an election was held for WMA President for 2012/13. Two nominations were received, from Dr. Shamsuddin Ahmed (Bangladesh) and from Dr. Cecil B. Wilson (USA). After each candidate had addressed the meeting, there was a vote and Dr. Wilson, past President of the American Medical Association, was elected. He will take up office at the 2012 Assembly in Bangkok, Thailand.

The Assembly then received a detailed report from Council about its activities since

the last General Assembly in Vancouver in 2010.

Among the significant activities not being discussed in Montevideo, were the WMA's work on the multidrug-resistant tuberculosis project and its involvement in the implementation process of the WHO Framework Convention on Tobacco Control. The report referred to work in monitoring the drafting process of the WHO strategy on alcohol and collaboration with the World Health Professions Alliance in stepping up activities on counterfeit medicines. Other issues included activities on climate change and the forthcoming UN Conference in Durban, South Africa in December and the WMA's continuing close involvement in the positive practice environment campaign.

The WMA Treasurer, Dr. Frank Ulrich Montgomery, presented his financial report, saying that the Association's net income had continued the positive trend it had shown since the turnaround in 2005. In 2010 there was a financial surplus of €60,000 which was very reassuring for the future. Total income for the year was €2,120,000 and expenses totalled €2,060,000. The membership dues had reached their highest level during 2010. He said the Association's money was safely and solidly invested.

The Assembly approved the Financial Statement for 2010 and the Budget for 2012.

The Assembly then adopted a number of policy documents brought to it by the Council.

From the Medical Ethics Committee it adopted three documents:

- **Recommendation on the Development of a Monitoring and Reporting Mechanism to Permit Audit of Adherence of States to the Declaration of Tokyo** (see p. 215), which sets out ways to increase support for physicians with dual loyalties



who are pressured to violate their professional ethics.

- **Statement on End of Life Care** (see p. 215) which emphasises the need for improved palliative care.
- **Statement on Professional and Ethical Usage of Social Media** (see p. 217).

From the Socio-Medical Affairs Committee it adopted the following:

- **Statement on the Global Burden of Chronic Disease** (see p. 218).
- **Revision of the Declaration on Prison Conditions and the Spread of Tuberculosis and other Communicable Diseases** (see p. 219).
- **Statement on Social Determinants of Health** (see p. 221).
- **Statement on Health Hazards of Tobacco and Tobacco-Derived Products** (see p. 224).
- **Statement on Protection and Integrity of Medical Personnel in Armed Conflicts** (see p. 222).
- **Resolution on the Access to Adequate Pain Treatment** (see p. 223).
- **Revision of the WMA Statement on Health Hazards of Tobacco and Tobacco-Derived Products (Protect Children)**.
- **Declaration on Leprosy Control Around the World and Elimination of Discrimination Against Persons Affected by Leprosy** (see p. 225).
- **Endorsement of the Global Leprosy Appeal 2012.**

## Social Determinants

In a short debate on the importance of social determinants, Dr. Vivienne Nathanson spoke about the forthcoming summit on the issue to be held in Rio de Janeiro. She said this presented important opportunities for the WMA to make sure that social determinants was not only firmly on people's agendas but that the medical community could offer help and expertise for health ministers to understand the importance of

cross government working. After the summit meeting in Brazil, it was hoped that the WMA would start to develop a bigger web resource that listed the types of activities that doctors had been involved in in different countries. So many countries had done remarkable things in changing health and health outcomes by looking at social determinants.

Dr. Gomes do Amaral said it was important that the WMA developed a regional network to implement this initiative.

From the Finance and Planning Committee the Assembly adopted:

- proposed **Baseline of Membership Dues**.
- applications for membership of the WMA from national medical associations from Trinidad and Tobago, Uzbekistan and Tanzania.
- This brought the total membership of the WMA to 100 NMAs, the highest ever recorded number.
- amendments on **Bylaws** relating to the duties and responsibilities of the Treasurer.
- amendments to governance documents relating to the termination of officers.
- Statement on **Disaster Preparedness and Medical Response** (see p. 227).

## Meetings

The Assembly agreed that the 2013 General Assembly should be held in Fortaleza in Brazil.

## Bahrain

The emergency resolutions on Bahrain and on the Independence of National Medical Associations were adopted (see p. 226).

## Organ Procurement

The Resolution from the Associate Members Group on Human Organ Procurement in the People's Republic of China was discussed. Dr. Nathanson said the WMA's current policy was that executed prisoners should not be organ donors and that prisoners should not, other than in the most exceptional circumstances, be living donors. She said the working party on organ procurement would be looking at WMA advice and revising it. The new document would contain more details about the situation of prisoners in different circumstances – prisoners who had died naturally, prisoners who had been executed and prisoners as living donors. She hoped the working party's report would be ready for next year's Assembly.

The Assembly agreed to remove from the title of the Resolution the words 'the People's Republic of China' and to send it to Council for further consideration by the workgroup.





## Past Presidents Network

The Assembly agreed to ask Council to consider setting up a network of Past Presidents and Chairs.

## Disaster Preparedness

In a special session on disaster response, Dr. Masami Ishii (Japan), Vice Chair of Council, spoke about the earthquake and tsunami that struck Japan in March and their aftermath. He said his hospital had been severely damaged and he referred to the ways in which medical help was organised and the role played by the Japan Medical Association.

Dr. Jeremy Lazarus (USA) described the American Medical Association's work on disaster medicine involving physicians. He said every physician should have a second speciality, that of disaster medicine and preparedness. He referred to the National Disaster Life Support Foundation, in which the AMA was involved, and its network of training centres.

Dr. Gomes do Amaral, the President, said that the Statement on Disaster Preparedness and Medical Response, which had been adopted by the Assembly, would be called the Declaration of Montevideo.

## Non Communicable Diseases

Dr. Julia Seyer, WMA Medical Adviser, reported on the toolkit on NCDs, the Health Improvement Card, which had been put together with the World Health Professions Alliance. This was an educational tool for physicians and the public to empower the individual to achieve a healthy lifestyle.

## Open Session

During the final open session of the Assembly, delegates heard from several NMAs



*Nigel Duncan*



*Annabel Seebhom*



*Clarisse Delorme*



*Roderic Dennett*



*Julia Seyer*



*Anne-Marie Delage*



*Lamine Smaali*



*Sunny Park*



about issues they were facing. Delegates from Venezuela and Uruguay raised their concerns about proposed legislation in Bolivia penalising poor medical activities and said they proposed to discuss this further at the next WMA Council meeting.

Dr. Peter Carmel, President of the American Medical Association, reported on two new AMA projects to tackle obesity, physical inactivity, tobacco and alcohol use.

Dr. Paul Ockelford (New Zealand) spoke about the earthquake that struck New Zealand in February. This led to 181

deaths and more than 6000 injuries. He described the immediate emergency response that took place.

## COUNCIL

The week's deliberations ended with a brief Council meeting at which it was agreed that the Resolution on Organ Procurement should be sent to the workgroup for consideration and that a network of Past Presidents and Chairs should be set up.

*Nigel Duncan,  
WMA Public Relations Consultant*





## WMA Recommendation on the Development of a Monitoring and Reporting Mechanism to Permit Audit of Adherence of States to the Declaration of Tokyo

*Adopted by the 62<sup>nd</sup> General Assembly, Montevideo,  
Uruguay, October 2011*

### The wma recommends that

1. Where physicians are working in situations of dual loyalties, support must be offered to ensure they are not put in positions that might lead to violations of fundamental professional ethics, whether by active breaches of medical ethics or omission of ethical conduct, and/or of human rights, as laid out in the Declaration of Tokyo.
2. National Medical Associations (NMA's) should offer support for physicians in difficult situations, including, as feasible and without endangering either patients or doctors, helping individuals to report violations of patients' health rights and physicians' professional ethics in custodial settings.
3. The WMA should review the evidence available, in cases brought to it by its members, of the violation of human rights codes by states and/or the forcing of physicians to violate the Declaration of Tokyo, and refer as appropriate such cases to the relevant national and international authorities.
4. The WMA should contact member associations and encourage them to investigate accusations of physician involvement in torture and similar abuses of human rights reported to it from reputable sources, and to report back in particular on whether physicians are at risk and in need of support. The WMA should provide support to the NMAs and their members to resist such violations, and as far as realistically possible, stand firm in their ethical convictions.
5. The WMA shall encourage and support NMAs in their calls for investigations by the relevant special rapporteur (or other individual or organization) when NMAs and their members raise valid concerns.

## Declaration on End-of-Life Medical Care

### INTRODUCTION

All people have the right to high-quality, scientifically-based, and humane healthcare. Therefore, receiving appropriate end-of-life medical care must not be considered a privilege but a true right, independent of age or any other associated factors. The WMA reaffirms the principles articulated in the WMA Declaration on Terminal illness and the WMA Declaration on Euthanasia. These Declarations support and complement the Declaration on End of Life Medical Care.

Palliative care at the end of life is part of good medical care. The need for access to improved quality palliative care is great, especially in resource-poor countries. The objective of palliative care is to achieve the best possible quality of life through appropriate palliation of pain and other distressing physical symptoms, and attention to the social, psychological and spiritual needs of the patient.

Palliative care may be provided at home as well as in various levels of health care institutions.

The physician must adopt an attitude to suffering that is compassionate and humane, and act with empathy, respect and tact. Abandonment of the patient when he or she needs such care is unacceptable medical practice.

### RECOMMENDATIONS

#### 1. Pain and symptom management

- 1.1. It is essential to identify patients approaching the end of life as early as possible so that the physician can perform a detailed assessment of their needs. A care plan for the patient must always be developed; whenever possible, this care plan will be developed in direct consultation with the patient.

For some this process may begin months or a year before death is anticipated. It includes recognising and addressing the likelihood of pain and other distressing symptoms and providing for patients' social, psychological and spiritual needs in the time remaining to them. The primary aim is to maintain patients' dignity and their freedom from distressing symptoms. Care plans pay attention to keeping them as comfortable and in control as possible and recognise the importance of supporting the family and treating the body with respect after death.

- 1.2. Important advances in the relief of pain and other distressing symptoms have been made. The appropriate use of morphine, new analgesics, and other measures can suppress or relieve pain and other distressing symptoms in the majority of cases. The appropriate health authorities must make necessary medications accessible and available to physicians and their patients. Physician groups should develop guidelines on their appropriate use, including dose escalation and the possibility of unintended secondary effects.
- 1.3. In a very limited number of cases, generally in the very advanced stages of a physical illness, some symptoms may arise that are refractory to standard therapy. In such cases, palliative sedation to unconsciousness may be offered when life expectancy is a few days, as an extraordinary measure in response to suffering which the patient and clinician agree is intolerable. Palliative sedation must never be used to intentionally cause a patient's death or without the agreement of a patient who remains mentally competent. The degree and timing of palliative sedation must be proportionate to the situation. The dosage must be carefully calculated to relieve symptoms but should still be the lowest possible to achieve a benefit.

## 2. Communication and consent; ethics and values

- 2.1. Information and communication among the patient, their family and members of the health care team is one of the fundamental pillars of quality care at the end of life. The patient should be encouraged to express his or her preferences regarding care, and his or her emotions and existential angst must be taken into consideration.
- 2.2. Ethically-appropriate care at the end of life should routinely promote patient autonomy and shared decision-making, and be respectful of the values of the patient and his or her family.
- 2.3. Physicians should directly discuss a patient's preferences with the patient and/or the patient's substitute health care decision maker, as appropriate. These discussions should be initiated early and routinely offered to all patients and should be revisited regularly to explore any changes patients may have in their wishes, especially as their clinical conditions change. Physicians should encourage their patients to formally document their goals, values and treatment preferences and to appoint a substitute health care decision maker with whom the patient can discuss in advance his or her values regarding health care and treatment. Patients who are in denial about the implications of their condition may not want to engage in such discussion at some stages of their illness, but should know that they can change their minds. Because documented advance directives are often not available in emergency situations,

physicians should emphasize to patients the importance of discussing treatment preferences with individuals who are likely to act as substitute health care decision makers.

- 2.4. If a patient is capable of giving consent, care should be based on the patient's wishes as long as preferences can be justified medically, ethically and legally. Consent needs to be based on sufficient information and dialogue, and it is the physician's obligation to make sure that the patient is adequately treated for pain and discomfort before consent is obtained in order to assure that unnecessary physical and mental suffering do not interfere with the decision-making process.
  - 2.5. The patient's next-of-kin or family should be informed and involved in the decision-making process, provided the patient is not opposed to this. If the patient is unable to express consent and an advance directive is not available, the views of the health care substitute decision maker, appointed by the patient on care and treatment, must be considered.
- ## 3. Medical records and medico-legal aspects
- 3.1. Physicians caring for a patient in the final stages of life must carefully document treatment decisions and the reasons for choosing particular procedures, including the patient's and family's wishes and consent, in the progress notes of the medical records. An adequate medical record is of the utmost importance for continuity and quality of medical care in general and palliative care in particular.
  - 3.2. The physician must also take into account that these notes may serve a medico-legal purpose, e.g., in determining the patient's decision-making capacity.

## 4. Family members

It is necessary to acknowledge the importance of the family and the emotional environment of the patient. The needs of the family and other close caregivers throughout the course of the illness must be recognized and attended to. The health care team should promote collaboration in the care of the patient and provide bereavement support, when required, after the patient's death. Children's and families' needs may require special attention and competence, both when children are patients and dependents.

## 5. Teamwork

Palliative care is usually provided by multiprofessional and interdisciplinary teams of healthcare and non-healthcare professions. The physician must be the leader of the team, being responsible, amongst other obligations, for diagnosis and medical treatment. Continuity of care is very important. The team should do all it can to facilitate a patient's wish to die at home, if applicable and possible.

## 6. Physician training

The increasing number of people who require palliative care and the increased availability of effective treatment options mean that end-of-life care issues should be an important part of undergraduate and postgraduate medical training.

## 7. Research and education

More research is needed to improve palliative care. This includes, but is not limited to, general medical care, specific treatments, psychological implications and organization. The WMA will support efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning.

## Conclusion

The care that a people give to dying patients, within available resources, is an indication of their degree of civilisation. As physicians representing the best humanitarian tradition, we should always commit ourselves to delivering the best possible end-of-life care.

The WMA recommends that all National Medical Associations develop a national policy on palliative care and palliative sedation based on the recommendations in this declaration.

# Statement on the Professional and Ethical Usage of Social Media

## DEFINITION

Social Media is generally understood to be a collective term for the different platforms and applications that allow user-generated content to be created and shared electronically.

## PREAMBLE

The objectives of the proposed policy are to:

- Examine the professional and ethical challenges related to the increasing usage of social media by physicians, medical students and patients.
- Establish a framework that protects their respective interests.
- Ensure trust and reputation by maintaining high professional and ethical standards.

The use of social media has become a fact of life for many millions of people world wide including physicians, medical students and patients.

Interactive, collaborative tools such as wikis, social networks, chat rooms and blogs have transformed passive Internet users into active participants. They are means for gathering, sharing and disseminating personal information, including health information, socializing and connecting with friends, relatives, professionals etc. They can be used to seek medical advice, and patients with chronic diseases can share their experiences with each other. They can also be used in research, public health, education and direct or indirect professional promotion.

The positive aspects of social media should be recognized such as in promoting healthy life style, in empowering patients and in reducing patients' isolation.

Areas, which may require special attention:

- Sensitive content, photographs, other personal materials posted on online social forums often exists in the public domain and have the capacity to remain on the internet permanently. Individuals may not have control over the ultimate distribution of material they post on-line.
- Patient portal, blogs and tweets are not a substitute for one on one consultation with physicians but may widen engagement with health services amongst certain groups. Online "friendships" with patients may also alter the patient-physician relationship, and may result in unnecessary, possibly problematic physician and patient self-disclosure.
- Each party's privacy may be compromised in the absence of adequate and conservative privacy settings or by their inappropriate use. Privacy settings are not absolute; social media sites may change default privacy settings unilaterally, without the user's knowledge. Social media sites may also make communications available to third parties.

Interested stakeholders such as current/prospective employers, insurance companies and commercial entities may monitor these Internet web sites for various purposes such as to better understand their customer's needs and expectations, to profile job candidates or to improve a product or a service.

## RECOMMENDATIONS

The WMA urges their NMA's to establish guidelines for their physicians addressing the following issues:

1. To maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just as they would in any other context.
2. To study carefully and understand the privacy provisions of social networking sites, bearing in mind their limitations.
3. For physicians to routinely monitor their own Internet presence to ensure that the personal and professional information on

- their own sites and, to the extent possible, content posted about them by others is accurate and appropriate.
4. To consider the intended audience and assess whether it is technically feasible to restrict access to the content to pre-defined individuals or groups.
  5. To adopt a conservative approach when disclosing personal information as patients can access the profile. The professional boundaries that should exist between the physician and the patient can thereby be blurred. Physicians should acknowledge the potential associated risks of social media and accept them, and carefully select the recipients and privacy settings.
  6. To provide factual and concise information, declare any conflicts of interest and adopt a sober tone when discussing professional matters.
  7. To ensure that no identifiable patient information be posted in any social media by their physician. Breaching confidentiality undermines the public's trust in the medical profession, impairing the ability to treat patients effectively.
  8. To draw the attention of medical students and physicians to the fact that online posting may contribute also to the public perception of the profession.
  9. To consider the inclusion of educational programs with relevant case studies and appropriate guidelines in medical curricula and continuing medical education.
  10. To bring their concerns to a colleague when observing his or her clearly inappropriate behaviour. If the behaviour significantly violates professional norms and the individual does not take appropriate action to resolve the situation, physicians should report the conduct to appropriate authorities.

## WMA Statement on the Global Burden of Chronic Disease

*Adopted by the 62<sup>nd</sup> General Assembly, Montevideo, Uruguay, October 2011*

### INTRODUCTION

Chronic diseases, including cardiovascular and circulatory diseases, diabetes, cancer, and chronic lung disease are the leading cause of death and disability in both the developed and developing world. Chronic diseases are not replacing existing causes of disease and disability (infectious disease and trauma), but are adding to the disease burden. Developing countries now face the triple burden of infectious disease, trauma and chronic disease. This increased burden is straining the capacity of many countries to provide adequate health care services. This burden is also undermining these nations' efforts to increase life expectancy and spur economic growth.

Ongoing and anticipated global trends that will lead to more chronic disease problems in the future include an aging population, urbanization and community planning, increasingly sedentary lifestyles, climate change and the rapidly increasing cost of medical technology to treat chronic disease. Chronic disease prevalence is closely linked to global social and economic development, globalization and mass marketing of unhealthy foods and other products. The prevalence and cost of addressing the chronic disease burden is expected to rise in coming years.

### Possible Solutions

The primary solution is disease prevention. National policies that help people achieve healthy lifestyles and behaviours are the foundation for all possible solutions.

Increased access to primary care combined with well designed and affordable disease-control programs can greatly improve health care. Partnerships of national ministries of health with institutions in developed countries may overcome many barriers in the poorest settings. Effective partnerships currently exist in rural Malawi, Rwanda and Haiti. In these settings where no oncologists are available, care is provided by local physicians and nurse teams. These teams deliver chemotherapy to patients with a variety of treatable malignancies

Medical education systems should become more socially accountable. The World Health Organization (WHO) defines social accountability of medical schools as the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public. There is an urgent need to adopt accreditation standards and norms that support social accountability. Educating physicians and other health care professionals to deliver health care that is concordant with the resources of the country must be a primary consideration. Led by primary care physicians, teams of physicians, nurses and community health workers will provide care that is driven by the principles of quality, equity, relevance and effectiveness. [see [WMA Resolution on Medical Workforce](#)]

Strengthening the health care infrastructure is important in caring for the increasing numbers of people with chronic disease. Components of this infrastructure include training the primary health care team, improved facilities, chronic disease surveillance, public health promotion campaigns, quality assurance and establishment of national and local standards of care. One of the most important components of health care infrastructure is human resources; well-trained and motivated health care professionals led by primary care physicians are crucial to success. International aid and development

programs need to move from “vertical focus” on single diseases or objectives to a more sustainable and effective primary care health infrastructure development.

Note: Depending on the country, different stakeholders will assume greater or lesser responsibility for change.

#### *For World Governments:*

1. Support global immunization strategies;
2. Support global tobacco and alcohol control strategies;
3. Promote healthy living and implement policies that support prevention and healthy lifestyle behaviours;
4. Set aside a fixed percentage of national budget for health infrastructure development and promotion of healthy lifestyles.
5. Promote trade policy that protects public health;
6. Promote research for prevention and treatment of chronic disease;
7. Develop global strategies for the prevention of obesity.

#### *For National Medical Associations:*

1. work to create communities that promote healthy lifestyles and prevention behaviours and to increase physician awareness of optimal disease prevention behaviours;
2. offer patients smoking cessation, weight control strategies, substance abuse counselling, self-management education and support, and nutritional counselling;
3. promote a team-based approach to chronic disease management;
4. advocate for integration of chronic disease prevention and control strategies in government-wide policies;
5. invest in high quality training for more primary care physicians and an equitable distribution of them among populations;
6. provide high quality accessible resources for continuing medical education;
7. support establishing evidence-based standards of care for chronic disease;
8. establish, support and strengthen professional associations for primary care physicians
9. promote medical education that is responsive to societal needs;
10. promote an environment of support for continuity of care for chronic disease, including patient education and self-management;
11. advocate for policies and regulations to reduce factors that promote chronic disease such as smoking cessation and blood pressure control;
12. support strong public health infrastructure; and
13. support the concept that social determinants are part of prevention and health care.

#### *For Medical Schools:*

1. develop curriculum objectives that meet societal needs; e.g., social accountability;

2. focus on providing primary care training opportunities that highlight the integrative and continuity elements of the primary care specialties including family medicine;
3. provide community-oriented and community-based primary care educational venues so that students become acquainted with the basic elements of chronic care infrastructure and continuity care provision;
4. create departments of family medicine that are of equal academic standing in the university; and
5. promote the use of interdisciplinary and other collaborative training methodologies within primary and continuing education programs.
6. Include instruction in prevention of chronic diseases in the general curriculum.

#### *For Individual Physicians:*

1. work to create communities that promote healthy lifestyles and prevention behaviours;
2. offer patients smoking cessation, weight control strategies, substance abuse counselling, self-management education and support, and nutritional counselling;
3. promote a team-based approach to chronic disease management;
4. ensure continuity of care for patients with chronic disease;
5. model prevention behaviours to patients by maintaining personal health;
6. become community advocates for positive social determinants of health and for best prevention methods;
7. work with parents and the community to ensure that the parents have the best advice on maintaining the health of their children.
8. Physicians should collaborate with patients' associations in designing and delivering prevention education.

## Revision of WMA Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and other Communicable Diseases

Prisoners enjoy the same health care rights as all other people. This includes the right to humane treatment and appropriate medical care. The standards for the treatment of prisoners have been set down in a number of Declarations and Guidelines adopted by various bodies of the United Nations.



The relationship between physician and prisoner is governed by the same ethical principles as that between the physician and any other patient. There are specific tensions within the patient/physician relationship, which do not exist in other settings, in particular the relationship of the physician with his/her employer, the prison service, and the general attitude of society to prisoners.

There are also strong public health reasons for reinforcing the importance of these rules. The high incidence of tuberculosis amongst prisoners in a number of countries reinforces the need for considering public health as an important element when designing new prison regimens, and for reforming existing penal and prison systems.

Individuals facing imprisonment are often from the most marginalised sections of society, may have had limited access to health care before imprisonment, may suffer worse health than many other citizens and may enter prison with undiagnosed, undetected and untreated health problems.

Prisons can be breeding grounds for infection. Overcrowding, lengthy confinement within tightly enclosed, poorly lit, badly heated and consequently poorly ventilated and often humid spaces are all conditions frequently associated with imprisonment and all of which contribute to the spread of disease and ill-health. Where these factors are combined with poor hygiene, inadequate nutrition and limited access to adequate health care, prisons can represent a major public health challenge.

Keeping prisoners in conditions, which expose them to substantial medical risk, poses a humanitarian challenge. An infectious prisoner is a risk to other prisoners, prison personnel, relatives and other prison visitors and the wider community – not only when the prisoner is released, but also because prison bars do not keep *Tuberculosis* bacilli from spreading into the outside world. The most effective and efficient way of reducing disease transmission is to improve the prison environment, by putting together an efficient medical service that is capable of detecting and treating the disease, and by targeting prison overcrowding as the most urgent action.

The increase in active *Tuberculosis* in prison populations and the development within some of these populations of resistant and especially “multi-drug” and “extremely-drug” resistant forms of TB, as recognised by the World Medical Association in its Statement on Drug Treatment of *Tuberculosis*, is reaching very high prevalence and incidence rates in prisons in some parts of the world.

Other conditions, such as *Hepatitis C* and *HIV* Disease, do not have as high a risk of person-to-person communicability as TB but pose transmission risks from blood to blood borne spread, or shar-

ing and exchange of body fluids. Overcrowded prison conditions also promote the spread of sexually transmitted diseases. Intravenous drug use will also contribute to the spread of *HIV* as well as the more contagious *Hepatitis B* and *C*. These need specific solutions that are not dealt with in this statement. However the principles set out below will also be helpful in reducing the risk from such infective agents.

### Actions Required

The World Medical Association considers it essential both for public health and humanitarian reasons that careful attention is paid to:

1. Protecting the rights of prisoners according to the various UN instruments relating to conditions of imprisonment. Prisoners should enjoy the same rights as other patients, as outlined in the WMA Declaration of Lisbon;
2. Not allowing the rights of prisoners to be ignored or invalidated because they have an infectious illness;
3. Ensuring that the conditions in which detainees and prisoners are kept, whether they are held during the investigation of a crime, whilst waiting for trial, or as punishment once sentenced, do not contribute to the development, worsening or transmission of disease.
4. Ensuring that persons being held while going through immigration procedures, are kept in conditions which do not encourage the spread of disease, although prisons should not normally be used to house such persons;
5. Ensuring the coordination of health services within and outside prisons to facilitate continuity of care and epidemiological monitoring of inmate patients when they are released;
6. Ensuring that prisoners are not isolated, or placed in solitary confinement, as a response to their infected status without adequate access to health care and the appropriate medical treatment of their infected status;
7. Ensuring that, upon admission to or transfer to a different prison, inmates' health status is reviewed within 24 hours of arrival to assure continuity of care;
8. Ensuring the provision of follow-up treatment for prisoners who, on their release, are still ill, particularly with TB or any other infectious disease. Because erratic treatments or interruptions of treatment may be particularly hazardous epidemiologically and to the individual, planning for and providing continuing care are essential elements of prison health care provision;
9. Recognising that the public health mechanisms, which may in the rarest and most exceptional cases involve the compulsory detention of individuals who pose a serious risk of infection to the wider community must be efficacious, necessary and justified, and proportional to the risks posed. Such steps should be exceptional and must follow careful and critical questioning of

the need for such constraints and the absence of any effective alternative. In such circumstances detention should be for as short a time as possible and be as limited in restrictions as feasible. There must also be a system of independent appraisal and periodic review of any such measures, including a mechanism for appeal by the patients themselves. Wherever possible alternatives to such detention should be used;

10. This model should be used in considering all steps to prevent cross infection and to treat existing infected persons within the prison environment.
11. Physicians working in prisons have a duty to report to the health authorities and professional organisations of their country any deficiency in health care provided to the inmates and any situation involving high epidemiological risk. NMAs are obliged to attempt to protect those physicians against any possible reprisals.
12. Physicians working in prisons have a duty to follow national public health guidelines, where these are ethically appropriate, particularly concerning the mandatory reporting of infectious and communicable diseases.
13. The WMA calls upon member associations to work with national and local governments and prison authorities to address health promotion and health care in their institutions, and to adopt programmes that ensure a safe and healthy prison environment.

## WMA Statement on Social Determinants of Health

*Adopted by the 62<sup>nd</sup> WMA General Assembly, Montevideo, Uruguay, October 2011*

The social determinants of health are: the conditions in which people are born, grow, live, work and age; and the societal influences on these conditions. The social determinants of health are major influences on both quality of life, including good health, and length of disability-free life expectancy. While health care will attempt to pick up the pieces and repair the damage caused by premature ill health, it is these social, cultural, environmental, economic and other factors that are the major causes of rates of illness and, in particular, the magnitude of health inequalities.

Historically, the primary role of doctors and other health care professionals has been to treat the sick – a vital and much cherished role in all societies. To a lesser extent, health care professionals have dealt with individual exposures to the causes of disease – smoking, obesity, and alcohol in chronic disease, for example. These familiar aspects of life style can be thought of as ‘proximate’ causes of disease.

The work on social determinants goes far beyond this focus on proximate causes and considers the “causes of the causes”. For example, smoking, obesity, alcohol, sedentary life style are all causes of illness. A social determinants approach addresses the causes of these causes; and in particular how they contribute to social inequalities in health. It focuses not only on individual behaviours but seeks to address the social and economic circumstances that give rise to premature ill health, throughout the life course: early child development, education, work and living conditions, and the structural causes that give rise to these living and working conditions. In many societies, unhealthy behaviours follow the social gradient: the lower people are in the socioeconomic hierarchy, the more they smoke, the worse their diet, and the less physical activity they engage in. A major, but not the only, cause of the social distribution of these causes is level of education. Other specific examples of addressing the causes of the causes: price and availability, which are key drivers of alcohol consumption; taxation, package labelling, bans on advertising, and smoking in public places, which have had demonstrable effects on tobacco consumption. The voice of the medical profession has been most important in these examples of tackling the causes of the causes.

There is a growing movement, globally, that seeks to address gross inequalities in health and length of life through action on the social determinants of health. This movement has involved the World Health Organisation, several national governments, civil society organization, and academics. Solutions are being sought and learning shared. Doctors should be well informed participants in this debate. There is much that can happen within the practice of medicine that can contribute directly and through working with other sectors. The medical profession can be advocates for action on those social conditions that have important effects on health.

The WMA could add significant value to the global efforts to address these social determinants by helping doctors, other health professionals and National Medical Associations understand what the emerging evidence shows and what works, in different circumstances. It could help doctors to lobby more effectively within their countries and across international borders, and ensure that medical knowledge and skills are shared.

The WMA should help to gather data of examples that are working, and help to engage doctors and other health professionals in trying new and innovative solutions. It should work with national associations to educate and inform their members and put pressure on national governments to take the appropriate steps to try to minimise these root causes of premature ill health. In Britain, for example, the national government has issued a public health white paper that has at its heart reduction of health inequalities through action on the social determinants of health; several local areas have drawn up plans of



action; there are good examples of general practice that work across sectors improve the quality of people's lives and hence reduce health inequalities. The WMA should gather examples of good practice from its members and promote further work in this area.

## WMA Resolution reaffirming the WMA Resolution on Economic Embargoes and Health

*Adopted by the 62<sup>nd</sup> General Assembly, Montevideo, Uruguay*

The World Medical Association is deeply concerned about reports of potential serious health impacts resulting from economic sanctions imposed by the European Union against Ivory Coast leader, Laurent Gbagbo, and numerous individuals and entities associated with his regime, including two major ports linked to Gbagbo's government. The sanctions aim to severely restrict EU-registered vessels from transacting business with these ports, which could inhibit the delivery of necessary and life-saving medicines.

The WMA General Assembly reiterates the following position from the *WMA Resolution on Economic Embargoes and Health*:

- *All people have the right to the preservation of health; and,*
- *the Geneva Convention (Article 23, Number IV, 1949) requires the free passage of medical supplies intended for civilians;*

The WMA therefore urges the European Union to take steps immediately to ensure the delivery of medical supplies to the Ivory Coast, in order to protect the life and health of the population.

## WMA Statement on the Protection and Integrity of Medical Personnel in Armed Conflicts and Other Situations of Violence

*Adopted by the 62<sup>nd</sup> General Assembly, Montevideo, Uruguay,  
October 2011*

### PREAMBLE

1. During wars and armed conflicts hospitals and other medical facilities have often been attacked and misused and patients and

medical personnel have been killed or wounded. Such attacks are a violation of the Geneva Conventions (1949), Additional Protocols to the Geneva Conventions (1977) and WMA regulations in times of war (2006).

2. The World Medical Association (WMA) has been active in condemning documented attacks on medical personnel and facilities in armed conflicts. The International Committee of the Red Cross (ICRC) Geneva Conventions and their Additional Protocols shall protect medical personnel in international and non-international armed conflicts. The warring parties have duty not to interfere with medical care for wounded or sick combatants and civilians, and not attack, threaten or impede medical functions. Physicians and other health care personnel must be considered as neutral and must not be prevented from fulfilling their duties.
3. The lack of systematic reporting and documentation of violence against medical personnel and facilities creates threats to both civilians and military personnel. The development of strategies for protection and efforts to improve compliance with the laws of war are impeded as long as such information is not available.

### STATEMENT

4. The World Medical Association condemns all attacks on and misuse of medical personnel, facilities and vehicles in armed conflicts. These attacks put people in need of help in great danger and can lead to the flight of physicians and other health personnel from the conflict areas with a lack of available medical personnel as a result.
5. Currently no party is responsible for collecting data regarding assaults on medical personnel and facilities. Data collection after attacks is vital to identify the reasons why medical personnel and facilities are attacked. Such data are important in order to understand the nature of the attacks and to take necessary steps to prevent attacks in the future. All attacks must also be properly investigated and those responsible for the violations of the Geneva Conventions and Protocols must be brought to justice.
6. The WMA requests that appropriate international bodies establish mechanisms with the necessary resources to collect and disseminate data regarding assaults on physicians, other health care personnel and medical facilities in armed conflicts. Such mechanisms could include the establishment of a new United Nations post of Rapporteur on the independence and integrity of health professionals. As stated in the WMA proposal for a United Nations Rapporteur on the Independence and Integrity of Health Professionals (1997), "The new rapporteur would be charged with the task of monitoring that doctors are allowed to move freely and that patients have access to medical treatment, without discrimination as to na-



tionality or ethnic origin, in war zones or in situations of political tension”.

7. When a reporting system is established the WMA will recommend to their member organisations reporting armed conflicts which they become aware of.

## WMA Resolution on the Access to Adequate Pain Treatment

*Adopted by the 62<sup>nd</sup> WMA General Assembly, Montevideo, Uruguay, October 2011*

### PREAMBLE

1. Around the world, tens of millions of people with cancer and other diseases and conditions experience moderate to severe pain without access to adequate treatment. These people face severe suffering, often for months on end, and many eventually die in pain, which is unnecessary and almost always preventable and treatable. People who may not be able to adequately express their pain – such as children and people with intellectual disabilities or with consciousness impairments – are especially at risk of receiving inadequate pain treatment.
2. It is important to acknowledge the indirect consequences of inadequate pain treatment, such as a negative economic impact, as well as the individual human suffering directly resulting from untreated pain.
3. In most cases, pain can be stopped or relieved with inexpensive and relatively simple treatment interventions, which can dramatically improve the quality of life for patients.
4. It is accepted that some pain is particularly difficult to treat and requires the application of complex techniques by, for example, multidisciplinary teams. Sometimes, especially in cases of severe chronic pain, psycho-emotional factors are even more important than biological factors.
5. Lack of education for health professionals in the assessment and treatment of pain and other symptoms, and unnecessarily restrictive government regulations (including limiting access to opioid pain medications) are two major reasons for this treatment gap.

### PRINCIPLES

6. The right to access to pain treatment for all people without discrimination, as laid down in professional standards and guidelines and in international law, should be respected and effectively implemented.

7. Physicians and other health care professionals have an ethical duty to offer proper clinical assessments to patients with pain and to offer appropriate treatment, which may require prescribing medications – including opioid analgesics – as medically indicated. This also applies to children and other patients who cannot always adequately express their pain.
8. Instruction on pain management, including clinical training lectures and practical cases, should be included in mandatory curricula and continuing education for physicians and other health professionals. Such education should include evidence-based therapies effective for pain, both pharmacological and non-pharmacological. Education about opioid therapy for pain should include the benefits and risks of the therapy. Safety concerns regarding opioid therapy should be emphasized to allow the use of adequate doses of analgesia while mitigating detrimental effects of the therapy. Training should also include recognition of pain in those who may not be able to adequately express their pain, including children, and cognitively impaired and mentally challenged individuals.
9. Governments must ensure the adequate availability of controlled medicines, including opioids, for the relief of pain and suffering. Governmental drug control agencies should recognize severe and/or chronic pain as a serious and common health care issue and appropriately balance the need to relieve suffering with the potential for the illegal use of analgesic drugs. Under the right to health, people facing pain have a right to appropriate pain management, including effective medications such as morphine. Denial of pain treatment violates the right to health and may be medically unethical.
10. Many countries lack necessary economic, human and logistic resources to provide optimal pain treatment to their population. The reasons for not providing adequate pain relief must therefore be fully clarified and made public before accusations of violating the right to health are made.
11. International and national drug control policies should balance the need for adequate availability and accessibility of controlled medicines like morphine and other opioids for the relief of pain and suffering with efforts to prevent the misuse of these controlled substances. Countries should review their drug control policies and regulations to ensure that they do not contain provisions that unnecessarily restrict the availability and accessibility of controlled medicines for the treatment of pain. Where unnecessarily or disproportionately restrictive policies exist, they should be revised to ensure the adequate availability of controlled medicines.
12. Each government should provide the necessary resources for the development and implementation of a national pain treatment plan, including a responsive monitoring mechanism and process for receiving complaints when pain is inadequately treated.



## WMA Statement on Health Hazards of Tobacco Products and Tobacco-Derived Products

*Adopted by the 40<sup>th</sup> World Medical Assembly, Vienna, Austria, September 1988 and amended by the 49<sup>th</sup> WMA General Assembly, Hamburg, Germany, November 1997 the 58<sup>th</sup> WMA General Assembly, Copenhagen, Denmark, October 2007 and the 62<sup>nd</sup> General Assembly, Montevideo, Uruguay, October 2011*

### PREAMBLE

More than one in three adults worldwide (more than 1.1 billion people) smokes, 80 percent of whom live in low- and middle-income countries. Smoking and other forms of tobacco use affect every organ system in the body, and are major causes of cancer, heart disease, stroke, chronic obstructive pulmonary disease, fetal damage, and many other conditions. Five million deaths occur worldwide each year due to tobacco use. If current smoking patterns continue, it will cause some 10 million deaths each year by 2020 and 70 percent of these will occur in developing countries. Tobacco use was responsible for 100 million deaths in the 20<sup>th</sup> century and will kill one billion people in the 21<sup>st</sup> century unless effective interventions are implemented. Furthermore, secondhand smoke – which contains more than 4000 chemicals, including more than 50 carcinogens and many other toxins – causes lung cancer, heart disease, and other illnesses in nonsmokers.

The global public health community, through the World Health Organization (WHO), has expressed increasing concern about the alarming trends in tobacco use and tobacco-attributable disease. As of 20 September 2007, 150 countries had ratified the Framework Convention on Tobacco Control (FCTC), whose provisions call for ratifying countries to take strong action against tobacco use by increasing tobacco taxation, banning tobacco advertising and promotion, prohibiting smoking in public places and worksites, implementing effective health warnings on tobacco packaging, improving access to tobacco cessation treatment services and medications, regulating the contents and emissions of tobacco products, and eliminating illegal trade in tobacco products.

Exposure to secondhand smoke occurs anywhere smoking is permitted: homes, workplaces, and other public places. According to the WHO, some 200,000 workers die each year due to exposure to smoke at work, while about 700 million children, around half the world's total, breathe air polluted by tobacco smoke, particularly in the home. Based on the evidence of three recent comprehensive

reports (the International Agency for Research on Cancer's Monograph 83, Tobacco Smoke and Involuntary Smoking; the United States Surgeon General's Report on The Health Consequences of Involuntary Exposure to Tobacco Smoke; and the California Environmental Protection Agency's Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant), on May 29, 2007, the WHO called for a global ban on smoking at work and in enclosed public places.

The tobacco industry claims that it is committed to determining the scientific truth about the health effects of tobacco, both by conducting internal research and by funding external research through jointly funded industry programs. However, the industry has consistently denied, withheld, and suppressed information concerning the deleterious effects of tobacco smoking. For many years the industry claimed that there was no conclusive proof that smoking tobacco causes diseases such as cancer and heart disease. It has also claimed that nicotine is not addictive. These claims have been repeatedly refuted by the global medical profession, which because of this is also resolutely opposed to the massive advertising campaigns mounted by the industry and believes strongly that the medical associations themselves must provide a firm leadership role in the campaign against tobacco.

The tobacco industry and its subsidiaries have for many years supported research and the preparation of reports on various aspects of tobacco and health. By being involved in such activities, individual researchers and/or their organizations give the tobacco industry an appearance of credibility even in cases where the industry is not able to use the results directly in its marketing. Such involvement also raises major conflicts of interest with the goals of health promotion.

### RECOMMENDATIONS

The WMA urges the national medical associations and all physicians to take the following actions to help reduce the health hazards related to tobacco use:

1. Adopt a policy position opposing smoking and the use of tobacco products, and publicize the policy so adopted.
2. Prohibit smoking, including use of smokeless tobacco, at all business, social, scientific, and ceremonial meetings of the National Medical Association, in line with the decision of the World Medical Association to impose a similar ban at all its own such meetings.
3. Develop, support, and participate in programs to educate the profession and the public about the health hazards of tobacco use (including addiction) and exposure to secondhand smoke. Programs aimed at convincing and helping smokers and smokeless tobacco users to cease the use of tobacco products and programs for non-smokers and non-users of smokeless tobacco products aimed at avoidance are both important.



4. Encourage individual physicians to be role models (by not using tobacco products) and spokespersons for the campaign to educate the public about the deleterious health effects of tobacco use and the benefits of tobacco-use cessation. Ask all medical schools, biomedical research institutions, hospitals, and other health care facilities to prohibit smoking, use of smokeless tobacco on their premises.
5. Introduce or strengthen educational programs for medical students and physicians to prepare them to identify and treat tobacco dependence in their patients.
6. Support widespread access to evidence-based treatment for tobacco dependence – including counselling and pharmacotherapy – through individual patient encounters, cessation classes, telephone quit-lines, web-based cessation services, and other appropriate means.
7. Develop or endorse a clinical practice guideline on the treatment of tobacco use and dependence.
8. Join the WMA in urging the World Health Organization to add tobacco cessation medications with established efficacy to the WHO's Model List of Essential Medicines.
9. Refrain from accepting any funding or educational materials from the tobacco industry, and to urge medical schools, research institutions, and individual researchers to do the same, in order to avoid giving any credibility to that industry.
10. Urge national governments to ratify and fully implement the Framework Convention on Tobacco Control in order to protect public health.
11. Speak out against the shift in focus of tobacco marketing from developed to less developed nations and urge national governments to do the same.
12. Advocate the enactment and enforcement of laws that:
  - provide for comprehensive regulation of the manufacture, sale, distribution, and promotion of tobacco and tobacco-derived products, including the specific provisions listed below.
  - require written and pictorial warnings about health hazards to be printed on all packages in which tobacco products are sold and in all advertising and promotional materials for tobacco products. Such warnings should be prominent and should refer those interested in quitting to available telephone quit-lines, websites, or other sources of assistance.
  - prohibit smoking in all enclosed public places (including health care facilities, schools, and education facilities), workplaces (including restaurants, bars and nightclubs) and public transport. Mental health and chemical dependence treatment centers should also be smoke-free. Smoking in prisons should not be permitted.
  - ban all advertising and promotion of tobacco and tobacco-derived products.
  - encourage the development of plain packaging legislation
  - prohibit the sale, distribution, and accessibility of cigarettes, and other tobacco products to children and adolescents. Ban the production, distribution and sale of candy products that depict or resemble tobacco products.
13. Recognize that tobacco use may lead to pediatric disease because of the harm done to children caused by tobacco use and second-hand smoke exposure, the relationship of tobacco use by children and exposure to adult tobacco use, and the existence of effective interventions to reduce tobacco use. Special efforts should be made by physicians to:
  - provide tobacco-free environments for children
  - target parents who smoke for tobacco cessation interventions
  - promote programs that contribute to the prevention and decrease of tobacco use by youth
  - control access to and marketing of tobacco products, and
  - make pediatric tobacco-control research a high priority
14. Refuse to invest in companies or firms producing or promoting the use or sale of tobacco.
  - prohibit smoking on all commercial airline flights within national borders and on all international commercial airline flights, and prohibit the sale of tax-free tobacco products at airports and all other locations.
  - prohibit all government subsidies for tobacco and tobacco-derived products.
  - provide for research into the prevalence of tobacco use and the effects of tobacco products on the health status of the population.
  - prohibit the promotion, distribution, and sale of any new forms of tobacco products that are not currently available.
  - increase taxation of tobacco products, using the increased revenues for prevention programs, evidence-based cessation programs and services, and other health care measures.
  - curtail or eliminate illegal trade in tobacco products and the sale of smuggled tobacco products.
  - help tobacco farmers switch to alternative crops.
  - urge governments to exclude tobacco products from international trade agreements.

## **WMA Declaration on Leprosy Control around the World and Elimination of Discrimination against Persons affected by Leprosy**

*Adopted by the 62<sup>nd</sup> WMA General Assembly, Montevideo, Uruguay, October 2011*

Leprosy is a widespread public health problem, with approximately 250,000 new cases diagnosed annually worldwide. It is a curable



disease and after starting treatment, the chain of transmission is interrupted. Leprosy is a disease that have been inadequately addressed from the point of view of investments in research and medical treatment.

The World Medical Association recommends to all National Medical Associations to defend the right of the people affected with leprosy and members of their families, that they should be treated with dignity and free from any kind of prejudice or discrimination. Physicians, health professionals and civil society should be engaged in combating all forms of prejudice and discrimination. Research centres should acknowledge leprosy as a major public health problem, and continue to research this disease since there are still gaps in understanding its patho-physiological mechanisms. These gaps in knowledge may be overcome through the allocation of resources to new research, which will contribute to more efficient control worldwide. Medical schools, especially in countries with high prevalence of leprosy, should enhance its importance in the curriculum. The public, private, and civil sectors should unify their best efforts in order to disseminate information that would counteract prejudice towards leprosy and that acknowledges its curability.

## WMA Resolution on Bahrain

*Adopted by the 62<sup>nd</sup> General Assembly, Montevideo, Uruguay, October 2011*

The WMA General Assembly notes that

A number of doctors, nurses and other health care professionals in the Kingdom of Bahrain were arrested in March 2011 after the civil unrest in that country and tried under emergency powers before a special court, led by a military judge. Twenty of this group were found guilty of a number of charges, on 29 September 2011 and sentenced to fifteen, ten or five years' imprisonment.

These trials failed to meet international standards for fair trials, including the accused not being allowed to make statements in their own defence, and their lawyers not being allowed to question all the witnesses. Allegations from the accused and their lawyers of mistreatment, abuse and other human right violations during arrest and while in detention have not been investigated.

While various criminal charges were brought it appears that the major offence was treating all the patients who presented for care, including leaders and members of the rebellion. Other charges appear to be closely related to providing such treatment and were, in any case, not proven to the standard expected in court proceedings. In treating patients without considering the circumstances of their

injury these health care professionals were honouring their ethical duty as set out in the Declaration of Geneva.

The WMA welcomes the announcement by the government of Bahrain of 6 October 2011 that all twenty will be re-tried before a full civil court.

Therefore, the WMA requires that no doctor or other health care professional be arrested, accused or tried for treating patients, regardless of the origins of the patient's injury or illness.

The WMA demands that all states understand, respect and honour the concept of medical neutrality. This includes providing working conditions which are as safe as possible, even under difficult circumstances, including armed conflict or civil unrest.

The WMA expects that if any individual, including health care professionals, are subject to trial that there is due process of law including during arrest, questioning and trial in accordance with the highest standards of international law.

The WMA demands that states investigate any allegations of torture or cruel and inhumane treatment by prisoners against its agents, and act quickly to stop such abuses.

The WMA recommends that independent international assessors are allowed to observe the trials and meet privately with the accused, so that the state of Bahrain can prove to the watching world that the future legal proceedings follow fair process.

The WMA recognises that health care workers and health care facilities are increasingly under attack during wars, conflicts and civil unrest. We demand that states throughout the world recognise, respect and honour principles of medical neutrality and their duty to protect health care institutions and facilities for humanitarian reasons.

## WMA Resolution on the Independence of National Medical Associations

*Adopted by the 62<sup>nd</sup> WMA General Assembly, Montevideo, Uruguay, October 2011*

National medical associations are established to act as representatives of their physicians, and to negotiate on their behalf, sometimes as a trade union or regulatory body but also as a professional asso-

ciation, representing the expertise of medical doctors in relation to matters of public health and wellbeing.

They represent the views of the medical profession, including attempting to ensure the practice of ethical medicine, the provision of good quality medical care, and the adherence to high standards by all practitioners.

These associations may also campaign or advocate on behalf of their members, often in the field of public health. Such advocacy is not always welcomed by governments who may consider the advocacy to have oppositional politics attached, when in reality it is based upon an understanding of the medical evidence and the needs of patients and populations.

The WMA is aware that because of those advocacy efforts some governments attempt to silence the medical association by placing its own nominated representatives into positions of authority, to subvert the message into one they are better able to tolerate.

The WMA denounces such action and demands that no government interferes with the independent functioning of national medical associations. It encourages governments to understand better the reasons behind the work of their national medical association, to consider the medical evidence and to work with physicians to improve the health and well being of their populations.

## WMA Declaration of Montevideo on Disaster Preparedness and Medical Response

*Adopted by the 62<sup>nd</sup> WMA General Assembly, Montevideo, Uruguay, October 2011*

In the last decade, the attention of the world has been drawn to a number of severe events which seriously tested and overwhelmed the capacity of local healthcare and emergency medical response systems. Armed conflicts, terrorist attacks and natural disasters such as earthquakes, floods and tsunamis in various parts of the world have not only affected the health of people living in these areas but have also drawn the support and response of the international community. Many National Medical Associations have sent groups to assist in such disaster situations.

According to the World Health Organization (WHO) Center for Research on the Epidemiology of Disasters (CRED), the frequency, magnitude, and toll of natural disasters and terrorism have increased

throughout the world. In the previous century, about 3.5 million people were killed worldwide as a result of natural disasters; about 200 million were killed as a result of human-caused disasters (e.g., wars, terrorism, genocides). Each year, disasters cause hundreds of deaths and cost billions of dollars due to disruption of commerce and destruction of homes and critical infrastructure.

Population vulnerability (e.g., due to increased population density, urbanization, aging) has increased the risk of disasters and public health emergencies. Globalization, which connects countries through economic interdependencies, has led to increased international travel and commerce. Such activity has also led to increased population density in cities around the world and increased movement of people to coastal areas and other disaster-prone regions. Increases in international travel may speed the rate at which an emerging infectious disease or bioterrorism agent spreads across the globe. Climate change and terrorism have emerged as important global factors that can influence disaster trends and thus require continued monitoring and attention.

The emergence of infectious diseases, such as H1N1 influenza A and severe acute respiratory syndrome (SARS), and the recent arrival of West Nile virus and monkey pox in the Western hemisphere, reinforces the need for constant vigilance and planning to prepare for and respond to new and unexpected public health emergencies.

The growing likelihood of terrorist-related disasters affecting large civilian populations affects all nations. Concern continues about the security of the worldwide arsenal of nuclear, chemical, and biological agents as well as the recruitment of people capable of manufacturing or deploying them. The potentially catastrophic nature of a "successful" terrorist attack configures an event that may demand a disproportionate amount of resources and healthcare professionals preparedness. Natural disasters such as tornadoes, hurricanes, floods, and earthquakes, as well as industrial and transportation-related catastrophes, are far more common and can also severely stress existing medical, public health, and emergency response systems.

In light of recent world events, it is increasingly clear that all physicians need to become more proficient in the recognition, diagnosis, and treatment of mass casualties under an all-hazards approach to disaster management and response. They must be able to recognize the general features of disasters and public health emergencies, and be knowledgeable about how to report them and where to get more information should the need arise. Physicians are on the front lines when dealing with injury and disease—whether caused by microbes, environmental hazards, natural disasters, highway collisions, terrorism, or other calamities. Early detection and reporting are critical to minimize casualties through astute teamwork by public- and private-sector health and emergency response personnel.

The WMA, representing the doctors of the world, calls upon its members to advocate for the following:

- To promote a standard competency set to ensure consistency among disaster training programs for physicians across all specialties. Many NMAs have disaster courses and previous experiences in disaster response. These NMAs can share this knowledge and advocate for the integration of some standardized level of training for all physicians, regardless of specialty or nationality.
- To work with national and local governments to establish or update regional databases and geographic mapping of information on health system assets, capacities, capabilities, and logistics to assist medical response efforts, domestically and worldwide, when needed. This could include information on local response organizations, the condition of local hospitals and health system infrastructures, endemic and emerging diseases, and other important

public health and clinical information to assist medical response in the event of a disaster. In addition, systems for communicating directly with physicians and other front line health care providers should be identified and strengthened.

- To work with national and local governments to ensure the developing and testing of disaster management plans for clinical care and public health including the ethical basis for delivering such plans.
- To encourage governments at national and local levels to work across normal departmental and other boundaries in developing the necessary planning.

The WMA could serve as a channel of communication for NMAs during such times of crisis, enabling them to coordinate activities and work together.

## Report on the World Conference on the Social Determinants of Health

*Rio de Janeiro, Brazil, 19–21 October 2011*



*Vivienne Nathanson*

When the Global Commission on the Social Determinants of Health (Closing the Gap in a Generation) reported to the WHO in 2009, one of its recommendations was that a global conference should be held to take forward its recommendations, to deliver commitments from governments and

to ensure that learning from the commission report and subsequent actions in different countries became embedded in governmental strategies.

In October, the conference was held in Rio de Janeiro. Hosted by the government of Brazil working with the WHO, the conference was an opportunity for activists, health care professionals and governments to come together and share this important agenda.

The conference was the largest WHO has pulled together since Alma Ata. Over 120 countries were present with ministers from the majority attending the ministerial “stream”. The question is whether Rio will become as seminal an event and the Rio Declaration as much of a “must read” for generations of health workers and policy advisers.

There could be no doubt from the opening of the conference that the government of Brazil “got it”. The various ministers, governors and the acting President (or their

respective speech writers) understood that this is not about simple inequities in health care access, but in the fundamental bases of health, wellbeing and prosperity. Poverty, education, access to education, housing, and work all matter; equitable access to health care complements these elements.

As Sir Michael Marmot states in his report, it is the conditions into which we are born and in which we grow, learn, live, work and age, that shape our expectation of health. It is by action within areas including the environment, housing and transport policies, access to employment, education, to food, clean water and sanitation that we can have an impact on children not yet born, and from their birth throughout their lives. Medicine and the delivery of health care can pick up some of the pieces, make good some elements of loss or damage but it cannot remove the differences these factors make to the lifelong expectations of health in people born into different circumstances.

In Brazil, we heard of work to raise tens of millions of people out of poverty; an essential step in securing the environmental and other factors that will promote health rather than cause illness. Reducing poverty means an improvement in living conditions every day for individuals, families and communi-

ties. But financial, power and resource differences remain in every society.

The gradients seen in every health and well-being measurement between the richest and poorest, the best and least well educated, those employed and those under or unemployed, the powerful and the powerless all remain. In countries where such social difference are relatively small, such as Finland, the differences between those with power, resources, money, education and so on and those without are relatively small. In most countries, where such differences can be very large, the differences can be enormous. The conference heard examples of differences within countries; in Glasgow, Scotland a 28 year difference in male life expectancy for those born a mere five kilometres apart. Similar pictures exist everywhere, but not always this extreme, and disparities also exist between countries. The North/South divide is seen in social determinants terms, with the poorest countries showing the lowest life and health expectancies. As well as the gradients between countries, even the poorest country has gradients within it.

Concentrating efforts to improve health and wellbeing on the poorest means missing out on the opportunity to help those just a little higher up the income, social class and other ladders, who are also falling far short of the best. This means either we tailor many different plans to deal with people in different groups or we work in a different manner to deal first with the underpinning causes of the causes of ill health.

If, in all our countries, we could not only reduce absolute poverty but ensure that the inequitable distribution of wealth, power and resources was lessened, producing a flatter curve on all these variables, we would be going a long way towards producing better daily living conditions for all our populations. If that work looked not only at our own countries but considered global resources, we would be able to affect the inequities between countries as well as within them.

But these interventions are not things that can be undertaken by one group alone. Time after time throughout the conference, speakers referred to working across disciplines, across government departments and across natural boundaries. The silo mentality of thinking will not and cannot work.

For doctors this is an interesting challenge. We are amongst the best educated members of our societies. Our education is focused on health and illness; thinking about well-being requires changing our mind-frames and normal spheres of reference. But our strength is that we are trained to examine the evidence, to consider trends, statistics, evidence bases and information and to critically appraise it. We are also well versed in the importance of evidence and of testing, monitoring and reviewing actions and activities. This will be essential as policy shifts strategically. If we fail to measure and to critically appraise and evaluate actions, we will fail to make effective policies.

### So what was said at the conference?

Firstly, and of course, every speaker recognised the importance of SDH, and of a social determinants based approach to health. Equally, however, it was clear that many of the speakers, especially those representing health ministries, were struggling with the concept, and were too willing to revert to discussing methods of dealing with inequities in access to health care.

One interesting technique used at the conference was to have a journalist interview speakers, rather than having too many "talking heads". Zeinab Badawi of the BBC, who hosts their daily World News and the series Hard Talk, filled several linked roles. On the opening day, immediately after the formal opening session, she chaired a panel in which she asked questions of a number of speakers. Her questions were incisive, demonstrated a real knowledge of the subject,

and as with good journalism attempted to get real answers from the politicians on the panel.

At the opening of the second day, she showed a film she had made in Rio and elsewhere talking to the public and highlighting the huge differences in life and health expectancy within and between countries.

Based as she is in the UK, she picked up the Glasgow example where life expectancy in men can vary by 28 years depending upon where they are born, live, work and age. There are many factors that adversely affect boys born into this part of Glasgow. They include the greatly increased risks of premature death due to violence, suicide and drug use, including alcohol and tobacco. There are also other factors common in the poorest populations in developed world countries, such as low educational attainment, poor employment prospects leading to insecure employment, and poorly paid employment. Housing is also worse for this cohort. So there are many factors which can in and of themselves lead to, for example, little hope for a better future, and therefore an increased risk of involvement in high risk activities such as drug and alcohol abuse.

These factors seen in poverty are the causes of the causes of ill health, and even the most equitable health care system in the world cannot deal with these factors and their consequences.

The interesting experiment in Brazil, to bring millions out of poverty, giving families money and tokens to use to buy food, household cleaners, and education, may well make a difference that passes through generations.

The Brazilian minister emphasised that this programme did not ignore the economic context. Policies are holistic and consider poverty and family allowances and seek to ensure no back slipping in social policies. They try to link human development with



new jobs. Redistribution of resources has, in Brazil, brought 28 million out of poverty and into the middle classes. They have used financial interventions to build up and underpin minimum wages and family finances. There is universal access to social and health care services. Specific schemes include a family tax credits schemes (conditional tax allowances) for 50 million Brazilians, and a programme which helps three million elderly. These schemes help to keep children in school, and better nourished. They are also still working to increase the minimum wage and other social benefits. Brazil accepts that it cannot eradicate poverty, but it is trying to improve incomes, opportunities, education, social welfare and security and to provide universal access, not least by targeting areas where poverty is rampant. Gains are emblematic and practical.

There are still problems. As Ms Badawi asked the minister, "Is there not a danger that a male family member might take the tokens by force to use to support, for example, his alcohol habit?", the reply was worryingly complacent, "This never happens." As doctors we know that even in the best regulated system such abuses are inevitable; the question for those running the system is what you can do to minimise that risk, especially as it carries an increased level of risk to the woman given the tokens, with the state essentially increasing her likelihood of being a victim of abuse.

### Soundbites from the opening session included the following from Margaret Chan

Margaret Chan of WHO stressed that there are elements in what needs to be done that stretch through all areas of life. We must embed social equity into mindsets and actions; if we succeed, we may have an effect. Millions of lives are cut short as the right policies are not in place. Governments worldwide could lift more than a billion

people out of poverty. All governments have a responsibility for the health of populations, which includes dealing with social issues. How many do not have a safety net to stop people from falling into poverty because of catastrophic medical bills?

Globalisation has benefits but has no rules to ensure fair dispersal of those benefits. The goal of advocates of globalisation is to produce benefits; consideration of the fair distribution is rarely an aim. The world is out of balance in health terms. This also means it is neither stable nor secure.

She went on to stress that there had been two momentous events in 2011: the Arab Spring and the UN conference on Non Communicable Diseases. Left unchecked, NCDs cancel out the benefits of modernisation and break the bank. It is essential that we tackle NCDs in all parts of the world. In the less developed world, such diseases are often diagnosed late. This can lead to catastrophic medical expenses for individuals and their families, and cause billions of lost incomes in terms of tax, as well as pushing millions below the poverty line.

Big tobacco's attempts to derail tobacco policies continue and, in Dr. Chan's view, the tobacco industry has reached a new low.

The challenges are enormous. Will governments put the health of all people ahead of the health of corporations? There are compelling personal and economic reasons for acting and, in many cases, we know what works. The benefits of real success in reducing the Social Determinants are a prize worth fighting for.

### Soundbites from Andreas Laverdos, Health and Social Solidarity Minister in Greece

He spoke about trying to maintain better social equity at a time of huge social and eco-

nomie pressures. It is widely known how bad the economic problems in Greece are. There is no time to hesitate; it is essential that the government get it right, and lower the cost of health care services while improving quality and equity. The health care system deals with 30% more cases than before 2009, with 20% less resources. It is essential that Greece decreases salaries and presses for better use of human and physical resources. They are seeking to assure the best buying of materials. They are also undertaking structural reforms, merging hospitals and departments within them, and upgrading the role of primary health care services.

They are also looking at who gets access to the health care system and seeking to improve public health. One practical example is that the waiting list for drug detoxification treatment used to be seven years and is now one month.

An excellent question from Ms Badawi on mental health in times of economic crisis led to a brief discussion of the lack of discussion of mental health at the NCD summit. While all accept that time and therefore the agenda was limited, there was certainly concern in the hall that this essential area was omitted.

### Soundbites from Kathleen Sebbelius, Secretary for Health in the USA

She explained that they are active in the US at trying to improve health coverage for marginalised peoples, including the elderly. They are working to promote inter-sectoral collaboration.

USA believes that working together we can produce a better world. Social causes of disease cost people and economies dear. Diabetes and Cardiovascular Disease cost billions but very few health care dollars are spent on prevention. The current trend is



that one in three children born in the USA will suffer from diabetes; higher rates are seen in Hispanic and African communities. This is imposing an economic burden on us all. The cost of poor health is continuing to grow.

It is essential to have a broad agenda to make sure every citizen has a chance to live well. She went on to say that we must recognize that health is not a health care issue. We must design neighbourhoods to make it easier to walk and cycle. Every government department is involved; every government decision should be considered to establish what the health consequences will be; an essential tool for Health in All Policies.

## Soundbites from Rebecca Greenspan of UN development agency

She identified some important areas for understanding and action including that poor people pay more for water, power supplies, etc. She also stressed that women are poor in terms of income and of time, which is itself an important driver of poor health.

During the discussion a number of other important points were raised. Societal and cultural influences are very important. Issues such as access by women to reproductive and health rights are very important, but no one seems to want to deal with this topic.

## The second session opened with Ms Badawi's film and then interviews with Sir Michael Marmot and Kathleen Sebbelius

The discussion with Michael Marmot addressed the issue of prioritisation. With so



*Prof. Sir Michael Marmot*



*Dr. Margaret Chan, WHO Director – General*

much needing to be done what do you do first? How do you set priorities? What is the most important action?

Sir Michael said we must first look at the problem, and consider doing things such as empowering and educating women, changing their life expectancy. We should recognise that all differences in life expectancy are preventable.

As a priority we must first determine to take a life course approach, and then there are priorities for all areas of that life course.

Ms Badawi asked how you do this in the current global economic crisis. Sir Michael commented that currently income inequalities are increasing almost everywhere. But governments can save money if they improve early child development and education. Giving all children better education increases happiness, and, for example, leads to less civil disruption including riots. Every dollar spent on early child development saves seven; this is good news economically. We cannot afford not to do this.

We are at a time of dramatic change. We now recognise this is not only about poverty and absolute deprivation. We are also seeing the gradient in health. The nature and content of our discussions has changed dramatically, hence the agenda for the global commission. Individuals must be at the centre of our considerations. We must

seek to empower people and create the conditions for individual to have control over their lives, which requires changes to social conditions.

In a second interview setting the scene for the day of workshops, Kathleen Sebbelius was interviewed.

The main determinants in US are poverty and education. While poverty crosses all racial and ethnic groups, leading are native Americans, African Americans and Hispanic people. They have more poverty with worse health outcomes. 1/3 of white children are obese, 40% of African Americans and Hispanic people are obese. In response to a question as to what health problems have arisen from neglect of NCDs, Secretary Sebbelius stated that as well as health costs there are workplace costs associated with absenteeism. These costs amount to two and a half trillion dollars a year. President Obama cannot fix the US economy without first fixing health and health care. The major cause of personal bankruptcy in the USA is health care costs. 2 1/2 trillion dollars on health are each year. Obama cannot fix the economy without fixing health and health care. Major reason for bankruptcy is health care costs.

Her department is now working in this area. One major focus is on prevention, wellness, etc recruiting more providers with cultural competency in barrio culture to access those traditionally hard to reach with health promotion interventions. There is a new focus on health and wellness in schools, reintroducing exercise classes and changing school diets. Identification of this strategy to improving health is now better resourced.

The conference then broke into different streams, with workshop presentations and discussions.

Although the conference was meant to be inclusive, it was noticeable that at each of



*President of WMA Dr. José Luiz Gomes Do Amaral (first from the right) during the discussion*

the workshops a wide panel of presenters each spoke, followed by questions clearly flagged up in advance; many respondents reading out pre-prepared answers. Few if any questions were taken from the floor, leaving the large numbers from civil society organisations and non-governmental organisations frustrated at the lack of interest in their views.

It was also noticeable that in answering questions, even those partially or wholly scripted, some speakers slipped into the old concept and reverted to discussing equitable access to health care, not equitable access to health. One minister was asked about whether educating women was important and responded, that it was at that made them better able to understand hygiene in the home! While we have come a long way in getting governments to speak about and espouse the cause of SDH, it is clear that many still fail to understand the core concepts. On the final morning, Ms Badawi

opened with a short film of interviews with people attending the conference and then interviews with a panel.

During this and a subsequent high level panel session chaired by Riz Khan of Al Jazeera, groups representing public and calling for a stronger voice for people made their voices heard.

A few short soundbites are set out below.

- Good governance brings transparency for public participation and leadership.
- Why is there a ten year gap in life expectancy between indigenous people and the rest of the population of Canada?
- We must deal with inequities. Health equity is a justice issue. And it is one that is cost effective to deal with.
- If countries addressed global commission's recommendations, they would improve the equity issue. A life cycle approach is at the centre of UNFPA approach.

- 50% of maternal deaths happen in Africa which has just 14% of world population. Why?
- Why are trade and food insecurity not in the Rio declaration? Agricultural subsidies are rampant and hugely increase food insecurity.
- We must consider unfair trade in health personnel. Africa and Asia are being stripped of their skilled personnel. We should look at compensation for brain robbery.
- Migration is an underconsidered issue. There are 214 million international migrants and 740 million internal migrants, eg in China. Migrants almost always ignored including in global commission on SDH. Since 1980s has been a feminisation of migrants.

At this point, there were some few questions from the floor, including a sideswipe at politicians, accused of being corrupt and bought off by commercial organisations such as tobacco and alcohol industries.

During the final session, another element that arose was the needs of indigenous peoples. These groups are, in every country, likely to be those at the bottom of the gradient in health and wellbeing. The reasons are often very similar; they are often in the worst housing, with the highest rates of poor educational achievement and therefore poor employment opportunities. In addition, in many countries they may have a far higher than average rate of alcohol or other drug dependence, which in addition to dire health consequences further reduces their opportunity to get and keep well paid employment. As a group, they are often seriously distanced from the wishes and aspirations of the rest of society, leading to further social distancing and isolation. Their social and cultural values may be dismissed by the larger society. To our shame, many societies do not care about this distancing, and rather than seeing it as something that the whole society should address, seeking a solution that works for all social and cultural groups,

societies may further reject their indigenous people.

And then, in the final session, the Rio Declaration was adopted. It is remarkably quiet in its references to the Global Commission report which led to the conference; perhaps the leadership is not ready to take on vested interests, including those of the 1% who control so much of global resources. Those of us who were not part of national delegations came away revitalised and reinvigorated, with new contacts, new role models and renewed hope that we can make a difference.

As Peter Carmel of the American Medical Association says of Michael Marmot, he is a quiet revolutionary. The need for that revolution is real and profound. Unless we

change the way in which all our societies consider the rights of all, and then act on those values to produce systems in which every person has an opportunity to thrive throughout their life, then we will continue to see gradients in health and wellbeing. These gradients are worsening in many countries where new techniques, knowledge and actions that improve the likelihood of achieving a good health outcome are the advantage most often taken by the educated élites. They therefore enjoy the best health improvements. To reduce the gradients, we must get the least well educated, the least affluent to aspire to better health, to demand educational and employment opportunities and to follow that with improved access to health promotion and ill health prevention as well as treatment for existing illness.

There are elements of good news. As Marmot told Zeinab Badawi, every dollar spent on child health improvement reaps a seven dollar reward so even the most reluctant politician may see the financial sense, if not the moral imperative. But the best news is that social movements to change the world, to give everyone a vice and an opportunity are spreading like wildfire. Change will happen, with or without governments. The people will make sure that we do “Close the Gap” in a generation. Michael Marmot’s quiet revolution is underway.

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## What can be Gained by Developing Psychological Therapies for the General Public?



Anita Timans

It is well known that both new diagnoses of psychiatric disorders and the suicide rate have gone up alarmingly since the recent

world financial crisis began, but the background psychiatric morbidity in most of Europe was already of concern. This paper looks at a previously relatively poorly served part of South London, which developed comprehensive psychological therapies services over the last decade. Comparisons are drawn with potential service development in Latvia and other similar states.

Currently about 18% of the adult population of England has at least one common mental disorder. A similar proportion experiences “subthreshold symptoms” [1]. Another survey found that 27% of the adult EU population had a mental disorder in the last year [2].

The King’s Fund, an organisation in England which researches important questions of funding, did a large survey of costs to society of mental health problems in 2006. They

looked at what might be described as “service costs” which included direct health and social care expenses. They added in, where possible, the expenses related to other “informal care”, and the criminal justice system. They also estimated costs to the state, especially the costs of lost employment. The current service costs for treating mental health disorders is around £22.5 billion pounds per year, whilst the cost of lost employment currently is £26 billion per year. There are estimates which add in other costs (e.g. time lost to work by family members looking after their unwell relatives). These estimates put the true total costs many times higher. In the EU, other researchers have found that the vast majority of the cost of mental ill health is not treatment. These studies looked at indirect costs marked by the loss of productivity due to early death, premature death or early retirement all of which mount up. The low direct costs of treatment contrast to the typical picture for somatic disorders.

The King’s Fund estimated various costs associated with depression, anxiety and personality disorders [8]. Something like 1.24 million people have a diagnosis of depres-



sion. The costs for treatment for depression in England in 2007 were approximately £1.7 billion. Lost employment brings the total cost to £7.5 billion. This doesn't include all the other associated costs. The number of people with anxiety disorders is estimated to be 2.3 million. The costs of treatment and for lost employment are about £8.9 billion. The prevalence of personality disorders in the community is estimated to be at least 5.8%. Thus at least 2.5 million people have a significant personality disorder. With lost employment, the costs come up to £8 billion for 2007.

In 2000, it was estimated that mental health could cost as much as 3 to 4% of the GNP of the EU states [3]. In 2006, the cost of depression corresponded to 1% of the total economy of Europe (GDP) [4]. Typically the early onset, high prevalence, persistence, and low treatment rates lead to high levels of disability in most EU countries.

Disability-adjusted life years (DALYs) are a measure of overall disease burden, and the number of years lost due to ill health, disability or early death. DALYs combine mortality and morbidity into a single common measure. The WHO (2008) figures for the UK in percentages are for cancer 16%, cardiovascular disease 16.2% and mental disorder 23%.

It has been found that mental health problems occupy at least one third of family doctor's time. In the UK no other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact. The reach of poor mental health is very wide [6]. It is not only on the patient, but the patients' families and community in general. For instance, children of parents with mental health problems can become young carers, and damage their own future mental health prospects. The effects also include poor educational outcomes for adults, and school dropouts among the children of those with mental health disorders.

Of course, there can be serious problems with employment. Sickness absence and chronic underperformance build up to a very significant matter for both patients and their employer. There is an association between poor mental health and poor diet, less exercise, more smoking, and alcohol and drug misuse which all have further consequences. Then there are the impacts on physical health. Patients with mental health difficulties in general suffer from reduced life expectancy. Depression is, for instance, associated with 50% increased mortality from all deaths. Anti-social behaviour of various types can be a consequence. Of course, there is the stigma and discrimination suffered by many with psychiatric disorders, which can become prolonging factors themselves.

In June 2006, the London School of Economics (LSE) produced a major report on depression and anxiety in the general population. This stated, "Crippling depression and chronic anxiety are the biggest causes of misery in Britain today... They are the great submerged problem which shame keeps out of sight. In Britain, only one in four of those who suffer from depression or chronic anxiety receives any kind of help. This is a waste of people's lives, and it is also costing a lot of money. The depression and anxiety make it difficult or impossible to work and drive people onto benefits" [7].

In Britain, it is noted we now have a million people on Incapacity Benefits because of mental illness. Whilst there are patients who have a diagnosis of schizophrenia, the great majority of the claimants have depression, anxiety disorders, and mixed depression and anxiety. There is another group of people not covered directly by the LSE report. These are the patients with a diagnosis of personality disorder or difficulties. It seems likely that many patients with chronic depression and anxiety may have elements of personality difficulties "hidden behind" the primary diagnosis. It is this which sometimes makes them

harder to treat. Of course, the costs of psychosomatic disorders should not be forgotten.

Whilst depression and anxiety account for a third of all disability in mental health disorders, they attract only a small percentage of health expenditure. Most finance usually goes to patients who suffer from schizophrenia or bipolar affective disorder and, of course, dementia.

There is also a great deal of evidence on how depression/anxiety in particular effect the quality of life in the Primary Care population [9]. Anxiety and depressive symptoms have been found to be significantly associated with difficulties in all domains of quality of life. As anxiety or depressive symptoms increase, the quality of life decreases. Furthermore, patients with moderate to severe anxiety or depressive symptoms suffer greater impairments in most quality of life domains than those with congestive heart failure or diabetes.

Mental well-being has increasingly been used as another way to look at mental health. There are numerous ways of describing mental well-being. The simplest definition of wellness is as an absence of mental ill health and thus the absence of the consequences noted earlier.

A well-known model is that of Myers, Sweeney and Witmer [10]. After reviewing literature from multiple disciplines, they concluded that wellness is:

a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving.

They divided the characteristics, which have been noted in good mental health, into twelve domains. These are having a sense

of worth, sense of control, realistic beliefs, emotional awareness and coping, problem solving and creativity abilities, a sense of humour, balanced nutrition, adequate exercise, appropriate self-care, ability to manage stress, a sense of gender identity, and a sense of cultural identity.

Studies on well-being in Europe give fascinating insights into the different cultural environments, the wealth and the history of individual countries. Improving mental well-being has been shown to improve resilience to a broad range of adversity, reduce physical and mental illness plus health care use and mortality [11,12].

As one might expect, the benefits outside health include improved educational outcomes, reduced anti-social behaviour and substance misuse, healthier lifestyle/reduced risk factors plus increased productivity in work and elsewhere and stronger social relationships.

There is an increasing understanding that we need to have wider mental health strategies, which emphasises good mental health is essential for everyone [13]. It is hoped that more people will have good mental and physical health and recover if they have been ill, plus experience less stigma and discrimination.

Many governments have been looking at a variety of ways to improve services for mental health patients. This has generated considerable work on evidence bases for the psychological therapies, their cost-effectiveness and outcomes of therapy at local and wider levels.

The United Kingdom government are intending to improve mental health services, and in particular psychological therapy services by trying to put patients at the centre in shared decision making, giving choice and information to patients and by making sure there is quality at the centre of the psychological therapies service. Patient choice

is taken seriously in the United Kingdom. Emphasis is given to aspects of care such as easy access to services, and special requirements of minority groups of various descriptions. It has, for instance, proven harder for men to take their mental health seriously, and indeed for service providers to take men's mental health seriously enough.

This is not to dismiss other important aspects of care especially for patients with depression. These are notably medication and for more complex patients in particular – social care. This important work is already done in the UK, by psychiatrists and their teams at the more complex level, and by family doctors and nurses plus others at primary care level.

Of course, depression can be well treated by medication. For many patients, that is an essential or an important part of the treatment, and, of course, it is cost-effective. Certainly there is excellent evidence of medication being extremely useful for many patients with psychiatric disorders. Some patients want this and nothing else.

However, for many patients, the addition of a psychological therapy to medication is vital. There is also increasing evidence that this is the case. For other patients, medication is not helpful, or makes a minimal impact. Some find the side effects intolerable or for some other reason find it impossible to take it.

A substantial group of patients with depressive, anxiety-related or psychosomatic disorders have symptoms that are clearly linked to previous history or current life problems. The taking of medication is just not a long-term solution to their difficulties. There is increasing evidence that a variety of psychotherapies are useful in treating such symptoms and disorders. Patients with personality disorders rarely respond to medication, except for some symptomatic relief. Medication is actively discouraged for

patients with a diagnosis of personality disorder, according to recent United Kingdom government guidance [14].

Setting up comprehensive psychological therapies service for all who might want or need them has got to be balanced against a reality of what a country can afford at any one time. Of course, not everything can be done at the same time. However, currently the British Government is rolling out a programme of services called "Improving Access to Psychological Therapies" (IAPTS) for the patients with primary care level depression and anxiety disorders [15]. This is a service which works with general practitioners. IAPTS treats all those who need relatively brief psychological therapy at Primary Care level. In our circumstances, Cognitive Behavioural Therapy and Interpersonal Therapy initially formed the great majority of this service. This complemented the psychodynamic psychotherapy available in the voluntary sector in the United Kingdom. Interpersonal Therapy can most conveniently be described as a "relative" of Psychodynamic Psychotherapy, though in a rather specialised focused format. The remit of IAPTS has now expanded to health-related and somewhat more complex conditions. IAPTS has added counselling of a short-term nature, short-term Psychodynamic Psychotherapy, couple work and a variety of problem solving type interventions to its portfolio. It is set up to be closely linked to employment services and involves the voluntary sector to help people begin to think about a return to work or vocational training. Despite the current economic problems in the United Kingdom, this continues to be funded.

Traumatic events and losses are closely linked to all the above mentioned conditions, particularly personality and psychosomatic disorders. Attachment theorists know that broken and disturbed early life attachments can lead to lifelong difficulties, but not only for those who suffer the



traumas and losses. The effects can be trans-generational, and thus can be passed to the children of those who experienced them originally. There is therefore a special need in many highly traumatised states, given their history, for the possibility to access somewhat longer-term Psychodynamic Psychotherapy, which particularly effectively tackles such difficulties. There is, of course now, a developing evidence base with exciting prospects. A newer form of brief psychodynamic psychotherapy, currently being researched in the USA and Canada, looks as if it will be particularly useful in treating patients with medically unexplained symptoms [16]. The cost savings of such interventions could be massive if a significant percentage of patients could improve their functioning and, for instance, be less dependent on relatives or even in the longer-term return to work.

Psychodynamic Psychotherapy can also make considerable changes to patients with a wide variety of complex presentations at secondary care level especially with traumatic, abusive or emotionally neglectful backgrounds [17].

A good example of the changes brought about by the government policies in the last decade is that of Croydon, a large borough in South London. Croydon has a population of about 330,000 which is ethnically and economically very diverse. It would be unrealistic to say that everything is perfect now or that anything has been achieved without considerable work. Ten years ago, there were relatively few psychological therapy services for patients who had what might be broadly called by the old-fashioned term "neurotic disorders", psychosomatic disorders and personality disorders within the National Health Service. Some psychologists covered parts of general psychiatry, which in the main were rather dated. There were some Primary Care level therapists and opportunities for a number of patients to find therapy in the voluntary and private sectors.

The last decade has brought numerous developments at various levels of care. The Croydon services now cover all levels of psychological therapies from mild depression, anxiety and associated disorders, to those suitable for extremely complex multi-diagnostic patients with personality disorders. There is a developing IAPTS.

A Croydon-wide department covers the psychological therapy needs of secondary care level patients who come mostly but not solely from the general psychiatric services. There is also an all-encompassing service for patients with a diagnosis of personality disorder or difficulty, with "built-in easy access". The work carried out by psychiatrists and managers re-structuring the general psychiatric services should not be minimised, nor should the increasing volume of work, mainly of psychodynamic nature done in the voluntary sector. The voluntary sector is, paradoxically, extensively supported by the government. In Croydon, there is, for instance, a particularly effective voluntary sector service for teenagers and young adults up to the age of 25.

To achieve major change, however, adequate funding was needed. This is essential if the wider population is to be reached. Strong leadership and excellent management skills were also vital to ensure that services were set up efficiently and remained highly competent, but also cost-effective.

Outcome measuring is carried after treatment, and for instance, within the psychological therapies service in Croydon significant improvements in levels of depression, anxiety and personality disorder have been recorded. These are fed individually to patients and in collated form to patient representative groups and those who fund the services.

An area, which was often neglected in the past, is that of the patients' own wishes about what would be particularly useful for their problems in their particular locality.

The involvement of patients and their carers or families has been invaluable. A wide range of ways has been used to try and help to obtain their views. There are, of course, many complications with getting genuine feedback from an appropriately wide range of people. However, matters such as the physical location of services and having appropriate access for ethnic minorities have been influenced for the benefit of the local people.

However, some of the best expressions of the change can be obtained from patients themselves. The Croydon mental health services run forums for patients to give feedback, both good and bad, to those running the services. A patient recently talked about how things had changed for her. She began by saying that she had woken up next to her husband, peeped in at her sleeping child before going downstairs, having an orange juice and some toast. As she ate, she thought about her day's work schedule. The former patient noted that this was ordinary for most people in the room, but for her a few years before it would have been unimaginable. She had been a chaotic young woman whose life was risky, and who seriously self-harmed on a regular basis, for which she frequently attended the emergency service at our local general hospital. She had significant mood swings, and vicious arguments with anyone she knew including boyfriends. She binge drank alcohol and her physical health was already deteriorating. She had a significant Borderline Personality Disorder. The chances of her having a husband, let alone a child that would not be taken into care by social services, had seemed remote. The author of this article was also involved in her psychological treatment. She had come to the conclusion that things just could not go the way they were. Most of the people at the patient forum were deeply moved by what she said.

Of course, job insecurity, indebtedness and unemployment have a major part to play in the mental health of a nation's people.



There is a well-known long-term association between the wealth of a country and broad mental health. As one would expect, a higher level of wealth is associated with a higher level of good mental health [18]. But, of course, this is not the entire picture. More than the right economic changes are needed to improve mental health.

The current economic pressures, significant as they are, also reveal major underlying problems. As Robert Kennedy somewhat cheekily said in 1968, "Gross National Product measures everything, except that which makes life worthwhile". The main resource of any nation, of course, is its people. The quality of their mental health plays a vital part in the functioning of the state.

Of course, there will be some people who are either unwilling or unable to take on any form of psychotherapy or indeed any kind of treatment. There will be people on whom it will have minimal effect. This is true of all treatments in medicine. However, if it is not possible to help ordinary citizens who wish to change, and are brave enough to want to attempt it, if it proves impossible to help these people become more compassionate adults who are satisfied with their lives, then other changes seem really rather pointless. Too many have been lost already. As the patient said, "It really is time things changed".

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## A New Milestone for the Tobacco Hazards Prevention Act

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The amended Tobacco Hazards Prevention Act in Taiwan was promulgated by the president on July 11, 2007 and after 18 months of grace period, it was put into effect on January 11, 2009. It represents a revolutionary advance for Taiwan's Tobacco Hazards

Prevention Act, and put Taiwan at the forefront of global tobacco control.

The amended Act focuses on enlarging the scope of smoke free environments to include indoor public places, indoor workplaces with

three or more people, public transportation and even some outdoor place. Venues are responsible for posting no smoking signs at all entrances and other places as appropriate, and ensuring that smoking paraphernalia is not installed. Violators can be fined from NT\$10,000 to 50,000 (approximately US\$ 350 to US\$ 1,750). In addition to test warnings, tobacco products are required to carry one of six graphic warnings and smoking cessation related information, and shall not use words like "low tar", "light", or "mild"



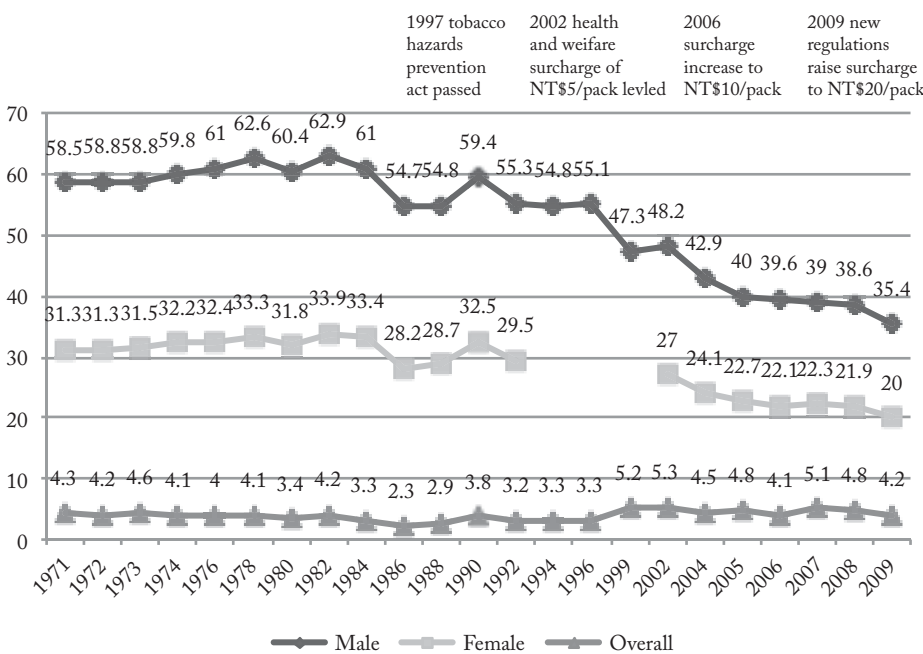
that might implicate less harmful health effects. To protect children and fetuses, pregnant women will not be allowed to smoke, and people who provide tobacco products to minors will face fines of NT\$10,000 to 50,000 (approximately US\$ 350 to US\$ 1,750). Tobacco hazards education will also

be provided to minors. Regulations governing tobacco promotions, advertising and sponsorship have been strengthened as well. Vendors are restricted on tobacco displays, and fines have been greatly increased. Penalties for illegal tobacco advertising have been increased from NT\$100,000–300,000

to NT\$5 million–25 million (approximately US\$ 3,500–10,500 to US\$ 175,000–875,000). In addition, tobacco manufacturers and distributors are now required to disclose tobacco product contents, additives, emissions, and their toxicity. People caught smoking in non-smoking areas can be fined NT\$2,000–10,000 (approximately US\$ 70–350). The regulations governing the collection and use of the Tobacco Health and Welfare Surcharge have been amended, with the surcharge now being used to fund services for the underprivileged.

**Table 1.** Perception of the New Law by Telephone Survey

ITEM	Jun 2008	Dec 2008	Mar 2009	Improvement
Public transportation: Train (Bus) Station	58.5	82.1	92.9	↑ 34.4
Restaurant, Mall, Online-game Cafe, KTV	58.8	87.0	95.4	↑ 36.6
Indoor Workplace	32.9	87.9	93.7	↑ 60.8
Ban of children, adolescent and pregnancy smoking	53.0	66.4	88.5	↑ 35.5
Smoking violation fine \$60–300	28.7	73.4	90.8	↑ 62.1
Non-smoking labeling violation fine \$300–1,500	16.4	56.7	83.0	↑ 66.6



**Figure 1.** Smoking rates in Taiwan among adults, from 1971

To carry out the new Tobacco Hazards Prevention Act that took effect on January 11, 2009, schools, governmental agencies, workplaces, and public places all must be smoke-free. In order to accomplish this, we have used education (law enforcement and hotline staff training, FAQs, and information meetings) and promotional materials in a wide variety of media including TV, radio, print, outdoor media (signs, TV walls, public transport, public displays), LED displays, websites, and banners. The Smoke Free Public Places, 25 County and Municipal Leaders Go All Out educational film was also released on May 30, the eve of World No Smoking Day. In order to secure county and municipal support for the new regulations, the Director General of the Bureau of Health Promotion has visited eight county and municipal leaders and held three meetings with county and municipal health officials. We have also conducted in-depth investigations and training with local companies in 25 counties and municipalities. Role play exercise helped train personnel in how to deal with potential issues that may arise. In December 2008, 22 county and municipal health bureaus hired 665 temporary workers to post no smoking signs and hand out promotional materials. 485 tobacco control volunteer training sessions were held and attended by 13,549 people, and a total of 31,517 promotional activities were held. Community organizations were also enlisted to help hang signs and undertake promotional activities.





A telephone survey conducted one month after the implementation of the new Tobacco Hazards Prevention Act found that over 90% of people are aware that public places are now smoke-free; awareness of regulations for smoking in workplaces of three people or more has risen over 60% since the regulations were announced in July 2008; and awareness of regulations governing public transportation, restaurants, hotels, and stores has risen by 35% (see Table 1).

**Smoking Rate**

A review at recent smoking levels among people 18 years of age and above shows that in 1980, 60.4% of males and 3.4% of females smoked. In 2002, the rate among males dropped to 48.2% while it rose to 5.3% among females, and in 2008, it fell further to 38.6% among males and 4.8% among females. After January 11, 2009, when the amended Tobacco Hazards Prevention Act took effect, changes include expanding the range of places where smoking is not permitted; prohibiting tobacco advertising, promotions and sponsorship deals; modifying health warning pictures and test on tobacco packaging, including info about quitting smoking; putting greater oversight on tobacco vendors; and raising the health and welfare surcharge on cigarettes. After these new regulations came into effect, the smoking rate among men dropped to 35.4% and females experienced a slight drop to 4.2% (see Figure 1).

There were about 3.61 million smokers 18 years of age and above in 2009, 3.23 million of whom were male and 380,000 of whom were female, representing a drop of 330,000 from the previous year. Data suggest, however, that the smoking rate increased dramatically among young males when they were between the ages of 18 and 25. Starting at age 18, the smoking rate for men increased as the age increased, reaching a peak

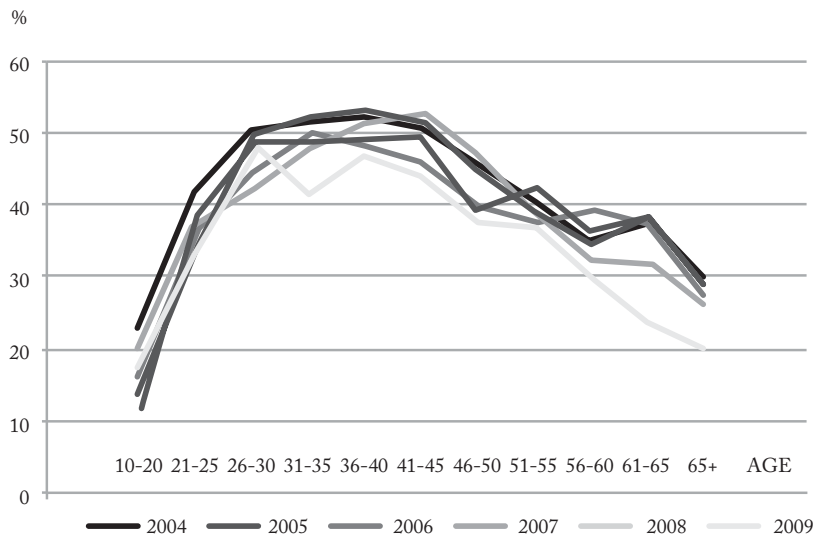


Figure 2. Line graph of smoking rates among males 18 and above.

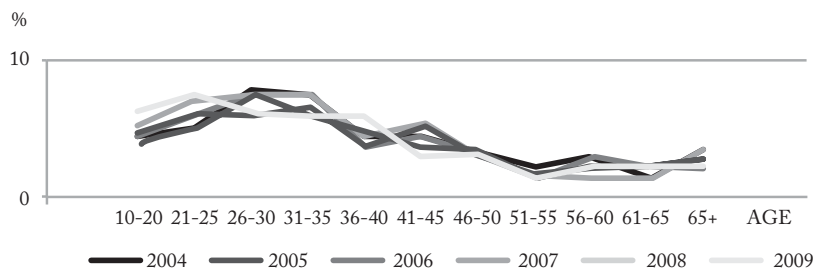


Figure 3 Line graph of smoking rates among females 18 and above.

in the 36 to 40 age category. In fact, of every two young-to-middle-aged adult males, one is a smoker (see Figure 2). For women, the smoking rate likewise rose with each increase in age, starting at 18 and reaching a peak in the 31 to 35 age category. For every 14 adult females, there was one who smokes (see Figure 3). The data reveal that planners and policymakers need to place their focus on the problem of smoking among young males and females.

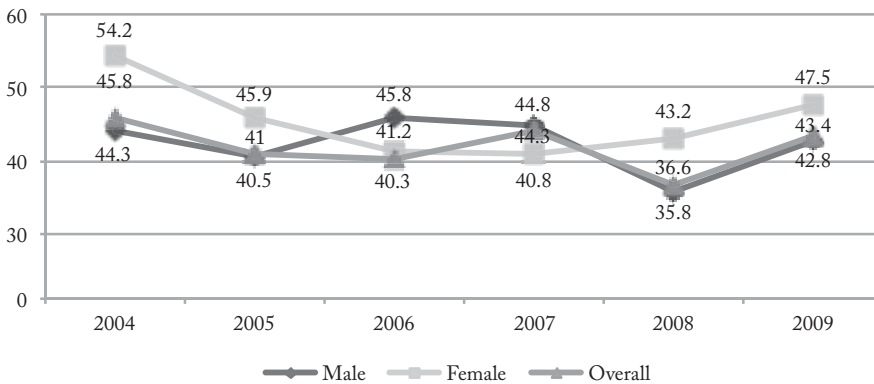
1. The Taiwan Tobacco and Wine Monopoly Bureau gathered the data from 1973–1996.

2. Professor L. Lan gathered the data from 1999.

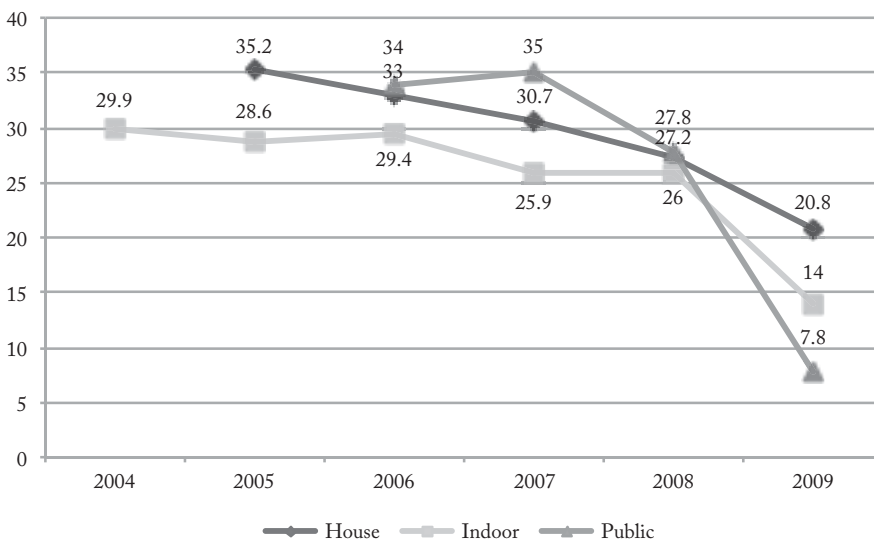
3. The data from 2002 were found in the Bureau of Health Promotion’s 2002 Survey of Knowledge, Attitude, and Behavior toward Health in Taiwan.

4. The Bureau of Health Promotion gathered the data from 2004–2009 in the Adult Smoking Behavior Survey.

5. For results from 1999–2009, a smoker was defined as a person who has smoked more than 100 cigarettes (five packs) and who smoked within the past 30 days.



**Figure 4.** Percentage of adult smokers who tried quitting smoking, from 2004



**Figure 5.** Exposure to secondhand smoke among adults

## Try to Quit Smoking

An investigation from 2009 showed a decrease in the smoking rate among adults and an increase over the past year in efforts to quit smoking (see Figure 4).

1. Data gathered from the Bureau of Health Promotion Adult Smoking Behavior Survey.
2. We defined a person who tried to quit smoking as a smoker who gave up cigarettes

for one day or more over the past 12 months because he or she wanted to quit.

## Exposure to Secondhand Smoke

In a 2009 survey that asked people about their exposure to secondhand smoke over the previous week, 20.8% of respondents said they were exposed to secondhand smoke in their households, 14.0%

said someone smoked in front of them in an enclosed workplace or office and 7.8% said they were exposed in indoor public places. Ever since the range of places where smoking is banned was expanded in 2009, there has been a decrease in secondhand smoke exposure in the household and at the workplace (see Figure 5).

1. Exposure to secondhand smoke at home was defined as having someone smoke in front of you at your home within the previous week. Data source: Bureau of Health Promotion, Adult Smoking Behavior Survey.

2. Exposure to secondhand smoke in the workplace indoors was defined as the rate at which the worker smelled cigarette smoke in enclosed spaces at the workplace. Data source: Bureau of Health Promotion, National Occupational Health Workplace Environment Investigation. Those surveyed were full-time employees aged 15 and above.

3. Exposure to secondhand smoke in public places was defined as having someone smoke in front of you during the previous week in an indoor public place, not including home or workplace. Data source: Bureau of Health Promotion, Adult Smoking Behavior Telephone Survey. Those surveyed were adults aged 18 and above. Since surveys on exposure to secondhand smoke from 2008 and 2009 subdivided indoor and outdoor locations, it is not easy to make a direct comparison between the results from these two years and previous years.

After nearly one year of promotion, a survey indicated that 94.6% of the population was aware of regulations related to banning smoking in certain locations and 92% was satisfied with the smoke-free environment created after the promulgation of the regulation. In addition, the proportion of entirely smoke-free workplaces increased from 55.8% in 2008 to 80.5% in 2009. Refusing tobacco is becoming a social norm.

*Taiwan Medical Association*

## In memoriam Jörg-Dietrich Hoppe

24 October 1940 — 7 November 2011

His life began with tragedy and hardship. Born in 1940 in Torun, his family had to flee from their home and a young boy's life started as that of a refugee and displaced person. Toward the end of World War II, at the age of four, he lost an eye from an exploding grenade and his memory of that time was strongly impressed by the starvation he suffered.

He wanted to help make this world a better place. So he became a doctor in 1966 and engaged in politics early on. Although a very non-dogmatic thinker from a strong Catholic background, he was active in the Christian Democrat Party. But they could not relate to the young man with these innovative ideas about social issues, working conditions and the environment. They never really understood him. He was decades ahead of them in his thinking.

His superior, Professor Ulrich Kanzow, a physician activist himself, became his initial mentor and brought him to organized medicine. In the physician trade union, Marburger Bund, his natural leadership began to reveal itself and in 1970—only four years into his medical career – he became one of the co-organizers of the first (and for a long only) post-war physician strike in Germany. In 1975 he qualified as specialist in pathology and family practice. He decided to stay in pathology where he built an extraordinary successful career.

Neither the success in his clinical work (he later became a Professor at the University of Cologne) nor his early success as a leader in organized medicine (he became chairman of the Marburger Bund in 1979), affected his ego-as positions of influence and power often do. He never pretended to have all the answers; instead he was constantly asking questions. He understood his work as a service to community and so he behaved. His authority was based on a sharp mind combined with a humble character and a strong commitment to philanthropy. It may have been his personal experience that made him so careful not to look down on anybody. His interest in medical ethics was always driven from a humanistic view, rather than a deontological perspective. His aim was to help, not to judge. To make him your foe was a very difficult exercise.

Jörg-Dietrich Hoppe was perceived as quiet but very efficient advocate for his profession. Indeed his ultimate interest always was that patients would receive the right care. That no group or individuals would be left behind was his concern, regardless of whether they were poor, asylum seekers, or just children. He was a truly caring physician.

In 1989 he became Vice-President of the Federation of the Bundesärztekammer, the German Medical Association, and he retired from his position as chairman of the Marburger Bund. Ten years later the An-



nual Assembly elected him President, succeeding his friend and mentor, Karsten Vilmar. He held the office of President of the German Medical Association for 12 years, until this past June when he retired. During the last Annual Assembly, it was visible that something was taking his life away. The tall and always very slim man now was cachectic and his voice was frail.

On November 7th, 2011, Jörg-Dietrich Hoppe died at the age of 71 after severe illness.

With Jörg-Dietrich we lose a strong supporter of the World Medical Association, a Council member for decades, and Treasurer from 2005 to 2011. To many of us he was a friend and teacher and foremost an outstanding person and inspirational leader.

*Otmar Kloiber with Joelle Balfe*

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