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- Research Ethics Committees:  
Identifying and Weighing Potential Benefit and Harm  
from Clinical Research
- What is “Deontological Ethics”?

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## A Difficult Start Into the Year

### Editorial

The current year began with remarkable problems for many physicians and their organizations. In Poland, the parliament tried to hold physicians financially responsible for the management of non-transparent entitlements of their patients. This is interesting in a country where the health insurance system is run by the state – the entity best positioned to fix the problem in the first place. Fortunately it appears that the actions might be reversed soon.

At the end of the year in the Slovak Republic, the government put the hospitals in a state of emergency, which placed hospital physicians under a kind of martial law, prohibiting them from going on strike. Do they really believe physicians waived all their rights upon entering the profession? Of course it is easy to save money at the expense of others, especially when you can “gag” them with the help of the police. This is yet another bitter attempt of a government to compensate for their financial problems by taking from those who serve most and work hardest. The fact that physicians in the Slovak Republic are already severely underpaid makes the situation even more deplorable.

But the worst situation has been the attempt by the Turkish government to dismantle physician self-governance, despite the fact that this responsibility was granted by law to the Turkish Medical Association. Through a government order, the Turkish government is attempting to take key self-regulatory functions away from the TMA and empower a government-controlled organization with oversight of all health professionals. This is a blatant attack on civil society and defies the principles of parliamentary democracy, in which laws made by the parliament must not be changed by the executive branch.

Letters of solidarity have come to the Turkish Medical Association, supporting them in their fight for self-governance, civil engagement, and the maintenance of basic democratic rules. The World Medical Association will have a presence in Ankara and Istanbul on April 16<sup>th</sup> and 17<sup>th</sup> to help the Turkish Physicians regain their rights of self-regulation.

Attacks on physician self-governance have not been limited to these very recent situations. We have seen this several times in the past years, with some efforts more successful and some less so. The common thread among these situations is the objective of “command and control” of the profession. In most affluent societies, health care is by far the largest identifiable sector of economy. To steer this sector holds strong appeal for all governments. Physicians, with their highly influential structures designed to maintain and develop health care systems, are the most targeted group in this changing environment because cutting entitlements for medical and health care is most easily accomplished when this group is disempowered. And in the end, it matters very little whether control of the profession is exercised by a government body, an insurance company, or a managed care company.

The profession has a lot to lose. Being regulated by a bureaucratic administration that does not understand medicine and the work of physicians is difficult. Being regulated by an administration that is not only disconnected from medicine and care but that has only cost-savings on its radar is even worse. And while these frustrations and difficulties are not to be underestimated, the ultimate threat is to be downgraded from a respected profession to a technical service.

Professional self-governance is not merely a means for physicians to exercise control to serve their own interests; it serves a critical patient-centered purpose and we must make that understood to all stakeholders. In health care, the objective of self-governance is to provide better medical care to the patients and services to our people, to protect the dignity of patients, and to improve public health in our communities. We must be able to demonstrate to our societies that it is to their advantage to have physicians who can freely exercise their duties according to professional standards and ethical rules rather than to be under the control of a government, or an insurance or a managed care company. When physicians are forced to follow third party orders, the interests of the patients will always come last.

*Dr. Otmar Kloiber*



## Research Ethics Committees: Identifying and Weighing Potential Benefit and Harm from Clinical Research



*Heiner Raspe*



*Angelika Hüppe*

### 1. Introduction<sup>1</sup>

Identifying, assessing, and weighing potential benefit and harm from clinical research is one of the central though most difficult tasks of any research ethics committee (REC). Article 15 of the World Medical Association's Declaration of Helsinki (Seoul 2008) explicitly states:

"The research protocol [of every medical research study involving human subjects] must be submitted for consideration, comment, guidance and approval to a research ethics committee before the study begins." And (according to Article 18) every study "must be preceded by careful assessment of predictable risks and burdens to the individual and communities involved in the research in comparison with foreseeable benefits to them and other individuals or

communities affected by the condition under investigation."

In addition, biomedical research and the role of RECs are governed at the European level by several legally binding instruments: One is the Directive 2001/20/EC relating to the conduct of clinical trials on medicinal products for human use. Article 3.2 states: "...A clinical trial may be initiated only if the Ethics Committee ... comes to the conclusion that the anticipated therapeutic and public health benefits justify the risks"...

The Council of Europe's Convention on Human Rights and Biomedicine [1] and its Additional Protocol concerning Biomedical Research [2] are binding only in States where they were ratified. The Convention states: "Research on a person may only be undertaken if ... the risks which may be incurred by that person are not disproportionate to the potential benefits of the research" (article 16).

The Additional Protocol explicates:

"In addition, where the research does not have the potential to produce results of direct benefit to the health of the research participant, such research may only be undertaken if the research entails no more than acceptable risk and acceptable burden for the research participant" (Article 6.2) and "Research on a person without the capacity to consent to research may be undertaken only if ... the research entails only minimal risk and minimal burden to the individual concerned" (Article 15).

The task of the "risk-benefit analysis" primarily addresses researchers and secondly the relevant REC (and later i.a. monitoring committees, industry, politicians, regulators, providers, purchasers, guideline producers; [13] and finally individual doctors and patients: Communicating Risks and Benefits: an evidence-based users guide [6].

In 2004 the German Drug Law (Medicinal Products Law, in German: Arzneimittelgesetz = AMG) incorporated the normative framework of the European Directive 2001/20/EG, transforming the role of Germany's more than 50 RECs considerably. In the case of assessing clinical trials of medicinal products they had to change from an intra-professional advisory to an approving body. The changes intensified the professionalisation of RECs and influenced the assessment of all study types. They gave RECs both a stronger position and an increased responsibility.

Over the last years the bioethical literature have been proposing different approaches to risk-benefit assessment [11]. The two best known are the component analysis [15, 16, 17] and the net risk test [18, 19], the latter being further developed into a seven-step framework by Rid & Wendler [12]. A recent overview of relevant problems and literature is provided by King and Churchill [10].

Since 2006 we have been developing and testing an own systematic approach to the

<sup>1</sup> We thank Prof. Elmar Doppelfeld for helpful comments on an earlier version of the manuscript

ethical analysis of risks and potential benefits from clinical research [8]. A preliminary version was applied to study protocols presented (in 2006) to the REC of our medical faculty [9]. The text below gives a brief description of the method – against the background of the normative situation of our country.

## 2. Evaluating potential benefit and harm: a stepwise approach<sup>2</sup>

### Step 1: Identifying potential beneficiaries and victims of possible harm

Principal beneficiaries are a) patients or healthy volunteers (proband) as study participants, b) patients or healthy volunteers outside the study with the same characteristics as defined by its in- and exclusion criteria, and c) a very broad range of other persons, organisations, communities, (segments of) public health or “the” economy, society, or environment. The same distinctions are to be used to classify potential victims of possible harm (“maleficiaries”).

A study implies potential individual benefit if each and every participant has a priori a chance to benefit directly from the diagnostic or therapeutic intervention under study; this is the case if the benefit can be expected as an effect of the specific intervention (as its cause) and not via the mere inclusion in the study (by e.g. early access to novel treatment, careful monitoring, financial rewards; “collateral benefit”). Participation in a well planned double-blind randomised placebo-controlled trial (RCT) convincingly hypothesising superiority of the experimental condition satisfies the criterion.

A study offers group benefit if its results can be more or less directly utilised in fa-

vour of patients/probands with characteristics identical to those of the study members exposed. One or few further – replicative or corroborative – studies may be necessary and acceptable. The first group to benefit from the results of a “positive” RCT may be the then unblinded control group followed by other prevalent or incident cases with identical characteristics. We thus referred to group benefit as a form of “delayed direct benefit” [8]. Note that we propose a deliberately narrow definition of group benefit – a category which is being discussed in Germany highly controversial, especially when loosely defined (as e.g. in Article 17.2 of the Oviedo Convention: “... other persons in the same age category or afflicted with the same disease or having the same condition”).

A study is said to have external benefit (or harm) if c) applies. This category includes a wide and heterogeneous spectrum of potential bene- and maleficiaries: it runs from less well defined future patients/probands with similar ailments and their relatives and other healthy persons to researchers, providers and purchasers and further to pharmaceutical companies, clinical medicine, biomedical science, “the” national economy or “the” community, society or environment.<sup>3</sup>

We therefore propose to define three types of possible benefits and beneficiaries – in contrast to prominent German ethicists and Members of the Parliament who cling to the dichotomy individual vs. external benefit. If they accept group benefit as an additional category at all, they regard it only as another subtype of external benefit. And external benefit is seen as insufficient

for justifying the inclusion of patients into studies and totally unacceptable where a trial addresses adults being “incapable of comprehending the nature, significance and implications of the clinical trial and of determining his/her will in the light of these facts” (§ 41 (3) AMG). This position still prevents Germany from ratifying the Convention on Human Rights and Biomedicine [1] and led our country to add an “explanation of vote” to the Universal Declaration on Bioethics and Human Rights [2].

The position poses particular difficulties for medicine as an evidence-based pragmatic science. Medicine has to rely, for example, on evidence-based diagnostic strategies and tests to be developed and evaluated in a series of diagnostic studies, be it in decisionally capable or incapable subjects (e.g. newborns, young children, dementia patients, stroke or accident victims). One indispensable early step in the series is the diagnostic accuracy study; it applies a new test to two groups separated on the outcome of an established “gold standard” test: subjects definitely with vs. definitely without the disease in question. Imagine the evaluation of a novel blood test presumably specific for adult Alzheimer’s disease. An early low-risk phase 2 diagnostic study (case-referent approach) would start with advanced cases and ask whether the results of the new test differ between the cases and a group of non-diseased subjects. Its results are evidently of no direct benefit for any of the study participants but imply potential benefit for 1. the preparation and conduct of a phase 3 study (cohort type in the clinical environment followed by phase 4 and 5 studies<sup>4</sup> and 2. – when again and again “positive” – for further prevalent and incident clinical cases (group benefit). An analogous example from the world of therapeutic studies is given by the strictly

<sup>3</sup> “External benefit” is an incomplete and imperfect translation of German “Fremdnutzen”, which means benefit not for the study participants themselves or the respective group but for undefined others. “Fremd” is the (German) antonym to “selbst” (English: self) and indicates a wide distance, even an opposition between individual and external benefit.

<sup>4</sup> A phase 4 study analyses therapeutic impact, often in a before-after design, a phase 5 study is a diagnostic RCT.

<sup>2</sup> The following focuses (paradigmatically) on clinical evaluative studies of diagnostic and therapeutic methods.

non-interventional cohort study assessing favourable and unfavourable effects of e.g. a certain drug under ordinary practice conditions, another by some non-inferiority RCTs. Again, one cannot expect a direct benefit for any of the study participants but possible benefit for equal patients outside the study, when for instance therapeutic alternatives have to be considered.

We can't discuss here in detail the ethics of group-beneficial studies but would like to state that if patients, clinicians, purchasers, legislators and regulators demand evidence-based diagnostic testing (and treatment) independently from the patients' decisional capacity then studies such as the mentioned above have to be conducted. If this is accepted it is unacceptable to outlaw such studies. We hope that our narrow definition of group benefit (as a third category) may help building a bridge between so far incompatible positions<sup>5</sup>.

## Step 2: Realising country-specific legal norms

Though – at least in the European context – a further convergence of legally binding norms can be expected, there are still national peculiarities (see for instance footnote 4). Hence it is necessary to realise and recognise all relevant country-specific norms and directives. Some address certain groups of beneficiaries, others require certain types of benefit or define upper limits for risks and burdens. All this serves the purpose of harm minimisation, an ethical requirement which is relevant not only when legally prescribed. It has to be observed whenever and wherever a study is planned and conducted. RECs should propose how to minimise study-associated potential harms.

## Step 3: Assessing equipoise

This step involves two assessments: The first evaluates whether any study group or individual subject is at risk of substandard care as defined by relevant clinical practice guidelines ("external equipoise"). This question is difficult to answer especially when "routine or usual care" serves as a comparator in a controlled study. Does the actual care meet relevant professional standards? For uncontrolled studies such standards provide a benchmark for the evaluation of the experimental condition (or the actual care in purely observational studies).

The second assessment addresses the potential benefit/harm relations between two or more arms within controlled studies ("internal equipoise"). We ask whether the different exposures imply comparable risks, potential benefits and harm-benefit relations – in the light of the current best available evidence as critically appraised by the respective expert community. If a certain clinician deliberately participates in a study he or she agrees, at least implicitly, with what was accepted as being "in equipoise". Confusion sometimes arises from study hypotheses which take a relevant clinical benefit already for granted and do not leave room for doubt and so far imperfect knowledge (i.e. for further research).

## Step 4: Identifying, measuring, and assessing single potential benefits and harms

The following distinctions apply to the analysis of both potential benefits and harms again: we assess their type/quality and relevance (e.g. mortality, morbidity, symptoms, quality of life) – magnitude/size (given e.g. as high relative risk, absolute risk difference, effect size) – likelihood of their occurrence (absolute risk, number needed to treat/harm) – time of onset and duration/sustainability of any favourable or unfavourable effect (minutes to years). We propose

to express the degree of relevance, size, and likelihood of any benefit/harm by means of simple trichotomous scales (at least: high – medium – low<sup>6</sup>). Finally, a similar rating of the certainty of each single estimate and of the aggregated benefit and harm is required (based on e.g. confidence intervals of point estimates). An open question addresses the degree of (un)certainly (bias potential) of the total body of evidence regarding possible benefits and harms: Germany's Drug Law (§ 5 (2)) requires not more than "reason to suspect" that a certain drug is unsafe – a standard nobody would accept for "proving" potential benefit. In view of the central role of RECs (to protect study participants) a lower standard of proof thus seems acceptable when risks and burdens are to be considered.

## Step 5: Analysing, comparing, and assessing summary benefits and harms

Summary statistics (rates, means, relative risks, effect sizes etc.) are more or less blind to underlying distributions: take, for example, a head-to-head comparison of two drugs, novel vs. standard; assume the RCT results in equal success rates (in %). Can you be sure (without additional data and analyses?) that the benefit is equally stochastically distributed within the two groups? Could it be that the interventional product favours females (one half of each sample) whereas the comparator favours males (the other half)? You can't be sure, even though the researchers started the trial under the (in the light of all current knowledge) justifiable assumption of stochastic effectiveness within both groups. A similar question arises when statistics for central tendencies (mean, median) are to be analysed (who benefits within a sample?) and compared (equal beneficiaries across samples?). These uncertainties

<sup>5</sup> The German situation is all the more incomprehensible as the law accepts group-beneficial studies in children (§ 41 (2) AMG) but not in decisionally incapable adults (§ 41 (3)).

<sup>6</sup> Wider ranging scales may be used, e.g. for expressing the potential frequency (fivefold between very frequent and very rare) or severity (fivefold of harms).

require both a close inspection of individual data and subgroup analyses.

Other problems are encountered where multiple and/or complex outcome measures are included such as a range of heterogeneous endpoints (e.g. clinical, laboratory, patient related), health related quality of life scales or – even more opaque – quality adjusted life years (QALYs). The widely used instrument SF36, for instance, comprises 8 components (vitality, physical functioning, bodily pain etc.) each made up by more than one item. All separate results can be summarised in two measures (physical/mental subscale summary) and a single overall score. Thus equal sum scores may well hide differences at the item, component or subscale level and/or different mixtures of positive and negative effects and thus may well have different meaning in the light of different patient preferences. The use of QALYs adds merely another incommensurable dimension (lifetime) to a measure already non-transparent. Similar problems result from the use of so called composite endpoints.

Though these considerations relate more to situations where completed studies have to be appraised they are not irrelevant for RECs. To get an estimate of potential benefit and harm RECs have to rely on the results of former evaluative (e.g. phase 1 and 2 drug) studies, besides case reports, lab and animal research, and preclinical human experiments.

## Step 6: Weighing all benefit against harm

Nevertheless, different approaches to the assessment of “net benefit” have been proposed (European Medicines Agency 2011<sup>7</sup>) – mathematical (aiming at an aggregate

statistic expressing the balance between all benefits and harm), “algorithmical” (aiming at a structured stepwise assessment and summary), and purely judgemental. We prefer and recommend the multidimensional judgement approach to be guided initially by the stepwise identification and assessment of every potential benefit and harm as mentioned above [8, 9]. The judgements then have to be worked out in a thorough discussion among all REC members. Though this may end up with only inconsistent “capricious” results, depending on numerous situational factors, the proposal takes into account the singular nature of each study, the fundamental incommensurability of different types of benefit and harm (see above) and the (to our opinion) indispensable exchange of various professional and lay perspectives.

However, before starting any discussion, it has to be made clear whether individual (potential) benefit always (or only in certain cases?) has to exceed harm, balance it, has to be only loosely related or may in some situations even be sacrificed for a greater good, e.g. “the anticipated significance of the medicinal product for medical science”<sup>8</sup> (§ 40 (1) 2 AMG) or public health.

It is surprising that virtually every REC in the world faces the task of “balancing benefits and risks”<sup>9</sup> and seems to cope with it successfully on an everyday basis – in the absence of any formal concept, advice and training. We are learning by doing and training on the job. The Guide for Research Ethics Committee Members designed to assist RECs and based on a number of European Conventions and Protocols [3] offers some help, for example it outlines key

questions which RECs should consider when reviewing a research protocol.

Is this an unsatisfactory situation? We think it is, but at present we are unable to offer a more complete solution. Nevertheless: our descriptive and evaluative taxonomy combined with the conceptual framework for comparing and balancing potential research benefit and harm should increase transparency of eventual judgements and facilitate the communication between and within research groups and RECs. It may help to standardise and harmonise ethical review, advice, and approval procedures.

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7 EMA's considerations refer to the evaluations of completed studies but seem useful in our context as well.

8 In German: “Heilkunde” which means “clinical medicine” and is to be distinguished from “medical science”.

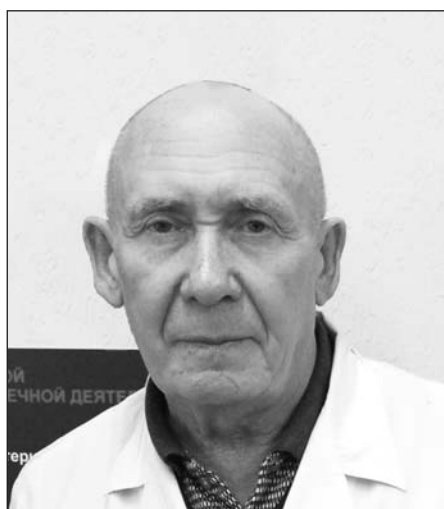
9 Which is eo ipso either impossible or trivial: “risk” refers to the probability of an unfavourable outcome within a defined period of time whereas “benefit” refers to a factually given but further unspecified advantage.



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## And Still, What is “Deontological Ethics”?



Vladimir Krylov



Pavel Mikhalevich

It is known that deontological ethics means a set of ethical and moral standards for

health professionals when they perform their professional duties. These notions were

derived from Latin word “ethica”, Greek word “ethice” – ethics and morality study, and Greek word “deon” – duty.

First records about medical ethics and deontology appeared in ancient sources: “The Code of Hammurabi” (Babylonian law code, XVIII BC), “On the Physician”, “Hippocratic Oath” and “Hippocratic Corpus” (V-IV BC), Indian “Book of life” – “Ayurveda” (V-IV BC). Term “ethics” as a criterion for human morality and ethics was set forward by Aristotle (384-322 BC). The notion of deontological ethics as “...a study of proper human conduct in order to reach his/her goal” was introduced in XVIII by English philosopher, jurist and priest Jeremy Bentham.

Today medical ethics includes the following aspects: scientific, which is studying ethical rules of health professionals’ activity, and practical which is development and appli-





cation of ethical rules in professional activity. Being a criterion for personal qualities of a health professional it studies and determines solution to different interpersonal issues between colleagues, with patients, their relatives, junior and senior personnel, administration.

The quality of performance of deontological rules by health professionals depends directly on political, economical and social condition of the states, which influence the level of ethical views of contemporary society. Currently global capitalization is happening in the world and its peak is about to reach heights. Population of economically developed countries is consistently increasing consumption of resources, which peter out tragically fast. Unstoppable consumption, especially when humans use for themselves much more than they create by their labor, is per se an immoral action. This attitude to life leads to tension in society, which causes social and political tempests, which in their turn intensify demonstration of immorality.

This is the picture we've observed in recent decades in CIS countries, including Belarus. Certainly, in circumstances like these the principles of ethical life of a society change and this concerns medical deontological ethics despite its somewhat traditional professional resistance to difficulties of life in society.

Hippocratic Oath is rarely remembered in today's society. Commercialization, which affected all levels of social life, firmly settled down in medicine as well. Profit in this once grand and genuine area of social life pushed moral principles aside from priority position, replacing them with economic efficiency of rendering medical aid, its substantiation of application effectiveness. Material significance began to replace not only ethic, but moral principles as well.

However the reasons of it aren't only in social and economical tempests of contempo-

rary social and political system. Disparity of obeying to deontological rules is based in the nature of human development. To understand that it's necessary to remember fundamental provisions of ethical notions, which humanity created in course of many thousands of years. Peculiarity of ethics as the code of human conduct in society and definition of duty we have to each other is in the fact that it wasn't created by separate individuals, but was formed by community in the process of making of humanity. It is a reflection of our life, expectations and actions of every one and each of us.

Ethics lies in the following. Development of humanity happens in two ways. One of them is materialistic, the other one is idealistic. The first one implies utilitarian, selfish and pragmatic character of mutual relations whereby the mindset is formed on the basis of principles of material priority in our life, the other one is altruistic, sacrificial, extra terrestrial spirituality is in its basis.

Contact of these two ways is across two notions: morality (formal duty of every person to other people) and ethics (heartfelt attitude to the formal duty, when duty to each other isn't based on principles "you do this for me and I'll do that for you" but when it is based on deep respect and love to people who are people just like you are). Human moral principles are secured by legislation (Constitution, codes, regulations, instructions and others) by a certain community and are binding. Ethical principles are not declared by laws, but are determined by each person's conscience, and they are demonstrated in mercy and sacrifice towards other people and it all is aimed at spiritual development.

Failure to obey moral principles, i.e. civil laws adopted by us, is called immorality, and their complete neglect is called degradation. On the contrary, idealistic way provides for further ethical development in order to reach spirituality and holiness. When a person loses ethical criteria it brings him/

her back to pragmatic way of development. Therefore, materialistic (pragmatic) way of development is determined by moral, immoral and degradation criteria. And idealistic way is determined by ethics, spirituality and holiness. Based on humanity development it is clear that humans make a way from primitiveness to high ethical standards.

The basis for these ethical rules is Moses' Decalog. His first three commandments became the grounds for formation of idealistic way of development by humanity, and others – of pragmatic. On the border between them there are so called good people. They follow moral principles, they don't violate them, and to a certain extent they are selfless and they tend to respect others. This condition is the basis for transition to idealistic way. At the same time it is necessary to clearly understand, that the way of development isn't chosen for a certain person but the person chooses it himself or herself.

Numerous studies showed that even in more simple biological life two thirds of society show characteristics of selfishness and one third sacrifice themselves to secure life. The same way in human society, two thirds of people follow pragmatic (naturalistic) way of life (development), and idealistic is followed only by one third. That said most of "idealists" are in the zone of ethical criteria because it is extremely difficult to reach spirituality and holiness. Therefore they may periodically stray away from moral stands to elements of pragmatic or utilitarian ambitions. However mobilization of efforts in development of altruism and mercy give them opportunity to harden at this ethical level.

It should be noted that there's a belief that the mentioned ratio 66.6 percent and 33.3% percent reflect biblical thought. In the Bible number 666 is mentioned as the devil's number. And it is logical to match it with the rating 66.6 percent, which reflects selfish attitude to life with utilitarian and mer-



cenary interests. Lucifer is considered to be the prince of this world. On the contrary in the Bible there's crucifixion of 33 years old Jesus Christ, symbolizing sacrifice for the sake of others and characterizing idealistic and altruistic attitude to life.

Therefore the majority of the population prefers utilitarian needs as the basis of their life interests, and these needs mainly determine the way of interpersonal relations. Sacrifice for the sake of others, selfless serving to interests of other people are more rare events in our real life.

This proportion is destroyed when the majority of people abandon moral stands. Immorality is a serious evidence of disease of society; it draws the people who are near into greedy rush of chasing after additional profit. When that happens it's impossible to talk about mercy or require from the person who hasn't grown to follow moral, not to mention ethical criteria, to be an altruist, to be selfless and sacrificial. These qualities should mature in a person, they don't just come from somewhere but they are the result of persistent seeking in everyday life for beautiful and genuine things which are love and mercy.

It is impossible to deny that many people go into medicine because of their calling, at the heart's dictation or because of intuition, so they are prone to mercy, serving others, sharing their pain and sufferings. However the experience has shown that among health professionals there are lots of those who either lost these genuine qualities or they have never had them and got into medicine accidentally or on opportunistic grounds.

What can you require from them? Can you require that they act genuinely and mercifully? They know how to do that in their minds but not in their souls. That is why they will adapt to these requirements, remaining self-centered in their souls, and not being able to share the sufferings of their

patients. Among them there can be spectacular professionals, who really do good for the patient but remain cold-hearted in their actions.

So here in this surrounding of health professionals, who live on the grounds of unstable moral criteria, where there are no moral principles in life, deontological problems arise. And furthermore it is necessary to clearly understand that it is connected with weak moral basis of an individual.

It's been known for a long time, and that is why at the beginning of making of nationality the rules of work for health professionals already existed and they governed their attitude towards patient despite absence of morality. Even Ibn Sina required treating patients in a special way: "You should know that every individual has special character, native personally to him/her. It is very rarely or never for someone to have the same character as somebody else's". In ancient Indian treatise the doctor told his disciples: "Now you should leave your passions, rage, greed, foulness, vanity, pride, jealousy, rudeness, fooling, falseness, laziness and any wrong behavior. From now on you will have your hair and nails close-cut, you will wear red clothes and live pure life"

However health professionals by no means always obey to moral requirements, not to mention ethical aspect, that is why in practice the main rule was formed: do no harm! Gradually in different countries very similar legislation was formed which was aimed at regulation of work of health professionals, which should stop ethical violations and errors in treatment of patients.

However in healthcare professionals' activity there may be not only errors but medical offence as well. That is why abiding to moral and ethical standards by health professionals means not only fulfilling one's duties but also being held liable for failure to fulfill or non-professional performance of one's duties.

Depending on the degree of seriousness of committed offence health professional is subject to administrative punishment (admonition, severe admonition, transfer to a less paid job, and etc.) or is subject to punishment in accordance with applicable legislation. Thus work with patients apart from accurate fulfillment of duties by health professionals assumes abiding to the principles of medical deontology and legal liability.

When mutual relationships were capitalized the concept of moral was substantially changed not to mention ethical grounds of medical treatment. It deprived of halo all sorts of activities which before that were considered honorable and were treated with reverence. Doctors, lawyers, priests, poets, scientists became paid salaried employees, which lead to decrease in the level of criteria of moral responsibility among them. Yet many famous doctors in the world have urged and urge today not to turn people's diseases into means of gaining profit.

There is not doubt that the main deontological and standard work offences in the field of medicine are driven by weak morals. Patients' sufferings form even deeper feelings of compassion and mercy only in deeply ethic employees. In these events patient say: "doctor, medical assistant or nurse with a God-given talent". In case of immoral view of life someone else's sufferings don't affect the soul of a medical employee, and this leads to an even bigger obduracy. This is the trouble of many employees. And it's impossible to change that with orders. That's where delicate work with them is needed, the work aimed at upbringing ethical standards.

Work of a health professional is hard work. The main problem is connected with considerable psycho emotional load. It is especially hard on responsible employees in connection with demonstrating by them the feelings of compassion and mercy. In this situation ethical upbringing and support of

# World Medical Journal



a health professional can not only preserve his or her psycho emotional status but also increase his or her spiritual qualities.

That is why it is important for the state to take care of social conditions and psychological climate of medical personnel. Support for health professionals may be in attention to them from administration, restriction from unneeded administrative tasks, the feeling of care and delicacy which will correspond to moral and maybe even ethical criteria of the manager. Work with personnel not only concerning professional issues but also studying the basics of medical ethics can bring up good results in treating patients and upbringing spiritual qualities specifically in every individual employee.

It is a difficult task, which can't be done by means of administrative actions only. Of course testing for compliance to working with patients could be introduced but it is not possible because it is very hard to orga-

nize it and there may be serious shortage in health professionals. At the same time team strategy has never lead people to ethics and moral standards as our life shows it's very hard for it to contain either.

We need a structural element which in its nature would be to a much lesser extent connected with administration. We have a nonprofit volunteer organization like that. It is Belarusian Association of Doctors. In it the work is based on volunteer principle of assisting each other within the framework of legislation of the state. Special role has Ethical Commission of the Association, the aim of which is to support and protect honor, dignity and professionalism of health professionals. The basis of work of this Commission must be moral and ethical principles.

Belarusian Association of Doctors, remaining an open nonprofit organization, has to keep to priority membership of best specialists, employees who adhere to moral and

ethic criteria. The main direction of it work must be ensuring rights, honor and dignity protection of its members in the framework of legislation and ethical rules, support of improvement of their professional level, help to the population concerning issues of mutual relationships between patient and health professional.

Coordination of work with the Health Ministry is necessary. For that it is reasonable to conclude an official agreement with it concerning format of joint venture stating clear dividing functions of work with health professionals in the form of mutual assistance and support to determine the structure of contact mechanism and the rules of its operation. For the purposes of Association popularization it is advisable to prepare the organization brochure stating rights, obligations and main directions of its activity.

MD, Prof. Vladimir Krylov  
MD, Pavel Mikhalevich

## Is the Colombian Health System Equitable?



Sergio Isaza

According to recent press releases, in 2012 the General System of Social Security in Health (SGSSS) in Colombia will receive nearly \$43'000.000'000.000 COP (US \$22,052,000,000). In January 2011, the Congress of the Republic of Colombia passed Law 1438 on Health and Social Security. Under the aegis of this law, the Colombian government presented the new POS or Benefits Plan that takes effect as of 2012 and about which President Santos stated: *"This benefit plan will be universal, fair, inclusive and comprehensive and will not exclude any illnesses, meaning that all Colombians will receive care for all types of medical conditions since the system that exists today does not provide care for certain types of illnesses"*. Thus, in his own words, the Presi-

dent recognized the inequity of the current SGSSS.

Nonetheless, and despite the Benefits Plan, that inequity will continue as long as profit-based financial intermediaries continue to manage the private EPS (Health Promoting Entities), which over the past 18 years have failed in their mission and are unnecessary for the operation of the system. Three examples that clearly demonstrate this failure are:

- The government handed over \$1'000.000'000.000 COP (US \$513,000,000) to a section of the public hospital network to save them from bankruptcy due to money owed them by the EPS;
- The government promised but did not deliver \$120.000'000.000 COP (US \$62,000,000) to the national EPS (Health Promoting Entities) under the

Subsidized Regime (CAPRECOM) and directly paid some hospitals in the public network part of what the EPS owed them, for fear that the money would disappear, as had already happened. Thus, the Department of Health will hand over the money directly to the hospitals through a mandated trustee;

- Since the start of Law 100, social security in health care for the Colombian Congress, national military forces, Ecopetrol, and the public school teachers is provided through a special regime that works directly, without discriminatory plans and without using the EPS as an intermediary.

With the eruption of the bankruptcy scandal of the SGSSS, it came to light that many private EPS were misappropriating a large part of the health funding to increase their revenues and using these funds for profit-making activities other than health care (private building projects, luxury hotels, golf courses, sports teams, capital export and investment, support for political campaigns, etc.). Furthermore, the public EPS under the Subsidized Regime has been used to support political campaigns for local politicians.

Despite all this, the government persists in maintaining the intermediary system.

In terms of the medical profession, article 105 of Law 1438 defines medical autonomy as “the guarantee that a health professional may freely **issue his professional opinion** in regard to the quality care and treatment of his patients, applying the standards, principles and values that govern the practice of his profession, and the **right to give his opinion on medical conditions and their respective treatments**”. By definition, therefore, medical professional autonomy implies the capacity to **act and resolve medical problems based on scientific knowledge and is not in any way limited solely to stating an opinion**. Clearly, the medical professional autonomy of Colombian doctors has disappeared by operation of the law and therefore, the very decisions and actions of the medical profession have also become subject to the whim of the financial entities of the SGSSS.

Colombian doctors have advocated for the need to change the Health System and to structure it in order to guarantee the patient the Fundamental Right to Health. The

current system is designed on the basis of economic production and profit-seeking private financial intermediation. As long as this structure continues, the intention of Law 1438 to develop a basic health care system will only result in another failure.

Given that this deficient structure undermines the development of proper training, skills and professional education, we support work stability without intermediaries and continuing education for members of the system to provide comprehensive and quality care and ensure the security of patients.

Let us remember: the “Benefit Plan” is not the health care system; it is only one of its components. The equity of the system is ensured by the structure of the system together with all of its components.

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## The Education of Medicine in the Czech Republic

The unbelievable progress in new technological developments represents an important factor in medical education at all levels. Medical students and young doctors are naturally amazed by these new technologies. This, however, may contribute to a certain tendency to dehumanise medicine. The *condicio sine qua non* for a good medical educator is to protect the humanitarian character of medicine. The physician must remain a doctor of medicine and not an engineer of medicine. Personalised care should remain the basis of the patient-to-doctor relationship. In other words, these new techniques, however es-

sential they may be for the patient, must not distract physicians from this basic obligation, which is expected by their patients.

The doctor-to-patient attitude is also changing in the sense that patients are becoming more and more informed and require more solid information about diseases, diagnostics and therapeutic measures. These patients' needs must be taken into account in medical education at all levels.

Reforming pre-graduate medical education is a continuous process. These reforms



*Jaroslav Blahos*



include organisational as well as structural changes. In some of the medical schools in the Czech Republic, a new curriculum system has been introduced to combine the basic and clinical sciences. This system seems very logical yet requires very detailed coordination of teachers and departments. It is uncertain whether this integrated system leads to better results than the "classical" system, which was based on a separation between the basic sciences, taught in the first two years, and the clinical sciences, which were taught afterwards.

However, new educational methods and techniques, like the use of telemedicine and the Internet, may shed a new light on and broaden educational horizons. Whatever system is used, new knowledge will have to be incorporated in the curriculum, such as new systems based on evidence, new methods of medical statistics, socioeconomic factors, legal aspects of medical practice and a basic knowledge of health-care systems in other countries.

An integral part of pre-graduate education should be research that will ensure that the student is acquainted with this kind of

emerging medical work and learns to deal with medical literature, publication techniques and related issues.

Continuing Medical Education (CME)-life-long learning-is mandatory in the Czech Republic. This is understandable given that 50% of medical science and technology changes every five to seven years. As mentioned above, CME includes both parts of medicine, from knowledge, techniques and skill to ethical and personal attitudes. A 30-year-old specialist without CME is no specialist at 50.

CME in the Czech Republic is managed and supervised by the Medical Association, the Medical Chamber, the Ministry of Health and the Institute for Postgraduate Medicine Education. The system of credit points has been taken as a model for assessment. The CME in the future will have to reflect the enormous explosion of knowledge. It will not be easy to find the most suitable method to educate physicians, as it will have to enable them to gain, retain and use new knowledge rapidly. The courses led by teachers will be complementary to Internet education, rather than

the other way around. The same will probably happen with seminars, symposia and congresses. The era of telemedicine is approaching, with all its unforeseeable technical advances. A good doctor, however, must always find adequate time to maintain a personal, friendly and relaxed attitude towards his patient.

The next WMA Council will meet in Prague, April 26–28, 2012. One of the topics proposed by the CzMA will be to coordinate the activities of The World Health Professions Alliance ([www.whpa.org](http://www.whpa.org)) in the Czech Republic, namely targeting tobacco smoking, the need for a holistic approach to health care, and the social determinants of health and other cultural, environmental and economic factors, with special attention to the elderly.

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Association (WMA)*

## Continuous Medical Education: Physicians' Professional Skills Improvement by Distance Learning

*In modern society physicians' skills upgrading through continuous education has become essential. Consequently, it is a topical issue for public health service in the whole world. We analyse the situation in professional skills improvement and describe the latest developments in Uzbekistan where for the first time the modern form of distance learning for physicians has been introduced.*

**Introduction.** Acquisition of medical knowledge and professional development should be an ongoing process with any practicing physician and done through continu-

ous medical education (CME). Alongside with improvement of professional skills and self-education of physicians CME includes raising of patients' health awareness [1, 3]. Fast changes in medical practice demand from physicians a constant improvement of their professional skills. Some North American research has revealed the expressed inverse relationship between the medical experience and the level of knowledge, as well as the diagnostic and the medical skills. Physicians possess the best clinical skills right after the internship [5, 6]. Attending courses on improvement of professional skills have

proved to be relatively ineffective and actually does not prevent gradual decrease in professional qualification of physicians [7].

In the developed countries paid short-term courses within the framework of the system for continuous medical education are offered to physicians for training them to pass examinations required for granting a license. A widespread form of improving physicians' skills with subsequent licensing is training by using the so-called transcription programmes which are published in journals of various medical as-



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sociations, accredited for CME. The given programmes are a kind of distance learning [4] described, for example, in the Journal of the American Academy of Dermatology. In Uzbekistan improvement of professional skills of medical workers is possible in two ways – by means of direct training (through educational programmes), and indirect training (no educational programmes involved as a rule).

Direct training includes a programme for general and thematic improvement of professional skills (upgrading). The indirect way embraces the following forms: on-the-job training; distance learning; self-education; exchange of experience; participation in seminars, congresses and conferences; courses on the development of information technology [2].

Distance learning as an indirect form of professional skills upgrading is based on information-communication technologies, applied for in-service training in various forms (case studies, on-line asynchronous and synchronous media, etc.). Distance learning can be carried out as an independent form of improving professional skills according to the respective programme or bringing it closer to the customary face-to-

face learning. Duration of a course and its structure depend on the programme and the respective tutor; the course duration might exceed the academic term. Acquiring of new knowledge is monitored by TashIUV, TashFarMI and a certificate is issued after a successful completion of the distance learning course; a sample of it in [2].

Distance learning of physicians is a perspective method for professional training and improving professional skills in medicine [3]. Participants in CME and distance learning are practicing physicians as this method features a number of advantages, e.g. they needn't leave their families and home, their medical institutions and patients [8].

**Research objective:** Study effective and approved methods of post-degree medical education in the developed countries of the world and introduce them in Uzbekistan.

**Materials and methods:** More than 70 000 physicians work in the Republic of Uzbekistan. Every five years each of them has to participate in a qualification upgrading course, covering 288 hours, and be conferred a respective certificate. Implementation of Resolution of the Cabinet of Ministers of

the Republic of Uzbekistan No 319 "On Improvement of the Retraining System and Professional Skills of Medical Doctors in the Republic of Uzbekistan" of 18 December, 2009, is assigned to the Tashkent Institute of Qualification Improvement of Physicians.

Analysing the reasons for physicians in Uzbekistan neglecting the traditional methods for upgrading professional skills the following factors can be singled out: unwillingness to leave the family and home, as well as the medical institutions and patients, shifting the workload to the colleagues, the travel expenses, accommodation and sustenance costs in another city.

To introduce modern training methods in 2010 an agreement was made for physicians becoming readers of the periodic journal "Bulletin of the Medical Association of Uzbekistan"; the certificate form has been approved as well.

The Medical Association of Uzbekistan together with the Tashkent Institute of Qualification Improvement of Physicians develop curricula of distance learning. In 2010–2011 in the "Bulletin of the Medical Association of Uzbekistan" nine curricula on the following themes have been published: the public health situation in Uzbekistan; stenocardia; current problems in oncology; valueology, the study on the formation of a healthy person; discirculatory venous encephalopathy: diagnostics and treatment problems; dysphagia; changes in the organism and uncomfortable sensations of the woman during pregnancy; modern approach to food for children in the first year of life; the basic directions for improving the outpatient clinic performance in the Republic of Uzbekistan. The curricula are developed taking into account the latest achievements in medicine and targeted at specialists in various fields.

**Results and analysis.** Each curriculum contains in paper format 16–20 tests of

different complexity and three choice answers for the task. After completion of the tests they are sent to the "Bulletin of Medical Association of Uzbekistan" within 6 months after the publication of the respective Bulletin edition. In case correct answers exceed 60% a certificate on distance learning (18 hours course) is conferred.

In 2010 the certificate was conferred to 140 physicians, in 2011 – to 112 physicians for doing the tests published in three issues of the Bulletin. In total in 2010–2011 the Medical Association of Uzbekistan received 302 completed tests, 252 physicians received the certificate, it making 83 % of all the submitted tests.

Thus, the physicians' professional skills have been improved without leaving home and interest in the "Bulletin of Medical Association of Uzbekistan" has been growing as its circulation increased twice in 2011.

**Conclusions.** In the present-day situation we should develop effective methods of postgraduate education that have already been approved in the developed countries of the world.

Improvement of professional skills through distance learning allows knowledge upgrading and retraining of physicians without leaving their medical institutions and patients, as well as saves the incurred expenses of travel, accommodation and sustenance costs.

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## Georgian Experience in Palliative Care Development – From Pilot Programs to International Collaboration



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*Gia Lobzhanidze*



*Zaza Khachiperadze*

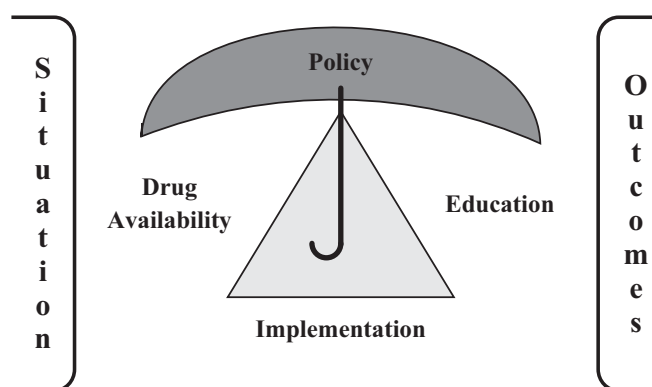


*Dimitri Kordzaia*

Approximately 42,000 deaths are registered annually in Georgia, which has a population of 4.5 million. Based on international data, approx. 60% of these terminal patients (or 25,000) require palliative care and pain relief.

Given that at least two family members are involved in caring for each terminal patient, palliative care services can significantly impact approximately 75,000 people each year, including both patients and caregivers [1].

During recent years in Georgia, through collaboration between Governmental Institutions and NGOs (including International Organizations), the basis for the development of Palliative Care as an integral



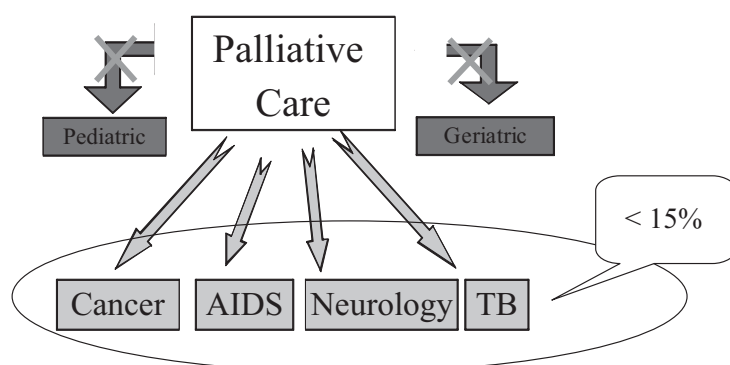
**Figure 1.**

part of the National Healthcare System was created. All activities were performed in accordance with WHO experts' recommendations for the integrated development of "Education", "Drug Availability" and "Services Implementation" under the united umbrella of "Governmental Policy" (Figure 1).

In the period between 2002 and 2011 the following results were achieved:

- Establishment of Palliative Care educational materials in the Georgian language;
- Creation of Palliative Care educational programs and their implementation in Medical Universities and Nursing Schools;

- Preparation and implementation of Palliative Care CME accredited programs;
- Training of medical professionals experienced in Palliative Care, including two international fellows (experts);
- Preparation of Video/TV and printed materials for public education and awareness;
- Improvement of legislative/normative standards regulating Palliative Care and Drug Availability, and promotion of the incorporation of Palliative Care in the National Healthcare system;
- Organization of hospices (in-patients units for Palliative care) and their financial support from the governmental budget;



**Figure 2.**

- Organization of Home-Based Palliative Care Teams and their financial support from the governmental budget;

In 2009-2010 under the leadership of the Georgian National Association for Palliative Care, a group of authors developed the Georgian National Program for Palliative Care [2]. The Program was approved by the Georgian Parliament's Healthcare and Social Issues Committee in July 2010.

Despite of the fact that current palliative care services cover less than 15 % of the needs of the population, and geriatric and pediatric palliative care are still absent (Figure 2), given the relatively short history of its development, the Georgian experience is evaluated by international experts as one of the most successful Palliative Care models among post-Soviet countries.

To share Georgia's knowledge and experience in Palliative Care, site trainings of foreign healthcare professionals in Georgia's capitol, Tbilisi, began in 2011. The first request for cooperation was received from the former Soviet countries of Tajikistan and Kyrgyzstan. The trainings were conducted by the support of Open Society Foundations (OSFs) – the New York office (Ms. Mary Callaway) and the Open Society Georgia Foundation (Irma Khabazi, Nino Kiknadze) – and the Soros foundations in Tajikistan (Nigora Abidjanova) and in Kyrgyzstan (Aibek Mukambetov). The Palliative Care Service of the National Cancer Center (PCSNCC), which includes an in-patient unit with 15 hospital beds, home-based Palliative Care services, and consulting services, was selected as the site for the international training programs. PCSNCC provides emotional support to patients and family members, guides and advises them during cancer treatments, and continues to support them after treatment. PCSNCC also provides home care services in Tbilisi, as well as Kutaisi, Telavi and Zugdidi. All physicians of the PCSNCC are well-trained to identify and re-



lieve physical and psychological symptoms of disease, and provide psychological and spiritual support.

PCSNCC collaborates with numerous national and international organizations working in the fields of practice, education and research related to palliative care and clinical oncology. It is also the clinical affiliate of the Iv. Javakhishvili Tbilisi State University (TSU), actively working with medical students, nursing students, residents, and general practitioners. Since 2011, the PCSNCC has been accredited as a Palliative Care and Oncology integrated centre (ESMO designated centre).

PCSNCC cooperates closely with the Palliative Care National Coordinator's Office of the Parliament of Georgia in advocating for the development of a national strategic plan for palliative care throughout the country, according the above-mentioned Georgian National Program for Palliative Care [2].

An educational/training program for healthcare professionals from Middle Asia was led by Georgian Academy of Palliative Care – Educational Training Resource Centre (GAPC). GAPC was branched from the Georgian National Association for Palliative Care (GNAPC) for better coordination of educational/training programs

and research activities in different fields of palliative care on the national and/or international levels.

The two-week pilot programs (bedside training courses) were conducted for four colleagues from Tajikistan in July 2011 and two colleagues from Kyrgyzstan in August 2011. These programs included the key topics in Palliative Care: essence of pain, evaluation of pain in advanced cancer patients, pain management by opioids administration, evaluation and management of delirium, nausea, vomiting, ascities, breathlessness, etc. All participants worked with experienced medical staff under the supervision of Dr. Rukhadze – the head of PCSNCC and founder of GAPC, who attended three years of specialty training at the Institute of Palliative Medicine & San Diego Hospice (California, USA). After successfully passing exams at the end of the training courses, participants received certificates confirming their skills and knowledge. The trainings were considered a success and at the end of 2011, it was decided that the project would be continued in 2012 and include 18–20 participants from Middle Asian Countries.

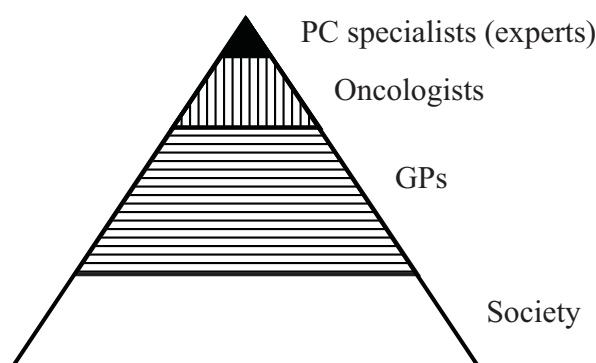
As illustrated in the model provided by J. Stjernsward (Figure 3), we can offer fully sufficient education and training programs

in Palliative Care for GPs and Oncologists from post-Soviet countries. At the same time we are realizing that the optimal approach to training in Palliative Care is should occur across the broad spectrum of stakeholders.

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MD, PhD Gia Lobjanidze, President of Georgian Medical Association;  
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**Figure 3.** *The Community Approach–Necessary to Achieve Palliative Care for All*

## EBM (Evidence Based Medicine), not an Absolute Reference but a Help for Making Decisions



*Roland Lemye*

When Claude Bernard and others introduced experimental medicine, they did not fundamentally upset the knowledge of the time from one day to the other; neither did they reform the way to take care of patients. What they brought in is a method which allowed reaching a better level of certainty in the matter of knowledge and, above all, to get the information in a faster way. But the acquisition of knowledge was still based on former data, since they were verified by experimentation. A huge step had been taken, though, and progress was on its way.

Experimental research allows going further and deeper into the understanding of processes, finding remedies which have a more and more accurate effect on them while restraining their consequences on vital phenomena which are not concerned (side effects). The action on identified risk factors has been clearly evidenced.

Yet, our societies have added other requirements to efficiency: security, which is very legitimate, and one more which we have to

deal with: the relationship between the cost of treatment and the expected benefit for a group of patients (the individual patient has never been taken into account).

From this point of view, researchers have been lead to ask themselves two questions:

- Does the correction of one factor really have the expected effect on, on one hand, reducing the risk and, on the second hand, the chances to survive?
- Doesn't a preventive or curative treatment of a given pathology cause more dreadful complications?

Large studies have been launched. The resulting knowledge has been summarized and EBM arose from it. The promoters of that synthesis imagined they would come up with a helping tool for medical decisions. Collective experience adds itself as a tool to personal experience and medical experimentation. The instigators of the project never imagined that they brought in a change of paradigm for financiers. Since the very beginning, physicians have always taken their decisions in a state of uncertainty. EBM was meant to reduce the degree of uncertainty. Besides, its developers have also established levels of evidence according to the degree of certainty.

Now one could believe, though, that what bears the EBM trademark is secure, the only medication to be authorized for prescription and that what doesn't belong to EBM is definitely discarded. Those who prescribe non-EBM medications should thus be strongly disapproved.

Such a dualistic attitude is not acceptable for a scientific mind. The highest degree of evidence in EBM is meta-analysis. By col-ligating all the studies that were undertaken

on a given subject, it really does have the benefit of reducing uncertainty, but without granting the degree of evidence. In the Middle-Ages, three hear-says were considered an evidence. Will we now admit that three studies amount to evidence?

The questions these studies try to answer are different most of the time. The conditions of the studies, the surveyed patients and, most of all, the results are not homogeneous. How is it possible to make certainties when, most of the times, they rely on facts that stand no comparison?

The resulting agreements have two shortcomings:

- Sometimes they do not stand for anybody's opinion but are the mean of different opinions.
- They are an instant picture of a constantly evolving knowledge on a given subject. They can become obsolete as soon as they are established.

As for experts' recommendations, EBM itself places them at the lowest level of the scale. They can be useful but only if there exist no more evidential elements. Yet, it is on the base of experts' opinions that the authorities produce guidelines for prescription which have nothing to do with a help for making decisions but are imposed like some sort of revelation which, when not followed, exposes a practitioner to disciplinary measures. The Church itself has no longer such power.

### Conclusions :

It is obvious that EBM reduces uncertainty and provides a helping tool for making medical decisions. But it is absolutely not a revolution which implies to sweep away individual experience, which remains an important element of the decisional process. EBM has not yet proven that individual experience and experimental medicine are tools that belong to the past.

EBM is based on statistics. These are established by discarding bad cases like multiple

pathologies, which means most of the cases general practitioners see every day. Statistics appeal to populations, GPs to individuals.

While EBM does give some answers, these are two few compared to the infinite field of questions. A physician has to help a patient even if EBM provides no answer. A physician has to keep on looking for solutions if a patient has been treated according to EBM and the treatment failed. EBM is

always outdated when it comes to medical field knowledge. Until now, EBM has failed to obtain a better care for all risk populations like diabetics, people with overweight, high blood pressure, hypercholesterolemia etc, which grow exponentially and are undertreated.

EBM has diverted from its purpose of being a help for making decisions and became a rationing and control instrument.

EBM's greatest achievement has been to help governments control their expenses. EBM has in no way fought against "magic thinking". Some social insurances, while advocating prescriptions submitted to EBM, do not mind refunding homeopathic prescriptions which have never been validated by EBM.

*Dr. Roland Lemye,  
des Syndicats Medicaux  
President Association Belge*

## Combating Antimicrobial Resistance



*Marie Wedin*

Recently I met my president-colleagues from the other Nordic medical associations. We meet twice a year to discuss current issues relating to political and professional developments in the Nordic countries. It is staggering to realize how dependent we are on international cooperation when it comes to issues such as the spread of infections, pharmaceutical chemicals in the environment, and political trends. In our information-intense societies, healthcare trends are rapidly moving across borders and will be observed and also used by our governments. It is therefore essential to share experiences with colleagues across borders.

One such issue we discussed is antimicrobial resistance, which is climbing on the EU-agenda. Antimicrobial resistant bacteria does not respect borders between professions nor does it recognize national borders. In Sweden there is a network called Strama (the Swedish strategic programme against antimicrobial resistance), which coordinates activities across sectors to maintain antibiotics as a strong tool both for humans and animals.

In November 2011 the EU-commission revealed an action plan for antimicrobial resistance with 12 actions for the next five years. A basic requirement for preventing antimicrobial resistance is monitoring and surveillance of the use of antibiotics in human and animal medicine. Since Denmark holds the Presidency of the Council of the European Union during the first half of 2012, they will prepare a common strategy on preventing antimicrobial resistance. There will be a conference the 14-15 of March in Copenhagen on the issue, with the hope that conclusions from the conference will be adopted by the Council of the European Union.

The Danish Medical Association, which is working closely with the Danish Veterinary Association, would like to see two main conclusions from the conference. The

first one is that all antibiotics used should be prescribed by a doctor or a veterinarian. The second one is that neither doctors nor veterinarians should be allowed to sell antibiotics, as this ability creates the wrong incentive. They would also like to share the Scandinavian model on combating antimicrobial resistance with other EU-countries. Since about two-thirds of the antibiotics in Denmark are used in the agricultural sector, strong cooperation with the veterinarians is crucial.

Antimicrobial resistance is a growing health problem. The EU-commission states that about 25,000 patients die per year in the EU from infections caused by drug resistant bacteria. We need to create awareness among patients and doctors about the risk of using antibiotics and the actions that must be taken. Doctors and veterinarians must show professionalism and present a common strategy for the use of antibiotics – a strategy that should include ethical considerations.

If doctors and veterinarians fail to lead the development in the right direction on issues such as antimicrobial resistance, pharmaceutical chemicals in the environment, and the health effects of climate change, we face an overwhelming risk of losing our best tools for treatment as well as the trust of the general public.

*Dr. Marie Wedin,  
The Swedish Medical Association*

## The World Federation of Public Health Association

Representing the Global Civil Society Voice for Public Health and Health Equity



*James Chauvin*



*Laetitia Rispel*



*Deborah Klein Walker*



*Bettina Borisch*

Public health strives to put into place conditions in which people can live healthy and productive lives. The cornerstones of these efforts are disease/injury prevention and health promotion and protection. Indeed, the steps necessary for people and their communities to be healthy, productive, and resilient starts long before they require medical treatment. Public health begins in the places where people live, learn, and work; in other words, in their families and communities. It takes into account that the health of a population is influenced by more than the health care system. The structural and social determinants of health encompass a wide range of factors, including political, social, economic, physical and technical environments, personal health practices, individual capacity, coping skills, human biology, genetics, early childhood development, life circumstances, income, education, gender and ethnicity. Public health seeks to mitigate preventable disease burdens along with their associated financial and social costs.

The World Federation of Public Health Associations (WFPHA) is the global civil society organization representing the interests of the world's public health community. Created in 1967, the WFPHA currently counts as a member of over 60 national and

regional public health associations, as well as regional associations of schools of public health and several academic, health-oriented institutions/organizations that share the Federation's mission and values (the right to health for all; social justice; diversity and inclusion, partnership and ethical conduct). Cumulatively, the WFPHA represents a voluntary membership community of over 250,000 public health professionals, researchers and practitioners. The WFPHA advocates for a strong civil society voice, the active participation of national public health associations, allied groups in national and global discussions and decision-shaping around public health policy and practice.

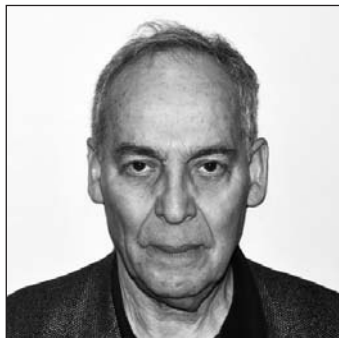
Over the past 44 years, the WFPHA has played a leadership role in global public health. In terms of global health advocacy, the Federation has produced over 40 resolutions, declarations and position papers. These policy statements cover a variety of topics, including the relationship between climate change and environmental health, conflict/peace and health, globalized trade and public health, as well as tobacco control, health systems sustainability, universal and equitable access to primary health care services, health human resources, and the prevention of infectious and non-communicable diseases. In 2010, the WFPHA

passed an innovative resolution calling for a comprehensive and equitable approach to the health of people incarcerated in prisons and other detention centers. The Federation has used these position statements to educate and advocate for stronger, more effective public health policies and strategies at the global level, through the World Health Organization and other multilateral organizations. Many WFPHA member associations have used these positions as instruments to support public health policy advocacy efforts in their own countries. They have also formed the evidence base for presentations and statements by WFPHA representatives at international and national conferences.

In recent years, the Federation has focused its advocacy on health equity. At its triennial World Congress on Public Health held in 2009 in Istanbul (Turkey), the WFPHA highlighted its commitment to the issue of Health as a Human Right for All. Through the *Istanbul Declaration*, the Federation reaffirmed the definition of health as a public good and the principles of solidarity, sustainability, morality, justice, equity, fairness and tolerance as fundamental underpinnings of all public health policies and practices. Global health equity is the theme of the Federation's 13<sup>th</sup> World Congress



on Public Health, which takes place April 23–27, 2012 in Addis Ababa (Ethiopia), hosted by the Ethiopian Public Health Association.



*Ulrich Laaser*

The Federation has helped to build the capacity of national and regional public health associations around the world. Over the past 25 years, through the efforts of several WFPHA member associations, such as the Canadian Public Health Association, the European Public Health Association and the American Public Health Association, the organizational and programmatic capacity of new and emerging public health associations in low- and middle-income countries and countries in political transition have been strengthened. Over the past quarter century, over 30 national public health associations have been created and become active members of the WFPHA and, in turn, have acted as mentors to other emerging national PHAs. This growing number of public health associations has enhanced the Federation's effectiveness as a global health advocate.

One of the more recent testaments to the growing importance of the public health movement was the establishment in August 2011 of the African Federation of Public Health Associations, through the combined efforts of over two dozen national PHAs on the African continent. The WFPHA collaborates closely with the AFPHA, as it does with the European Public Health Association and the emerging networks of na-

tional PHAs in the Asia Pacific region and Latin America, to advance action on priority global public health issues and build a strong collective civil society voice for public health.

The policy influence and public health programming impact of national public health associations is impressive. Several PHAs have played leadership roles in tobacco control by influencing the decisions of national governments to ratify and apply locally the Framework Convention on Tobacco Control (FCTC), which was the world's first public health treaty. Others have focused their efforts on public health education and training, the expansion and quality of access to public health services, such as immunization, water supply sanitation, maternal-newborn and child health services, the prevention and control of both infectious and non-communicable diseases, the prevention and treatment of HIV and AIDS, and access to essential medicines. Some of the PHAs have become strong advocates for a social determinants approach to achieving health and health equity.

The WFPHA looks forward to contributing, in an effective and productive manner, to achieving health equity for all. Over the next few years, the Federation will review and refine its organizational strategic plan to advance public health practice, education, training and research and help facilitate and support efforts to improve the organizational and programmatic capacity of national PHAs. The WFPHA intends to expand and strengthen its partnerships with organizations such as the World Medical Association and other civil society movements that share our values. It will also enhance its advocacy capacity to shape global public health policies and strategies through more pro-active participation in future World Health Assemblies, the development and dissemination of bold position statements on issues that affect the public's health and visibility through participation in global and regional conferences and events.

In partnership with other global federations and associations and in support of a strong leadership role for the World Health Organization, the World Federation of Public Health Associations will continue to make its mark helping put into place the conditions and opportunities for people and their communities to be healthy, productive and resilient.

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## A Globalized World – and a Unified Global Approach for Health Professions



*Orlando Monteiro da Silva*

### The global context

For any professional association working in the medical field, it is very important to be globally present and make sure that the interests of the profession, and in particular the interests of the public, are well represented, promoted and defended at an international level.

The reason that associations and institutions federate locally, nationally, regionally and internationally is that they believe that joining forces with like-minded associations at each level gives them a better chance of achieving their goals. It means they can discuss, debate, sometimes dispute, and generally arrive at some kind of compromise to move forward.

For our colleagues, it is sometimes difficult to understand the reasons behind the existence of certain international organizations and what they do beyond that which a regional, national or even local organization can achieve.

Dentistry and dental medicine have always been one of the best organized professions around the world at the national level. World Dental Federation (FDI) was set up over 110 years ago as a forum for dentists globally to share views and experiences together.

Its continued existence today implicitly recognizes that the profession needs an international voice to defend its positions and promote its views. Let me give you three examples:

#### 1) A focus on prevention

As we all know, teeth have a vital function in the human body: healthy teeth are a vital part of human health. Caring for teeth and oral health is essential for a healthy population. Tooth decay and periodontal (bone and gum) disease currently affect 90% of people around the world.

With limited funds available for restorative care in many countries, an essential part of FDI's work is to raise awareness of the importance of oral health and focus its projects and activities on prevention strategies. This, for example, is the key message of the landmark Global Caries Initiative, GCI for short.

The GCI vision is to improve oral health through the implementation of a new paradigm for managing dental caries and their consequences – a paradigm that is based on our current knowledge of the disease process and its prevention, so as to deliver optimal oral and thus general health and well being to all peoples. In practice, the goal is to achieve a paradigm shift from the restorative to the preventive model of oral care.

FDI launched the GCI in 2009, with some very concrete priorities and actions:

- Eradicate very early childhood caries in children 0–3 years of age by 2020
- Carry out primary and secondary prevention and health promotion activities
- Achieve consensus on terminology

FDI was joined in its efforts by founding partners Colgate, GlaxoSmithKline, Procter and Gamble Oral health, Unilever and Wrigley. The aim was to establish a broad alliance of key influencers and decision-makers from research, education, clinical practice, public health, government and industry, partnering in a common goal: to achieve the 2020 goal by effecting fundamental change in health systems and individual behaviour.

The GCI's first task was to design and develop a prevention-oriented caries classification and management system (CCMS), thereby laying the foundation for the preventive model of caries management. It is now in the process of developing an overarching Global Oral Health Improvement Matrix (GOHIM) to integrate oral health into health, thereby establishing a collaborative, prevention-oriented model of oral health care. It is precisely this preventive model of care that FDI is advocating, along with professional partners, within the context of the global fight against noncommunicable diseases.

#### 2) Oral health and noncommunicable diseases (NCDs)

It is now time to admit that viewing oral health as somehow separate from general health is truly obsolete, and nowhere is the indisputable relationship between the two better illustrated than in the area of NCDs, or chronic diseases as they are sometimes known.

NCDs, which include cardiovascular disease, cancer, chronic respiratory disease and diabetes, among others, are responsible for 60% of deaths worldwide: in 2008, 36 million people died from NCDs, around 80% of them in low to medium income countries.

With this in mind, FDI undertook a project to develop a practical tool to help in the fight against NCDs, the NCD toolkit. It carried out the work on behalf of the WHPA World Health Professions Alliance—representing well over 20 million health professionals worldwide, including dentists, physicians, physical therapists, pharmacists and nurses. The Toolkit was funded by the International Federation of Pharmaceutical Manufacturers and Associations.

The Toolkit focuses on common risk factors—poor diet, physical inactivity, smoking and alcohol abuse—and includes a ‘Health Improvement Card’ for the individual to assess personal risk, in consultation with a health professional. The Toolkit also contains support materials for the health professional as well as for the patient, together with advice on how to reduce or eliminate certain risk behaviours.

Naturally, some people have asked why FDI and ‘dentistry’ agreed to lead the WHPA project: after all, oral diseases do not account for high death rates. There are two main reasons:

- Neglected NCDs such as tooth decay and periodontal disease affect more than 90% of the world’s population and have an enormous impact on health;
- There is increasing association and scientific evidence between the presence of oral conditions (especially periodontal disease) and systemic diseases, including cardiovascular and cerebrovascular diseases, adverse pregnancy outcomes, diabetes mellitus, pulmonary infections and different forms of cancer.

Furthermore, it is my view that that the dental profession, and dental medicine in general, should have a much broader ambition. Within the medical sphere, the various fields of education, prevention, diagnosis, treatment and rehabilitation are becoming increasingly interrelated. Equally, relations between dental medicine and medicine in general, as well as other fields

such as nutrition, psychology and sociology, are growing.

Indeed, dental practitioners are in a unique position when it comes to detecting risk factors. They are one of the few medical professions to see patients who are not actually ill but just there for a check-up. Furthermore, many behaviours are immediately visible during the course of a dental check-up, so dentists are well positioned to initiate discussion on risks.

FDI’s next move will be to field test the WHPA Toolkit in one or two key developing countries to assess how well it integrates into health strategy and its methods of use by health professionals.

On a wider level, FDI is now looking to establish the Global Oral Health Partnership (GOHP). This is envisaged as a multi-stakeholder partnership to address the NCD burden with a special responsibility for oral diseases: dental caries, periodontal disease and oral cancer. The GOHP’s objective is to provide strategic leadership to co-ordinate and synergize policy, strategy and programmes within a common stakeholder framework. This will enable the implementation of a model of oral health care based on health promotion, disease prevention and preventive disease management worldwide.

### 3) Oral health and development

The major contribution to the NCD Toolkit and the associated WHPA NCD campaign project allowed FDI—along with a number of other agencies and groupings working in the field of oral health—to achieve an important goal: to have oral disease specifically referenced in the Political Declaration of the United Nations Summit on NCDs held in New York in September 2011.

In practical terms, Summit Declarations contain principles to guide development strategy and projects. Having oral health mentioned within the context of NCDs and primary health care means that dental

medicine is now officially linked with general health policy.

This is certainly what many developing countries would wish for. This was clearly illustrated by an event I attended during the course of the Summit entitled ‘Putting the teeth into NCDs’ and by the Republic of Tanzania. It highlighted the importance of oral health in health strategy. In fact, one speaker, Helen Clark, Administrator of the United Nations Development Programme (UNDP), called oral diseases “obstacles to development”.

I am gratified to see how FDI is so much in tune with concepts of development: it is indeed time to face the fact that viewing oral health as somehow separate from general health is truly obsolete.

And also obsolete is approaching health without a political and public understanding of health inequities and social determinants of health: it is necessary to take action simultaneously on the broader factors that influence people’s health behaviour; the conditions in which they are born, grow, live, work and age; and the influence of society.

Together with its coalition members, WHPA is in a unique position to raise awareness on this approach at a global level, in light of the scope of the recent WHO World Conference on Social Determinants of Health in Rio de Janeiro.

### Conclusion

We at FDI have recently intensified our dialog, with the aim of encouraging governments to prioritize and promote oral health and consider it as a citizens’ right. It is essential that we continue to stress the fundamental point: “Good oral health is a primary factor in general health”.

*Orlando Monteiro da Silva,  
FDI President*

*E-mail: orlando@orlandomonteirodasilva.com*

## The Medical Association of Thailand



*Wonchat Subhachaturas*

### Standing and domestic Activities

- Continuous Medical Education and research promotion.
- Provision of scholarships for postgraduate study and research in Japan in collaboration with the Takeda Science Foundation.
- Provision of the Research Grants to member.
- Lecture tours on Special topics: Continuous Medical Education and Medical Ethics.
- Monthly Publication of the Journal of Medical Association of Thailand.

- Launching of E-Journal to Members and public.
- Supply Accommodation for members at the club house.
- Provide consultative support for members with professional legal problems.
- Organize charity golf tournament for the fund raising.
- Organize Post congress tours to study Health Care abroad.
- Performing Medical Advocacy through social Medias: Radio, Television and Newspaper.

**International Activities:** Participation at the International congresses and medical association meetings as invited and as a member – WMA; CMAAO; MASEAN; National Medical Associations in Asia, Australia, Europe, North and South America etc.

### Special Events.

- Hosting the 1st International Summit on Tobacco Control in Asia and Oceania Region on February
- 25, 2010 at Rose Garden Riverside Hotel, Sampran, Thailand resulting in Sampran Declaration.
- At the WMA Congress and General Assembly 2010 in Vancouver, Canada, Dr. Wonchat Subhachaturas, the President Elect of the MAT, was elected at the

General Assembly to be the 61st President of the World Medical Association for period of 2010–2011, the ninth from Asia and the first from Thailand

- Organizing the 90<sup>th</sup> Anniversary Celebration of the MAT on September, 27–30, 2011.
- Exchange visit with the Chinese Medical Association on August 4–8, 2011 in Beijing.
- Promotion of community Tobacco Cessation Programs through the Thai Health Alliance Against Tobacco Network (THPAAT)
- Setting up health and rehabilitation visiting teams for the flood victims in collaboration with the Thai Health Professionals against Tobacco (THPAAT).
- Organizing the robes presentation to the priests at the temple with donation.

### Contact Persons of the Current Executive Board of the MAT:

President: Dr. Wonchat Subhachaturas; President Elect: Assoc. Prof. Dr. Prasert Sarnvivad; Vice President: Prof. Dr. Teerachai Chantrarojanasiri; Secretary General: Prof. Dr. Saranatra Waikakul; Treasurer: Group Captain Dr. Paisal Chantarapitak; International Relations: Lt. General Dr. Nopadol Wora-urai; CEO: Prof. Dr. Somsri Pausawasdi

**The Medical Association of Thailand committed itself to host the 2012 General Assembly of the World Medical Association during October 10–13, 2012 in Bangkok.**

### Flood in Thailand 2011

The flood in Thailand this year, 2011 was the heaviest and the worst in the history of the country. Twenty-six provinces out of seventy-seven were affected mostly in the north and the central basin with the loss of 540 lives mostly from land slide, drowning and electric shock. More than 2 millions of the population have been the victims of the flood and more than 300,000 people were evacuated from their home places to the higher evacuation grounds. The estimated loss of the country could reach 1,000 billion Baht (31 Baht = 1US\$) in total. However, with the superb collaboration of the governmental and nongovernmental health organizations and institutions and massive health volunteers, no epidemics were detected so far.





## Celebrating 125 Year Anniversary – NZMA Challenges and Opportunities



*Paul Ockelford*

The New Zealand Medical Association (NZMA) is the largest medical professional organisation in New Zealand. We are pan-professional, representing doctors from all disciplines within medicine and at every stage of their career. The pan-professional focus differentiates our organisation from the other medical bodies in the country and gives us the mandate to advocate on issues that influence the medical profession as a whole.

It was with significant pride that the NZMA celebrated its 125-year anniversary in 2011. NZMA Chair Dr. Paul Ockelford, speaking at a function late last year which showcased and celebrated 125 years of the NZMA, said that the Association had a long and proud history but continued to be proactive by anticipating emerging health sector issues impacting on doctors and patients.

He referred to the Role of the Doctor Consensus Statement, recently published in the New Zealand Medical Journal, as

an example of the NZMA taking a leadership role. The NZMA hosted medical leaders from throughout New Zealand at a two-day seminar to develop the statement, which highlights the key skills and personal attributes required by doctors to ensure patient care is not compromised in a health sector undergoing significant change. It reflects the greater role of the patient in making decisions about their health care and also considers the role of the doctor within the wider healthcare team. The statement reinforces the role and the responsibility of doctors as leaders in the healthcare team, and as public health advocates. The statement, endorsed by the medical colleges, will serve as the foundation for ongoing discussions with government and the wider health sector to deliver optimal healthcare to New Zealanders.

The NZMA's direction is driven by our mission statement: to provide leadership of the medical profession; to promote professional unity and values, and the health of all New Zealanders. We have developed a strategic plan for the next five years which will build on these principles and shape the Association's future work. The six priorities in the plan provide a strategic focus to advance the health of New Zealanders and leadership of the profession in the context of a rapidly changing health sector. Key themes include improving the health status and health outcomes of all New Zealanders; proactively advocating on behalf of the profession; being one profession with one vision and one voice; targeting both national and global health issues; being responsive to concerns raised by members and championing quality in health policy and systems.

The NZMA is highly respected for its knowledge, reasoned commentary and

robust evidence based positions. It has a strategic programme of advocacy with politicians and officials at the highest levels of government and works consistently to maintain strong relationships within the health sector and other government agencies, including the Ministry of Health, Accident Compensation Corporation, Department of Labour, and Ministry of Social Development. The Association is influential in shaping health policy and it has a growing membership which reflects increasing recognition among doctors that a strong, unified voice for the profession is essential, especially in a time of rapid health sector changes.

The NZMA also advocates on a wide range of issues, with the medical workforce and health equity being two major areas of activity.

### Medical workforce

At the forefront of NZMA advocacy is the medical workforce. New Zealand is facing shortages of doctors (and other health professionals), and there are challenges in recruiting and retaining staff. The competitive global health market means many local graduates choose to work in other countries often for higher salaries. New Zealand has an over-reliance on overseas trained doctors – around 45 percent of doctors working in New Zealand did not train here. After years of little progress, with governments not even acknowledging a problem existed, we are beginning to see real progress.

Health Workforce New Zealand (HWNZ) has been formed to lead and coordinate the planning and development of our country's health workforce to achieve a self-sufficient, fit for purpose workforce that meets the healthcare needs of New Zealanders. This new agency has implemented a number of initiatives, including: increases in medical student numbers, a voluntary bonding

scheme and interest free loans for medical students who stay in New Zealand. The NZMA is generally supportive of HWNZ's goals and has forged a good working relationship with the organisation. We are nevertheless concerned about some of the initiatives, particularly those that have been undertaken with little wider policy analysis and without adequate consultation with doctors and medical students. The NZMA will continue to voice these concerns to HWNZ and work with the organisation to provide input into its projects.

High quality training for our doctors is another issue crucial for NZMA's workforce advocacy. Many of our doctors in training members are concerned there is excessive emphasis on service delivery at the expense of training. Ensuring that trainee doctors have sufficient learning time, mentoring and supervision is essential to effective health workforce development.

New Zealand's medical workforce has many challenges – an increasing demand for health services, especially in light of our ageing population, the ageing doctor workforce which is not being adequately replenished, doctor dissatisfaction and morale, doctors leaving New Zealand for

overseas and optimal scopes of practice. Well-informed and determined advocacy can make a discernable difference towards improving these and other workforce issues.

## Health equity

The NZMA has taken a leadership role in raising awareness of health inequity and the correlation between social factors and health outcomes. In our Health Equity Position Statement we have recommended a whole of government, inter-agency approach to address the social determinants of health (such as housing, education and employment) to help bridge health inequities. The NZMA has urged the Government to invest more in preventive care, particularly in early childhood, and supports investment into disorders such as Rheumatic Fever that disproportionately affect Maori and Pacific communities. There appears to be a growing willingness from throughout the political spectrum to address health inequity and certainly increased recognition of the key actions required such as a minimum income for healthy living and investing in housing and education to achieve health outcomes.

## 2012

Commemorating 125 years of the NZMA has provided a platform to celebrate the Association's achievements and reflect on the major milestones. It has also been an opportunity for the NZMA Board to consider and evaluate the NZMA's future direction.

The NZMA is anticipating another active year advocating on a range of issues facing the healthcare sector. These include proposed changes to medicines management, enhancing clinical leadership and governance, delivering electronic health records for all New Zealanders, and the passage into law of the Medicines Amendment Bill which seeks to align the prescribing framework for health professionals. The NZMA is concerned that there has been a shift in the general approach to change in the health sector with less being debated at a policy level and more being introduced in an experimental way. Challenges therefore lie ahead but also opportunities, as we strive to attain a health system which maintains New Zealand as a world leader in quality healthcare delivery.

*Dr. Paul Ockelford, Chairman,  
New Zealand Medical Association*

## Development of Family Medicine in Estonia – from Nothing to Modern Specialty

Prior to independence, the Primary Health Care (PHC) System in Estonia was based on the Soviet Semashko model. Primary care services were mainly provided in polyclinics at first-level patient contact. Polyclinics were staffed by clinicians, gynecologists, surgeons, pediatricians and other specialists. There was no specialist training in family medicine, thus the specialty did not exist. The health centers were owned by municipalities [1, 2].

Following independence, PHC reforms were introduced in 1991. The reforms aimed to develop a family medicine-centered PHC system and to establish family medicine as a medical specialty and academic discipline. In 1993, Estonia was the first post-Soviet country to designate family medicine as a medical specialty. New postgraduate training programs were introduced, including a three-year residency program for new graduates and an in-service retraining program



*Katrin Martinson*

for specialists who were working in PHC. Courses were formed on voluntary bases mainly by clinicians and district pediatricians.

In 1997, significant health reforms were introduced in primary health care, which required citizens to register with the list of family doctors (FDs). The economic status changed for family doctors and they became independent contractors. As independent contractors, family doctors had to establish contracts with the Estonian Health Insurance Fund (EHIF) to provide primary health care services to their registered populations and be remunerated by according to a new mixed payment system comprising basic payment for practice and capitation payment (now 79.9% from income), and fee-for-service (now 18.2% from income) [5].

In 2006 a pay-for-performance (P4P) system was introduced by initiating incentives to promote clinical quality in family medicine. The system was developed in collaboration with the Estonian Society of Family Doctors (ESFD) and EHIF. The system's development remains an ongoing process. While physician participation in the program is voluntary, in 2011, 95% of family doctors were participating in clinical quality assessment (EHIF 2011).

The clinical quality assessment system consists of three parts:

1. Prevention (vaccinations and follow-up of preschool age children, prevention of cardiovascular diseases at the age of 40–60)
2. Management of chronic diseases (type 2 diabetes, arterial hypertension, myocardial infarction and hypothyreosis)
3. Professional competence and CME (recertification and competence of the family doctors and nurses), follow-up for pregnancies, gynecological and surgical activities.
3. Quality of the treatment/therapy (Standards: promoting health and preventing diseases, diagnosing and solving individual health problems, consistency of medical care, cooperation with the patient, safety and quality, education and training)
4. Practice as an educational/scientific base (Standards – practice as an educational base, practice as a base for scientific work)

When family doctors meet 80% or more of the criteria, they are paid on the basis of P4P. The P4P maximum level is 1,2% of the family doctor's income.

In 2009, ESFD defined standards for good practice, publishing the Quality Guide for Estonian Family Doctor Practices (photo added). The manual describes how best to organize work in a family medicine practice. The book was published in the Estonian and Russian language and is also translated and digitally available in English.

Contents of manual:

1. Availability of family doctors and access to the practice (Standards: access to practice, patient information)
2. Organisation of the practice (Standards: working order of the practice, managing medical information, work-rooms and access to them, medical accessories and devices, clinical supporting processes).



**Picture 1.** *The Quality Guide for Estonian Family Doctor Practices*

Appendices to the document are the questionnaire for patients feedback and a table of indicators.



*Eret Jaanson*



*Ruth Kalda*



*Anneli Rätsep*



*Madis Tiik*



**Picture 2.** *The ESFD award for A-level practices*

On the basis of The Quality Guide for Estonian Family Doctor Practices, the development of a practice accreditation system was launched. The ESFD uses an intranet SVOOG as a tool for digital practice accreditation assessment. Family doctors complete the table regarding quality indicators for the practice and receive a score from A (maximum) to C (minimum). This is voluntary and open only to doctors who are members of ESFD. (Of 805 Estonian family doctors, 787 are the members of ESFD). In the first year (2009/2010) 79 practices performed this self-analysis. The number rose to 109 in 2010/2011. The total number of family practices in Estonia is 468.

The board of ESFD has decided to audit the best practices (A-level) through site visits to these practices by volunteer auditors. The auditing protocol was agreed by both sides (the auditor and the practice representative).

As our system is unique – bottom to top organized, voluntary, without any P4P quality

incentives – the only motivation for participants is recognition and positive public attention. In 2011, the President of the Estonian Republic Toomas, Henrik Ilves, specifically acknowledged the A- level practices. ESFD also provided a beautiful pennant (Picture 2), designed by textile artist, Ene Pars.

ESFD is also very proud of our digital distance learning environment for family doctors. Our SVOOG (intranet) system now includes approximately 400 different lectures. Learner can listen to the online lecture, view slides, and answer the questions about the issue. SVOOG also assists family doctors in meeting continuous medical education requirements, through links to different educational centers' homepages and the possibility of collecting educational points for recertification. As mentioned above, SVOOG also facilitates practice accreditation.

Another very important development in Estonian health care is a nationwide e-health system. The idea of national e-health information system (EHR) emerged in 2002, with the purpose of developing a nationwide database of different medical documents in digital format to facilitate the exchange of health information. Beginning on January 1, 2009, care providers have been obliged to forward medical data to the health information system. Patients have the right to set restrictions regarding access to their data. Patient take full responsibility for consequences that may occur from banning access to their medical data [3].

Also part of the e-health system is the e-prescription program, launched on January 1, 2010. Within a year more than 80% of prescriptions were made digital. Both doctors and patients have been satisfied with the development.

The Estonian e-health system is unique. It encompasses the whole country, registers

virtually all residents' medical history from birth to death, and is based on a comprehensive state-developed basic IT infrastructure [4].

The biggest problems are the lack of doctors and nurses in primary care (and in specialist care as well), and trained staff leaving for Europe to earn larger salaries. The system for temporary substitution in time of vacation or illness of regular staff is underdeveloped. In addition, payment for primary care is unbalanced in comparison with specialist care.

In conclusion, a lot has happened within 20 years of family medicine in Estonia. Starting from scratch, there are now 486 family medicine practices, led by 805 family doctors. Family medicine, as the widest medical specialty, has become the most logical and well-functioning base for Estonian health care.

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## Turkish Medical Association (TTB)



*Eriş Bilaloğlu*

The Turkish Medical Association was constituted by Law No. 6023, enacted in 1953. The managing and auditing bodies of the Association are elected by its members (medical doctors) under the supervision of a judge. The mission of the Association is to ensure that the profession of medicine is practised so as to promote the benefit of the public in general as well as individuals, and to protect the rights of physicians. However, recent arrangements by the Government are but negative interventions both to the autonomy of the profession and to the duties of the Association in this regard.

Government Decree no. 663, in Force of Law on the Organization and Duties of the Ministry of Health and its Associated Organizations, reorganizes the field of health in a way that creates many legal and social problems. In fact, under the present Constitution, the authority to introduce primary legislative arrangements rests with the Turkish Grand National Assembly as the legislative body of the Republic. However, by means of an authorization act, the Council of Ministers was equipped with authori-

ties that should actually belong to the legislature. Consequently, new arrangements were unconstitutionally introduced in some domains where the Council of Ministers is normally denied the authority establish rules or codes.

Now we want to share with you the nature of these arrangements that **destroy the universal values of the profession** and require your support and solidarity to find a solution.

1. A new board, the **“Board for Health Professions”** which was previously non-existent was recently formed and equipped with authority pertaining to a large spectrum of health affairs, including physicians themselves and their work.

The Board comprises 14 members designated by the Government plus one member from the Turkish Medical Association which, according to its laws of constitution, is supposed to form and express opinions regarding the profession. Hence the Board is composed of members whose professional and scientific freedom and autonomy is highly questionable.

Duties assigned to the Board are as follows:

- Providing opinions on such matters as educational curricula and training in health; identification of professional areas and branches and planning for the employment of health workforce,
- Establishing ethical codes and principles in health profession,
- Deciding on procedures to be followed in such issues as testing professional competencies of health workers, training of health workers in ethics and patient rights, as well as content and duration of trainings,
- Deciding on bans to practising the profession on grounds of health problems, and

- Deciding on temporary or permanent exclusion from the profession.

As such, the Board assumes the authorities of medical schools, the Turkish Medical Association, and even the legislative body itself by introducing new offences and penalties.

There are over 30 health professions in Turkey and both the respective functions of these professions and the conditions of recruitment are prescribed by law. There are nearly one hundred fields of specialization and sub-specialization solely in the field of medicine. Thus, the members of the Board appointed by the Minister will exercise authority concerning fields in which they may have no competence.

The Board will be in charge of assessing competence in all health professions, setting codes of professional ethics, handing down decisions for exclusion from the profession, measuring professional competence, and developing curricula! In short we face a situation not compatible with any democratic society.

Meanwhile, for 58 years, the Turkish Medical Association has been setting the rules of professional deontology, investigating and applying sanctions for practices not in line with deontology, and organizing trainings to support advancements in the profession. The latest arrangement by the Government virtually eliminates the established duties and authorities of the Turkish Medical Association and other professional associations and undermines the autonomy of the profession and its guarantees by delegating full authority to a board whose members are to be appointed by the Ministry of Health.

2. The expression **“ensuring that medical profession is practised and promoted in line with public and individual well-being**



**and benefit**" in Article 1 of the Constituting Law of the Turkish Medical Association has been deleted from the text.

This amendment is tantamount to excluding from the mandate of a professional association **the task of practising and promoting medicine for public and individual well-being and benefit.**

The new arrangements taken as a whole deprive the medical profession of the means to be managed and supervised autonomously by its own professionals within the framework of values specific to the profession itself. They also completely disregard the principle of exemption from the control of any Governmental office or agency, which is a precondition for being a constituent member of the World Medical Association.

As the Turkish Medical Association, we urge all Medical Associations to support us in the fight against this unacceptable action taken by the Government. We request that you use your strong and important influence to assist us in this regard. The Turkish Medical Association kindly asks for the solidarity of your Medical Association in stating its position on this issue.

## In defence of universal values of the profession of medicine and rights of the physician in Turkey

While the TTB was founded back in 1953 with its present name, its background dates back to Etibba Chambers of 1929. Its history runs parallel to the history of the Republic of Turkey founded in 1923 and the development of democracy.

The TTB was originally a professional organization with compulsory membership for all physicians. However, after the military coup of 12 September 1980, which violently eliminated democratic organization and introduced constitutional arrangements for

preventing the flourishing of democracy, the requirement for compulsory membership was lifted, except in the case of freelance doctors. Turkey started with 700 physicians in 1923, reaching over 7,000 in 1953, and at present has over 120,000 physicians.

The first president of TTB was also the head of the World Medical Association in 1957-58. The 11<sup>th</sup> World Medical Congress was held in İstanbul in October 1957 and the "Attitude of Doctors in Conflict Situations" was adopted at that meeting.

The TTB has 65 local chambers throughout the country and their executives are elected every two years. The TTB is engaged in all problems in the field of medicine and carries out its activities with its members working on voluntary basis. Under the umbrella of TTB, students of medicine, general practitioners and associations of specialists are organized as autonomous bodies. The TTB is in close contact with the European Union of Medical Specialists (UEMS). The following are among specific activities that the TTB is engaged in:

- Organizing Workshops for developing professional ethics (1998) and ethical guidelines
- dealing with disciplinary actions relating to the profession
- developing and presenting draft legislation about the rights of physicians, cases of malpractice, and medical practices
- supporting and participating in such processes as planning for the health workforce, training and education in medicine, life-long professional development, crediting and National Medical Education Accreditation
- developing and annually publishing guides for medical examination fees
- delivering health services in emergencies
- conducting work in such areas as the rights of patients, women's issues, and female physicians
- categorization of medical services
- drawing attention to problems and issues such as public health, abuse of children

and elderly people, and the health status of persons in prisons

- protesting against human rights violations, smoking, and nuclear plants and hydraulic power plants that harm environmental health
- standing against wars and defending peace in all circumstances.

Of the above activities, the personal rights of employed physicians and medical education/training enjoy special priority and importance.

- During its more recent history following 1980, the TTB became the focal point in defending the personal rights of employed physicians. Particularly after 2003, its struggle against the dominant attitude, "knowing the price but not the value of everything", devaluation of the work of the physician, and countrywide practices of sub-contracting and lack of secure employment were recognized even in the official statements of the Ministry of Health as "TTB's intensive and noisy opposition". In addition to presenting draft laws and opinions on personal rights and benefits for the health workforce and associated initiatives, the TTB also organizes demonstrations and other actions including temporarily stopping work.
- Due to top-to-down approaches imposed by the Government, Turkey is among the leaders in the number of new schools of medicine opened. In 2006 there were 50 medical schools. There are 83 today. In 2011, approximately 9,000 new students enrolled in these schools. A large proportion of these newly enrolled students eventually graduate. However, despite the full commitment of the academic staffs, these schools were launched without consideration of the necessary infrastructure and standards, leading to the problem of poorly qualified graduates.

The TTB also has a legal affairs board composed of professional lawyers. This body manages a large work burden, since the

government's arbitrary acts outside of the legal framework are rather frequent. Publications of the Association are prepared by editorial boards composed of persons working voluntarily, and include "Continuous Education in Medicine" targeting primary level health services; "Occupational Health and Safety Journal" targeting those engaged in this area; the periodical "Community and Physician" that contains articles in medicine and politics; and the bulletin "World of Medicine" providing information about centrally organized activities and other issues and events of interest.

Unfortunately, the TTB has had significant experience in very difficult and undesirable issues. Mushrooming events of torture, cruel and degrading treatment and human rights violations-particularly after the military coup of 1980-brought to the forefront the unity of medical professionals in terms of spotting and reporting such cases and the actions required by medical ethics in the face of such events. It is based on this experience that the TTB was able to significantly contribute to the Guidebook to the Istanbul Protocol on the Effective Investigation and Documentation of Cases of Torture and other Cruel, Inhuman and Degrading Treatment or Punishment, which was also approved by the United Nations.

The Board Members of the TTB have been charged and prosecuted twice, in 1985 and again in the 2000s, with the objective of their removal from positions to which they were elected. In the first case, it was for TTB's objection to capital punishment on the ground of professional ethics and its insistence that physicians be excluded from executions although it was legally obligatory. The second case was TTB's stance on the attitude of physicians in regard to widespread hunger strikes going on in prisons at that time. In both cases and beyond, in defense of the right to life and health, the TTB insistently stood for peaceful and democratic solutions to en-

vironments of conflict and associated assaults and killings.

In short, the TTB promotes and defends the universal values of the profession of medicine in Turkey and stands for the rights of physicians on the basis of professional values and the right to health. The TTB is committed to protecting the profession from established government policies that create dilemmas regarding both physicians' and patients' rights. The TTB evaluates its responsibilities in the context of the overall situation in any given period-in Turkey or in the world-to develop suggestions about health policies and determine its stance with regard to the right to health. The TTB is the representative of an approach that refutes negative medical practices of the past and strives to maintain and promote its accumulated knowledge and experience by upholding the principles of public health.

Turkey is endowed with a strong legacy in the medical profession. The history of the young Turkish Republic has witnessed strenuous efforts of physicians in diverse areas and particularly in combating contagious diseases. However, in spite popular support and prestige, physicians and the TTB wrestle with many difficulties, mostly created by the government. In this context, two periods deserve special mention. The first was the practice and discourse of the military junta following the coup of 12 September 1980 and the second is the period that began in 2003 and continues today. Pressure on and harassment of physicians in the present period of civilian Government have assumed dimensions one might expect to see in satire magazines. For example, regulations and instructions determine even the door and window measurements and heights of stairs in facilities where physicians receive their patients. At present, the policy pursued by the Government aims at creating disrespect for the profession of medicine and physicians. This policy is accompanied statistics, such as one of every

three patients visit the emergency service when at a hospital, and "efficiency" is defined as a physician examining over 100 patients a day. The rights of patients are reduced to ordinary consumer rights in terms of satisfaction, while the demand for health services is transformed into "customer demand". Further provoked by irresponsible and hostile discourse by politicians, this situation instigated physical violence against physicians. In the face of this threat, the TTB created a "Group for Zero Tolerance to Violence" to combat violence targeting health workers. The Ministry of Health, on the other hand, just ignored a parliamentary investigation proposal on this issue lodged by some deputies.

The stance of the TTB vis á vis government policies and practices is subject to defamation by describing it as "raising opposition", "engaging in politics", or "acting with ideological motives". Another policy being pursued is geared toward ending TTB's connection with and representation before the Government, and the Ministry of Health in particular. There are initiatives to position the TTB as a hierarchical subordinate of the Ministry. And finally, there is the Government Decree in Force of Law on which the WMA circulated its letter dated 11 January 2011 informing its members.

**We should be proud that in the face of all difficulties, Turkey still has physicians dedicated to their profession and there is the turkish medical association!**

*Dr. Eriş Bilaloğlu  
President of Turkish Medical Association*

# World Medical Journal

## Serbian Medical Chamber

The Serbian Medical Chamber is an independent, professional, self-governing and self-financing organization of Serbian medical doctors based on mandatory membership. Founded according to the Law on Health Care Professionals Chambers, the Serbian Medical Chamber was created to improve the medical profession's working conditions, protect its professional interests, and actively participate in developing and managing the healthcare interests of citizens, particularly in attaining their healthcare protection rights.

### The Republic of Serbia assigned to the Serbian Medical Chamber the following authorities:

- To adopt the Code of Professional Ethics
- To register medical doctors and to keep an index of all members
- To issue, renew and revoke medical licenses and to keep records on them
- To mediate disputes among its members or between its members and patients
- To organize the Courts of Honor for investigation of alleged breaches of professional duties and to apply penalties, maintaining a separate index on these issues
- To issue the official records, certificates and confirmations from the directories
- To establish membership and license fees
- To issue identification cards and license numbers to its members

At the same time, the Serbian Medical Chamber represents and protects the professional interests of its members, and promotes and defends the reputation of the profession and health care services provided according to the Code of Professional Ethics. It responds to illegitimate and unfounded public statements in media for the sake of protection of its members.

The Serbian Medical Chamber was originally founded in 1901 and remained active

until 1945, when it was cancelled by the Communist Decree. Its work was restored in December 2006. The Serbian Medical Chamber has exercised its given authority and has become one of the most important stakeholders in the health care system of Serbia. There are approximately 30,500 medical licenses issued in Serbia, today, which are required for medical doctors to practice.

### The Main Working Principles of the Serbian Medical Chamber are:

- **Serbian medical chamber independence.** The Serbian Medical Chamber is self-governing professional organization that is financially autonomous, since it is financed by membership fees and not from the state budget of the Republic of Serbia
- **Legality of the assigned authorities.** Among the most important authorities assigned by the State are licensing and re-licensing of medical doctors
- **Protection of the medical profession, and promotion of the honor and reputation of medical doctors and medical profession.**
- **Absolute equality of private and public practice.**
- **Decentralization and regional organization of the serbian medical chamber.**
- **Transparency.**

### The Serbian Medical Chamber Mission:

As a specialized organization, the Serbian Medical Chamber protects the medical profession, the honor and reputation of physicians, and the overall health profession

and, at the same time, actively works to re-inforce public and individual patient trust in medical doctors.

### The Serbian Medical Chamber Vision:

The Serbian Medical Chamber strives to be an important factor in medical problem resolution and to influence the outline, scope and contents of all medically-related laws, including the Medical Law itself.

Based on the professional potential of its members and its professional bodies, the Serbian Medical Chamber has the vision to move from the margins of

the Serbian health care system (where it currently stands despite of all its efforts), and to actively participate in core dialogue and decision-making within the health care system of Serbia. **We can. We know how. We will. We are responsible and we act exclusively according to the law.**

### Serbian Medical Chamber Plan for the Following Period

1. Developing a strategic and sustainable five year business plan
2. Improving the Serbian Medical Chamber IT system in terms of communications networking
3. Expanding its assigned public authority in the area of medical expert supervision
4. Introducing clinical protocols as a mandatory segment of the Serbian Health Care System
5. Outlining the national strategy for minimizing professional and medical mistakes
6. Introducing clinical audit and peer review as part of the licensing process
7. Outlining the national anti-corruption strategy

*Dr. Tatjana Radosavljevic,  
General Manager, Lekarska Komora Srbije*



*Tatjana Radosavljevic*



## Cyprus Medical Association (CyMA)

### A Glance to the Past, the Present and the Future



*Andreas Demetriou*



*Alkis Papadouris*

The Cyprus Medical Association was established in 1967 and represents all practicing physicians in Cyprus. The main aims of the Association are to unite all members of the medical profession who are practicing in Cyprus and to safeguard their interests. According to the Cypriot Law, membership to the CyMA is compulsory to all physicians that are practising in Cyprus. Furthermore, the CyMA provides advice and assistance to its members in their mutual relations, and in their relations with the State or other authorities and organisations. In addition, the CyMA cooperates with other national and international bodies in order to foster its aims.

The Cyprus Medical Association is not only a professional body but also acts in various ways for the benefit of patients and the public in general. Objectives of the Association include protecting medical ethics; developing the health care system so that every patient enjoys the right to adequate treatment; offering its members professional training and advancement opportunities; introducing new legislation and regulations governing health issues; and managing the members' pension fund and life insurance schemes.

has an administrative board of 24 members. It meets once a month and appoints its nine sub-committees. These sub-committees are the Ethics Committee, the Continuing Medical Education Committee, the Bioethics Committee, the Scientific Committee, the Law and Regulations Committee, the Pension Fund Committee, the Communication Committee, the National Health Insurance Scheme Committee and the International and European Affairs Committee.

According to the new General Charter of the CyMA, its administrative board has been constituted as follows:

1. The Presidents of each regional Medical Association (Nicosia-Kyrenia, Famagusta, Larnaca, Limassol and Paphos.)
2. Representatives of each Regional Association according to the number of its members (Nicosia-Kyrenia = 5, Limassol = 4, Famagusta = 2, Larnaca = 2, and Paphos = 2) and
3. Four members elected from the General Assembly of the CyMA

In total, the CyMA has 2584 active members, of which 36% are women and 64% are men.

The Association administers its authority through five regional medical associations: 1) Nicosia-Kyrenia, 2) Famagusta, 3) Larnaca, 4) Limassol and 5) Paphos.

The Cyprus Medical Association

Currently, the Cyprus Medical Association participate in various regional, European and international medical bodies such as:

- The Standing Committee of European Doctors (CPME)
- The European Union of Medical Specialists (UEMS)
- The European Forum of Medical Associations (EFMA)
- The World Health Organization (WHO)
- European Accreditation Council for Continuing Medical Education (EACCME)
- Conference Europeene des Ordres de Medecins (CEOM)
- GIPEF – Regional Medical Association of Mediterranean countries
- Conferenza degli Ordini dei Medici Euro Mediterranei (COMEM)
- World Medical Association (WMA)
- Commonwealth Medical Association (CMA)
- Balkan Medical Association (BMA)

Among other events, for 2012 the Cyprus Medical Association will host the annual meetings of the CPME and the UEMS in the second half of the year.

Two other Medical Associations are active in Cyprus, besides CyMA. The first one is the Cyprus Government Physicians Union, whose members are also members of CyMA. The second one is the Turkish Cypriot Medical Association, which is registered under the illegal regime in the occupied northern part of Cyprus and thus has no legal validity. Moreover a number of Turkish Cypriot physician that are practicing in the north are also members of the CyMA.

*Dr. Andreas Demetriou,  
President of the CyMA,  
Dr. Alkis Papadouris,  
Secretary of the CyMA*

## Mission 2012 – Taiwan Medical Association



*Ming-Been Lee*

Humanity, professional innovation, and medical quality are the three core values that guided the work of Taiwan Medical Association (TMA) in 2011. Some noteworthy activities in the past year include: promoting medical malpractice civil liability, establishment of a Medical Specialty Think Tank, revising the standards of medical establishments, promoting safety medical practice, organizing long-term care training course, reviewing clinic-based global budgeting, improving patient-centered care at the primary level, advocating holistic care to ensure safety and quality, and hosting the 27<sup>th</sup> Confederation of Medical Associations in Asia and Oceania (CMAAO) Congress and 47<sup>th</sup> Council Meeting. Key agenda items for 2012 include international participation, the national health insurance program, medical services audit, medical care act reform, continuing medical education and member welfare.

### International participation and exchange

The TMA encourages and recommends that physicians and experts attend inter-

national professional meetings. In addition, the TMA sends goodwill delegations to visit national medical associations or medical societies around the world in order to strengthen ties and facilitate professional exchange on various issues, such as medical administration, drug administration, the healthcare environment and other health affairs. In particular, the TMA hopes to play an active role in the operation, document revision and activities of the World Medical Association. By close interaction and participation with international non-governmental organizations, the TMA enhances its capacity and performance.

### National health insurance

Being a key stakeholder in the health care system, the TMA studies policies and operations related to the National Health Insurance (NHI) financial system. By ensuring full understanding of the systems, the TMA is able to provide solutions to achieve fair resource allocation. At the same time, the TMA maintains regular communications with the Bureau of National Health Insurance (BNHI) to improve people's health and to assist members in carrying out projects commissioned by the Bureau. The TMA also monitors development of pilot projects under the NHI and provides suggestions. Of course, establishing a comprehensive global budget implementation methodology is also a continuous effort of the TMA.

### Clinic-based medical service audit

The TMA has been commissioned by the BNHI to design and implement a mechanism that performs clinic-based medical service auditing. This mechanism aims to

increase efficiency, and ensure regulatory compliance and effective management.

### Coping with the global budget system

The TMA stresses the importance of self-management by the medical community and the existence of a fair and objective audit mechanism in the global budget system. To this end, the TMA will participate in setting reasonable practice guidelines. While the global budget payment system incorporates external auditing, it is the responsibility of the TMA to take part in the negotiation process and uphold the independence and dignity of the medical community.

### Medical Care Act revision

To address the increasingly complex issues involving medical malpractice, the TMA has been working since last year to revise the Medical Care Act to specify criminal malpractice and its consequences. The TMA will continue promoting the revision in 2012 by approaching government agencies for better understanding, mobilizing its members to lobby for consent, and submission of the draft to parliament for endorsement.

### Violence in the healthcare setting

To prevent violent episodes in healthcare facilities, the TMA requests medical societies to collect information and investigate the causes of such occurrences. The TMA also demands that local chapters protect physicians' rights when they are threatened or injured, and requires that they follow up existing cases. Furthermore, for the safety of patients and medical staffs, the TMA ap-

# World Medical Journal



peals to the authorities to increase punishments for these offenses and will formulate a standard operating procedure dealing with workplace violence.

## Improved continuing medical education for higher quality medical care

The TMA coordinates among professional groups to organize continuing medical education (CME) for general practitioners. CME comes in multiple formats, includ-

ing the Taiwan Medical Journal and TMA's online program. Course announcements are updated on a regular basis on the TMA homepage. The TMA, along with local and regional academic institutions, offers video conferences to provide CME for members in the remote areas.

## Member benefit program development

To improve member benefits, the TMA will offer favorable options for its members by

having several insurance companies design policies that meet members' needs, specifically malpractice insurance. In the public sphere, the TMA will also appeal to the government to reaffirm the contribution of physicians and pass legislation protecting physicians' welfare.

*Dr. Ming-Been Lee, President of TMA and CMAAO.*

## French Medical Association (AMF)



*Xavier Deau*

France has been represented at the WMA by the French Medical Association (AMF), of which the French Medical Council (CNOM) is a member. The year 2012 is important for French representation since the French Medical Council and the French Medical Association have decided to submit to the WMA the French Medical Council's application for membership.

The French Medical Council, an independent and autonomous institution, recognized to be of public utility by the French

legislation, manages the recognition of the professional qualifications, the registration to the Register of the Order, the authorization to practice and the discipline of the profession. The French Medical Council's opinion is regularly sought before any drafting of a law in the field of public health in France.

At the international level, the French Medical Council has a permanent office in Brussels in order to be as close as possible to the European legislature. It also serves as the Secretariat of the European Council of Medical Orders (CEOM), chaired by the Belgian Medical Council, in close cooperation with all the other Orders. The CEOM adopted on June 10, 2011 the European Charter of Medical Ethics.

The French Medical Council also provides the Secretariat for the Conference of the Francophone Medical Councils (CFOM), chaired by the Gabonese Medical Order; The CFOM brings together many European and African francophone states.

As we are facing the revision of several European Directives (notably in 2012, the revision of the Directive on the recognition of professional qualifications, but also the Directive on protection of personal data) and

French bioethics laws, we understand that deontology can differ, depending on the legislation in force in each country, but we remain convinced that there is a single and universal ethic since Hippocrates.

This ethic must be fully respected by any doctor, whatever the country of practice. It is essential that each government respect the independence of the physicians and comply with this right to ethic.

This, is one the principal reasons why we wish to strengthen our presence in the WMA in collaboration with the French Medical Association, indispensable partner.

For more information:

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*Dr. Xavier DEAU,  
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## Award for Physicians in The Republic of Kazakhstan



*Aizhan Sadykova*

ALTYN DARIGER is the highest public recognition award for physicians' contribution to the development of national public health, selfless work in protecting people's health and an active involvement in social activities, established by the National Medical Association (NMA) of the Republic of Kazakhstan.

ALTYN DARIGER, translated from the Kazakh language, means a golden physician, implying the high evaluation of the physician's merits.

The Association established ALTYN DARIGER in 2009, the year when the Association of Doctors and Pharmacists of Kazakhstan celebrated its 20<sup>th</sup> anniversary and, accompanied by re-registration, it was renamed as the National Medical Association. We have always focused on moral encouragement. I believe that many people will share my opinion that we all feel gratified if our work has been appreciated and when putting one's heart and soul into the work it is rewarded not only financially, but also morally in the form of

letters of appreciation, badges, medals and titles.

The members of the Association are awarded not only letters of appreciation, but also badges of several categories: the ALTYN DARIGER badge, the NMA golden badge, the NMA diamond badge, as well as the title of Honorary Member of the National Medical Association. For organizations providing a high quality health care, the merit award Public Recognition of High Quality Health Care has been established. Moreover, people and organizations involved in charity work, aiding patients, clinics or doing philanthropy work are awarded the title *Mayirim* that means mercy. To commemorate our colleagues who died, providing medical assistance to people during the Great Patriotic War, as well as in peacetime, in 2000 in the 28 Panfilov Heroes Memorial Park in Almaty a memorial stone was erected and trees planted in the avenue *Ave Vitae*.

Doctors of the South-Kazakhstan region followed suit and in 2010 in Turkistan city a memorial was unveiled and an avenue set up, financed by medical professionals and supported by H. Yasavi International Kazakh-Turkish University. L. T. Tashimov, President of the University, already at the 2010 commencement ceremony conferred diplomas to young doctors at this sacred place.

Why is the place sacred? In 2008 in Turkistan city three doctors died, trying to save the life of a young woman. Struggling for her life and attempting to stop the bleeding, they were infected by a deadly contagious disease. All of them were awarded posthumously the honorary title together with five other doctors of Kazakhstan. Besides, according to the Resolution of the Central Council of the

National Medical Association the ALTYN DARIGER badge shall be awarded to doctors of other countries for great contribution to the health protection system of our country. Members of WMA, WHO and other international organizations have promoted the development of our organization and Kazakhstan, and the following distinguished persons have been awarded the ALTYN DARIGER:

- Dr. Joe Asvall, former Director General, WHO EUROPE
- Dr. Allan Rowe, WHO EUROPE
- Dr. Rene Salzberg/European Forum of Medical Association and WHO
- Dr. Yoram Blachar, President, Israel Medical Association
- Dr. Andrey Kehayov, SEEMF President, Bulgaria.

NMA has over 60 branches (regional and specialty-specified), Individuals, various official institutions and public organizations may apply for membership. To become a candidate member to our Organization at least five-year experience is required, and what is most important – the candidate should meet the requirements set for the high rank of ALTYN DARIGER.

The NMA golden badge and the NMA diamond badge were established in honour of the 15<sup>th</sup> anniversary of our Organization. ALTYN DARIGER is awarded twice a year – during the NMA General Assembly held on the eve of the Medical Workers Day and when celebrating independence of the Republic of Kazakhstan. Each Association branch may nominate only one candidate for ALTYN DARIGER, therefore the candidates undergo a rigorous selection.

*Dr. Aizhan Sadykova  
President of National Medical Association  
of the Republic of Kazakhstan*



## Nepal Medical Association



*Bhupendra Kumar Basnet*

Established on March 4<sup>th</sup>, 1951, the Nepal Medical Association is the largest and oldest professional organization of medical doctors in Nepal. The goals of the NMA are increased coordination, efficiency improvements and advocacy related to the needs and deeds of our medical doctors. The association has been regularly publishing an indexed medical journal and organizing scientific workshops, seminars and conferences to keep our medical professionals fully up-to-date with the advances in medical science. Basic health care has been enshrined as a fundamental right under the Interim Constitution of Nepal. With this important recognition in the Constitution paving the way, we are working closely with our government to provide basic health services to the people of Nepal.

The NMA has granted affiliation under our constitution to 25 specialty societies working in Nepal. All of these societies are involved in professional and academic activities and include the Society of Surgeons of Nepal, the Society of Internal Medicine of Nepal, the Nepal Orthopedic Association

and many others. The NMA, itself, operates 14 zonal branches spread across Nepal and has a total of 4,171 life members, to date. The NMA is an affiliate of the World Medical Association, the Indian Medical Association and the Confederation of Medical Associations in Asia and Oceania.

### Aims and Objectives

- Maintain a Code of Conduct to protect the medical profession.
- Facilitate the formulation of health policies with the government.
- Protect and advocate for human rights and medical ethics.
- Encourage its members to maintain the highest professional standards.

To achieve these objectives, the NMA is specifically focused on the following categories

### Professional Activities:

Rights, Regulations, Ethics, and Advocacy of Medical Professionals.

### Academic Activities

The NMA has published a peer reviewed medical Journal since 1963 and an indexed in PubMed/MedLine since 2005.

Continuing Medical Education (CME) Programmes conducted include:

- National Consultative Meeting on Undergraduate vs. Postgraduate's Seats: Rationale, Challenges and Future Prospective in Nepal (June 28, 2009)
- Review of Kidney Transplantation Challenges, Recent Trends and Future Perspectives in Nepal (Sep 21, 2009)
- Malaria Diagnosis & Treatment Guideline of Nepal (November 1–3, 2010)
- Various other CME programmes

### CME Programmes Proposed:

- Capacity building for Nepal Medical Association members

- Training for Medical Journal Editors, Author and Peer Reviewer
- One-day workshop to implement the Health Professional Protection Act in Medical Institutions.
- One-day medical conference entitled "The Importance of District Coverage and Primary Health Care Services"
- A medical wastes management workshop

### Institutional Activities

1. NMA has actively participated in and chaired the Professionals' Alliance for Peace and Democracy in the country
2. NMA has a small guest house with 12 beds available only to NMA Life Members who are visiting.
3. NMA has some scholarship programs for undergraduate and post graduate medical students.
4. NMA has some provisions to provide scholarships for the children of deceased Life Members.
5. NMA has plan to construct a new building for official as well as commercial purposes.
6. Submission of a proposal on "Digitalization of the Journal of Nepal Medical Association".

The present day world, especially in underdeveloped countries like ours, is experiencing a difficult phase of uncertainty. Performing our respective duties efficiently, honestly and sincerely in such an insecure atmosphere of instability and mismanagement is somewhat risky. As a result, the working situation is deteriorating in the field of health services. The proposed forum seeks to address the obstacles a doctor in a developing country is encountering. With the cooperation of the Ministry of Health, our population and different health agencies like the WHO, the Nepal Medical Association is working towards better health for our people and a better working environment for medical professionals in our country.

*Dr. Bhupendra Kumar Basnet,  
General Secretary, Nepal Medical Association*

## EU Umbrella Organizations Call for a Concrete EU-level Action for Better Adherence to Therapies

A lunch debate held at the European Parliament in Brussels EPF, CPME, PGEU and EFPIA brought together perspectives of patients, doctors, community pharmacists and the research-based pharmaceutical industry presenting examples of best practices on adherence to therapies and demonstrating how a coordinated, multi-stakeholder and patient-centred approach – involving patients, their carers/families, health professionals, industry, and the public, is a key factor in improving patient safety and the quality of healthcare tailored to patients' needs.

Hosting MEPs **Linda McAvan (S&D)**, **Christofer Fjellner (PPE)** and **Cristian Silviu Buşoi (ALDE)** opened the event by emphasising the vital importance of adherence to therapies *"In the EU alone 194,500 deaths each year are due to misdose of and non-adherence to prescribed medication. Poor adherence carries a huge cost, both in terms of patient safety and quality of life. It also presents a serious problem for health systems, both in terms of inferior health outcomes, unnecessary treatments and hospitalisations"* said Linda McAvan. *"The World Health Organization has stressed that increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments"* added Christofer Fjellner.

*"When long-term medication is prescribed, 50% of patients fail to adhere to the prescribed regimen"* said Prof. Przemysław Kardas from the Medical University of Lodz, Poland, who gave an overview of facts and figures on non-adherence. *"Adherence-enhancing interventions should be adopted as a routine part of normal care, and provided to every patient"*.

The patients' perspective was presented by Christos Sotirelis, who said: *"Adherence support and concordance are key components of good quality care. We believe that concordance in healthcare decision-making will lead to higher adherence by the patient. Health professionals should engage with patients as equal partners in the prescribing process, really listening to and taking account of their views. We need to empower patients and educate health professionals in order to create such an environment and promote meaningful dialogue."*

*"Doctors believe that much can be done from the communication point of view in order to improve medical adherence. eHealth tools could be used on a more regular basis in order to facilitate easy and fast communication, particularly between doctors and pharmacists, under the condition that data protection and privacy is safeguarded"* added Dr. Lemye, Vice-President of CPME, who presented the role of doctors in a health care team with patients and pharmacists.

Raj Patel from the National Pharmacy Association of UK, member of PGEU, illustrated how pharmacists in the UK contribute to a better medicines management through the Medicines Use Review service. *"Pharmacists' interventions to improve adherence – such as medicine use reviews – have been shown to be effective, both in terms of patient outcomes and cost efficiency. The need for new approaches to counselling patients on medicine use will only grow as our population ages, and more of our fellow citizens take a number of different medicines at the same time. But to really make an impact we need to develop such initiatives on a large scale. Partnership with patients and other health professionals is cru-*

*cial for this. The opportunities are there – we cannot afford to miss them"* said John Chave – Secretary General, PGEU.

Speaking at the conference today Mr Richard Bergström – Director General of EFPIA – explained how the pharmaceutical industry can contribute: *"EFPIA and its member companies are committed to improve adherence to therapies. This will contribute to better health outcomes and support sustainable healthcare systems in times of economic constraints. EFPIA wishes to encourage more data gathering and evaluation, encourage best-practice sharing and involve all relevant stakeholders. A medicine that is sold but not taken is a waste for everyone – only cost and no benefit"*.

Finally, in his closing speech, MEP Cristian Silviu Buşoi added: *"There is still a lack of coordination between health professionals, patients and the industry. The Steering Group of the European Innovation Partnership on Active and Healthy Ageing, which is a pilot flagship initiative within the EU "Innovation Union" has recognised the importance of addressing treatment adherence and polypharmacy. The Partnership will be an excellent opportunity to explore potential innovative solutions that can support individual patients and carers, improve data sharing and communication between health professionals, and improve the integration of care"*.

EPF, CPME, PGEU and EFPIA called for a concrete EU-level action on adherence, for example through:

- Prioritising adherence and concordance in the future EU Health Programme, in the Steering Group of the European Innovation Partnership on Active and Healthy Ageing and the Research Framework Programmes
- Setting up information and awareness campaigns targeted to patients and the public, as part of an EU strategy for health literacy and information to patients
- Using the Structural Funds to implement adherence intervention

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# Contents

Editorial .....	1	The Medical Association of Thailand .....	22
Research Ethics Committees: Identifying and Weighing Potential Benefit and Harm from Clinical Research .....	2	Celebrating 125 Year Anniversary – NZMA Challenges and Opportunities .....	23
And Still, What is “Deontological Ethics”? .....	6	Development of Family Medicine in Estonia – from Nothing to Modern Specialty .....	24
Is the Colombian Health System Equitable? .....	9	Turkish Medical Association (TTB) .....	27
The Education of Medicine in the Czech Republic .....	10	Serbian Medical Chamber .....	30
Continuous Medical Education: Physicians’ Professional Skills Improvement by Distance Learning .....	11	Cyprus Medical Association (CyMA) .....	31
Georgian Experience in Palliative Care Development – From Pilot Programs to International Collaboration .....	13	Mission 2012 – Taiwan Medical Association .....	32
EBM (Evidence Based Medicine), not an Absolute Reference but a Help for Making Decisions .....	16	French Medical Association (AMF) .....	33
Combating Antimicrobial Resistance .....	17	Award for Physicians in The Republic of Kazakhstan .....	34
The World Federation of Public Health Association .....	18	Nepal Medical Association .....	35
A Globalized World – and a Unified Global Approach for Health Professions .....	20	EU Umbrella Organizations Call for a Concrete EU-level Action for Better Adherence to Therapies .....	36
		WMA Directory of Constituent Members .....	37