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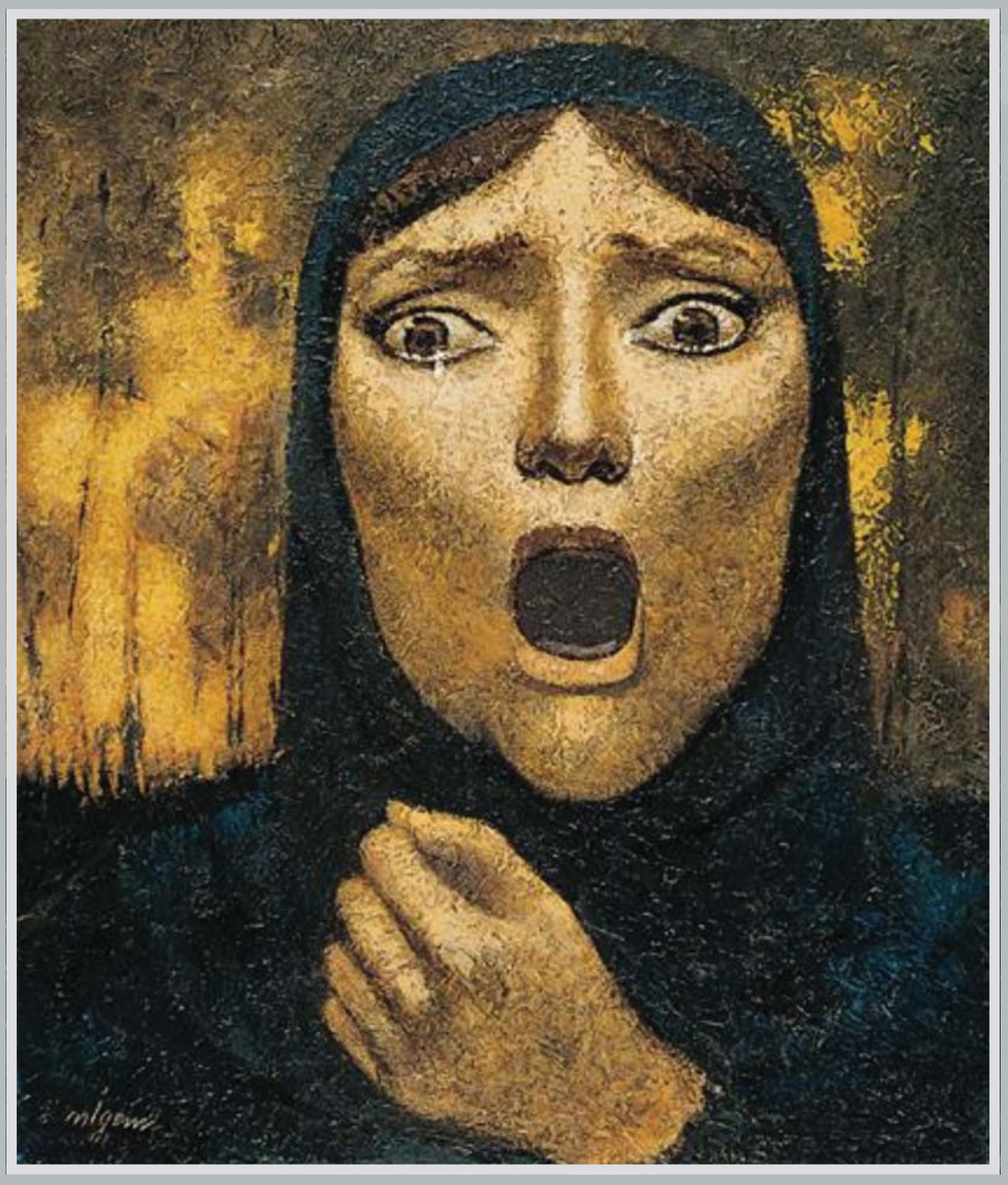
World Medical Journal

Official Journal of the World Medical Association, INC Nr. 2, May 2012 vol. 58



- 191st WMA Council Meeting
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Official Journal of the World Medical Association

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Cover painting:
Painting by Nuri Iyem (Turkish, 1915–2005)
Oil on canvas

Publisher
The World Medical Association, Inc. BP 63
01212 Ferney-Voltaire Cedex, France

Publishing House
Publishing House
Deutscher-Ärzte Verlag GmbH,
Dieselstr. 2, P.O.Box 40 02 65
50832 Cologne/Germany
Phone (0 22 34) 70 11-0
Fax (0 22 34) 70 11-2 55
Producer
Alexander Krauth

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50859 Köln, Dieselstr. 2, Germany
IBAN: DE83370100500019250506
BIC: PBNKDEFF
Bank: Deutsche Apotheker- und Ärztebank,
IBAN: DE28300606010101107410
BIC: DAAEDEDD
50670 Cologne, No. 01 011 07410
Advertising rates available on request

The magazine is published bi-mounthly.
Subscriptions will be accepted by
Deutscher Ärzte-Verlag or
the World Medical Association

Subscription fee € 22,80 per annum (incl. 7% *MwSt.*). For members of the World Medical Association and for Associate members the subscription fee is settled by the membership or associate payment. Details of Associate Membership may be found at the World Medical Association website www.wma.net

Printed by
Deutscher Ärzte-Verlag
Cologne, Germany
ISSN: 0049-8122

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Editorial

In Memoriam Alan J. Rowe

My first meeting with Alan Rowe was at the German Annual Assembly in Dresden, 1992. He explained me his plans for the European Forum of Medical Associations and WHO (EFMA), for which he was Secretary from 1984 to 2001. With the fall of communism in East Europe, the Forum should take on a new role and he was very clear about the importance of reaching out to the medical communities of the new democracies.

My first meeting with Alan Rowe was, in a way, a disappointment, I thought. He would not argue with me. Whatever I criticized, he reflected my criticism and did not oppose any point. My arguments weren't that good, I knew. So was he an opportunist? The impression of him as a passive man stayed with me all day. But in the following days, I observed a man who was driven by a cause, a mission: a unified Europe. One that was more than the Europe of the rich, or the European Economic Community as it was called then. He was looking for all of Europe and actually beyond. Very soon it became clear that my first impression was wrong and that Alan Rowe was a true philanthropist constantly searching for harmony and understanding. A very rare species in this world.

The humble General Practitioner from the east of England was his outer appearance, but in his portfolio was a number of important positions he held and filled during his long career. He was rooted in a very thorough and traditional education. After his basic medical education in London, he studied pathology and then became a General Practitioner in 1954. He served in this capacity in Ixworth Suffolk, during what others would consider a full work life until 1988. It would be unfair, however, to describe his medical interest strictly by his role as a family physician. He engaged as well in specialised fields of medicine such as rheumatology and oncology, as well as in general fields, such as medical education and, most important, public health. The latter found him cooperating with the World Health Organization, to whose European Branch in Copenhagen he always stayed closely connected.

His work brought him respect and recognition in many countries of Europe and there are probably not many other physicians who have been recognized and awarded in so many countrie – and in some even several times! Aside from his home country, which made him an Officer of the British Empire, he received honours in Italy, France, Portugal, Germany, Poland, Kazakhstan, Georgia, Romania, and Macedonia. (This list is probably not exhaustive.)

Alan Rowe engaged in organized medicine and volunteered for many duties in the British Medical Association, the European Union of General Practitioners, the Standing Committee of European Doctors, the European Forum of Medical Associations and WHO, and neither last nor least, the World Medical Association. In 2003 he joined and volunteered to edit the World Medical Journal and he reviewed it from a mere existence to being a real membership journal. He only promised to do it for a year or two and when finally Peteris Apinis took over as Editor in 2007, he remained committed and continued to volunteer as a co-editor.

On a few occasions he treated us with his special gift as a musician. Whenever there was an opportunity he gave us – sometimes spontaneously – an organ concert.

His health limited him during his last years of life more and more, but he still participated in our European meetings and collaborated enthustiastically over the phone and by e-mail until the very last weeks.

On April 30th Alan peacefully passed away and many of us have lost a good friend, a kind and gentle colleague, an artist and a great European spirit. And while my first encounter with him appeared to be disappointing for a moment, the rest was a wonderful friendship.

Dr. Otmar Kloiber
Secretary General, WMA

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Activities of WMA since October 2011

Jose Luiz Gomes do Amaral

In the last six months, a full working agenda has been accomplished by the Presidency of the World Medical Association (WMA). After taking the Office in Montevideo (Uruguay), in October last year, the Brazilian Dr. José Luiz Gomes do Amaral, hold a debate on Social Determinants of Health as his first commitment at the International Conference in Rio de Janeiro in the same month.

At that time, having the opportunity to represent physicians from a hundred Nations, he expressed the importance of finding a solution for social inequalities, observed in both the rich and the developing countries. These inequalities are the main responsible for the health level populations are facing. They refer to the conditions people are born and grow up, to the differences in education, opportunities and working conditions and to the conditions people age. Physicians play an important role in this field, since, besides assisting people in need, the profession comprehends the intervention in the factors that give rise to poor health. For instance, tobacco and excessive alcohol consumption are causes of several diseases. And the question arises what makes us smoke and drink excessively? The "causes of causes" of diseases, i.e., their social determinants, require analysis and intervention. Increased taxation on tobacco, sale of alcoholic beverages to the underaged made cumbersome, tobacco and alcohol advertisements banned are examples to deeply impact the access and consumption of these products.

In Chihuahua, Mexico, last November, the President of the WMA offered solidarity to the Mexican colleagues at the Assembly of Mexican Medical College, where the issue was a response to the violence against health professionals fighting drug trafficking, mainly in the city of Juarez. Various aspects of insecurity doctors in many areas around the world have to face were revealed.

On November 19th, in Panama, several NMAs from Latin-American nations met. Among the problems that threaten the quality of medical services and particularly, the Medicine, there were brought out the repeated political interferences in doctor organizations, mainly in Bolivia and Venezuela. In Bolivia today, the government tries to disassemble the medical profession and regulate it, as well as decide on ethical issues and technical competences which qualify different specialties. The objective of the government is to take total control of the profession. Still, on 25–26 November, Portuguese medical students met to debate the European economic crisis viewing it from the professional perspective of young doctors in a continent that is going through major challenges.

From January 30th through February 1, in São Paulo, at the headquarters of the Medical Association of the State of São Paulo and in Rio de Janeiro, doctors announced the worldwide campaign for 2012 – "Global appeal" against the discrimination faced by persons affected by leprosy.

One year after the earthquake followed by a tsunami and nuclear accident in Japan, on March 11th, 2012, the "Montevideo Statement" was presented, which deals with the role of medical association and physicians in response to disaster situations. At the Japanese Medical Association, in Tokyo, the successful mobilization of Japanese physicians around this key issue, sharing such experience, carry enormous benefits for diminishing the impact upon the lives of people of the less and less infrequent catastrophic events.

In April this year, in Taiwan, at the opening of the 20th International Conference on Health Promoting Hospitals, the opportunity to approach the role of hospitals and health services for the promotion of health and tackling social determinants of health was underlined. The experience of two hospitals from the city of São Paulo was presented. One of them was Pirajussara General Hospital which was built 13 years ago in a poor area of the city and which has successfully contributed to the improvement of local social conditions. Similarly, the experience of Hospital Israelita Albert Einstein was presented, demonstrating relevant social actions to the community of Paraisópolis, a poor community with almost 60 thousand inhabitants. At the same event, the meeting for "Health without Danger" took place, which is oriented to management processes of health institutions and preservation of the environment. The environmental impact of modern hospitals has been capturing more and more the attention of society.

Also past April in Ankara and Istanbul, Turkey, the WMA was represented by the President and the Council Chair for the intermediation of physicians and parliamentary group of that country because of the crisis caused by a decree recently pro-

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mulgated and brutally restricting the independence and authority of doctors concerning their professional, ethical and technical self-regulation. The growing animosity of the Turkish government against medical profession, creating a hostile environment against health professionals, has generated serious situations: physicians have been blamed responsible for the consequences of an erroneous public system; dissemination of false information on the lack of doctors as a justification for "importing" physicians from the neighboring countries or other parts of the world and which, to a great extent, has been influenced by the crisis. The crisis culminated in the murdering of a 30-year old doctor, followed by a great demonstration throughout the country. In Istanbul the President of the WMA participated in the demonstration of more than 20 thousand doctors, bringing the city of Istanbul into a halt and raising a popular outcry as a response to this tragedy.

In April 23, the President of the WMA and its Council participated in the meeting of "Health Care in Danger", an initiative, convening such organizations as the World and the British Medical Association, the International Red Cross/Crescent and Doctors without Borders to discuss the growing violence wave against health professionals in several regions of the world, e.g. Somalia, Libya, Egypt, Bahrain, Syria, Iraq, Afghanistan, Israel, Mexico, Colombia, the civil and military conflicts. Using the opportunity, the WMA presented its position in the field of ethics and medical neutrality in conflict situations. Physicians and other medical professionals have been arrested, kidnapped, tortured and murdered in retaliation for assisting people that eventually belong to an opponent group. Hospitals have been bombed and invaded. Such incidents have interrupted humanitarian actions, causing the withdrawal of voluntary teams whose security could not be ensured and, thus, leaving a great amount of unassisted people behind.

At the end of April, namely April 24–29, a Council Meeting of the World Medical Association took place in Prague, the Czech Republic. In addition to the problems mentioned above, other important issues were tackled as well, such as opening of one more revising of the Declaration of Helsinki, an initiative started by Dr.Urban Wiesing from Tubingen University and Dr.Ramin Parsa-Parsi from the German Medical Association. The Meeting also dealt with the prohibition of physician participation in death penalty and the repudiation of the organ use from sentenced prisoners-donors for transplanting, which is unacceptable, since it contradicts the professional ethical foundations of medicine.

Dr.José Luiz Gomes do Amaral,
President of WMA

191st WMA Council Meeting

Prague, the Czech Republic (April 26–28, 2012)

The 191st Council meeting of the World Medical Association opened with Dr. Mukesh Haikerwal, Chair of the Council, presiding. Almost 150 delegates from 40 National Medical Associations attended the meeting, which was held at the Marriott Hotel in Prague, the Czech Republic.

The President Dr. José Gomes do Amaral began by giving an oral report on his activities and the many meetings he had attended. He said that he and Dr. Haikerwal had been able to give particular support to the Turkish Medical Association on their recent visit to Istanbul, joining a demonstration of doctors after the death of a young Turkish physician.

The Secretary General Dr. Otmar Kloiber presented a detailed report on his activities and the activities of the WMA staff. He said the WMA was still being asked to do more than it could do. However, the organisation was growing in its networking activity and partnership with other organisations.

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Declaration of Helsinki

Dr. Ramin Parsa-Parsi (Germany), Chair of the Workgroup on the revision of the Declaration of Helsinki, reported on the preparation for two conferences, the first in Rotterdam in June and the second in Cape Town in December, Prof. Urban Wiesing, the WMA's ethics adviser on the Declaration, gave an oral report on the Workgroup's progress.

The committee agreed to recommend to the Council that an invitation for a public consultation be sent out after the Council had approved a draft version of a revised Declaration, possibly as early as Spring 2013; that National Medical Associations should be asked to put forward suggested topics for the revision process; and that the Workgroup be authorised to continue planning the two conferences.

Finance and planning

Dr. Leonid Eidelman (Israel), Chair of the Finance and Planning Committee, presided.

Membership Dues

Mr Addy Hällmyer, the WMA's Financial Adviser, said that there were still substantial amounts of dues outstanding for 2012 membership payments. He thanked all those NMAs who had paid their dues.

Financial Report

Presenting the financial report, Mr Hällmyer said that 2011 had been another year of financial turbulence. But despite this the WMA had not suffered any loss in its financial assets. Dr. Frank Montgomery (Germany), the Treasurer, assured the meeting that the Association was financially in good standing.

Business Development

Mr Tony Bourne (United Kingdom), Chair of the Business Development Group, said the main topic of discussion at the Group's latest meeting was the idea of setting up a round table of outside organisations. But the proposal now was for it to be a non-revenue raising forum. There would be no specific fees derived from these organisations. What would be required from them would be a registration fee designed to cover the costs of administering a round table. The idea for the composition of a round table would be that it should be a mixture of non-governmental organisations, multilateral organisations and commercial companies. Ideally it would meet initially once a year at the time of the WMA General Assembly. He said the British Medical Association had undertaken to draft a charter or memorandum of understanding about the rules of engagement. This would be circulated to the Council Executive. He hoped that between ten and fifteen organisations would be approached in a pilot scheme over the next one to two months.

Disaster Preparedness

Dr. Miguel Jorge (Brazil) gave an oral report from the Workgroup on Disaster Preparedness and Medical Response. The group was continuing to work with other bodies, such as the Red Cross and the World Health Professional Alliance, and it was now think-

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ing of conducting a survey among NMAs to identify their programmes and activities. It was also considering an online course for the WMA's website. To do this he asked that the Workgroup's mandate should be extended.

The committee agreed to recommend this to the Council.

Future WMA Meetings

Dr. Kloiber said there had been many applications from NMAs to host future General Assemblies. Applications had been received from Argentina, Columbia, Indonesia, Latvia, Russia, South Africa and Taiwan.

Short oral presentations were then given by each NMA to the meeting, and after a vote it was decided to hold the 2014 Assembly in Durban, South Africa.

Strategic Plan

Dr. Robert Ouellet (Canada), Chair of the Strategic Planning Group, reported on progress of the three-year rolling strategic plan that had been discussed at the last General Assembly. He introduced Emmanuelle Morin from the Canadian Medical Association who said they had now moved to the stage of preparing a final strategic plan. She spoke about the results of the survey of members and stakeholders. This had identified the core business areas of ethics and guidance, advocacy and representation, and networking and outreach. What now had to be decided were the priority strategic objectives, such as operational excellence, and partnership and collaborations. Members had to ask themselves whether this plan would provide the direction needed for the WMA over the next 3–5 years.

The committee decided that the latest document on the strategic plan should be circulated to NMAs for further consideration.

Membership

Junior Doctors Network

Dr. Xaviour Walker, Chair of the Network, gave an oral report about the Network's activities. He said the Network had been in existence now for two years as the first global organisation of its kind. It was planning to network with other junior doctors' organisations and to work with NMAs that did not have junior representation. The Network was involved in developing two papers for the WMA, one on physician wellbeing and the other on ethical global health training.

Membership

Applications for membership were received from the Myanmar Medical Association and from the Sri Lanka Medical Association. The committee decided to recommend the Council to forward the applications to the General Assembly for acceptance

France

An application for membership was received from the Conseil de l'Ordre National des Medecins to replace the French Medical Association. Dr. Michel Legmann (Conseil de l'Ordre National des Medecins) said that the 270,000 French physicians had to be registered with the Conseil in order to be able to practice.

The committee recommended the Council to forward the request to the General Assembly for adoption.

Election Procedure

Dr. Ouellet proposed an amendment to the WMA's election and voting procedures, stating that in order to be elected a candidate must be present at the time of the election. This would be in line with the election requirements of most national medical associations.

In the debate that followed, a number of concerns were identified, and Dr. Ouellet decided to withdraw the amendment for further consideration.

WMA Awards

A proposal was considered for a new WMA awards scheme to recognise physicians and lay persons who had helped to improve medical care. The idea was put forward by Dr. Peteris Apinis (Latvia), but after the details were explained, it was decided that the idea should not be pursued.

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Dr. Peteris Apinis, editor in chief of the Journal, said the WMJ had been published for 58 years. Since 2010 it had been published bi-monthly. He said he would like to publish the Journal 12 times a year, but this would be financially challenging. His ideas for developing a scientific edition would also depend on finding the necessary resources.

Socio-Medical Affairs Committee

Social Determinants

Sir Michael Marmot (United Kingdom), Chair of the Socio-Medical Affairs Committee, opened the proceedings of his committee, by giving a report on social determinants. He said he was conducting a review of social determinants and the health divide in the European region and there would be a report to the WHO later this year. The WMA had an important role to play about

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what doctors and other health professionals could do in this arena.

Health and the Environment

Dr. Dongchun Shin (Korea) gave an oral report about the UN Climate Change Summit which he attended in Durban, South Africa last year and the parallel Global Climate and Health Summit. These brought together key health sector people to discuss the impact of climate change on public health and solutions to promote greater health. The WMA was one of the partners in the event.

Dr. Vivienne Nathanson (United Kingdom) said she had attended a follow up Health Sector Climate Strategy discussion held to build on the work of the Durban Summit. She said there was a worrying trend of health repeatedly slipping from the agenda when talking about climate change. There was a need to produce a resource which identified what the health environmental and economic cases were for averting climate change.

Sir Michael Marmot referred to the forthcoming UN Conference on Sustainable Development in June and expressed his concern that there was almost no health component in it. People were going to discuss climate change without looking at the impact of health.

Health and Mercury

Dr. Peter Orris (USA) reported on the UN Mercury Treaty negotiations which he had been following for the WMA. Although the process was moving forward slowly, a health perspective was missing from this discussion and delegates from Environment Ministries had little understanding of the topic. However, there had been tremendous progress in phasing out mercury thermometers.

Protection of Health Personnel

The committee considered the proposed revision of the WMA Regulations in Times of Armed Conflict and Other Situations of Violence.

Dr. Vivienne Nathanson reported on the project "Healthcare in Danger" launched by the International Committee of the Red Cross to raise public awareness about attacks on health care personnel and institutions and find solutions to the problem. The ICRC had carried out research on the extent of the problem in a selection of countries. The aim of the project was to try to get a global movement to push hard at governments to give to those institutions, their workers and patients legal protections. She also spoke about a conference organised that week jointly by the ICRC, the WMA and the British Medical Association on the issue. The key message of the conference was that every time a doctor was kidnapped, injured or killed it was patients, often the poorest and most vulnerable, who suffered. It was often the case that healthcare provision was withdrawn.

The committee considered the revised policy on Regulations in Times of Armed

Conflict and decided to forward it to the Council for sending it to the General Assembly for adoption.

The committee also considered a Resolution on Danger in Health Care in Syria and Bahrain which it agreed should go to the Council for (see p. 55) approval.

Ethical Implications of Physician Strikes

Leah Wapner (Israel) spoke about the proposed Statement on Physician Strikes, presented by the Israeli Medical Association last year after the physicians' strike in Israel. She said there was a lot of controversy surrounding the issue and the role that the WMA should have in this area. As a result it was clear that the Statement needed further discussion. She proposed that a Workgroup should be set up to consider the whole issue.

The committee agreed to recommend this to the Council.

Electronic Cigarettes

The committee considered the proposed Statement on Electronic Cigarettes. Dr. Jeremy Lazarus (USA) introduced the paper and said it had undergone some amendments since the last discussion in Montevideo.

Dr. Vivienne Nathanson said that some tobacco companies in the United Kingdom were branding their electronic cigarettes with the brand names of high selling cigarettes, hoping that people would switch between the two. She wanted to see the WMA deplore the idea of brand stretching.

It was agreed to amend the document accordingly and forward it to the Council with the recommendation that it should go to the General Assembly for adoption.

Violence in the Health Sector

Malke Borrow (Israel) introduced the proposed Statement on Violence in the Health Sector paper which was first presented in 2010 and had since been amended to address the issue of mental health.

The committee decided to recommend to the Council that the document be sent to the General assembly for adoption.

Forced Sterilisation

Dr. Vivienne Nathanson introduced a new proposal for a Statement on Forced and Coerced Sterilisation that had arisen out of

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discussions with the International Health and Human Rights Organisations. Around the world, forced sterilisation was extremely common, and this was not an issue that applied only to women. Men were also subject to it. She said the proposed Statement declared that no-one should be sterilised without their consent and she asked that the document be circulated to NMAs for consideration.

The committee agreed to recommend this to the Council.

Turkish Medical Association

The meeting heard a plea for help from the Turkish Medical Association. Dr. Feride Tanik (Turkey) said that as a result of a decree from the Turkish Government last year the medical association was facing financial and political pressures. The authority of the association on self-regulation had been transferred into a new bureaucratic body of the Ministry of Health. As a result the association no longer had the authority to establish and issue ethical guidelines for physicians, conduct investigations about alleged malpractice by physicians, determine disciplinary sanctions against physicians or develop core curricula for medical education, post-graduate medical education. They were particularly concerned that the Government had removed from the medical association's mandate the words to ensure "that the medical profession is practiced and promoted in line with public and individual well-being and benefit". As a result of this, the association could no longer challenge actions that adversely affected the right to health, the provision of health care, public health, and individual patient well-being. This diminished the independence of physicians, as well as the health of their patients.

The committee considered a Resolution expressing concern about the Turkish Government's action and urging it to restore to the Turkish Medical Association the responsibilities for professional autonomy and self-regulation that it took from them. It called on all physician members of the Turkish Parliament to remember their duties as physician leaders and to support the right of the medical profession to autonomy and self-regulation. And it commended the Turkish Medical Association and those members of the Turkish Parliament who had challenged their Government. It was agreed to forward the Resolution to the Council for approval.

Autonomy of Professional Orders in West Africa

A proposed Resolution was submitted by the Medical Association of Senegal requesting that the professional autonomy and self-regulation be guaranteed within the countries of the Economic and Monetary Union of West Africa, which brought together eight countries of West Africa.

It was agreed to forward the Resolution to the Council for approval.

Vaccination

Dr. Jon Snaedal (Iceland) introduced a proposed new Statement on the Prioritisation of Vaccination that had come from the Iceland and Irish Medical Associations. He said the WMA had a multitude of policies on public health but nothing on vaccination which was one of the most effective interventions. The proposed Statement endorsed the global vision on vaccination of the World Health Organisation and UNICEF and emphasised the importance and effectiveness of vaccination. But it also pointed to the dangers arising from many ill thought out ideas about the risks, leading to a decrease in vaccination in some parts of the world, thereby increasing the prevalence of diseases.

It was agreed that the paper should be circulated to NMAs for consideration.

Counterfeit, Falsified and Substandard Medicines

The Secretary General, Dr. Kloiber, introduced a paper, entitled "How to Achieve International Action on Falsified Medicine: A Consensus Statement", that had been received by the WMA for endorsement from outside the organisation. The paper had been written against the background of the large amount of substandard, fake and counterfeit medicines that existed in the world. But Dr. Kloiber said the issue was dominated by questions of intellectual property rights which were a minefield and he doubted whether it would be helpful for the WMA to endorse the paper.

After a debate, during which delegates expressed strong reservations about the document, it was agreed that no further action should be taken.

Advocacy

Paul Emile-Cloutier (Canada), newly appointed Chair of the Advocacy Advisory Workgroup, highlighted some of the advocacy developments of the WMA which he said were reaping some positive results. The Group had discussed some of the challenges the WMA was facing, such as how to better align the strategy on advocacy with the strategic plan and how to assist the NMAs with their advocacy by providing them with the necessary tools. The Group would eventually come forward with some concrete proposals.

Health Care in Danger

Dr. Jorge (Brazil) said that given the increasing concern about doctors being threatened around the world and the new ICRC campaign "Health Care in Danger" that a WMA Workgroup should be set up to identify and follow up events in this area.

This was agreed and the proposal was forwarded to the Council for approval.

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Bolivia

The committee heard a plea from CONFEMEL (the Medical Confederation of Latin America and the Caribbean) for doctors in Bolivia to be supported by the WMA in a dispute with their Government. It was reported that doctors' leaders in the country were currently involved in a hunger strike in protest at recent Government actions to change the laws governing the practice of medicine. These included changing the presumption of innocence in cases of malpractice. In addition doctors' salaries and income had been reduced, their working hours increased and work conditions had deteriorated. The WMA was urged to send a letter of support to the Bolivian doctors. The proposal was deferred to the Council.

Medical ethics committee

Dr. Torunn Janbu (Norway), Chair of the Medical Ethics Committee, presided.

Ethical Organ Procurement

Dr. Vivienne Nathanson, Chair of a Workgroup on the issue, presented a revised version of the proposed Statement on Organ and Tissue Donation. Significant amendments had been made about prisoners being organ donors with a prohibition on organs being taken from executed prisoners. A new section had also been added about living donors, the biggest increasing section in many countries.

The committee debated the document at some length and made a number of amendments relating to the description that should be given to decision makers, on transplant co-ordinators and the wording on opposing the commercialisation of donation and transplantation.

It then agreed to send the amended Statement to the Council for forwarding to the General Assembly for adoption.

Ethics in Palliative Medicine

Dr. Fernando Rivas (Spain), Chair of the Worgroup on Ethics and Palliative Sedation, said the Group had concluded that the WMA's existing Declarations on Euthanasia, Terminal Illness and End-of-Life Medical Care were sufficiently relevant and that no new Declaration was required. The Spanish Medical Association had offered to circulate guidelines to help NMAs promote education on palliative care and relationships between physicians and patients, and to write an article in the World Medical Journal on this topic.

Dr. Marco Gomez Sancho (Spain) said the purpose of suggesting a new Declaration had been to allow members to make a distinction between two things that were totally different – palliative sedation, which was a medical process that was universally accepted all over the world and euthanasia which was a process that was absolutely rejected by a strong majority of doctors, though not all of them.

The committee thanked the Workgroup for their work.

Capital Punishment

Dr. Cecil Wilson (USA) presented a new Resolution on Capital Punishment reaffirming the WMA's prohibition on physicians participating in capital punishment. He reminded the committee that the Workgroup had been set up to evaluate whether the WMA should have a mandate to examine the options for developing a Statement opposing capital punishment.

The proposed Resolution, including a prohibition on physicians facilitating the importation or prescription of drugs for execution, was debated and after several amendments were agreed it was decided to send the document to the Council for forwarding to the General Assembly for adoption.

Human Rights

Ms Clarisse Delorme, the WMA's advocacy adviser, updated the meeting on the situation in Bahrain of the trial of a number of physicians and on the continuing conflict in Syria.

Person Centered Medicine

Dr. Jon Snaedal (Iceland) introduced a proposed new Statement on Person Centred Medicine. He said one reason for this was the fragmentation of health which tended to be more and more organ specific. The WMA was now involved in various initiatives on person centred medicine and it was time the Association developed policy on the issue.

The committee decided to circulate the document to NMAs for consideration.

Council

The third and final day of the meeting was taken up with the Council considering the reports from the three committees.

It approved three Resolutions: on Threats to Professional Autonomy and Self-Regulation in Turkey, on Danger in Health Care in Syria and Bahrain, and on the Autonomy of Professional Orders in West Africa.

From the Socio-Medical Affairs Committee it decided to forward to the General Assembly for adoption the following documents:

- Revised Regulations in Times of Armed Conflict.
- Statement on Electronic Cigarettes.
- Statement on Violence in the Health Sector.

The Council agreed to the setting up of a Workgroup on physician strikes and to circulating to NMAs papers on forced sterilisation and vaccination.

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From the Medical Ethics Committee it decided to forward to the General Assembly for adoption:
- Revised Statement on Organ and Tissue Donation.
- Resolution on Capital Punishment.

The Council also agreed to the idea of a public consultation on the revision of the Declaration of Helsinki after the Council had approved a draft proposal and to circulating a paper to NMAs on person centred medicine

From the Finance and Planning Committee it decided to forward to the General Assembly for adoption:
- Membership applications from the Myanmar and Sri Lankan Medical Associations.
- Membership of the Conseil de l'Ordre National des Medecins to replace the French Medical Association.

The Council also agreed to extend the mandate of the Workgroup on disaster preparedness and to circulate to NMAs the amended paper on the strategic plan.

Bolivia

CONFEMEL proposed an emergency Resolution urging the WMA to express its support for the doctors in Bolivia who were on hunger strike in protest at the actions that the Bolivian Government had taken against the Bolivian Medical Association. One suggestion was that the WMA should help to mediate between the two sides.

The Council decided that this issue should be sent to the Council Executive to take forward.

World Veterinary Association

Dr. Tjeerd Jorna, Past President of the World Veterinary Association, addressed the meeting about the history and work of his association. Its mission was to ensure animal health and animal welfare at a global level and to protect public health. He said he hoped the WMA and the WVA could co-operate more on issues such as anti-microbial resistance and the control of zoonotic diseases, such as rabies and avian influenza. He hoped the two organisations could agree a memorandum of understanding and he had sent a draft memorandum to the WMA's Secretary General.

Disaster Preparedness

The Council agreed to extend the mandate of the Workgroup to explore developments in terms of specialisation and online training courses and other possibilities by surveying constituent members.

Primary Care Conference

The Chair, Dr. Haikerwal said it was hoped to have a primary care conference early in 2013.

World Health Assembly

Dr. Kloiber said that the forthcoming World Health Assembly would give the WMA the chance for some advocacy activities. One topic coming up at the WHA was a report on intellectual property which in part called for the lifting of patents for drugs for poor countries. He said the WMA had a tradition of asking for equitable access to drugs which was extremely important for the provision of drugs to patients in poor countries. However, the way the report was being proposed was questionable because a lifting of patents would lead immediately to a production of drugs which would flood the market. There would be no more protection for producing new drugs. This was something the WMA would have to monitor closely and he suggested that the WMA might eventually have to consider policy on the whole area of the sustainability of the pharmaceutical supply in the world, equitable access to drugs and how innovations would be financed in the future.

Election Procedure

Dr. Ouellet put forward a revised amendment to the WMA's election and voting procedures, having taken into consideration concerns expressed in the Finance Committee.

The new amendment read that "In cases of officers elected by the Council and committee chairs elected by committee, candidates must to the degree possible be present at the time of the election, except in circumstances deemed acceptable by the electing body. Candidates will have the opportunity to speak to their candidacy". The Council accepted the proposal.

The Council meeting ended with thanks to the Czech Medical Association for their hospitality.

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Secretary General's Report

Non-communicable diseases

Non-communicable diseases have emerged as one of the most important topics on the public health agenda. The WMA has concerns regarding the WHO's identification of four specific NCDs – cardiovascular disease, cancer, lung and respiratory disease, and diabetes – as a focus of the initiative. The risk of this is returning to a silo-based approach to public health**.** If governments concentrate only on improving health outcomes in these identified areas, other critical NCD threats will not receive adequate attention. Therefore the WMA, together with the other health professionals, has been lobbying to revise the WHO's approach to make it more holistic and suggesting that targets should address the elimination of inequalities in health care.

Together with our partners in the World Health Professions Alliance (WHPA) the WMA has participated in the development of the NCD toolkit to assess the risk level in life style behaviours and bio measures in form of NCD indicators. The Brazilian Medical Association has translated this into Portuguese.

Multi drug resistant tuberculosis project

The WMA has launched the revised MDR-TB online course, updating the original 2006 course. Printed courses have been translated into Azeri, Chinese, French, Georgian, Russian and Spanish. All courses can be accessed free of charge from the WMA webpage.

The printed TB refresher course has been nominated by the United States Center for Disease Control (CDC) as an educational highlight and has received an award.

Tobacco project

The WMA was involved in the implementation process of the WHO Framework Convention on Tobacco Control (FCTC) *http://www.who.int/tobacco/framework/en*, the international treaty condemning tobacco as an addictive substance and imposing bans on the advertising and promotion of tobacco.

The WMA is also cooperating with the public private partnership "QuitNowTXT program" to develop information for tobacco cessation via mobile phones to reach people at risk for preventable NCDs.

Alcohol

The WMA continues to monitor activities relating to the Global Strategy to Reduce the Harmful Use of Alcohol. This requires concerted action by countries, effective global governance, and appropriate engagement of all relevant stakeholders, including health actors. The WMA Secretariat has monitored the process in this direction, so that medical associations at national and global levels continue to be engaged in this area.

Counterfeit medical products

The WMA and the members of the WHPA have stepped up their activities on counterfeit medical issues and developed an Anti-Counterfeit campaign with an educational grant from Pfizer Inc. and Eli Lilly. The basis of the campaign is the 'Be Aware' toolkit for health professionals and patients to increase awareness of this topic and provide practical advice for actions to take in case of a suspected counterfeit medical product.

Health and the environment

Climate change

The WMA had had observer status to the UN Climate Change Conference in Durban in December 2011, which brought together representatives of the world's governments, international organizations and civil society. The discussions aimed to advance the implementation of the Climate Change Convention and the Kyoto Protocol. The WMA Secretariat has been able to facilitate the participation of medical associations interested in the Summit.

The Association also agreed to be a partner for a Global Climate and Health Summit in December 2011 organised by Health Care Without Harm, the Climate and Health Council, the World Federation of Public Health Associations and Nelson R. Mandela School of Medicine (University of KwaZulu-Natal). The purpose of the event was to galvanize health sector work around climate change. A Declaration and Plan of Action were adopted by all partners. Prof. Dong Chun Shin (Korean Medical Association), a member of the former WMA working group on health and the environment represented the WMA at the Summit. As a follow-up to the Durban Summit, a Health Sector Climate Strategy discussion of the partners was held in London in March to build on the success of the work achieved in Durban. Professor Vivienne Nathanson represented the WMA at the meeting. The WMA had also continued its work in the areas of mercury and chemicals.

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Social determinants of health

Council Member, Sir Michael Marmot (British Medical Association), was a member of the advisory Committee for the World Conference on Social Determinants of Health in Rio de Janeiro. The goal of the Conference was to bring Member States and other actors together and engage high-level political support to make progress on national policies that address social determinants of health, with the objective of reducing health inequities. The Conference adopted the Rio Declaration at the end of the meeting, which emphasized the role of the health sector in reducing health inequities.

Health systems

Global health systems face the challenges of delivering high quality, accessible care under increasing budgetary pressure. Health data has a critical role to play in improving the quality, accessibility and efficiency of health services and, therefore, an important role in ensuring that health systems continue to improve. However, across all health systems there are situations in which accurate health data are not available. The lack of availability and access to health data can result in unsafe or ineffective services or lead to a waste of resources. The World Economic Forum organized a working group to develop and define the principles of a Global Charter on Health Data. The WMA represented the physicians' perspective in this working group and demanded the anonymity and aggregation of data and the right of the patient's ownership of the data.

Positive Practice Environment Campaign (PPE)

The WMA has continued its close involvement in this global 5-year campaign, which aims to ensure high-quality health workplaces for quality care. Activities are taking place in Uganda, Morocco and Zambia, which are among the fifty-seven countries worldwide suffering from a critical shortage of health care workers. The PPE Partners and Secretariat are working with national health professional and hospital organisations in these three countries to develop country projects and improve their practice environments.

Migration and retention

The WHO has developed the Guidelines on Retention Strategies for Health Professionals in Rural Areas and the WMA took part in the drafting process. The guidelines are based on three pillars: educational and regulatory incentives, monetary incentives and management, and environment and social support.

Workplace Violence in the Health Sector

Preparations for the 3rd Conference on Workplace Violence in the Health Sector (24–26 October, 2012, Vancouver) have started and the WMA is a member of the planning committee. The Chair of Council, Dr. Mukesh Haikerwal, will be opening the conference with a keynote speech.

Education and Research

The World Federation for Medical Education (WFME) has started a discussion process about the future role of the physician, in which the WMA will be involved. There will be a WFME World Conference on medical education in Malmö, Sweden from November 14–16, 2012 and all medical associations are invited to attend and participate.

The WMA participated as a member of steering groups in two projects commissioned by the European Union on the Mobility and Migration of Health Professionals, one led by the European Health Care Management Association and the other by the Research Institute of the German Hartmann Bund, a private physicians' organization. The objective of the projects was to assess the current trends of mobility and migration of health professionals to, from, and within the European Union, including their reasons for moving. Research will also be conducted in non-European sending and receiving countries, but the focus lies within the EU.

In December, the two research projects came to an end and an International Conference, "Ensuring Tomorrow's Health: Workforce Planning and Mobility", was held 7–9 December, 2011 together with the launch of the final research publication: 'Health Professional Mobility and Health Systems – Evidence from 17 European Countries. The WMA presented the physicians' perspective on this topic and actively took part in the workshop organisation.

Patient safety

The WMA had been involved in the issue of patient safety and was a member of the WHO reviewing committee for the multiprofessional guidelines.

Caring physicians of the world initiative leadership course

The CPW Project, which began with the Caring Physicians of the World book, published in October 2005 in English and in

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Spanish, has continued with regional conferences and leadership courses organized by the INSEAD Business School.

Speaking book

The speaking book on clinical trials, a collaborative effort with the South African Medical Association, the SADAG (South African Depression & Anxiety Group) and the Steve Biko Center for Bioethics in Johannesburg and the publisher "Books of Hope", had been launched during the General Assembly in Seoul, 2008. In 2010, Books of Hope, with the support of Pfizer, the Chinese Center of Disease Control, the Chinese Medical Doctors Association, the Chinese Association on Tobacco Control and the WMA, presented a speaking book on the dangers of smoking.

Health politics

The WMA has intervened several times on health politics matter at the request of member associations:

In Slovakia the government put hospitals in a state of emergency in order to stop protests and industrial action by physicians fighting for better working conditions and against the privatisation of public hospitals. In consultation with the Slovak Medical Association, the WMA wrote to the Prime Minister and the President of the Republic to ensure proper working conditions and fair payment.

In Poland the physicians were made liable for managing the reimbursement entitlements for the insured. All people in Poland are insured under a state insurance scheme which gives various entitlements for reimbursement. These different entitlements were at least in part non-transparent to the physicians, who should not be held liable for wrongly assigning reimbursement statuses for drug on prescriptions. Together with the Polish Chamber of Physicians and Dentists the WMA protested against this measure, which later was revoked.

At the end of 2011, the Turkish Government removed from the Turkish Medical Associations and other self-governing institutions key functions such as supervision of physicians and the regulation of post graduate education. Interestingly, these institutional rights were assigned by law and the government is trying to lift them by a government order. Together with the Turkish Medical Association the WMA will stage public events in Ankara and Istanbul April 16th and 17th respectively to fight for retaining these critical rights of physician self-governance.

Human rights

In January 2011, the Special Rapporteur launched a public consultation on the right to health of older persons, and the WMA Secretariat coordinated the consultation with national medical associations, encouraging them to contribute to the process and increase the visibility of medical associations' action in the area of health and human rights.

Bahrain

For more than a year the WMA Secretariat and its members have been monitoring the situation in Bahrain, where assaults by security forces on health professionals were reported by Amnesty International. Several letters were sent to the authorities of Bahrain expressing deep concerns on the access to appropriate healthcare for victims, as well as on health professionals' independence. The WMA Secretariat and its members have been closely following the trial of physicians.

Syria

The Association has also issued press releases about the situation in Syria and are closely watching the situation.

Protection of health professionals in armed-conflicts areas

The growing threats to health personnel in armed conflicts areas and other situations of violence had been the subject of increasing global debate and actions over the last year, in which the WMA had been closely involved. The Association was now supporting the International Committee of the Red Cross four-year campaign "Healthcare in Danger" about the security and delivery of effective and impartial health care in armed conflict and other situations of violence.

Detention

As an elected member of the Executive Committee (ExCo) of the IRCT, Clarisse Delorme attended the ExCo meeting which took place last November in London. Issues discussed included the preparations for the coming General Assembly (November 2012, Copenhagen) as well as the activities of the UN Subcommittee on Prevention of Torture (SPT) and more generally the Human Rights Council.

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The WMA Secretariat had contacted the United Nations Office on Drugs and Crime about the possible revision of the UN Standard Minimum Rules for the Treatment of Prisoners with suggestions for recommendations and these were welcomed by the UN office.

Woman and children, and health

A joint press release has been issued with the International Federation of Human Rights and Health Organisations in which the practice of forced/coerced sterilization was denounced and condemned.

In 2009, the WMA amended its Declaration of Ottawa to foster the protection of children. With the 'Fit for School' project, the WMA had an implementation activity to increase the health status of children. Currently, the German Development Aid Agency GIZ together with the South East Asian Ministers of Education Organisation (SEAMEO) and the WMA are developing the 'fit for school course', which aims to promote and facilitate effective school health programmes worldwide through building conceptual, implementation, and management capacity with governments, international organisations and NGOs in low and middle-income countries.

The course will be developed in a comprehensive yet modular way allowing for adaptation to different target audiences and country settings. It will cover a broad range of topics related to effective school health programmes, including concept development to implementation, child health, evidence-based interventions, day-to-day management, and to evaluation and monitoring–all with a strong practical approach.

Ethics

The WMA Workgroup on the Declaration of Helsinki was continuing to examine ways in which the Declaration might be revised.

The Chair of the WMA Medical Ethics Committee, Dr. Torunn Janbu, had participated as the WMA representative in a workshop organised by the Council for International Organisations of Medical Science on the ethical aspects of clinical research conducted in developing countries and community consultation in the preparation of research. The workshop covered areas such as community customs and codes, community engagement, multiple communities, traditional knowledge, authority structures and the role of elders.

Medical and health policy development

The Center for the Study of International Medical Policies and Practices, George-Mason-University, which is one of the WMA's Cooperating Centers, has studied the need for educational support in the field of policy creation. The surveys performed with cooperation of the WMA found a demand for education and exchange. The Center invited the WMA to participate in the creation of a scientific platform for international exchange on medical and health policy development. In the fall of 2009, the first issue of a scientific journal, the World Medical & Health Policy, was published by Berkeley Electronic Press as an online journal. In the meantime Berkley Electronic Press has been obtained by De Gruiter. The World Medical & Health Policy Journal can be accessed at: *http://www.psocommons.org/wmhp*.

World health professions alliance

Together with the other members of WHPA, the WMA launched the WHPA NCD campaign, the core of which is a simple, universal educational tool allowing everyone to assess and record their lifestyle/behavioural and biometric risk factors. The information obtained through using the Health Improvement Card can help the individual and health professional develop specific interventions to address individuals risk factors and actively improve health and well-being.

In a second phase, the card will be piloted and evaluated. The objective of the project is to develop a tool that is usable in all health care settings throughout the world and that increases awareness of the individual responsibility of each person for their health, and serves as an advocacy tool for improved health care systems.

Membership

The Medical Association of Myanmar and the Sri Lanka Medical Association have both applied to join the WMA and the Italian Order of Physicians has also indicated its intention to rejoin.

Dr. Otmar Kloiber

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WMA Council Resolution on Threats to Professional Autonomy and Self-Regulation in Turkey

Adopted by the 191st WMA Council Session, Prague, April 2012

Introduction

The WMA is extremely concerned about recent actions by the Turkish government that drastically reduce the self-governing authority and professional autonomy of the medical profession in Turkey. In particular, the newly enacted Government Decree 663 on the Organization and Duties of the Ministry of Health and its Associated Organizations establishes a Health Professions Board, controlled by the Ministry of Health, and delegates authority to this Board for certain critical functions that should remain with the Turkish Medical Association in keeping with the principles of professional autonomy and physician self governance. The Turkish Medical Association was established by the Turkish Parliament in 1953, while Decree 663 was passed by the government ministers of Turkey in an extraordinary process that bypassed the Parliament.

Of grave concern is the fact that the Turkish Medical Association no longer has the authority to:

- Establish and issue ethical guidelines concerning physician conduct
- Conduct investigations regarding alleged malpractice by physicians
- Determine disciplinary sanctions again=st physicians in cases of malpractice
- Develop core curricula for medical education, post-graduate medical specialty curricula, and content and accreditation for continuing medical education (all of which were previously done in partnership between the TMA and universities)

In addition, Decree 663 amends Article 1 of the Constituting Law of the Turkish Medical Association (originally drafted and adopted by the Parliament) by removing the following language in the TMA's mandate: "ensuring that medical profession is practiced and promoted in line with public and individual well-being and benefit". As a result of this restriction of its mandate, the TMA no longer has the right to legally challenge actions and regulations that adversely affect the right to health, the provision of health care, public health, and individual patient well-being. Examples might include, for instance, efforts against restrictions on which medical procedures would be reimbursed under the national health system or initiation of action to address public health hazards such as the use of cyanide in silver and gold mining and processing. The narrowing of the TMA's mandate in this regard not only diminishes the independence of physicians, but also jeopardizes the health of their patients.

Therefore

Reaffirming its unequivocal commitment to the independence and professional self-governance of the medical profession, as defined in the WMA Declaration of Madrid on Professional Autonomy and Self-Regulation, and the WMA Resolution on the Independence of National Medical Associations, the WMA Council:

1. Urges the Turkish government to rescind Decree 663 and restore to the Turkish Medical Association its duties and responsibilities for professional autonomy and self regulation, properly established by the Parliament in 1953 through the legitimate and transparent national democratic process.
2. Urges all physician members of Parliament, regardless of political affiliation, to recall their duties as physician leaders and support the right of the medical profession to autonomy and self-regulation.
3. Supports and commends the Turkish Medical Association and those members of the Turkish Parliament who have challenged these recent actions and requested a legal review of this Decree by the Constitutional Court.
4. Calls on all physicians in Turkey and around the world to join actively in advocacy efforts to promote and support professional independence, the right to health, and the health of the people of Turkey.

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WMA Council Resolution on the Autonomy of Professional Orders in West Africa

Adopted by the 191st WMA Council Session, Prague, April 2012

Preamble

The Economic and Monetary Union of West Africa (Union Economique et Monétaire Ouest Africaine; UEMOA) brings together eight countries of West Africa using CFA Franc as a currency. This tool of integration advocates for the free circulation and settlement of physicians in the countries of UEMOA.

There is a College of the Orders of Physicians, bringing together the Orders of member countries of the Union. The Orders are often under the supervision of the health ministries. This situation often confines the technical and administrative autonomy and impedes the good management of the medical mapping of the region, undermining access to health care for the populations.

Recommendation

Reiterating its Declaration of Madrid on Professional Autonomy and Self-Regulation and its Resolution on the Independence of National Medical Associations, the WMA requests that the independence, professional autonomy and self-regulation be guaranteed within the countries of the Economic and Monetary Union of West Africa

WMA Council Resolution on Danger in Health Care in Syria and Bahrain

Adopted by the 191st WMA Council Session, Prague, April 2012

The WMA recognises that attacks on health care facilities, health care workers and patients are an increasingly common problem and the WMA Council denounces all such attacks in any country.

These often occur during armed conflict and also in other situations of violence, including protests against the state. Patients, including those injured during protests, often come from the poorest and most marginalised parts of the community and suffer a higher proportion of serious health problems than those from wealthier backgrounds.

Governments have an obligation to ensure that health care facilities and those working in them can operate in safety and without interference either from state or non-state actors, and to protect those receiving care.

Where services are not available to patients due to government action or inaction, the government, not the health practitioners, should be held responsible. Noting that recent and ongoing conflicts in Bahrain and Syria have seen physicians, other health care personnel and their patients attacked while in health care facilities, the WMA demands:

1. That states fulfill their obligations to all their citizens and residents, including political protestors, patients and health care workers, and protect health care facilities and their occupants from interference, intimidation or attack.
2. That governments enter into meaningful negotiations wherever such attacks are possible, likely or already occurring to stop the attacks and protect the institutions and their occupants, and
3. That governments consider how they can contribute positively to the work of the International Committee of the Red Cross on promoting the safety of health care provision through awareness of the concepts within their project Health Care in Danger.

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Health Care in Danger Symposium

Nigel Duncan

The first ever consultative event on the problem of safely and effectively delivering healthcare to people in situations of conflict and violence took place in London in April. A symposium at BMA House, jointly organised by the International Committee of the Red Cross (ICRC), the British Red Cross, the World Medical Association and the British Medical Association, was held to discuss the ICRC's project 'Health Care in Danger' that was launched last year.

It was the first of a series of global workshops, attended by health care workers and key stakeholders from around the world, to brainstorm solutions and possible ways forward for the project. As part of the project, the ICRC is also running a public campaign, 'It's a Matter of Life and Death', which seeks to raise public awareness of the problem and mobilise a community of concern among health care workers, armed forces, states and weapons carriers.

The conference was opened by Geoff Loane, Head of Mission for the ICRC, who said the threat to health personnel, to ambulances, hospitals and clinics from direct attacks and kidnapping in armed conflicts was one of the biggest and most unacknowledged humanitarian challenges today. This was particularly the case in North Africa and the Middle East. The ICRC's recent 16-country study had analysed 655 incidents of attacks against health care between mid 2008 and late 2010, leading to 1,834 people being killed or injured. The analysis gave them a clearer picture of the type of activities causing health care to be impeded as well as who was doing this and how it was happening. The purpose of the ICRC's campaign was to ensure the security of the delivery of effective and impartial health care in armed conflict.

He said the conference was a call for action, although at the moment the action that was required was not entirely obvious. The solution did not lie with the health community alone. The responsibility for security lay with governments, military bodies, police forces and local communities and the purpose of the conference was to examine possible solutions and actions.

Mr Paul-Henri Arni, the head of the ICRC project, said the symposium was the first of several planned conferences to look for practical recommendations. Some suggestions included urging the states to develop appropriate military and police practices for managing checkpoints for ambulances and other vehicles evacuating the wounded and for entering health facilities. Another was for states to develop domestic law to assure greater security of health care and a third idea was for the health community to extend research and to develop teaching modules on the implications of insecurity for health care.

Dr. Unni Karunakara, International President of Médecins Sans Frontières, gave several examples of the effects of attacks on medical personnel on the delivery of health care. MSF staff had been kidnapped and attacked in several countries, leading the organisation having to scale back or even evacuate its work in refugee camps. Medical teams had had to be withdrawn in a number of places resulting in thousands of consultations with patients not taking place. He explained how his organisation had had to suspend services in its recently opened maternity hospital in Khost, Afghanistan, after an explosion in the hospital compound. And in Somalia alone since 1979 there had been more than one thousand incidents against MSF teams.

Carolyn Miller, chief executive of the medical charity Merlin, set three challenges to the meeting, calling on health professionals and the NGO community to take practical action quickly, for local people to be given a strong voice in fashioning responses and for charities to work in forgotten and underserved places, such as the Central African Republic. She said that Merlin had campaigned vigorously on the risks to health care, and she expressed the hope that building sets of 'communities of concern' would deliver the critical mass of attention that was needed for policy makers to be persuaded to respond.

Professor Sir Michael Marmot, chair of the WMA's Social and Medical affairs committee, spoke about insecurity in health and inequality. He said conflicts could cause deprivation and deprivation could cause conflict. Conflict disempowered people. He gave examples of maternal mortality rates in Afghanistan and death rates in Russia resulting from social disruption and conflict. While only one in 46,500 women in Europe died during childbirth, the figure in Afghanistan was one in ten. So, when a maternity hospital had to close the loss could be devastating.

He said it was also vital to examine the causes of the causes of ill health, includ-

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ing education, deprivation and general inequity. The issue of the social determinants of health was now being taken up in many countries throughout the world.

Sir Michael suggested that the Red Cross was such a highly admired organisation worldwide that it could and should play a greater role in dealing with the wider issue of health in the population.

Nick Young, Chief Executive of the British Red Cross, said the aim of the conference was to raise awareness throughout the world. What was needed was a united and coherent voice to mobilise action, more evidence about the extent of violence against health that was going on throughout the world and then a set of practical recommendations that could be actioned. He emphasised that this was not just a case of "a launch, a lunch and a logo".

Professor Sir Andrew Haines, Professor of Public Health and Primary Care at the London School of Hygiene and Tropical Medicine, said there was a need for the systematic collection of data on this subject. He urged academic institutions to get involved in this issue and for the subject to be incorporated in medical school curricula. Carolyn Miller, Chief Executive of Merlin, spoke of her organisation's work in this area, in particular the need to create a community of concern around the issue of health workers.

Ms Mohini Ghai Kramer, Head of Corporate Communication at the ICRC, said that the target audiences for the ICRC's campaign were political authorities and arms carriers, public opinion and affected populations. She said they wanted to focus on the victims of violence rather than presenting medical personnel as heroes.

Panel discussions were held throughout the day to follow up the speeches with ideas for practical action. Speakers from the floor emphasised the current lack of awareness of the problem among non-governmental organisations, the fact that there were too many initiatives and also the need to target arms suppliers.

The conference heard from Gilles Thai Larsen, International Law Adviser with the British Red Cross, about the legal framework governing military hostilities and he said there already was a legal framework for protecting healthcare workers and patients. This derived from international humanitarian law and international human rights law, and was often also addressed in domestic law. The rules declared that measures should be taken to provide health care to the wounded and sick on a non-discretionary basis and that access to health care facilities should not be denied or limited. The rules also stated that health care personnel should not be hindered in the performance of their medical tasks and that the wounded, the sick and health care personnel should be protected against interference by third parties.

Dr. Peter Hill, Associate Professor from the Australian Centre for International and Tropical Health at the University of Queensland, spoke about the impact on health systems of violence against health personnel. This included the effect on the supply of drugs and vaccine and on technology. Dr. Rudi Coninx, from the World Health Organisation, said one of the most frequently asked questions put to him on this subject was "Is the WHO doing anything?" His reply was that the WHO was doing many things – expressing concern publicly, documenting evidence and getting involved in diplomacy. There was also a resolution requiring the organisation to develop methodologies for collecting health attack data. But he emphasised that health facilities must be treated as neutral premises and should not be used by one side or the other in conflicts.

Professor Len Rubenstein, from the Centre for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health, said there was only episodic reporting by human rights groups on health attacks and there was limited sharing of internal security information among humanitarian organisations. However, the US State Department was now collecting data for annual country reports on human rights practices of attacks on health care and there was the WHO resolution on the need for assuming leadership in this field.

He said that despite the current lack of evidence, the lack of integration and the rarity of prosecutions, there had been promising developments. But what was needed now was a global coalition, an integrated and collaborative approach to this whole problem from international bodies.

Dr. Jose Gomes do Amaral, President of the WMA, spoke about the Association's policy on the protection of medical personnel in armed conflicts, emphasising the importance of the Declaration of Geneva. He said the WMA had been active in condemning documented attacks on medical personnel. Surgeon Rear Admiral Lionel Jarvis, Medical Director General for the UK Navy, spoke about the role of the medical defence services and the ethical challenges faced by military personnel in Afghanistan. He said the medical defence service was absolutely committed to treating only on the basis of prioritisation by clinical need, with total impartiality and without any discrimination whatsoever. And he added that those in the medical defence services must know the laws of armed conflict and to this end they underwent training in medical ethics.

He said that the 21st century conflict was very different from the situation in the two world wars. There was now rapid electronic communication, enhanced media interest and increasing multinational coalitions. Dilemmas for medics on the front line included self defence, protection of comrades and casualties, triage, disposal of casualties and the use of protective emblems.

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Dr. Vivienne Nathanson, from the British Medical Association, who chaired the final session, emphasised the importance of the WMA's statement that medical ethics in time of war were the same as medical ethics in peace.

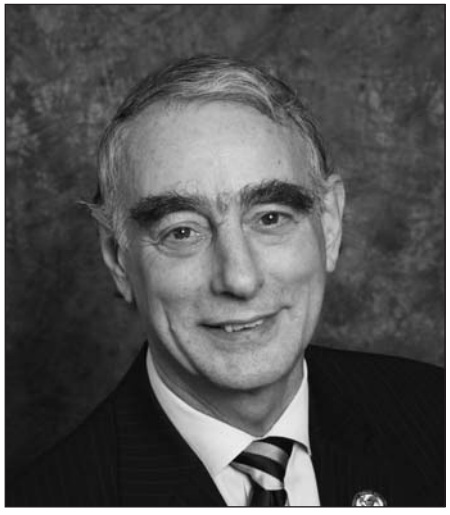
Summing up the day's discussion, Dr. Robin Coupland, medical adviser at the ICRC, said the main points he drew from the day were the need to gather more data about violence against health care, the need to raise awareness of the problem, getting greater academic attention to the problem and improving co-ordination between all those involved. He said it was important to avoid competition between different agencies. A mosaic of measures was needed, but what was critical now was to build awareness of the threats to health care. Without awareness nothing would be done by policymakers.

Although he said it was clear there was no need for the development of international human rights law, since it already existed, it might now be time for the appointment of a special rapporteur on the security of health care.

Dr. Coupland ended by saying that the results of the conference would eventually be summarised in a public document that would be posted on the website of the four organising associations and would form the basis of a dialogue with policy makers.

Nigel Duncan
WMA Public Relations consultant

Responsible Use of Antimicrobials – World Veterinary Association Perspective



Tjeerd Jorna

Lyle Vogel

WVA members

WVA is an umbrella organisation for:
- national veterinary associations
- international assocations of veterinarians working in different areas of veterinary medicine

Antimicrobial resistance is a problem that threatens both animal health and public health. Resistance to antimicrobials has the potential to take away this tool to protect animal health in two ways: 1) loss of effectiveness due to the development of resistance to antimicrobials by animal pathogens, and 2) through the loss of approval to use important antimicrobials in animals in order to preserve their use in human medicine. Therefore to protect the effectiveness of antimicrobials to treat animal and human diseases, the World Veterinary Association (WVA) has developed responsible use guidelines for veterinarians. The WVA believes that the use of the guidelines will lessen the development and spread of antimicrobial resistance. The guidelines recognize and acknowledge the fact that veterinarians must balance the sometimes competing needs of animal health and public health. Human medical providers are not challenged with achieving that balance. Instead they only need to concern themselves with protecting the health of humans. Decisions must be science-based and risk-based. Risk analysis needs to consider both the benefits and the risks to human health that are created through the use of antimicrobials to treat, control and prevent diseases in animals. The use of the risk analysis process (risk assessment, risk communication, and risk management) can result in different risk management decisions in different countries or regions in the world because of differences in risk tolerances

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and in the respective importance given to human health over animal health. For example, in the United States, the previously approved use of fluoroquinolones to treat colibacillosis in poultry has been withdrawn while other countries and regions continue to use fluoroquinolones. Similarly, Europe and other regions have banned the use of antimicrobials to promote feed efficiency and growth in animals while other countries and regions have not. These differences are due to a multitude of factors such as differing animal production systems, different patterns of antimicrobial use in animals and humans, differing acceptance of risk by different cultures, different values placed on the importance of animal health, different recognition of the benefits to human health from the use of antimicrobials in animals.

Antimicrobial resistance is a growing public health concern worldwide. Antimicrobial resistance creates problems for animal health as well. Infections caused by antimicrobial-resistant microorganisms can fail to respond to standard treatments, thereby reducing the possibilities of effective treatment and increasing the risk of morbidity and mortality in serious diseases. Both the public health and animal health concern is the response to the loss of effectiveness of antimicrobials because of resistance. But the animal health concern is also the response to the existing or proposed restrictions on the use of effective antimicrobials by veterinarians. For example, in the United States veterinarians are no longer allowed to use the previously approved fluoroquinolone to treat colibacillosis in poultry because of suspicion that this use was the cause of resistant Campylobacter infections in humans. In Europe there is a total ban on growth promoters to prevent the development of antimicrobial resistance.

The reason for growing problems with antimicrobial resistance can be explained easily. It is a fact of nature that bacteria may mutate or acquire genetic material from other bacteria and develop the ability to survive treatment. Through selective pressure imposed by the use of antimicrobials, these bacteria, starting as a tiny fraction of the overall population, may become an increasingly dominant part of the population over time.

But not all bacteria are the same. The likelihood of developing resistance varies among the different genus and species of bacteria. There are also differences in the likelihood of certain antimicrobials to cause the development of resistance. There are also differences in the importance of specific classes of antimicrobials for both animals and humans. There is also a variety in the way the antimicrobials are used, such as the reason for the use for treatment, prevention or control of disease, as well as in the frequency of use, the length of use, and the total quantities that are used over time.

These differences cause difficulties in determining the appropriate risk management actions that are effective in protecting public health without unnecessarily eliminating a valuable tool for protecting animal health. Actions to eliminate or restrict certain antimicrobials or certain classes of antimicrobials from use in animals may sacrifice the health of animals. And public health may not be improved. For example, the previously mentioned ban in the United States in 2005 on the use by veterinarians of a fluoroquinolone to treat colibacillosis in poultry has not improved public health. The surveillance data show that the ban has not decreased the prevalence of resistant infections in humans. In fact, the prevalence has increased since the ban.

For a long time, the World Veterinary Association has addressed the problem of antimicrobial resistance in multiple ways, such as participation in international working groups that were working on solutions in order to protect public health and animal health. For example, the president of the WVA at that time, Dr. Herbert Schneider, chaired the World Organization for Animal Health/OIE Ad Hoc Working Group on Antimicrobial Resistance. That group developed the list of antimicrobials that are important in veterinary medicine. The list was approved by the OIE in 2007. The WVA also participated in the Codex Alimentarius Commission Intergovernmental Task Force on Antimicrobial Resistance. Over the last 3 years, Past President Leon Russell and current president Dr. Jorna, represented the WVA in the discussions that resulted in Guidelines for Risk Analysis of Foodborne Antimicrobial Resistance. The Guidelines for Risk Analysis were approved earlier this year.

Previously, in about 1998, the WVA developed policies that addressed antimicrobial resistance to guide both the organization and the veterinary profession. The policies included a position statement on responsible use of antimicrobials. More recently the WVA decided it was time to review those policies and update them as necessary. The review and update was carried out during the last 18 months. It included development of a policy, proposed by the members of the EXCOM and the Council and the publication of the draft policy on the WVA Web site with a request for review and input from the WVA members and other interested organizations. The process has resulted in the current policy, the WVA Position on Responsible Use of Antimicrobials.

As explained in the introduction to the responsible use principles, the policy incorporates several premises or ideas that form the basis of the principles:

1. Good animal health and welfare always starts with good care and management. The animals must be provided with a proper diet, clean water, and sufficient space. Stress must be minimized including minimizing exposure to adverse environmental factors.
2. Prevention, control and treatment of animal diseases are necessary parts of successful animal husbandry.
3. The availability and use of a variety of antimicrobials for animals is essential

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to assure animal health and welfare. Protecting animal health, through the prevention and relief of conditions that cause animal suffering, is an essential part of ensuring good animal welfare.

4. However, there is a risk that the use of antimicrobials in animals can result in resistance to antimicrobials which negatively affects public and animal health.
5. Therefore, the availability and use of antimicrobials in animals must be balanced to achieve both good animal health and public health.
6. Veterinarians must consider both human and animal health when deciding on the use of antimicrobials. Neither human health nor animal health and welfare can be ignored. It differs from human health practitioners who do not consider animal health when they advocate for restrictions on veterinary medicines.
7. Decisions on how to manage the risk of antimicrobial resistance must be based on risk analysis. The three components of risk analysis are risk assessment, risk communication and risk management. All three components must be incorporated into the decision process. Through the process of risk assessment the available scientific information can be gathered and evaluated. Then risk communication is applied to inform all of the stakeholders of the results of the risk assessment. Risk communication must occur among all of the affected stakeholders including public health officials, veterinarians, physicians, farmers, the general public, and officials responsible for regulation of veterinary medicines. This should lead to discussions regarding the levels of expected risk compared to the levels of acceptable risk among the various stakeholders. Decisions regarding whether to take or impose risk management actions and the extent of the risk management actions, if imposed, must be based on risk assessment and risk communication. Then, if necessary, risk management techniques can be applied that balance the appropriate measures for public health and animal health. Because of the importance of antimicrobials for both animal health and public health, risk analysis must be comprehensive. The risk analysis must include evaluations of the risk to both animal health and public health, as well as the benefits to public health, animal health and animal welfare from the use of antimicrobials in animals. Healthy animals create healthy food and consequently improved public health.
8. The WVA recognizes that different countries and regions have chosen different risk management actions based on risk analysis. For example, some countries license certain antimicrobials to be used in food-producing animals to enhance production through growth promotion and feed efficiency, although such use is prohibited in other countries and regions. And as previously mentioned, the United States has chosen to ban the use of enrofloxacin by veterinarians to treat colibacillosis in chickens and turkeys. These differences between countries and regions can occur because of cultural differences in the level of risk acceptance or tolerance, and as well as because of differences on the emphasis placed on risks versus benefits to public health from the use of antimicrobials in animals.
9. Risk analysis cannot be generalized to evaluate broad categories, such as the reason for use, prevention of disease, control of disease, or growth promotion. Instead, the particulars such as class of antimicrobial, ability to confer resistance, frequency of use, method of administration, and importance in veterinary and human medicine need to be considered.
10. Responsible use of antimicrobials by veterinarians plays an important role in protecting public health. Veterinarians play a key role in helping to minimize and prevent the development and spread of antimicrobial resistance. Therefore, veterinarians need to be involved in antimicrobial use decisions as well as policy and regulatory decisions.

The foregoing premises form the basis of principles of the WVA position on responsible use of antimicrobials. The following are the 12 principles:

1. In case of animal disease, the animals should be examined by a veterinarian, who makes a diagnosis, and recommends and plans an effective treatment programme. If a decision is reached to use antimicrobials for therapy, veterinarians should strive to optimize therapeutic effectiveness and minimize resistance to antimicrobials in order to protect public and animal health.
2. Antimicrobials used for therapy are health management tools that are licensed to be used for the purposes of:
   a. disease treatment;
   b. disease control;
   c. disease prevention.
3. Codes of good veterinary practice, quality assurance programmes, herd health control and surveillance programmes, and education programmes should promote responsible and prudent use of antimicrobials. Veterinarians must assume responsibility to possess current information on resistance because they are accountable for safe and effective use of these medicines.
4. Antimicrobials should be used only with veterinary involvement. Regular, close veterinary involvement is essential for informed advice concerning the effective use of antimicrobials. Regardless of the distribution system available in the country, the use of antimicrobials should be subject to appropriate professional advice of a veterinarian.
5. The availability of effective antimicrobials should be based on risk analysis that considers the OIE list of Antimicrobials of Veterinary Importance. The OIE International Committee adopted the list of Antimicrobials of Veterinary

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Importance in May, 2007. Veterinary antimicrobials are classified according to their importance as critical, highly important or important. Risk analysis should consider the OIE list, as well as the list developed by the World Health Organization, that classifies the importance of human antimicrobials.

6. Therapeutic antimicrobials may be used when it is known or suspected that an infectious agent is present which will be susceptible to therapy. It is the responsibility of the veterinarian to choose the antimicrobial product, based on his or her informed professional judgment balancing the risks and benefits for humans and animals. The veterinarian shall have due regard to the public health risks because of using veterinary medicines. At the same time, benefits shall be taken into account, such as promoting the health and welfare of animals, assuring safe and affordable food from healthy animals, while reducing human exposure to bacteria of animal origin.
7. When antimicrobials need to be used for therapy, bacteriological diagnosis with antimicrobial sensitivity testing should, whenever possible, be part of the informed professional clinical judgment. Ideally, the antimicrobial sensitivity of the causal organism should be determined before therapy is started. However, in disease outbreaks involving rapid transmission of disease among contact animals or with high case mortality rates, treatment may be started on the basis of clinical diagnosis. But even in this case, the antimicrobial sensitivity should be determined so that, if treatment fails, the regimen can be changed in the light of the results of sensitivity testing. Surveillance or monitoring systems should be established to measure antimicrobial sensitivity trends over time so that the trends can guide clinical judgment on antimicrobial use.
8. Label instructions should be carefully followed and due attention paid to species and disease indications and contra-indications, dosage regimen, withdrawal periods, storage instructions, and expiration dates for products. Off label or extra-label use of antimicrobials should be exceptional and under the professional responsibility of a veterinarian, with careful justification, written prescription or instructions, and in accord with the governmental regulations and guidance.
9. Antimicrobials used for therapy should be used for as long as needed, over as short a dosage period as possible, and at the appropriate dosage regimen. It is essential to administer the antimicrobial in accordance with the recommended dosage regimen. This will minimize therapy failures and exploit fully the effective potential of the product. Insufficient duration of administration can allow the infection to break out again. This may increase the likelihood of selecting bacteria with reduced antimicrobial sensitivity. But limiting the duration of use to only that required for therapeutic effect will minimize the exposure of the bacterial population to the antimicrobial. The adverse effects on the surviving commensal microflora are minimized. Theoretically, antimicrobial use should be stopped as soon as the animal's own host defense system can control the infection itself.
10. Records should be kept of all antimicrobial administrations.
11. Coordinated susceptibility monitoring and surveillance should be conducted and the results should be provided to the prescriber/supervising veterinarian and other relevant parties. Monitoring and surveillance should target micro-organisms of both veterinary and public health importance. Data should be quickly provided to allow timely modification of veterinary recommendations for treatment in order to balance the benefits with the risks.
12. Efficacious, scientifically proven alternatives to antimicrobials are needed as an important part of good husbandry practices. Some of the potential alternatives include vaccines, probiotics, competitive exclusion products, nutrition, and improved livestock management. Research is needed to further develop these alternatives and to evaluate the impact of these alternatives on selection for resistance.

Continued availability of all classes of effective antimicrobials for veterinary medicine is a critical component of safe food supply and optimal animal health and welfare.

Safeguarding animal health is of paramount importance to the economic welfare, public health, and food supply of nations and states. Animal and human health are inextricably linked.

Responsible use of antimicrobials by veterinarians is in the best interests of both animal health and public health. The WVA believes that the implementation of the WVA principles for responsible use will decrease the selective pressures that cause the spread of antimicrobial resistance and will help retain both the effectiveness and the availability of veterinary antimicrobials.

Dr. Tjeerd Jorna,
Immediate Past President, WVA
Dr. Lyle Vogel,
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World Veterinary Association meets World Medical Association

During the 191st Council Session of the WMA Dr. Tjeerd Jorna, Past-President of the WVA, presents his global organisation:

On a global scale the World Veterinary Association (WVA) is a small organisation and therefore it has to be presented as one profession with one vision and one voice in the perspective of veterinary medicine and animal and public health.

In 2011 the veterinary profession marked its 250 years of activity and that was a good reason to look back and evaluate what has been achieved and even a better reason to become inspired and look ahead. Therefore, the slogan **Vet for Health-Vet for Food-Vet for the Planet.**

The WVA is an umbrella organisation for national veterinary organisations and international associations of veterinarians working in different areas of veterinary medicine. The structure of the WVA includes Presidential Assembly represented by all members; the Council represented by elected representatives of six regions [the five continents and North Africa and the Middle East]; the Associate members and the WVA EXCOM, consisting of an elected President, two Vice Presidents and Past-President.

The WVA sees its **Mission** in cooperation of its member organisations for the support of veterinarians of different positions and all over the world for promoting the health and welfare of animals and people, because **Healthy Animals mean Healthy People.** The **Vision** of the WVA is to be the global voice for veterinarians in order to strengthen their position in promoting animal health and well-being and protecting public health.

In 2013 the WVA will celebrate its 150th anniversary as in 1863 Dr. John Gamgee organized an international veterinary congress, a body that was professionalized in 1959 bearing the new name WVA. The themes discussed at the first congresses did not differ much from those of today: zoonoses, food safety, veterinary law, education and the application of veterinary medicines.

The main goals of WVA include the following: to be recognized as the global veterinary voice, to promote high quality veterinary education, to win recognition of the veterinary profession as Global Public Good, to support veterinarians in delivering their responsibilities by optimising the preconditions required for full filling their tasks and to ensure and safeguard long-term viability of the WVA.

Veterinary medicine rests on three pillars: animal health, animal welfare and public health, and if to draw a parallel with a building, be it a temple, a church or a mosque, any building needs to have a good foundation, and in our case the foundation is high quality veterinary education. The veterinarian is the mediator between the animals, the animal owners and society and his/her performance should be science based, using knowledge and skills accompanied with the proper attitude and ethical principles. He/she has to work objectively, independently and impartially. The veterinarian's roles are different for a practitioner, a hygienist (meat inspection), a state veterinary officer (policy control and public health inspector), in industry and institutes, in education (Veterinary faculties and Agricultural schools), in military and in environment and climate change disease monitoring.

The responsibilities of veterinarians include meeting the requirements set by society,

controlling animal health, animal welfare and public health [including zoonoses] and participating in environmental and eco-system health. The veterinary duties are to prevent and early detect outbreaks of animal diseases and zoonotic diseases; to certify healthy animals for trade; to ensure the safety of products of animal origin; to investigate and diagnose animal diseases and to decide upon correct intervention and treatment.

To perform this duties by veterinarians all over the globe and in all countries the WVA has to strengthen the veterinary profession by encouraging all countries to develop robust veterinary legislation and an autonomous statutory body, encouraging the veterinary profession to establish a representative well-organized veterinary Association and to adopt and act upon a veterinary act and a code of conduct, promoting public-private collaboration and continuously creating preconditions aimed at the vets meeting their responsibilities in the best possible way. As regards **Animal Health** it implies promoting of prevention which is better than cure; encouraging vets to perform monitoring, surveillance, early diagnosis and reporting of animal and zoonotic diseases; supporting of global disease control programs and promotion of availability of veterinary medicines [drugs] ,encouraging responsible use and preventing antimicrobial resistance. Regarding **Public Health** it means to continuously emphasise the role vets play in food safety; to maintain control of zoonotic diseases; to control food

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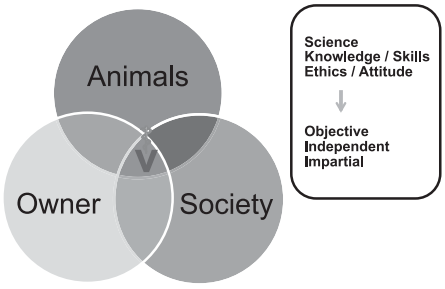

security and food safety and to support the structure of National Veterinary Services.

As already mentioned above, the veterinary medicine needs a good foundation that is ensured by Veterinary Education and Life Long Learning. The WVA has to develop and implement a strategy for enhancing veterinary education and skills development; to analyse the accreditation/evaluation systems; to work towards all newly graduates acquiring the necessary "Day-One Competences"; to promote institutionalisation of Life Long Learning programs and to be an active partner in global veterinary education projects. The definition of **Day-One Competences** are the combination of knowledge, skills/experience, attitude and aptitude that veterinary graduates need to possess for safe entering the veterinary profession and enabling them to perform most of their duties. The expectations of s**ociety** include the following: the veterinarian has to act as a link between animals, animal owners and society in the interests of society that needs to have confidence and trust in the high standards of veterinary education and professional implementation. Thereby we have to ensure that society knows the practitioner and is aware of all his/her public health-related duties. To meet the expectations of the **Veterinary Profession** there is required a level of education/training provided by schools that ensure that the young graduates have acquired solid Day-One Competences to start real professional independent activities by performing the various daily duties of vets, at the same time being aware that the Day-One Competences are only the starting competences.

The collaboration between veterinarians and physicians is promoted by the **ONE HEALTH concept** that means a unified approach between veterinary and human medicine to improve Global Health. This concept is not new as the founder of the first veterinary school in Lyon [France] in 1761 cooperated with the physicians of that time. Later this concept was renewed by Virchow and in the new millenium by Roger Mahr [the former president of AVMA] in North America. Cooperation can be of great importance in the control of zoonoses and the prevention of antimicrobial resistance. Examples of physicians and vets cooperating nowadays is the control of rabies, a very severe disease in Africa and India, taking more than 60.000 deaths per year and most of them being children; or the control of avian influenza and all kinds of food poisonings by salmonellosis or campylobacteriosis. The WVA likes to confirm this collaboration with the WMA in a Memorandum of Understanding and the WVA has submitted the first draft to the board of WMA. Your President Elect will make the first comments helping to reach the final draft in the nearest future. The Memorandum focuses on the control of zoonoses, food safety and security and the prevention of antimicrobial resistance. The use of antimicrobials cannot be only risk-based, but it could be that we have to separate antimicrobials for the use in humans. The WVA has written a position paper about the responsible use of antimicrobials that reflects its meaning on a global level in 2011. In the World Veterinary Congress 2011 in Cape Town the WVA, supported by WHO, FAO and OIE [the World Animal Health Organization in Paris], organized the Global Summit "Lessons Learned and Future Approaches on the Use of Antimicrobials".

The WVA is communicating its policies through its website *www.worldvet.org* and through newsletters by website and mail. New is our communication through direct mail of short WVA news and by organizing regional meetings as on-site meetings of congresses and symposia/conferences organized even by related organizations. Our experience has revealed that many vets in the world do not read websites or newsletters and cannot afford the congress-related expenses in expensive venues. It is more beneficial if the WVA board visits the members in their own region.

I would like to finish by inviting the WMA to visit our Assembly and Congress next year, the year of our 150th anniversary, and I would like to cooperate fruitfully in the future and thank everybody for your hospitality.

Dr. Tjeerd Jorna,
Immediate Past President, WVA

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International Health Economics Association (iHEA)

Thomas E. Getzen

Anne Mills

The International Health Economics Association (iHEA) *www.healtheconomics.org* is an academic society of 2,600 health economists in 73 countries worldwide that has become the central source for professional activity and critical evaluation of health economic research. iHEA focuses on the colleagueship and advancement of individual health economics scholars, students, and researchers, with a mission *"to increase communication among health economists across the globe, foster a higher standard of debate in the application of economics to health and to healthcare systems, and to assist young health economists conduct high quality researcher at the start of their careers."*

Background

Although as early as the 1920s economists began getting together to review each other's work in the area of health and to trade ideas on the subject, there was no formal field of health economics until the 1970s. Over the years various regional and national health economics associations were started, many of those in Europe and Anglophone countries following the Health Economics Study Group (HESG) model in the UK. There were discussions among health economists about the need for creating an international membership society to encourage communication among health economics worldwide, and in 1994 the International Health Economics Association (iHEA) was established following meeting in Zurich and Boston.

Regional and National Affiliates of iHEA

- African Health Economics and Policy Association (AfHEA)
- American Society of Health Economists (ASHEcon)
- Asociacion de Economia de la Salud Latinoamerica y Caribe (AES LAC)
- Australian Health Economics Society (AHES)
- China Health Economics Association (CHEA)
- Collège des Economistes de la Santé (CES)
- Colombian Health Economics Association (ACOES)
- Croatian Society for Pharmacoeconomics and Health Economics (CSPHE)
- European Committee on Health Economics (ECHE)
- Finnish Society for Health Economics (TTTS)
- German Association for Health Economics (DGGOE)
- Health Economics Study Group (HESG)
- Indian Health Economics and Policy Association (IHEPA)
- Health Economics Association of India (HEAI)
- Italian Association of Health Economics (AIES)
- Japan Health Economics Association (JHEA)
- Portuguese Health Economics Association (APES)
- Spanish Health Economics Association (AES)
- Swedish Health Economics Association (SHEA)
- Swiss Association for Health Economics (SAG)
- Taiwan Society of Health Economics (TaiSHE)
- Turkish Health Economics and Policy Association (THEPA);
- Young Researchers in Health (YRH)

Funding and Organizational Structure

The International Health Economics Association (iHEA) is a charitable non-profit organization largely self-funded through individual dues and fees, which helps it to maintain independence from the specific interests of industry, government agencies or medical organizations. Its organizational structure consists of: an executive director; a president, who is elected by the membership; a secretary/treasurer; a board of directors; program chairs for the biennial meeting; and the association's operational staff, which consists of three individuals. Members of the board of directors serve four-year overlapping terms.

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Main Activities

The Association's main activities include: presenting the annual Kenneth J. Arrow Award in Health Economics for the best published paper in health economics; editing and maintaining *HEN*-the Health Economic Network electronic archive in collaboration with the Social Science Research Network at SSRN.com; distributing health economics related information to its members including a weekly online newsletter; maintaining a world directory of health economics; and conducting the World Congress of Health Economists. The first "iHEA Congress" was held in Vancouver, B.C., Canada in 1996. Subsequent conferences were held in Rotterdam, Holland in 1999; York, England 2001; San Francisco, California 2003; Barcelona, Spain 2005; and Copenhagen, Denmark 2007; Beijing, China 2009; and Toronto, Canada 2011. Upcoming Congresses are scheduled for Sydney, Australia in 2013; Dublin, Ireland in 2014, and Milan, Italy in 2015.

Prof. Thomas E. Getzen,
Executive Director
Prof. Anne Mills,
President 2012–2013

The Research-Based Pharmaceutical Industry Expands its Code of Practice Governing Interactions with the Healthcare Community

Eduardo Pisani

In March 2012 the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) expanded the IFPMA *Code of Practice* which governs how member companies interact with healthcare professionals, medical institutions and patient organizations. IFPMA requires all members, which comprise the research-based pharmaceutical industry, to adopt and implement this Code around the world.

Advancing medical knowledge and improving public health depend on information-sharing interactions by the entire medical community – from researcher to attending physician, nurse, pharmacist and patient – and integrity is essential to these exchanges. In these interactions, it is vital that healthcare providers, patients, and governments are confident that pharmaceutical companies act in an ethical and professional manner wherever they operate in the world. Such ethical practices should apply not only to the promotion of medicines, but more broadly to all interactions with the healthcare community. The Code is a public statement of the standards of practice to which the healthcare community and others can expect our industry to adhere.

Concerning our industry's interactions with healthcare professionals, the IFPMA *Code of Practice* clarifies which promotional aids and medical products, such as pharmaceutical product samples, are permitted while reconfirming that personal and cash gifts are not. It prohibits pre-approval promotional activities for pharmaceutical products while providing clear guidance for supporting continuing medical education. This includes ensuring that meetings are held in appropriate venues that are conducive to scientific or educational objectives.

Beyond interactions, the Code now also includes high-level guiding principles for practice, a requirement for member companies to train employees, a provision on disclosure of clinical trial information, and clear guidance for filing complaints.

The research-based pharmaceutical industry highly values trust in interactions with healthcare professionals and others.

Ensuring trust promotes high quality exchanges of medical information which, in turn, benefit patients' health. This expanded IFPMA *Code of Practice* is one more element of our commitment to patients and healthcare professionals.

By September 2012, IFPMA members will have implemented this Code wherever they operate in the world. This includes aligning national industry codes and ensuring that employees receive training and adhere to these high ethical and professional standards.

We encourage others – doctors, nurses, pharmacists, academics, patients and consumers – to not only be aware of this expanded Code, but also to ensure equally high ethical and practice standards across the healthcare sector. By working together, we can continue to improve the lives of people around the world.

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About IFPMA:
IFPMA represents the research-based pharmaceutical companies and associations across the globe. The research-based pharmaceutical industry's 1.3 million employees research, develop and provide medicines and vaccines that improve the life of patients worldwide.

Based in Geneva, IFPMA has official relations with the United Nations and contributes industry expertise to help the global health community find solutions that improve global health.

IFPMA manages several global initiatives including: the IFPMA Developing World Health Partnerships which studies and identifies trends for the research-based pharmaceutical industry's long-term partnership programs to improve health in developing countries; the IFPMA Code of Practice (*http://www.ifpma.org/ethics/ifpma-code-of-practice/ifpma-code-of-practice.html*) which sets unsurpassed standards for interactions with the healthcare community; and the IFPMA Clinical Trials Portal helps patients and health professionals learn out about clinical trials and trial results.

IFPMA Guiding Principles on Ethical Conduct and Promotion

The International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) member companies engage in medical and biopharmaceutical research in order to benefit patients and support high-quality patient care. Pharmaceutical companies, represented by IFPMA, promote, sell and distribute their products in an ethical manner and in accordance with all the rules and regulations for medicines and healthcare.

The following Guiding Principles set out the basic standards to inform on the 2012 IFPMA Code of Practice which applies to the conduct of IFPMA Member Companies and their agents. This helps ensure that their interactions with stakeholders are appropriate.

1. The healthcare and well-being of patients are the first priority for pharmaceutical companies.
2. Pharmaceutical companies will conform to high standards of quality, safety and efficacy as determined by regulatory authorities.
3. Pharmaceutical companies' interactions with stakeholders at all times must be ethical, appropriate and professional. Nothing should be offered or provided by a company in a manner or on conditions that would have an inappropriate influence.
4. Pharmaceutical companies are responsible for providing accurate, balanced, and scientifically valid data on products.
5. Promotion must be ethical, accurate, balanced and must not be misleading. Information in promotional materials must support proper assessment of the risks and benefits of the product and its appropriate use.
6. Pharmaceutical companies will respect the privacy and personal information of patients.
7. All clinical trials and scientific research sponsored or supported by companies will be conducted with the intent to develop knowledge that will benefit patients and advance science and medicine. Pharmaceutical companies are committed to the transparency of industry sponsored clinical trials in patients.
8. Pharmaceutical companies should adhere to both the spirit and the letter of applicable industry codes. To achieve this, pharmaceutical companies will ensure that all relevant personnel are appropriately trained.

Eduardo Pisani, Director General
International Federation of Pharmaceutical Manufacturers and Associations

The International Federation of Biomedical Laboratory Science (IFBLS)

The International Federation of Biomedical Laboratory Science (IFBLS) is an independent non-governmental association of national societies in 40 countries, representing more than 185,000 biomedical laboratory scientists, technologists and technicians worldwide. Providing a critical service assisting physicians in the diagnosis and treatment of human diseases, these health professionals serve as key personnel by maintaining medical laboratories and providing needed medical laboratory services. In a recent report the Institute of Medicine in the United States has documented an excess of 70 percent of the information in a typical patient's chart in hospital at any time is information generated by the biomedical laboratory from testing performed by biomedical laboratory scientists.

The IFBLS (originally called the International Association of Medical Laboratory Technologists – IAMLT) was founded in 1954 when Ms. Elizabeth Pletscher and her Swiss colleagues invited national medical technology associations, from a number of countries, to meet in Zurich,

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Vincent S. Gallicchio

Switzerland. The response to the invitation was so great that the decision was made to create an international association. Ms. Pletscher became the first Secretary and later the Honorary Executive Secretary and was in office from 1954 to 1973.

At the Triennial Conference of the Institute of Medical Laboratory Technology (now the Institute of Biomedical Science) in Nottingham, United Kingdom, in 1955, a meeting was held and the first draft constitution of the future International Association was discussed. A further meeting was held on the occasion of the first Inter-American Convention in Quebec, Canada, the following year.

In 1957 a delegates meeting was held in Amsterdam, Holland, when study groups were formed by different nations to make enquiries on the situation of medical laboratory technologists all over the world. In addition, the legal status of the Association was discussed. On the occasion of the Triennial Conference of the IFBLS in Bristol, United Kingdom, in 1958, the draft statutes were discussed and the first Council was elected. Mr. R. J. Broomfield from the United Kingdom became the first President.

The following year a General Assembly of Delegates (GAD) was held in Hamburg, Germany; the statutes were finally adopted and the preliminary reports of the study groups were discussed. In 1960 the American Society of Medical Technologists and the Canadian Association joined IFBLS, making it truly a "World" organization. The first week-long international Congress, with a large participation from all over the world, was held in Stockholm, Sweden, in 1961. Two years later saw the publication of the first Newsletter of the IFBLS. 1964 saw the 10th anniversary Congress being held in Lausanne, Switzerland. Over 400 delegates from 16 countries attended. For the future a decision was reached to hold the Congress biennially.

Congress was held in Berlin, Germany in 1966; Helsinki, Finland 1968; Copenhagen, Denmark 1970; Vienna, Austria 1972; Paris, France 1974; Chicago, USA 1976; Edinburgh, Scotland 1978; Durban, South Africa 1980; Amsterdam, The Netherlands 1982; Perth, Australia 1984; Stockholm, Sweden 1986; Kobe, Japan 1988; Geneva, Switzerland 1990, Dublin, Ireland 1992; Hong Kong 1994; Oslo, Norway 1996; Singapore 1998; Vancouver, Canada 2000. Orlando, USA 2002; Stockholm, Sweden 2004; Seoul, South Korea 2006; New Delhi, India 2008; Nairobi, Kenya 2010; and will take place in Berlin, Germany later in 2012.

In 1965 the IFBLS became a consultative member of the Council of Europe in Strasbourg. A resolution was introduced to the Secretary General of the Council of Europe in 1966, asking for a committee of experts to be formed to investigate the standardization of training, in order to issue diplomas acceptable to other countries. The resolution was accepted and the committee of experts formed. In the same year the IFBLS Newsletter (Med Tech International – MTI) began twice yearly publication.

The IFBLS was approved as a non-governmental organization in official relationship with the World Health Organization (WHO) in 1972. On her retirement, at the Vienna Congress, Elizabeth Pletscher was awarded the first Honorary Membership of the Association, having served 19 years as Executive Secretary.

At the World Congress in Orlando in 2002 the General Assembly of Delegates – GAD – voted to change the name of the organization from IAMLT to IFBLS, this latter title being more reflective of the educational standards and role of the members of the profession. It was also agreed to move the registered office from Stockholm to Hamilton, Canada where it is presently located.

The Mission of IFBLS is:

- To support, advance and promote good laboratory practice through the development and adherence to high quality standards in diverse environments throughout the world;
- To support, advance and promote the education, training and professional development of Biomedical Laboratory Scientists and technologists;
- To support, advance and promote ethical and professional values in the biomedical laboratory profession;
- To promote the exchange of ideas and the active participation of biomedical laboratory professionals through seminars, research and educational forums;
- To promote the coordination of activities within the healthcare and biomedical laboratory professions through the development of international partnerships and programs and;
- To support, promote and advance such activities of IFBLS as are incidental and ancillary to the foregoing objects.

For more information on IFBLS please contact our website at *www.ifbls.org*

Vincent S. Gallicchio,
PhD, Dp (hon), MT(ASCP),
FRSA, FASAHP
President, IFBLS

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The World Federation for Mental Health (WFMH)

Deborah Wan

Mission: To promote, among all peoples and nations, the highest possible level of mental health in its broadest biological, medical, educational and social aspects.

The Federation was founded in 1948 as an international multi-disciplinary organization to bring together health professions to work for the improved treatment of mental illnesses. The founders saw a great need to expand understanding of mental illnesses at government level and with the general public. The need for advocacy is real, and it can change attitudes. Mental illnesses are not rare, yet individuals and families are often reluctant to speak about them. According to the World Health Organization just one of these disorders, unipolar depression, is the third leading cause of the global burden of disease–and will rise to the first place by 2030.

Evidence-based treatments are available, but even in developed countries many people who could benefit do not receive them for various reasons. In low- and middle-income countries the situation is much worse. In low-income countries public knowledge of mental disorders is often lacking and government spending on their treatment within the health budget is very limited, even although low-cost treatments exist.

The Federation believes in fostering positive mental health as well as improving care for illness. WFMH believes that good mental health is a valuable asset for individuals and their communities and should be supported and encouraged in society. For every age group good mental health is a part of overall well-being.

The goals of the Federation are:

- To heighten public awareness about the importance of mental health, and to gain understanding and improve attitudes about mental disorders.
- To promote mental health and optimal functioning.
- To prevent mental, neurological and psychosocial disorders.
- To improve the care and treatment of those with mental, neurological and psychosocial disorders.

The Federation's Board of Directors

WFMH currently has a Board of 22 Directors from 16 countries, headed by the President, Deborah Wan of Hong Kong. The Executive Committee consists of 8 Officers from 6 countries. The Board members have extensive, varied experience in the mental health field and offer broad international perspectives from their regional viewpoints. They consult by email, Skype, and conference calls and confer once a year in person.

Advocacy

WFMH maintains a strong role in civil society advocacy. It founded World Mental Health Day (10 October), which is celebrating its 20th anniversary in 2012. Each year the WFMH Board selects a theme, material is developed and translations are made into a number of languages. The information is circulated via email and post to organizations and individuals who arrange their own local events of many kinds for public education. The flexible campaign format has been successful in reaching many levels from villages to government ministries, as it can be easily adapted to suit requirements. For 2012 the theme is "Depression" and the material will provide basic information about this common illness.

The WFMH Congress held every two years in a different part of the world also promotes public attention for mental health issues, with a diverse program of presentations by international speakers together with numerous parallel sessions and additional activities. The Congress in 2011 was held in Cape Town, South Africa. In 2013 it will be in Buenos Aires, Argentina, and in 2015 in Singapore.

The "Great Push for Mental Health" program has built up a network of over 500 organizations from 110 countries that have indicated their support for this new advocacy program (including individuals, the network currently numbers 1,428 contacts). The "Great Push" has adopted a slogan of "unity, visibility, rights and recovery" with the aim of providing a platform for the views of civil society. It is planning to use a survey this year to obtain the opinions of the organizations about priorities for the World Health Organization's proposed Action Plan for Mental Health.

Recent Activities at the United Nations and World Health Organization

WFMH is a non-profit organization with Consultative Status at the United Nations and maintains official relations with the World Health Organization. Volunteer representatives participate in NGO activities

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in New York and Geneva, and work with Board members and staff to monitor UN and WHO developments related to mental health. In 2011 WFMH participated in efforts to have mental health included in the international discussion on non-communicable diseases which led to a UN High-Level Meeting on the topic. The Federation succeeded in organizing a symposium for an invited audience in New York just before the High-Level Meeting, where key government officials from Brazil, India, Guyana and the United States stated the case for the inclusion of mental health.

To read more about our other important activities and programs, please, go to our website at www.wfmh.org.

Dr. Deborah Wan,
Board President

Protecting the Rights and Interests of Physicians

The Mozambican Medical Association

How do you protect the legal, judicial and financial interests of your colleagues?
Most of the Mozambican physicians work for the government and they are protected by the General Statute of the agents and public workers.

Do you have a legal counsel?
At the Mozambican Medical Association (AMM) we do have a legal counsel that advises on different matters needing legal counselling.

Are the rights to protect your colleagues included in your countries' legislation?
Yes. In Chapter II Article 3 and Article 5g) of the Mozambican Medical Association and it reads as follows: Article 3 – AMM promotes, with independence and responsibility, the defense of its associates' legitimate interests, fights for the dignification of the medical class, and assumes an active position regarding all issues that affect or may affect the health condition of the population in the Country, the Continent or the World. Article 5g) – Care for the full compliance with the law and respective regulations, namely in what concerns the doctor's title and profession.

Have you organised strikes, rallies and other activities?
The AMM had never had the need to organize strikes. Sometimes it makes statements in the public and private newspapers about matters that need a position from the medical class.

Do you turn to the government?
We turn to the government for matters that are of interest to the AMM, for support to some issues (like the Physicians Statute), to advise on some law proposals (e.g., the Transplant Law) and as a partner in some activities, such as the continuous medical education.

The Slovak Medical Association

How do you protect the legal, judicial and financial interests of your colleagues?
The Slovak Medical Association (SkMA) is a non-profit, non-governmental organisation with voluntary membership. We protect the interests of our organization and our members, if their activity is related to the subject of our activities.

The mission of the SkMA is to make broad medical circles aware of the latest scientific findings and professional observations through organised scientific events and other professional meetings, to support the involvement of our own experts in similar events abroad and to publish and support the issue of professional magazines and publications.

Do you have a legal counsel?
Yes, one of the employees of the Secretariat of the SkMA is a lawyer.

Are the rights to protect your colleagues included in your countries' legislation?
Yes

Have you organised strikes, rallies and other activities?
No, but last year we supported the strike of health workers.

Do you turn to the government?
Yes

The Macedonian Medical Association

How do you protect the legal, judicial and financial interests of your colleagues?
In general, issues arising from legal and juridical regulations are left to be solved by the individuals themselves, the physicians and other health personnel.

Exemptions are the rights arising from collective agreements that are coordinated and signed by trade unions and employers, i.e. the minister of health. These are issues from work-related legislation. Physicians can apply to the Administrative Court for legal acts arising from legal and juridical regulations and approved by the managing bodies or organs of the state.

There is another possibility, which is very often used by individuals. Physicians and citizens use the Supreme Court for exploring the constitutionality of legal decisions

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that refer to the rights of the physicians and their work.

Trade Unions and their institutions and bodies play the key role in financial matters. Attorneys are being engaged to represent the interests of trade union members in front of the Administrative and regular courts.

Do you have a legal counsel?
There is no legal advice although general practitioners or the Society of Private Physicians has its attorney with restricted/limited rights. For example, he/she is not allowed to be present at debates about signing contracts between the Fund for Health Care and physicians. In this context the Medical Chamber is not involved, and as a rule, the Chamber represents the rights of the physicians not only verbally but in front of legitimate and state institutions.

Are the rights to protect your colleagues included in your countries' legislation?
There is no legal or any other obligation for protection of the rights included or determined in the state laws.

Have you organised strikes, rallies and other activities?
Over the last two decades there was one strike interrupting the work for several hours. A few demonstrations and similar activities, mostly manifested by interruption of the work, have taken place, but they referred to the work organization and not to the rights of the employed.

Do you turn to the government?
Communication with the Government has been initiated, although still without any results. Suggestions from the doctors' associations, representing the interests of the physicians, are not accepted in most instances. It has also to be emphasized that physicians who are members of the State Parliament/Republic's Assembly represent the interests of the political parties and not of the profession.

The Hong Kong Medical Association

How do you protect the legal, judicial and financial interests of your colleagues?
Partnering with the Medical Protection Society in the UK, we help our colleagues defend professional negligence and misconduct cases. All expenses and compensations for damages are paid out of the funds pooled in this Society so that colleagues can practice medicine having peace of mind. Our Duty Council Member scheme helps answer questions from colleagues who have problems in their daily practice.

Do you have a legal counsel?
To advise us on legal matters, several legal counsels are retained by the Association on a pro bono basis.

Are the rights to protect your colleagues included in your countries' legislation?

The rights to practice medicine are mainly written in the Medical Registration Ordinance. Others include the Pharmacy & Poisons Ordinance, the Supplementary Medical Professions Ordinance, the Medical Clinics Ordinance and related ordinances and regulations.

Have you organised strikes, rallies and other activities?
One of the main objectives of the Hong Kong Medical Association is to promote the welfare and protect the lawful interests of the medical profession.

At times, we have to resort to strikes, rallies or sit-in demonstrations to get ourselves heard or turn to the government if required. In 2007, we had a sit-in protest and a march against the "unequal pay for equal work" wage scale of the junior doctors working in public hospitals. In 2008, we had another march against the sharp increase in rents of clinics in public housing estates.

Do you turn to the government?
We collect views of the profession by conducting surveys and then present them to the authorities via the media or via our representatives in the respective government and non-governmental organizations.

FMH Swiss Medical Association

How do you protect the legal, judicial and financial interests of your colleagues?
The Swiss legislation on social insurance asks for collective tariffs (http://www.admin.ch/ch/f/rs/832_10/a46.html) which gives some protection to the practitioner.

FMH can asssit members in financing legal procedures of general interest to the medical community.

Do you have a legal counsel?
FMH has a legal department.

Are the rights to protect your colleagues included in your countries' legislation?

The Swiss legislation grants its inhabitants the right to found private associations. FMH as a private association is free to define its aims. SIWF-ISFM as a part of FMH which regulates the postgraduate training (http://www.fmh.ch/bildung-siwf.html) has a mandate of the state and does not interfere with the political branches of FMH.

Have you organised strikes, rallies and other activities?
The FMH is currently, like it already did in 2008, taking a leading role in federal referendums (see referendum on managed care legislation of June 17th, 2012, http://www.parlament.ch/f/dokumentation/dossiers/care/pages/default.aspx).

Do you turn to the government?
FMH has regular contacts with members of the government and the public administration

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The Serbian Medical Chamber

How do you protect the legal, judicial and financial interests of your colleagues?
The legal interests of our colleagues are protected in health system via proposed laws and bylaws that the Serbian Medical Chamber suggests or in some cases disputes in front of the Constitutional Court of the Republic of Serbia. Financial interests of medical doctors in Serbia are protected by health care trade unions. Currently there are six medicine trade unions in Serbia. We are not pleased with this sort of disunion.

Do you have a legal counsel?Are the rights to protect your colleagues included in your countries' legislation?
Referring to the judicial protection of Serbian physicians, the Serbian Medical Chamber takes actions via an official lawyer and legal adviser. Furthermore, the Ethical Board works on the Serbian Medical Chamber Litigation Rule Book. The Serbian Medical Chamber, therefore, has its legal counsel and, at the same time, the legal team that consists of 16 lawyers. The rights to protect medical doctors in Serbia are defined in the Serbian Medical Chamber Statute and in the Law on Health Care Professionals Chambers of the Republic of Serbia.

Have you organised strikes, rallies and other activities?
We have not organized strikes and rallies. However, the Serbian Medical Chamber officials very often meet with Government and Ministry of Health representatives.

Do you turn to the government?
Those meetings result with variable outcomes.

The Icelandic Medical Association

Background information
Iceland is a small country with the population of approx. 320,000. In 2010 there were around 1070 practicing medical doctors in the country, thereof 860 with specialist licences. Approx. ¾ of the medical workforce worked full time or part time in the public health sector; in hospitals, health care centres and health institutions. Over 90% of the doctors are members of the Icelandic Medical Association (IMA), established in 1918.

Legal Provisions on Icelandic Medical Doctors
For decades there has been in force a special legislation on doctors, defining their obligations and basic rights. The legislation does not give IMA any legal role, neither to protect nor assist its members when legal matters arise.

However, IMA has from early on given its members legal advice and in some instances provided legal assistance to them. IMA has a lawyer among its staff members and when needed attorneys are engaged to bring cases to court. Most such cases are due to the employers' failure to comply with wage contracts or other work related agreements.

Working Conditions and the Right to Strike
One of the roles of IMA is to negotiate wage agreements. A legislation on wage agreements within the public sector stipulates that all salaried employees, who receive salaries based on wage agreements reached by their association, are either obliged to be a member of their association or pay a yearly fee to it. Consequently, doctors who receive salaries based on IMA's wage agreements need either be a member of IMA or pay a fee to it.

Within IMA a negotiating committee is responsible for the negotiation process and other work related matters within the public health care sector. If the negotiating parties do not reach an agreement IMA has the legal right to call for a general strike of doctors. However, this happens very rarely, mainly due to very extensive legal exemptions to the right of doctors to strike. Furthermore, many Icelandic doctors believe it is unethical to strike and are of the opinion that other measures are to be used to raise wages, shorten working hours and improve working conditions.

IMA continuously has a dialogue with the relevant health authorities on issues relating to health and the situation of doctors.

Belgium

The Belgian Association of Medical Trade Unions has been set up in 1963.

The Belgian Medical Body wanted to be a liberal profession and had to fight against the government's will to nationalize health care.

After a 3 week's medical strike, the government withdrew the law. Medical practice would remain liberal and every year a mutual agreement would be made between doctors and insurance companies, about medical fare in order to insure fare security for the patient in a social funded system.

Since then, we have set up a complex system of concertation which allows us to give our opinion on any medical matter or on public health. This system gives us a real power but, if we achieve a reasonable consensus, and it has happened very often, we take action against such measures as strikes, demonstrations, etc.

Of course, to have a fair balance between actions and negotiations we need to have legal advisors. It is more difficult to come to the same opinion in the whole medical body. Every speciality often sees to its own interests. We have to conciliate the two communities (the Flemish and French speaking) hospitals and ambulatory care, etc.

But, up to now, we manage to keep a strong solidarity. And, anyway, don't forget that the government decides eventually.

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The Royal Dutch Medical Association (KNMG)

KNMG is a federation of associations of doctors: GPs, medical specialists (consultants), occupational health doctors, nursing home doctors and doctors working in the public health domain. KNMG represents about 60% of all doctors in the country. The federation defends the so-called immaterial interests of all doctors, in the fields of quality and safety of care, professional behaviour standards, medical ethics, legal and judicial aspects, education, lifelong learning, career planning, prevention and public health. KNMG has 25 policy advisors working on these issues, among whom 5 legal advisors. KNMG intensively lobbies stakeholders, ministries and parliament in order to realize its objectives. High KNMG officials regularly meet with government officials, the minister of health and members of parliament. We have a high profile in the media due to a very active media policy.

Material interests (wages, fees, insurance rates) are looked after by the separate professional associations, which also cover the specific quality aspects for their own professional communities. There is close cooperation between KNMG and its federation partners to take joint action wherever possible, and in case of common interests to jointly move toward stakeholders, government and parliament and thus reinforce the message.

The Canadian Medical Association

The Canadian Medical Association is a voluntary, member-driven physician representative organization. We advocate actively on behalf of our members with the government and other important stakeholders at the national level and through our Provincial and Territorial Medical Associations (PTMA's) at the provincial and territorial level. In Canada, health care provision and funding is a provincial and territorial obligation, although the federal government plays an important role in transfer funding, care of certain populations (such as Canadian Aboriginals) and policy setting.

Physician malpractice insurance is provided mainly through the Canadian Medical Protective Association (CMPA). This association is separate from the CMA, although we share close ties. Members receive legal advice and representation through their membership in the CMPA. Further information is available at *www.cmpa-acpm.ca*.

Financial interests are primarily addressed by the PTMA's through their negotiations for physician fee schedules and billing codes with their respective provincial governments. On occasion, PTMA's have had to organize targeted strikes and job actions in the past although this has thankfully been quite rare.

Cyprus Medical Association

The Cyprus Medical Association was established in 1967 and represents all practicing physicians in Cyprus. According to the Cypriot legislation, a physician who is practicing in the island is obliged to become a member of the Association. At present, the Cyprus Medical Association has approximately 2650 members.

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. Furthermore, CyMA provides consultation and assistance to its members in their mutual relations, in their relations with the State or other authorities and organisations. Additionally to that, CyMA cooperates with other national and international bodies in order to foster its aims.

Moreover, the Cyprus Medical Association is not only a professional body but also acts in various ways for the benefit of patients and the general. public The Association aims at the protection of medical ethics, the development of a health care system so that every patient enjoys the right to adequate treatment, enhancement of its members professional training and advancement opportunities, introduction of new legislation and regulations governing health issues and the management of its members' pension fund and life insurance schemes.

The Association has an administrative board of 24 members. It meets once a month and appoints its eight sub-committees. These sub-committees are the Ethics Committee, the Continuing Medical Education Committee, the Scientific Committee, the Law and Regulations Committee, the Communication Committee, the National Health Insurance Scheme Committee, the Trade-Union Committee for the Private sector and the Trade-Union Committee for the Public sector.

The Cyprus Medical Association secures the legal and judicial interests of its members through a multilayered and coherent policy that is based on the one hand, on full implementation of the Cypriot Law in relation to the physician profession, and on the other hand on intensive cooperation and dialogue with the Cypriot Government and Parliament. Moreover, the Cyprus Medical Association buys services from a legal counsel and, in close cooperation with him, the members of the Law and Regulations Committee participate in open discussions at the Cypriot Parliament concerning healthcare issues.

The financial interests of the CyMA members are secured through the operation of two Committees, the Trade-Union Committee for the Private sector and the Trade-Union Committee for the Public sector. The Trade-Union Committee for the Private sector organizes and coordinates all of the local medical specialities boards and every two years on behalf of its members negotiates with insurances companies and specific employers insurance funds the price of medical acts. It has to be noted that according to

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the Cypriot Law all the bilateral contracts are signed between each individual doctor and the insurance companies. CyMA acts as the representative of the physicians during the negotiations for the content of the bilateral agreement.

Since the establishment of CyMA and until today the Association has not organised a strike or rallies as there has been no need for it. The main diachronic philosophy of the Association is to maintain excellent relations with the state decision makers in order to secure the interests of its members. Until today, any problems the medical profession has been facing were resolved through dialogue and lobbying.

Nevertheless, CyMA supported a number of strikes that were organised by the Union of the Public Doctors aiming to improve their rights at work. During those strikes CyMA had a constructive role in the resolution of the problems due to the strikes by transferring patients from the public to the private sector.

According to the World Health Organization, health care in Cyprus meets high standards. Today CyMA has a leading role and supports the creation and establishment of a National Health Plan that will combine all the medical services from the private and public sector. It will further improve the service provided to the patients of the island.

News from the Standing Committee of European Doctors (CPME)

Introduction

The CPME spring meetings in Brussels on 3–5 May saw many new developments:
Firstly, the CPME together with the ECDC (European Centre for Disease Prevention and Control) hold a joint conference on vaccination and prevention, entitled: "Prevention through Childhood Vaccination – Defining Doctors' Roles in the Stakeholder Debate".

On the following day, at its Board meeting in Brussels on 5 May 2012, the CPME adopted policies concerning professional regulation as well as public health which demonstrates the variety of health policy of interest to the European Medical Profession.

The General Assembly on the same day elected the new Executive Committee for the period 2013–2015.

CPME/ECDC conference on childhood vaccination

The half day conference gathered together speakers from ECDC, WHO-Europe, the European Commission, Médecins du Monde, the European Patients Forum and delegates from the National Medical Associations. European Doctors and policy makers agreed that high quality, evidence-based information and good communication between doctors and patients/parents as well as modern media tools are key for prevention and form part of the recommendations for future policy actions and joint action. In conclusion, it was stated that doctors should engage more in supporting vaccination programs for children. Special emphasis was put on the importance of vaccination against measles which is a condition for near eradication of this disease in the world.

Outcome of CPME's Board and Executive Committee meeting in May 2012

Professional Qualifications Directive

As previously reported, the CPME is very active on the revision of the professional qualification directive (Dir.2005/36 EC)[1] to which the Commission in December 2011 published its proposal COM (2011) 883 final[2].

The CPME Board endorsed the amendments of the Executive Committee to the European Commission's proposal to revise the Professional Qualification's Directive (PQD)[3].

The main issues of concern in a nutshell are that competent authorities must not be restricted in the capacity to grant recognition of qualifications; for the sake of legal certainty and patient safety "tacit recognition" cannot be accepted. Partial access (access without fulfilling the minimum training requirements) is not appropriate for the medical profession, otherwise patient safety and quality of care is at high risk. While alert mechanisms should apply to all health care professionals, data protection standards and the principle of the presumption of innocence must be respected. There should be no change to the minimum training requirement of basic medical training as set out in the current directive (stipulating 6 years or 5500 hours) in order to safeguard the quality of the increasingly complex education and training. Initiatives to develop and elaborate the minimum training requirements must be driven by the medi-

1 http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:255:0022:0142:en:PDF

2 http://ec.europa.eu/internal_market/qualifications/docs/policy_developments/modernising/COM2011_883_en.pdf

3 http://cpme.dyndns.org:591/adopted/2012/CPME_AD_EC_27032012_009_Final_EN.pdf

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cal profession, in particular the competent authorities.

Doctors' knowledge of the language must be sufficient to safely communicate with patients as well as consult with their professional, regulatory, administrative and commercial infrastructure. Language verifications shall not be used as barriers to mobility.

Apart from its own amendments, the CPME also adopted a draft statement on PQD to be signed together with all main European Medical Organisations.

Medical devices

The Board approved also a statement on medical devices[1] in which CPME welcomes the statement of the European Health and Consumer Policy Commissioner John Dalli made on 9 February 2012 where he called on EU Member States for immediate action to be taken at national level to ensure full and stringent implementation of the current legislation on medical devices. Going further than this, CPME calls for legislation which follows the same principles as Pharmacovigilance, since medical devices have reached a degree of complexity that easily compares with the one in use in the pharmaceutical industry. Also, a centralised monitoring mechanism to ensure the highest safety standards of the notified bodies across the EU is considered desirable.

Alcohol and Youth policy

The new CPME statement reaffirms European doctors' commitment to actively contributing to the prevention of alcohol-related harm to this vulnerable group. One of the actions highlighted is the pro-active engagement with children and young people on the topic of alcohol. These 'brief interventions' by doctors have been proven a highly effective tool in preventing harm. Also, doctors up-hold their call for regulatory action to be taken both on maximum blood alcohol levels for drivers and on the advertising of alcohol products. In addition, the statement addresses the need for more effective enforcement of legislation on alcohol sales to minors and highlights the importance of choosing a participatory approach in school-based training programmes on alcohol related harm.

Ethical and fair patents

At its Executive Committee meeting on 3 May, the CPME adopted a policy which calls for ethical and fair patents[2]. While the regulation implementing enhanced cooperation in the area of the creation of unitary patent protection is currently blocked in the Council of Ministers, since there is no agreement as to whether the future European Patent court shall be established in London, Munich or Paris, in the view of European Doctors a clearer defined exemption in the regulation on the human genome is of high importance. Also, development as well as fair pricing of new treatment should not be impeded by the regulation; otherwise health care itself will be endangered in the future.

New CPME Executive Committee and Internal Auditor for 2013–2015

The CPME members at their General Assembly on 5 May 2012 elected the new

CPME Executive Committee 2013–2015

- **CPME President:**
  Dr. Katrín Fjeldsted

Dr. Fjeldsted completed her general practice training in 1979 in London, United Kingdom after receiving her Medical Degree from the University of Iceland in 1973. She has been a family physician at the Efstaleiti Health Centre since 1980 and was the medical director from 1980 to 1982 and again from 1997 to 2003. She has furthermore held inter alias the following offices: Chairman of the Icelandic College of Family Physicians 1995–1999, Member of National Parliament from 1999–2003, Member of the Icelandic parliamentary delegation to the United Nations General Assembly in 1999 and 2000, CPME Vice President for 2006–2007 and 2008–2009 and CPME Treasurer for 2010–2012. At the CPME General Assembly in May 2012, Dr. Fjeldsted was elected CPME President for 2013–2015.

- **Vice-President 2013–2015:**
  Dr. Heikki Pälve (Finland)
- **Vice-President 2013–2015:**
  Dr. Milan Kubek (Czech Republic)
- **Vice-President 2013–2015:**
  Dr. Jacques de Haller (Switzerland)
- **Vice-President 2013–2015:**
  Dr. Istvan Éger (Hungary)
- **CPME Treasurer:**
  Dr. Frank Ulrich Montgomery (Germany)
- **CPME Immediate Past President:**
  Dr. Konstanty Radziwill (Poland)

Internal Auditor

Dr. Gordana Kalan-Živčec (Slovenia) was elected **CPME Internal Auditor 2013–2015**.

Next CPME general meetings

The next CPME general meetings will take place in Limassol (Cyprus) on 23–24 November 2012.

Dr. Konstanty Radziwill
CPME President

Birgit Beger
CPME Secretary General

1 http://cpme.dyndns.org:591/database/2012/EC_2012_026%20CPME.FOR.BOARD.Statement.Medical.Devices.pdf

2 http://cpme.dyndns.org:591/database/2012/EC_2012_053.Draft.CPME_Statement_Patenting.Human.Genome.pdf

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In memoriam Alan John Rowe

3 February 1926 – 30 April 2012

Educated

Haughley Grange Stowmarket Suffolk IP 14 QT
Brentwood School
Kings College, University of London (Vice-President Union Society)
Charing Cross Hospital
LMSSA(Lond) 1950 MRCGP 1968: FRCGP 1988

Occupation

Consultant European Health Affairs
Hon. Editor in Chief World Medical Journal 2004–2008,
Hon. Co-Editor 2009–2012
JHO/SHO Royal East Sussex Hospital 1950–1951
Medical Registrar Royal East Suffolk Hospital 1953
Junior Specialist in Pathology RAMC (DADP War Office 1952/1953) 2 I/C No 1 Blood Transfusion Unit, (Reserve) RAMC 1993–1999)
Medical Registrar Hastings and Bexhill Group 1953–1954
General Practitioner, Ixworth, Suffolk l954–1988
Hospital Practitioner Rheumatology & Rehabilitation
Addenbrooke's Hospital, Cambridge 1960–1986
Consultant DG V European Commission 1988–1992
Adviser in General Practice, Course Director, European School of Oncology 1988–1998
Secretary Suffolk Local Medical Committee 1992–1996
Founding Editor Oncology in Practice 1991–1994
Secretary-General EFMA/WHO 1984–2001 *(see below)*
Consultant WHO (*see below)*
Temp. Adviser WHO (*see below)*

Honours

Officer of the British Empire (OBE) 1976
Gold Medal Giornata Nazionale del Medico (Italy) 1978
Hippocrates Medal (S.I.M.G.) 1986
Fellow British Medical Association 1986
Medaille de Mérité Européen (Gold)1993 Silver (1988)
Hon. Member Ordern dos Medicos (Portugal) 1988
Hartmann-Thieding Medal (Hartmannbund, Germany) 1988
Hon. Specialist Clinica Geral (Portugal) 1988
Vice-President, British Medical Association 1998–2012
Papal Bene Merente Medal 1999
Bereinstein Medal, Polish Medical Chamber 1999
Ehrenzeichen der Deutschen Ärzteschaft (Medal of Merit of theGerman Medical Association) 2000
Hon Member: Medical Association of Kazakhstan 2000
Hon. Member: European Forum of Medical Associations &WHO 2001
Hon Member: Romanian Medical Association 2001
Kaspar Roos Ehrenmedaille, NAV-Yirchowbundes 2002
Macedonian Medical Chamber for service to Macedonia Health Services – 2004

Appointments

- Member Jury (National Secretary) Prix "Europe et Medecine" 1992–2004
- Member of Livery, Worshipful Society of Apothecaries,
- Freeman of City of London

Medical Defence Union

- Member of Council, Medical Defence Union 1986–1996
- Member of Cases Committee 1986–1996
- Adviser on EEC 1980–1990

National Health Service (UK)

- Member Executive (Health) Council, West Suffolk 1962–
- Suffolk "DHSS Best Buy Hospital" Planning Group
- Member Clothier Committee on Rural Dispensing (DHSS) 1979–1983
- Member of East Anglia Regional Health Authority (DHSS) 1974–1982
- Chairman Rural Practice Payments Committee 1980–1982 (DHSS)
- Member East Anglia RHA General Practice Advisory Committee 1984–1988
- Member RHA/Cambridge University Liaison Committee
- Member General Practice Postgraduate Medical Training Committee (RHA) 1987–1993
- Black Interprofessional Working Group on Data Protection and access to medical records 1984–1990 Dept. Health & Soc. Serv. (DHSS)
- Member UK Council for Postgraduate Medical Education 1978–1986
- Member C.M.O's (DHSS) Working Group on Specialist Training) (Liaison with EEC group) 1999

UK Government and European Parliament

- 1975 Adviser to H. M. Government Opposition on Draft Doctors' Directives (EEC/75/362/363) on Mutual Recognition of Medical Qualifications
- Expert to H M Opposition Rapporteur, House of Commons, Alan Tyrell
- Expert to Amedee Turner MEP European Parliament Rapporteur on Directive General Practice (86/457/EEC) (*see also European Community)*

Europe

Medical Profession

Chairman BMA Committee on European Economic Community (EEC) 1971–73, 1975–1990, (Vice-Chairman 1974–5).
Standing Committee of Doctors (CPME)

- Head of UK Delegation 1971–1990 (Observer 1968–71)
- Chairman "Health Professions" Committee

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- Vice-Chairman Ethics Committee 1980–1985
- Member Juristes Committeel971–1990, Education Committee 1972–1990, Social Security 1975–90 General Practice (1971–1988)
- Rapporteur various topics including Pharmaceutical Directives, Liability for Defective Products, Radiological Safety, the Elderly population in the EEC etc.
- UEMO Liaison Officer to CP *(vide infra)*

European Union of General Practitioners (UEMO)

- President 1982–1986 (adoption of EU Directive Specific Training for General Practice 1986)
- Head of UK delegation 1971–1990 (Observer 1969–71)
- Liaison Officer with the European Commission, Council of Europe & the World Health Organisation (1972–1982; 1986–1990), Standing Committee of Doctors of EEC 1974– 1982;1986–1990
- Chairman various working groups

European Community (EU)

European Commission

- Consultant DGV 1988–1992); (Europe against Cancer Programme);
- Member GP Organisations' Representatives Group DGV 1992– 98;
- Member Advisory Committee on Medical Training (ACMT) 1983–93: Chairman Working Group "ACMT visiting system for Medical Schools & Faculties"
- Consultant Europe against Cancer General Practice Strategy 1994

AIM Programme DGXIII

- Member of Committee on "Computer Security and Legal issues in Medical Information"
- Presentation on Medical Confidentiality" AIM European
- Parliamentary Hearing on Confidentiality 1989

Economic and Social Committee (EEC)

- Rapporteur's Expert various health topics – consolidation of directives on mutual recognition of professional qualifications, product liability, Drug consumption etc.

European Parliament

- Consultant to Rapporteur (Amedee Turner EMP) on G. P. Directive (457/86 EC) 1985–86

World Health Organisation

- General Secretary, European Forum of Medical Associations & WHO 1991–2001, Secretary General 1984–1991
- Organisation of Oncology Services (Primary Care) in Bulgaria
- Consultant: Health Professionals' recognition, licensing & regulation in Kosovo (1999)
- Consultant-Organisation of PHC Oncology Services in Bulgaria
- Consultant – Relations between WHO & Health Professions NGOs (Geneva – 2000)
- Consultant – Regulation and Licensing of Physicians in Europe *2001–2002* (see bibiliography 46)
- Temporary Adviser – various topics, CINDI, Appropriate Health Care Technology, General Practice, CME, Cancer Prevention and Control, Tobacco Control(various), Youth & Alcohol, Inter-ministerial Conference on Tobacco 2001, Family Medicine/GP- definition and future development, Patient empowerment, etc.
- Member European Tobacco Partnership Group EURO 1998–2002
- Inter-Ministerial Conf. Tobacco and Health, "Doctors and Tobacco" Workshop, Stockholm, Sweden
- Consultant TCRC Symposium (E. U., WHO TCRC.) Edinburgh 2004

Other European

- Director European Seminars on Specific Training for General Practice (Oncology) SEMG Florence 1993
- Director European Seminars on Specific Training for General Practice-Florence 1994 (Eng/Fr)
- Director ESO/EEC French and English Workshops for GP Trainers on Oncology in General Practice Training-Venice, Orta, Florence, Coimbra, Antwerp. 1990–96
- Consultant Workshop Primary Prevention of Cancer in Genffi®k Practice, University of Southampton 1993
- BIS/World Bank Consultant on Reform of Health Care Law- Macedonia 2001–2002.

British Medical Association

- Vice-President 1997–*2012*
- Fellow 1988
- Member of BMA Council 1971–1990
- Past President Suffolk Branch
- Past President West Suffolk Division
- Chairman East Anglian Regional Council
- Chairman EEC Committee 1971–1974, 1976–1990 (vice-chairman1975–1976)
- Member Central Ethical Committee 1971–1990 (vice-chairman 1978–1990)
- Chair Working Party and contributor Handbook of Medical Ethics (1984–1988)
- Member(Chair) BMA/Life Offices Assn. Committee
- Member General Medical Services Committee 1965–1990 (Negotiator 1968–1973)
- Chairman Rural Practices Committee UK 1968–1974
- Chairman ABPI/BMA Liaison Committee 1986–1990
- Member:

Health Services Financing Advisory Panel 1967–1970; Review Body Joint Evidence Committee 1968–1973; Medicines' Legislation Working Party (Tunbridge) 1968–1970; In-vitro Fertilisation Committee: various, other committees and working parties; National Joint Committee on Dispensing (BMA/R Pharm Soc); Clothier Committee on Rural Dispensing; GMS

Education Committee

- Member Interprofessional Working Group on Access to Personal Health Information Black Committee (Dept.. of Health/BMA) Chairman Handbook Working Party "Philosophy & Practice of Medical Ethics" – BMA 1988
- BMA representative Presidency of Professions 1976, 1979, 1980
- Founding Member Board, Tobacco Control Resource Centre 1997–2012
- Consultant 2002–2005 (Editorial body "Doctors and Tobacco" 2004–2005

World Medical Journal

Royal College of General Practitioners
- Fellow 1982
- Observer on Council
- Member of GMSC/RCGP Liaison Committee
- UK Representative, European Commission. "Europe against Cancer"
- GP committee 1994–95

World Medical Association
- Hon Editor World Medical Journal 2003–2008
- Member BMA delegation General Assemblies Honolulu, Venice, Lisbon, Madrid:
- EFMA/WHO Observer General Assembly, Edinburgh, Hamburg, Helsinki;
- Observer various Council meetings
- Expert Adviser Ethics Committee
- Past Chairman Associates Group

Other
- Member Interprofessional Group on EEC (Law Society) 1978–1982
- World Congress on Medical Law 1979
- Member of UK Cancer Co-ordinating Committee, Europe against Cancer 1994–2002
- Member of Council, Queen's Institute of District Nursing
- Member of Advisory Group on SEN role in local authority nursing services (Q.I.D.N)
- Member Advisory Panel, Association of Occupational Therapists 1989–1991
- Member of Jury (UK National Secretary) "Prix Medicine Europeene" (Institut Sciences de la Sante) Paris 1980–2005
- Member of Livery, Worshipful Society of Apothecaries of London. Freeman City of London

Societies
- Ethics in Health Care Forum
- Medico-Legal Society
- Fellow Royal Society of Medicine
- Past Fellow Royal Society Tropical Medicine and Hygiene

Publications/Reports/Lectures
- EpidemicHaemorrhagic Fever Lancet, Nov 15, 980.1952
- Memorandum on Immunological Procedures (edit) – HMSO (1953)
- Epidemic Haemorrhagic Fever – R.Soc. Trop.Med.& Hyg 1953
- "Implications for general practice of Britain's entering the Common Market", BMA Junior Members Forum, Cambridge 1971, BMA
- "General Practice and the Common Market", Proc.Roy.Soc.Med. 65,927–9,1972
- "Psychosomatic factor in Rheumatoid Arthritis" The Practitioner 1972,208,81–85
- "Libre Circulation des Médecins" – Cahiers de Droit Européene 1976 Nos 5–6,733–66
- "The EEC Commission, Health and Medicine – a new Directorate General for *Yt-edXÙf!".summary* in BMJ 1977, 12th March
- "Institutions of the European Community & Occupational Health" Royal Society of Medicine 1977
- "Collaboration and cooperation between the professions in the EEC" International Seminar "Background to nursing in the EEC" Royal College of Nursing, UK 1977
- "Formazione complementare del medico generico nel Paesi délia CEE" International Conference "Europa Bianco", FNOOM, Naples, 20 May 1978
- "Primary health care in Europe" – Bristol Postgraduate Centre 1978
- "Local Ethics Research Committees" Rutgers University USA1979
- "Problems of Ethics & Research – Local Ethical Research Committees". National Academy of Medical Sciences, Washington, DC, US A, April 3rd 1980
- Local Ethical Research Committees "Presentation" Institutional Review Boards Symposium-Rutgers University, USA, 11 April 1980.
- "Why Social Policy in the EEC?" Wilson School of Political Science, Princeton University, USA
- "The UK National Health Service", Hastings on Hudson Ethics Centre USA,^10 April 1980
- "Medicina General y Salud Publica en Europa" Congresso Nacional de Medicos Titulares Espagnole, Torremolinos. Spain. 1988
- "Quelle vérité faut il dire au malade?" – Ligue Nationale Française contre le Cancer, Paris, 1983
- "Technological, Scientific Progress and Human Rights: Genetic Engineering" WMJ 31,25-26,1984"
- "Formation continue aux Royaumme Uni" Europe Blanche, Inst des Sciences de la Santé, Paris 1985
- "Role et Formation Spécifique du Medecin Generaliste selon le le CEE – Colloque International de l'Universite de Bobigny, Paris.
- "L'organisation de la formation Medical Continue – Angleterre" l'Institut des Sciences de la Santé, Paris 1986
- "Continuing Medical Education in the United Kingdom", Europe Blanche (Paris) 1988.
- "La jurisdiction professionelle en Grand Bretagne" – Colloque "Ordre des Médecins et son devenir", Ordre des Médecins, Oct 1981
- "Health and the European Community" WHO (EUR/ICP/ Cor.010103) 1986
- "Raising Standards through Common Action – The Battle for Health" The European, 1 No 6,1987
- "Les systèmes de Soins étrangers" – Pays du Nord-Systèmes Nationalisées" l'Institut d'Études Politiques, Paris, 1991
- "The EEC and the Internal Market in Medicine", Postgraduate Centre, Colchester, 1991
- Europe against Cancer – the role of general Practitioners. Europe Social, European Communities 1/1991
- "The EEC and Medicine" – European Society of Parkinsons Organisations, Glasgow 1991
- "Specific Training in Family Medicine and the European CommunityHealth Services" – Ministry of Health Symposium, Madrid 1991
- "Role of G. P's in Female Cancer Screening" – SIMG/EEC Florence 1991

World Medical Journal

- "Medicine in the European Union and Greater Europe"– Hertford Postgraduate Centre 1991
- "Overview of EEC Professional Directives" *in* Standards of Excellence (Health Care delivery in the European Community) NHS Training Directorate. 1992
- "La Medicine de Famille dans les Pays du Nord" – l'Institut d'Études Sciences Politiques, Paris 1993.
- "Regard sur d'autres systèmes de santé – Systeme de Santé Anglais" l'Institut d'Etudes Politiques Paris 20 June 1993
- "Health and the European Community" – EFMA/WHO Meeting 1988-WHO Copenhagen E 65564 pp 67–70
- "Europe against Cancer Programme – an overview" UEMO Handbook 199
- Reports of Annual meetings of European Forum of Medical Associations and the World Health Organisation, 1986,1987,1988, 1990,1991,1992, 1993,1994, 1995,1996, 1997, 1998,1999, 2000, 2001 – WHO European Regional Office/ICP/EXM 019
- "Le Cancer et les styles de vie" – III ieme Cours Européen d'Oncologie pour les Maitres de Stage Médecins Generalistes – Univ. Coimbra 1995
- "Europe against Cancer GP Strategy" UEMO Handbook 1999,115–118
- "The General Practice Directive 86/457/EEC – the end of 30 years struggle?" UEMO Handbook Kensington Publications 1994
- "Core content of cancer in specific training for general practice" – Proceedings of Consensus Conference on cancer training for General Practitioners Copenhagen 1991 EEC/UEMO
- "Role of General Practitioners in Tobacco Control" – Europe against Cancer, Athens 1992
- "Cancer", UEMO Handbook, Kensington Publications 1993
- "Primary and Secondary Cancer Prevention in General Practice" – European Commission Symposium, Brussels 1990
- "Medical Education in the EEC" – Karolinska Managers – Univ. Sussex 1982
- "Medicine and the EEC" Karolinska Managers – Univ. Sussex 1983
- "Les Personnes Agées dans la Communauté Européene – present et l'avenir"– Bonnel, Hennigan & Rowe IPSEN 1990
- "Europe against cancer – the role of general practitioners" – Social Europe 1/91, p94–95. European Commission ISSN 0255-9776
- "European Code against Cancer – a booklet for general practitioners" Scand. J. Prim. Health Care 1994 Suppl. 1 (and 3M first version of Code) 1993)
- "Title IV of the E.U. Council Directive: Specific training in General Medical Practice" UEMO Handbook, Kensington Publications l995
- "Dispensing of Medicines by General Practitioners" – an overview of trends in the European Union – Austrian Arztekammer, Vienna-1995
- "The European Medical Profession – problems, challenges and opportunities at the beginning of the 21st century." Bull 2/02 Société des Sciences Médicales du Grand-Duche de Luxembourg 2002.p
- "European Legislation" *in* "The Law and General Practice" 1992, *Radcliffe Press.*
- "International Partnerships for Health", WHO address General Assembly, Polish Medical Chamber, Warsaw 1997
- Editorials in World Medical Journal 50 (1–4), 2004, 51 (l–4)–2005,52 (1–4), 2006, 5J-(1–4), 2007.
- Licensing and Regulation of Physicians in the WHO World Health European Region Copenhagen. EUR/05/5051794C 2005
- Licensing and Regulation of Physicians EuroMed, Barcelona 2005
- Handbook European Forum of National Medical Associations & WHO(Rowe & Vigen) 1981–2001
- Clinica Geral, 1985

Other activities

Kings College, University of London Vice President Union Society

Music

- Organist St Michael's Church, Gidea Park 1941–1944
- Organ Scholar, Kings College, London, 1945–1947, President and Conductor
- Music & Dramatic Society
- Sub-Organist St. Martins in the Fields 1947–1950
- Organ recitals in UK & abroad, including, St. David's Cathedral, St. Margaret's Westminster, Oude Kirke Amsterdam, Basilica Wilten, Innsbrook, St., Innsbrook, Cathedrals in Santiago da Compostella, Toledo and Lisbon, San' Giorgio Basilica Venice, Wilten Innsbruck Basilica, Du PresConcert Hall Meudon, Paris:, Ljubljana and Chapel, Princeton University

Harpsichord /Organ Continuo

- Ipswich Bach Choir-harpsichord continuo Bach Matthew & John Passions, Christmas Oratorio, Magnificat, Mozart Requiem, Monteverdi Vespers
- Cheltenham Bach Choir-harpsichord & organ continuo (Christmas Oratorio) Kidderminster Bach Choir-harpsichord continuo
- Eye Bach Choir-organ continuo Haydn"Spazen Messe", "Messe de Minuit, Messiah. (many) Clerambaut etc.
- Various orchestral works Handel' Messiah, Israel in Egypt, Hoist Hymn of Jesus
- Organist Gustav Holst Centenary Memorial Service Aldborough with Aldborough Festival Choir.
- Holst Hymn of Jesus, (keyboard) St Martin in the Field

Conducting

- Appointed conductor Ipswich Orchestral society
- Other conducting Handel, Acis and Galatea, J. S, Bach B minor Mass, Haydn Harpsichord concerto in D, etc.. Cantata 51, Mozart 12th Mass and Mozart Requiem, Haydn "Nelson", "Harmonie" and "Sparrow" Masses, Schultz Passion etc. Vaughan Williams Coronation Te Deum
- Director of Music St Edmunds Church, Bury St. Edmunds 1958–1993
- Organist l958–2011

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Publications by Alan J. Rowe in WMJ

Medical profession

(WMJ 2007, Vol 53. Nr 1)

Wherever one looks the medical profession it seems to be facing more and more problems despite, or sometimes due to, advances in medical science and their introduction into medical practice. They range from the global problems of human resources and health professionals including physicians, inequities in their distribution across the world, continuing efforts to maintain standards for professional practice and ensuring maximum patient safety, the changing face of medical practice with increasing emphasis on prevention, huge increases in the intrusion of management and administrative bureaucracy associated with medical practice both in hospitals and the communities.

As these problems are addressed, it is vital that the profession in each country is seen to have considered them and prepared its own position, rather than reacting to short term policies proposed by others which may be neither in the best interests of the community, of individuals, or of the profession.

The contents of this issue of WMJ reflects the diversity of both the positive developments in medicine, science and in disease control, strategic plans and health policy developments, as well as some of the problems which still need to be solved.

It includes some further WMA policy statements, one of which, that on medical education, is also the subject of a report on a new strategic partnership between the World Health Organisation and the World Federation of Medical Education. There is also a report on the first meeting of the Taskforce of the Global Health Workforce Alliance (GHWA) to seek practical solutions to the health workforce problems, including investment in education and training of all healthcare workers. The WMA Secretary General comments on one particular effort seeking to persuade physicians who have emigrated to return to practice in their own country where there is a grave shortage of physicians. Another article addresses the problems of medical research ethics posing a question as to whether or not there are limits to the possible har- monisation of activities of ethical research committees. Two papers given at the WMA scientific meeting in South Africa address the important topic of "Health as an investment"

In the context of the problems of shortage of physicians it is interesting to note the results of a ten year cohort study of 545 of doctors who graduated in one country in 1995 [1]. Of approximately 1400 of the final year students who expressed willingness to participate in the survey, a sample of 600 were drawn and of these 545 participated in the questionnaire which was sent to all participants each year for ten years. This was combined with focus groups which were random sub-samples each year, where questions could be more deeply examined. Apart from information on type of work, career choice and training, questions were asked about working conditions and about participants' attitudes to medicine as a career, in the light of their experience year by year.

While all the results of this study are interesting, as will be those of the next ten year cohort study, in the context of the debate on human health resources (particularly recruitment and retention of physicians), it is interesting to note that in this study

- 2 in every 5 doctors in the cohort study (40%) found that the reality of a career in medicine was very different from that envisaged on graduation in 1995;
- While three quarters (75%) of the cohort doctors ten years after graduating were satisfied with practising medicine, a fifth (20%) reported a lukewarm desire to practice medicine.
- The rest (5%) had little or no desire to practise medicine. (3% of the cohort had left medicine during the 10 years of the study, the most common reason being dissatisfaction with medicine as a career.
- 15% had changed their career choice during the study period, a key factor in this being "hours of work and working conditions" followed by working/pay conditions.

While these findings are disturbing (20% having a weak desire to practice medicine after 10 years), when planning to educate more physicians to meet needs it is unfortunate that no other countries have carried out comparable extensive cohort studies. If the profession is to address its future in the light of the problems it faces, then such studies could contribute valuable information in the formulation of such plans.

Medical professionalism

(WMJ 2007, Vol 53. Nr 3)

The second half of the 20th century and the beginning of this one have experienced unprecedented and ever increasing rapidity of technological development, scientific discovery, research and the production of innovative diagnostic tools and therapeutic agents. All have had enormous impact on medical practice, some have posed major ethical problems and – not to be disregarded – increased public expectations of scientific discoveries and their application in medicine, together with calls for, and the need of consequent changes in medical practice.

In parallel, the huge expansion in the availability and accessibility of information

1 BMA Cohort Study W report 2005

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about medicine, medicines and medical research through the growth of communication via the mass media and IT development, has played a major role in changes taking place in the organisation and the conduct of medical practice. At the same time it has also, through the instant availability on information via the media (both TV and the web) supplied compelling information about the increasing instances of natural disasters and their consequences. The instant availability of information has also highlighted to a wider public the problems of disparity in the provision of health care in differing parts of the world. The impact of information about the incidence of infectious diseases and the reality of the role of poverty in disease, relayed through media readily accessible in the home, conveys an even more realistic and compelling image of catastrophes, diseases and poverty, than that previously available through the spoken or written word.

The impact of these developments has had substantial political, social and economic effects in both developed and developing countries, leading to consequent changes in medical practice and its organisation, as well as challenges to the nature of the role of physicians in health care.

These developments have had far reaching impacts on the medical profession, including effects on basic medical education, postgraduate education, licensing and regulation, continuing professional development and re-accreditation, not to mention the nature of health care and the delivery of medical care. All of this has been accompanied by the increasing burden of administrative, managerial functions and economic constraints.

On a number of occasions in these columns we have commented on these trends, the challenges which they are producing and the increasing need for the medical profession to address them. Indeed, some of the issues have already been addressed in various parts of the world[1,2], and a Charter[3] endorsed by a number of organisations in at least 28 countries.

At its next meeting in October, the WMA Council will be considering these issues and with this in mind , the current issue of WMJ is substantially devoted to a paper on the issue of Medical Professionalism, in particular the role of the National Medical Associations. As will be seen, this paper highlights important problems which should be considered urgently by individual physicians in whatever aspect of medical practice as well as NMA's.

The inclusion of this substantial paper has substantial constraints on the normal contents of the journal which we will include in the next issue. While this topic has already been addressed in some parts of the world, we hope that it will stimulate further debate and contribute, to a clear-affirmation of the qualities of medical professionalism in the 21st century.

The challenge to medical care

(WMJ 2007, vol 53 Nr. 4)

The Tobacco Control Resource Centre, a resource supported by the British Medical Association, the European Commission and the European Regional Office of the World Health Organisation, published in 2000 a report in the context of Tobacco Control Programme under the title "Tobacco – Medicine's Big Challenge." Now at the end of 2007, while Tobacco remains a problem and the great scourges of disease still challenge medicine, a huge challenge (possibly "The Challenge" for the medical profession) faces the health professionals providing medical care, namely the problem of the supply and distribution of health care workers. The 2006 World Health Report of WHO[4] highlighted the problem, notably the huge discrepancies in the distribution of Physicians, Dentists, Nurses, Midwives and other Health care workers, not only within countries but more significantly between countries. Scientific advances have made great contributions in our knowledge of the nature and causes of many diseases, accompanied by discovery and development of many new drugs to cure or ameliorate the effects of disease. All of these call for increasing skills and increased demands on all sectors of the medical workforce in developed countries It places increased demands on the sparse, sometimes almost non-existent supply of health care workers in underdeveloped countries, where healthcare was already minimal, obstructing any implementation of advances in healthcare available elsewhere.

Hitherto the limited attempts to address manpower problems in the healthcare workforce had, unsurprisingly, concentrated on workforce problems within national health care systems, substantially disregarding the huge disparities between countries, regions and even continents. At the same time concern has been expressed by both the profession and by some other authorities about the recruiting of physicians in developed countries from developing countries who are already under-doctored, Codes of practice and statements of policy to change this have been issued by the World Medical Association[5] and by some governments and authorities.

While a great tribute should be paid to those organisations and governments who, in one way or another have, over many years, en-

1 Royal College of Physicians "Doctors' in Society: Medical Professionalism in a changing World. Report of a Working Party of the Royal College of Physicians, London: RCP 2005

2 Rosen R, Dewar S., On being a doctor Medical Professionalism in a changing world Kings Fund Publications 2004

3 Medical Professional Project. Medical Professionalism in the new millennium. A physician charter. Ann. Intern. Med 2002 136 (3) 243-246

4 "Working together for health" The World Health Report 2006 WHO, Geneva, ISBN 92-4-156317-6

5 WMA Statement on Ethical Guidelines for the Recruitment of Physicians, Helsinki 2003

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couraged the provision of doctors, nurses and other medical assistance to those countries in need, and to those health professionals who undertook to meet the needs, it was effectively only with the arrival of HIV/AIDS and, more recently the risk of pandemic disease, coupled with increasing political awareness of the need to deal with poverty, inequity and human rights, that the need to address the problems associated with the global health workforce have been forced to the forefront of discussion.

In previous editorials in the World Medical Journal, *WMJ 52 (1) and (2)* we have drawn attention to emerging trends not only in the changing or expanding role of individual health professions, but also to problems of training, mobility and availability of health professionals. Further problems complicating the whole issue relate to the changes in role and functions of health professionals, reflecting not only the increasing aspirations of the individual health professional, but also the increasing specialisation within individual health professions.

In the first part of 2008 at least two conferences will address some of the issues involved. The first is a World Health Organisation Global Conference to be held in Addis Ababa Ethiopia in January 2008, when the conference will address the topic of Task Shifting. "Task Shifting" is defined in a number of WHO documents as "the name given to a process of delegation whereby tasks are moved, where appropriate, to less specialised health workers".

The second conference, organised by the World Health Professions Alliance in the week preceding the WHO Assembly, is the First World Conference the Role and Regulation of Health Professions which will be held in Geneva. Both Conferences are of huge importance in relation to the provision of health care across the globe in both developed and developing countries.

The conferences have great relevance to the future role and functions of the Medical Profession. Whereas previously, physicians, when recognised for full registration as a medical practitioner, held the sole licence to carry out certain specific acts such as the right to prescribe and to engage in the practice of medicine, in an increasingly sophisticated and technical world it is clear that some of these reserved functions can be carried out by other health professionals under regulation, after appropriate technical specialist training. This has substantial implications for changes in the protected role that physicians have previously held in certain areas, while possibly calling for new roles in other areas, essentially calling for a reassessment of the role and functions of physicians in society. In some countries such changes have already occurred in areas such as the extension of limited prescribing rights to other health professionals such as nurses, and extending the acts carried out by other health professionals By enhancing the role of some health professionals, such changes increase the provision of certain health services to a much wider population in both developed and developing countries.

Nevertheless, as indicated earlier, if there is a basic shortage of health care workers in all the health professions, the world is faced with a major problem. This shortage does not only apply to underdeveloped countries. In more developed countries as scientific and technical knowledge and development have increased there is also increased demand for the implementation of these discoveries and a consequent demand for more health workers. Thus the USA estimates that by 2020 they will require at least 200,000 physicians to meet their needs, more than the current need of the rest of the world!

The WMA Secretary General in his column refers to another problem associated with the changes in role and functions of physicians, namely the need for clarity in identifying the roles of health professionals and the titles used to identify them to the public. The differences in titles used for physicians across the world are illustrated in an article by Dr. Doren, to which Dr. Kloiber refers.

The Health Workforce problem which the 2006 World Health Report highlighted is now being actively pursued and it is essential that, as indicated in the editorials referred to above, both individual physicians and their representative organisations actively address these issues. The distribution of certain diseases has been radically changed as a result of greatly increased international travel, with the potential for wider dissemination of communicable diseases including newly emerging diseases, and the risk of major pandemics need to be balanced with attention to the global problems of inequitable distribution of physicians, with such huge conditions. On this list a number of existing medicines are however lacking because they have not been adapted for childrens use.

It has been known for a long time that there is a substantial gap between the availability their distribution. With the calls for "task shifting" as part of the solution, this may also call for radical changes in the career cycle of physicians, nurses, pharmacists, including professional practice in foreign countries as a normal part of the professional career structure. All of these considerations require urgent attention at a time when the very nature of the regulation of the health professions in also under review, including the question of the degree to which the professions themselves should play a role in regulation, a matter of major concern to those professions whose proud role has for millennia been that of "Carmg Professions". It is to this end that the medical profession defends its position in self-regulation of standards of care and its ethical code of conduct in the interests of both patients and profession. All of this must be urgently considered both in discussions at individual, at national level and in the global conferences referred to above. There is no time to be lost. Just as the profession has taken a stand on Tobacco so it must face up to this Big Challenge to the profession itself. Both individual physicians and their leaders must act. Time waits for no man!

33rd World Medical and Health Games from July 7th to July 14th 2012 in Antalya!

A Brief History

Founded in 1978 by "Le Quotidien du Medecin" (a magazine for the medical professions) and initiated by the journalist Liliane Laplaine-Montheard, the Medicine and Health World Games (aka Medigames) have become the most important international athletic event exclusively for health professionals. The World Medical and Health Games (WMHG) gather more than 2000 participants from 40 countries. They are open to all health professionals: doctors, dentists, pharmacists, nurses, veterinarians and students in those fields. The games offer a unique ambiance where the participants can exchange both their professional ideas and life experiences as well as compete in their favourite sports.

23 Sports, one Rallying Philosophy...

For the baron Pierre de Coubertin, founder of the modern Olympic Games, the beauty of sports and the pure joy in the athletic effort was paramount. It is in this "Olympic" spirit that every year the participants meet in the Medigames. There is a choice of individual sports (tennis, judo, swimming, half marathon, squash, golf, athletics...) or team sports (volley-ball, beach volley, soccer, basket-ball...). As in the Olympics the Medigames traditionally start with a "parade of nations" and an "opening ceremony". The week that follows not only offers many athletic competitions but also a variety of entertainments. It ends with a "closing ceremony" in honour of the Games.

Sport... For the Neurons

Every year since their creation, and beyond the focus on sports, the Medigames have always been a international forum where several medical themes are studied and discussed, thus allowing the participants to ally sport with a furthering of their professional expertise. This year it will presided by Dr. André Monroche (France). Finally, the Medigames offer an opportunity to discover a new part of the world every year. After Germany (2008), Spain (2009), Croatia (2010) and Las Palmas-Spain (2011), it is now the turn of Antalya to host the games. Antalya, real pearl of the Turkish Riviera, is a really nice seaside city. Its charming little port, Mediterranean weather, warm welcome from its habitants, as well as great sport facilities, will make the participants have a wonderful stay in this city.

The rendez-vous is set from July 7th till July 14th in Antalya!

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