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- White Paper On Ethical Issues Concerning Capital Punishment
- Violence in the Health Care Sector
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Da Yi Jing Cheng, literally translated as great doctor
is both exquisite skilled and sincere. This is the title
of an article from the classic medical work **One
thousand golden prescriptions for emergency
medicine, volume I**. The book is written by the
famous doctor SUN Simiao in the Tang Dynasty
(618AD-907AD), it is a must-read medical book for
the doctors in the ancient China. This article states
two issues on medical ethics: one is Jing (exquisite)
which requires the doctor be excellent in their medi-
cal skills as medicine is considered from fine to ex-
quisite; while doctor should also be Cheng (sincere),
with empathy and noble moral. This demonstrates
the early ethics in ancient China that calls on doc-
tors to be outstanding in both hand and mind.

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Editorial

In 1964 the World Medical Association adopted, in Helsinki, a Declaration regarding the Ethical Principles for Medical Research Involving Human Subjects. As we approach the fiftieth anniversary of the Declaration of Helsinki we should pause to reflect on how the world and medicine have changed, and examine our current needs and challenges.

As civilizations evolve and mature the epidemiology of disease changes. New morbidity patterns have evolved, especially in Europe, North America and Australia in the last 50 years. Whereas infectious diseases and traumatic disorders predominated in the past, chronic and degenerative processes are more common today. Cancer is taking its prominent place in the spectrum of chronic diseases. The numbers of doctors and medical staffs have grown significantly, but significant specialization has also taken place. We still take medical histories and examine patients, but rely more and more on modern medical technology to arrive at diagnoses.

To an increasing degree in modern times, medical philosophy focuses on topics of life and death, such as the management of patients who have cardiac arrests. In these instances, cardiopulmonary resuscitation is provided not only by medical personnel, but also by non-professionals who have obtained training in vocational schools.

In solving the dilemma of whether or not to begin resuscitation in a life-threatening emergency, the doctor should focus on the expected outcome – what will be the quality of life for the patient upon discharge from the hospital? Using modern medical expertise it is usually possible to return patients to fully functional lives and normal life expectancy following cardiac insult.

Cardiopulmonary resuscitation of cardiac arrest is successful in 70–98 per cent of attempts. After successful resuscitation, quality of life is ensured for most survivors, and it is very common for people to have long life expectancy in spite of serious cardiac disease.

An ethical dilemma arises when one has to allocate limited financial resources for health care in the 21st century: how much should be expended to prolong the life of one person versus spending the scarce health care dollar on a larger portion of the population? Since 1990 the average lifespan has been extended by one year every four years. During this same time period health care expenditure has increased three to five per cent a year, a figure much higher than the growth of the gross national product.

Today, given enough resources, people's lives can be significantly prolonged with the aid of modern medicine. Doctors, patients and

their families understand this. These resources are expended especially on prevention, early diagnosis and rehabilitation.

There is competition for the health care dollar. A certain portion usually comes from social security funds that have been paid for by individuals during their lifetimes to which they are entitled. The remainder is typically paid for by the state, to which people also believe they are entitled.

Regardless of the economic wealth of any country, resources are not unlimited. As a result, dissatisfaction with the health care system develops among medical professionals and the general public. In reality, the delivery of medical care in the 21st century has become a paradox: the more money that is expended on health care, the longer people live (although suffering from their chronic illnesses), but the more financial resources are needed.

Leaders of medical associations and other influential health officials around the world are paying increasing attention to health issues, such as disease prevention, smoking, alcohol, vaccination, nutritious food, physical exercise, ecology and a healthy lifestyle. And, a cornucopia of ethical problems has opened – public health issues exist in Europe and Africa, North and South America, Christian and Muslim countries. Implementation of public health improvements has often been met with a hypocritical attitude toward issues such as the calamity of smoking and the widespread use of narcotics. More than three million newborns die each year, mostly in developing countries. Lack of food in poor countries leaves 170 million children underweight, while at the same time, nearly a billion people in the world are overweight due to excess food consumption and lack of exercise.

In studying the social determinants of health, the World Health Organization has focused on nine broad areas: early child development, globalization, health systems, measurement and evidence, urbanization, employment conditions, social exclusion, priority public health conditions and women and gender equity. A dominant figure in the study of inequalities of health care and their causes is England's Sir Michael Marmot. He maintains that social standing is an important determinant of health and life expectancy.

Recognizing the far-reaching changes that have occurred in medicine in the 21st century, it is obvious that a new document that addresses the ethics and philosophy of our modern time is in order. There is no organization better suited to produce this Declaration than the World Medical Association.

Dr. Peteris Apinis, Editor in Chief

White Paper On Ethical Issues Concerning Capital Punishment

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This paper was drafted by the Danish Medical Association with the support of WMA Working Group on capital punishment.

1. Why has the WMA engaged in discussing the use of capital punishment?

The WMA has a strong tradition opposing the involvement of physicians in capital punishment. Recently, it has been debated whether it is morally and ethically wrong that drugs produced to cure people are also used in prisons with the aim of ending a person's life.

A Danish Pharmaceutical company, H.S. Lundbeck A/S had to take a stance and act

to try to prevent the use of one of its products, Nembutal, for executions after massive pressure from media and human rights' groups as well as the medical community.

This makes it relevant to discuss the ethics of capital punishment and how it is executed today. Since many executions are performed by the use of drugs requiring some kind of guidance from health care personnel, the question reappears: Does the medical community have to take a stance against the use of capital punishment?

In China prisoners are executed by the use of fire arms. But still a doctor may be involved giving a drug before the execution and after when pronouncing the death of the prisoner. Iran and Saudi Arabia have other methods. Mostly death by hanging is used here. In the United States capital punishment is mainly performed by the use of lethal injection. In a few states other methods can be used including firing squad. 94 % of all executions happen in these four countries according to Amnesty International (2005).

2. Is capital punishment torture?

The definition of torture according to the United Nations (UN) Convention against Torture is: "Torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain

or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions".

The crucial point being that capital punishment is not regarded as torture since the definition in the UN Convention against Torture does not include pain and suffering arising only from inherent in or incidental to lawful actions, which capital punishment is.

3. Is the use of capital punishment unethical?

This question is related to the question of whether capital punishment is just. Therefore in the following paragraphs different schools of ethics will be summarized and for each paragraph a conclusion will be drawn as to whether, from the point of view of the individual way of thinking, capital punishment can be regarded as ethical.

4. Is Capital Punishment just?¹

a. Liberty/Libertarianism

What matters most for justice is liberty. Article 3 in the Universal Declaration of Hu-

¹ In an abstract by Matthew Robinson "Government and Justice Studies, Journal of Theoretical and Philosophical Criminology 2011", different theories of justice are applied to study whether capital punishment achieves its purpose of bringing justice to society. The author investigates whether libertarian, egalitarian or the utilitarian school of thought will come to the conclusion that death penalty is just. The abstract is based on a number of references and statistical material (see reference). The author states (p. 50) that the individual opinion on the death penalty is affected by many factors such as race, gender, age, level of income, political party and ideology, geography of residence and religious beliefs.

man Rights posits: "Everyone has the right to life, liberty and security of person."

The issue over which capital punishment supporters disagree is whether the right to life espoused in the US and International Law should be maintained after a person commits murder. Death penalty supporters maintain that, by taking a life, murderers should sacrifice their own life as a form of retribution; opponents disagree and argue that these rights cannot be sacrificed¹.

Robinson continues that such philosophical arguments can be resolved with empirical evidence:

"Thus we must simply examine whether capital punishment as actually practiced in the US helps achieve liberty or diminishes it. Empirically it is easy to see that capital punishment is so rarely used that capital punishment does not help achieve or assure liberty in society. Stated simply, if an execution was necessary to help achieve and assure liberty for potential victims, states fail citizens 98–99% of the time because only 1–2 % of convicted murderers are executed or sentenced to death respectively².

It is also worth noting that innocent people are wrongly accused of murder, sentenced to death and occasionally executed which is an affront to liberty. Sometimes people who would be regarded as not mentally competent may be executed in other jurisdictions.

The libertarian argument of capital punishment is thus that the death penalty is unjust."

b. Free market libertarians

Most of the arguments put forward by these libertarians are economic in nature. Free market libertarians have not written

about the death penalty but it is interesting to know that capital punishment is generally more expensive than other sanctions including life imprisonment.

As an example a study in North Carolina showed that the cost of a death penalty sentence was 216,000 \$ and the total cost per execution was \$ 2.16 million more than life imprisonment³.

c. Equality/Egalitarianism

What matters most for justice is equality of opportunity in society and taking care of the least advantaged citizens.

There are significant racial disparities, class disparities and gender disparities in capital punishment practice⁴.

The underlying causes are both the race and gender of the prosecutors, the jurors and characteristics pertaining to both the defendants and the victims. Thus an undeniable conclusion of capital punishment practice is that the death penalty is applied in an unequal fashion.

d. Utilitarianism

The view of utilitarianism is that whether something is just depends on whether it maximizes the utility or greatest happiness for the greatest number of people.

As a specific deterrent capital punishment is efficient: the perpetrator cannot kill again and more innocent lives might be saved. The relevant question might however be: to what degree are murderers likely to kill again?

Is capital punishment likely to prevent future killings? A study quoted by Robinson

says that, out of 238 paroled offenders, less than 1 % were returned to prison for committing a subsequent homicide.

Sunstein and Vermeule suggest that studies show that 18 lives are saved per execution⁵. The very high figure seems to run contrary to other views cited in this paper.

You can however argue that executions may be excessive because effective incapacitation can be achieved through life imprisonment, although leaving a risk that the offender might kill again while in prison.

Capital punishment can also bring closure for the victim's family but the delay in conviction often makes this point of little comfort or use to the family.

To determine the relative utility of capital punishment one must assess the benefits against the costs of capital punishment. Assessing the contribution of capital punishment to the overall welfare of society is difficult however. How can you measure the worth of closure to the families? And how should we evaluate the racial and social bias that has been proven statistically to be true for capital punishment? Robinson concludes that "In spite of all this, it is a safe conclusion that capital punishment as practiced in the United States has only modest benefits but enormous costs. Thus the utilitarian argument of capital punishment is that the death penalty is unjust." Sunstein and Vermeule argue to the contrary⁶.

e. Virtue

Aristotle's theory suggests that justice demands giving people what they deserve or what they are due.

⁵ Cass R. Sunstein and Adrian Vermeule: "Is Capital punishment morally required? Acts, omissions and life-life trade offs" 58 STAN.L. Rev. 703.

⁶ See above reference.

¹ Robinson, p. 43.

² Robinson p. 44.

³ Robinson, p. 44.

⁴ Robinson p. 45 and 36–42.

With regard to virtue based theorists we must recall that the most important question is whether capital punishment respects and promotes our values, our moral goodness and whether it is the right thing to do. The questions are difficult to answer given the wide variety of values, morals, and sense of right¹.

f. An eye for an eye

If a state kills only 1 % of murderers, do we achieve an eye for an eye? Should the state execute more?

The biblical argument to uphold capital punishment is an eye for an eye, a tooth for a tooth i.e. the argument of retribution. In opposition to this broad definition which addresses capital punishment is the text "*Vengeance is mine said the Lord*".

Different philosophers have related to the subject of the death penalty but have interpreted the great thinkers and schools of philosophy differently. Some philosophers might find the utilitarian school in favor of capital punishment and others might argue against.

The Norwegian philosopher Lars Fr. H. Svaldsen ("The philosophy of cruelty") says about Emmanuel Kant:

"The death penalty is a problem with regard to the fundamental idea of humanity because humanity is based on the idea of the absolute value of a person's life no matter what and the death penalty represents the absolute denial of a person's right to life.

But this idea can collide with the idea of a just society:

To Kant justice is absolute and he thinks that the death penalty is the only right way to punish murder because the punishment has to be a goal in itself. He believes in the "ius talionis" where the wrong doing

is punished by a similar punishment. But in fact you can also find arguments in the categorical imperative by Kant against the death penalty which says that a person has to be considered a goal in itself and never as a means to achieving a goal. If you use the perpetrator as a means to achieving justice you then violate the categorical imperative."

Sunstein and Vermeule say about Kant that he is a retributivist: For a retributivist the penalty of death is morally justified or perhaps even required. Other defenders of capital punishment are consequentialists and often also welfarists who believe that ethics involve the greatest amount of welfare for the biggest amount of people².

As opposed to these schools of philosophy many deontologists believe that capital punishment counts as a moral wrong³.

g. Racial disparities

Amnesty International (AI)⁴ finds significant racial disparities in prosecutors decision on charging, noting that the death penalty is sought far more frequently in cases where the victims were white than when they were black.

A quoted study by William J. Bowers from 1975–1976 shows that the racial combination of a black killing a white was virtually "*as strong a predictor of a first degree murder indictment as any of the legal relevant factors except a felony circumstance*."

William J. Bowers and Glenn L. Pierce found that in Florida, as in other states, the large majority of homicides were intraracial, i.e. committed within the same racial

group. Although there was a high homicide rate among both whites and blacks in all states examined (Florida, Georgia, Texas, Ohio), far more killers of whites than killers of blacks were sentenced to death. They also found that although most killers of whites were white, blacks killing whites were proportionately more likely to receive a death sentence. In Florida and Texas for example blacks who killed whites were respectively five to six times more likely to be sentenced to death than those who had killed blacks. No white offender in Florida had ever been sentenced to death for killing a black person during the period studied (late 1970's). The first case presented was in 1980 where a white man was sentenced to death for killing a black woman.

h. The dilemma of revenge

Kant points out that the necessity of achieving justice is a deeply rooted in us: Crimes need to be punished. However, it is unclear what can be regarded as a suitable punishment from a retribution point of view:

"When it comes to people like Saddam or Eichmann the question is whether any punishment can ever counterbalance/make up for their actions".

Also the humane person may reach the conclusion that a death penalty is suitable, explains Inga Floto:

"You can say that the human life is so valuable that we do not have any right to take it away. But you can also say the opposite: that it is so valuable that he who wastes his life has lost his right to live.

This is a dilemma, which I think we cannot solve. I do not believe that we have the right to take another person's life – not even the life of murderers, but I cannot judge others who think that murder is such a cruel act that it should be punished with death. We do not have any higher authority to decide this. We only have our own conscience", she says.

1 Robinson p, 51.

2 Sunstein and Vermeule 58 STAN. L. Rev 703 p. 704.

3 Sunstein and Vermeule.

4 Amnesty International, United States of America, The Death Penalty, p.30–31.

Human rights organizations state that the use of capital punishment is denial of the ultimate human right, the right to life i.e. the willful state induced denial of the person's right to life. Some may say that a person can forfeit his right to life by committing a terrible crime.

Capital punishment is also a dilemma for the UN. In the dilemma lies the idea of a just society and at the same time the idea of humanity.

5. Criminal law and the argument of deterrence and retribution

The reason to uphold capital punishment in modern times is the argument of deterrence and to some degree retribution since certain crimes are so grievous and affront to humanity *"that the only adequate response may be the penalty of death"*¹. Still it is debated whether capital punishment violates the 8th amendment's ban on cruel and unusual punishment.

a. Gregg vs. Georgia 1976

In a legal challenge to the death penalty as cruel and unusual punishment under the Eighth Amendment, the Supreme Court of the United States upheld a state's right to use capital punishment as a tool in the criminal court. Though the court admitted that retribution is no longer a dominant objective in criminal law, it emphasized its role in capital punishment where it is *"the community's belief that certain crimes are themselves so grievous an affront to humanity that the only adequate response may be the penalty of death."*

The Court cited to the British Royal Commission on Capital Punishment which

stated that capital punishment in extreme cases is supportable because *"the wrong-doer deserves it, irrespective of whether it is a deterrent or not."*

The issue of deterrence was also explored by the Court. At the time of the case, the Court thought statistical studies of capital punishment's deterrent effect were inconclusive, citing a variety of studies from the 1950's–1970's. They assumed that the death penalty may be a significant deterrent for some criminals, but not for others. In the end, the Court emphasized that it is the state's role to adjudicate criminal violations, and permitted capital punishment in accordance with the state's moral consensus and the social utility of such a sanction, citing deterrence and retribution as justifiable rationales.

States vary in whether they cite retribution (the more controversial justification) and/or deterrence as justifications for employing capital punishment. Some states have deemed retribution an invalid rationale for criminal punishment, but there is evidence that, in practice, this retribution is still used to justify criminal punishment in these states.

In the period between 1972 and 1976 the Supreme Court of the United States produced an effective moratorium on capital punishment.

In a discourse on capital punishment, Sunstein and Vermeule² – using state data from 1977–1999 – focused on the murder rate in each state before and after the death penalty was suspended and reinstated. The authors find a substantial deterrent effect.

However, a recent study offers more refined findings. By disaggregating state data, Joanna Shepherd finds that the nationwide

deterrent effect of capital punishment is entirely driven by 6 states that are executing more people than the rest³.

b. Base vs. Rees 2008

In a videotaped debate in the New England Journal of Medicine three physicians and a lawyer in 2008 debated the case of Base vs. Rees. The case was brought before the court of Kentucky and the object was to establish whether or not the formula used for capital punishment was in violation of the 8th amendment on cruel and inhuman punishment.

The formula dates back to 1977 and was introduced by a doctor A.J. Chaplin. It consists of thiopental (to sedate), pancuronium bromide (to avoid twitching and spasms) and potassium chloride (to stop the heart).

The court found that the petitioners failed to show that Kentucky's execution method amounted to *"cruel and unusual punishment"*.

One of the judges of the court decided that although the use of pancuronium bromide raised legitimate concerns, the petitioners failed to show that Kentucky's execution method amounted to *"cruel and unusual punishment"*. However this judge also remarked: "Although the death penalty has serious risks – e.g. that the wrong person may be executed, that unwarranted animus about the victim's race, for example, may play a role, and that those convicted will find themselves on the death row for many years – the penalty's lawfulness is not before the court".

AI addressed the question of deterrence in a publication from 1987⁴.

3 Shepherd: "Deterrence versus Brutalization", supra note 9.

4 Amnesty International: United States of America, The Death Penalty, Amnesty International Publications, p. 162–166.

1 Gregg v. Georgia, 184.

2 Sunstein and Vermeule: "Is capital punishment morally required? Acts, omissions, and life trade offs" 58 STAN. L. Rev. 703.

AI states that detailed research in the USA and other countries has provided no evidence that the death penalty deters crime more effectively than other punishments. In some countries, the number of homicides actually declined after abolition. In Canada for example the murder rate fell from 3.09 per 100,000 in 1975 (the year before abolition) to 2.74 in 1983.

A United Nations study published in 1980 found that: "Despite much more advanced research efforts mounted to determine the deterrent value of the death penalty, no conclusive evidence has been obtained on its efficacy."

According to AI, US studies have shown that, under past and present death penalty statutes, the murder rate in death penalty states has differed little from that in other states with similar populations and social and economic conditions. A study by Thorsten Sellin who studied murder rates between 1920 and 1974 is referenced.

In the same publication by AI, crime trends are referenced. In Florida and Georgia research has shown an increase in homicides in the period immediately following the resumption of executions. Florida had carried out no executions for nearly 15 years when a prisoner was executed in 1979. Three years following the resumption of executions in 1980, 1981 and 1982 Florida had the highest murder rates in the state's recent history, with a 28 percent increase in homicides in 1980.

6. Why the use of medication in capital punishment?

A member of the panel of the New England Journal of Medicine, Professor Deborah Denno (lawyer), states why the combination of drugs was introduced in 1977.

"The law turned to medicine to save the death penalty". The drugs were to replace

the electric chair and the object was to make the death penalty look more humane.

Soon after this, the AMA took a position against the involvement of physicians in executions. From Gawande – "When law and ethics collide"¹:

"But medicine balked. In 1980, when the first execution was planned using Dr. Deutsch's technique, the AMA passed a resolution against physician participation as a violation of core medical ethics. It affirmed that ban in detail in its 1992 Code of Medical Ethics. Article 2.06 states, "A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution," although an individual physician's opinion about capital punishment remains "the personal moral decision of the individual." It states that unacceptable participation includes prescribing or administering medications as part of the execution procedure, monitoring vital signs, rendering technical advice, selecting injection sites, starting or supervising placement of intravenous lines, or simply being present as a physician. Pronouncing death is also considered unacceptable, because the physician is not permitted to revive the prisoner if he or she is found to be alive. Only two actions were acceptable: provision at the prisoner's request of a sedative to calm anxiety beforehand and certification of death after another person had pronounced it. The code of ethics of the Society of Correctional Physicians establishes an even stricter ban: "The correctional health professional shall . . . not be involved in any aspect of execution of the death penalty." The American Nurses Association (ANA) has adopted a similar prohibition. Only the national pharmacists' society, the American Pharmaceutical Association, permits involvement, accepting the voluntary provision of execution medications by pharmacists as ethical conduct".

1 Gawande A. (2006) "When Law and Ethics Collide — Why Physicians Participate in Executions". NEJM 354:1221-1229

The method of lethal injection has given rise to problems and concerns in the medical community worldwide. The WMA adopted its policy on non involvement of physicians in capital punishment in 1981. The Resolution on Physician participation in Capital punishment has since been amended in 2000 and 2008.

Recently in 2010 and 2011 some pharmaceutical companies and some European governments have adopted policies against exporting drugs that may be used for executions with or without pressure from human rights activists.

Turning back to the New England Journal of Medicine, the panel concludes:

"The involvement of physicians in some part of the procedure is necessary if it should be performed without complications and pain."

7. Some statistics on capital punishment

Source: web.amnesty.org

- In 2005 at least 2,148 people were executed in 22 countries and at least 5,186 people were sentenced to death in 53 countries.
- 94 percent of all executions took place in China, Iran, Saudi-Arabia and the US.
- AI estimates that at least 1,770 were executed in China in this year but the number may be higher.
- AI estimates that at least 20,000 people await their execution.

Reported death sentences and executions in 2010:

Where "+" is indicated after a country and it is preceded by a number, it means that the figure Amnesty International has calculated is a minimum figure. Where "+" is indicated after a country and is not preceded by a number, it indicates that there were executions or death sentences (at least more than one) in that country but it was not possible to obtain any figures.

Reported executions

in 2010

China 1000s	Zambia 35	Bahamas 5+
Iran 252+	Saudi Arabia 34+	Equatorial Guinea 4
North Korea 60+	Viet Nam 34+	Jamaica 4
Yemen 53+	Bangladesh 32+	Laos 4
United States of America 46	United Arab Emirates 28+	Morocco/Western Sahara 4
Saudi Arabia 27+	Yemen 27+	South Korea 4
Libya 18+	Tunisia 22+	Kuwait 3+
Syria 17+	Ghana 17	Belarus 3
Bangladesh 9+	Mauritania 16+	Madagascar 2+
Somalia 8+	Mali 14+	Malawi 2
Sudan 6+	Central African Republic 14	Myanmar 2
Palestinian Authority 5	Japan 14	Benin 1+
	Gambia 13	Burkina Faso 1+
	Lebanon 12+	Guyana 1+
	Palestinian Authority 11+	Bahrain 1
	Liberia 11	Barbados 1
	Sudan 10+	WMA page 12
	Syria 10+	Chad 1
	Jordan 9	Guatemala 1
	Taiwan 9	Maldives 1
	Singapore 8+	Sierra Leone 1
	Somalia 8+	Brunei Darussalam +
	Zimbabwe 8	Cameroon +
	Indonesia 7+	Democratic Republic of Congo +
	Thailand 7+	Iran +
	Ethiopia 5+	Libya +
	Kenya 5+	North Korea +
	Tanzania 5+	Sri Lanka +
	Uganda 5+	Trinidad and Tobago +

Reported death sentences

in 2010

China +		
Pakistan 365		
Iraq 279+		
Egypt 185		
WMA page 11		
Nigeria 151+		
Algeria 130+		
Malaysia 114+		
United States of America 110+		
India 105+		
Afghanistan 100+		

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World Health Assembly Report, Geneva, Switzerland, 2012

Highlights on the WMA's activities during the World Health Assembly

The last World Health Assembly has been a busy time for the World Medical Association. This year, the WMA co-organised two side-events with other organisations – one on palliative care and the other on social de-

terminants of health. In parallel, the World Health Professions Alliance (WHPA) – in which the WMA is an active member – presented four public statements respectively on non-communicable diseases, the Millennium Development Goals (MDGs), Counterfeit medicines and on the role of WHO in collecting and disseminating data on attacks on health in complex humanitarian emergencies.

Reducing the Burden of Pain and Suffering: Developing Palliative Care in Low and Middle Income Countries

This side-event took place on May 23rd at the initiative of Human Rights Watch, in cooperation with the Worldwide Palliative Care Alliance, the WMA and other relevant partners¹. The event was sponsored by

1 Union for International Cancer Control, International Association of Hospice and Palliative Care, Trivandrum Institute of Palliative Sciences, Open Society Foundations, Kenya Hospice and Palliative Care Association. With the support of the Open Society Foundations.

the Republic of Kenya, the United States of America, the Republic of Panama and Australia.

Following the September 2011 UN General Assembly Political Declaration on Non-Communicable Diseases, which committed countries to ensure the availability of palliative care, the WHA was seen as an important forum for sharing experiences in implementing palliative care and providing guidance to countries as they implement this commitment.

Dr. Cecil Wilson, the WMA President-Elect, talked about the critical role of the medical community in ensuring the avail-

ability of palliative care. Denouncing the negative economic impact and human suffering of inadequate pain treatment, Dr. Wilson called for equal access to pain treatment without discrimination and the inclusion of end-of-life care issues in undergraduate and postgraduate medical training. As well, Dr. Wilson reminded the participants that the duty of physicians was to heal where possible, to relieve suffering and to protect the best interests of their patients.

Other interventions included Hon. Dr. Beth Mugo, Minister of Public Health and Sanitation of the Republic of Kenya; Hon. Dr. Christine Ondo, Minister of Health of the Republic of Uganda; as well as leading ex-

perts on palliative care. Ambassador Jimmy Kolker, Principal Deputy Director of the Global Health Office, the United States Department of Health and Human Services, moderated the event.

It is hoped that this event will encourage sustained attention from the World Health Assembly to the situation of millions of people with incurable illnesses who currently do not have access to palliative care.

WMA Resolution on the Access to Adequate Pain Treatment, Montevideo October 2011 : <http://www.wma.net/en/30publications/10policies/p2/index.html>

Governments Must Do More to Invest in end-of-life Care

Governments and research institutions must be encouraged by national medical associations to invest additional resources in developing treatments to improve end-of-life care, according to Dr. Cecil Wilson, President elect of the World Medical Association.

Speaking in Geneva today (Wednesday), he said that millions of people around the world with cancer and other diseases suffered moderate to severe pain without access to adequate treatment.

'A consequence of inadequate pain treatment is a negative economic impact and human suffering,' he said. 'In most cases pain can be stopped or relieved with inexpensive and relatively simple treatment interventions.'

Dr. Wilson, who was speaking at a side meeting of the World Health Assembly, added 'All people should have the right to ac-

cess to pain treatment without discrimination....Governments must ensure the adequate availability of controlled medicines, and governmental drug control agencies'.

He said that the appropriate use of morphine, new analgesics and other measures could relieve pain and other distressing symptoms in the majority of cases. Health authorities must make necessary medications accessible and available to physicians and their patients.

Yet in many parts of the world palliative and life-sustaining measures required technologies and/or financial resources that were simply not available. He also said that as far as pain and symptom management were concerned it was essential to identify patients approaching the end-of-life as early as possible

The increasing number of people who required palliative care and the increased availability of effective treatment options meant that end-of-life care issues should be an important part of undergraduate and postgraduate medical training. The duty of physicians was to heal where possible, to relieve suffering and to protect the best interests of their patients.

Social Determinants of Health: Building capacity to achieve health equity

In October 2011, the World Health Organization invited the member states and civil society partners to the World Con-

ference on Social Determinants of Health (SDH) in Rio de Janeiro. The purpose was to build support to implement policies and strategies to reduce health inequities, by addressing these social determinants. The Rio Declaration adopted by the Conference translated this call into a global polit-

ical commitment for the implementation of a SDH approach to reducing health inequities and achieving other global health priorities. Further reorienting the health sector towards reducing health inequities was one of the identified priority action areas.

As a follow-up, the UK Government, in partnership with the WMA and the International Federation of Medical Students Associations (IFMSA), with the support of WHO, held a side-event on May 24th to explore concrete mechanisms for the health sector to engage in achieving health equity.

This side event was moderated by Kathryn Tyson, Director of International Health and Public Health Delivery, Department of Health, United Kingdom. It opened with a film produced by WHO, Department of

Ethics, Equity, Trade and Human Rights, following the World Conference on Social Determinants of Health.

Professor Sir Michael Marmot, Chair of the Socio-Medical Affairs Committee of the WMA and former Chair of the WHO Commission on Social Determinants of Health, underlined the role of doctors and national medical associations to advance health equity through Social Determinants of Health. Christopher Pleyer, President of IFMSA, talked about education and training as a pre-requisite to reduce and

prevent health inequities. Finally, Dr. Rüdiger Krech, Director of the Department of Ethics, Equity, Trade and Human Rights at WHO, emphasized the indispensable role of the UN in promoting a global agenda for health equity.

In parallel, the Rio Declaration was officially adopted by the World Health Assembly.

The presentations of the side event are available on WHO website:

http://www.who.int/social_determinants/ad-vocacy/en/index.html

Outcome of the World Conference on Social Determinants of Health

The Sixty-fifth World Health Assembly, Having considered the report on the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011);¹

Reiterating the determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 on reducing health inequities through action on the social determinants of health, which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action;

Recognizing the need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels;

Recognizing also the need to safeguard the health of the populations regardless of global economic downturns;

Further acknowledging that health equity is a shared goal and responsibility and requires the engagement of all sectors of government, all segments of society, and all members of the international community, in “all-for-equity” and “health-for-all” global actions;

Recognizing the benefits of universal health coverage in enhancing health equity and reducing impoverishment;

Reaffirming the political will to make health equity a national, regional and global goal and to address current challenges – such as eradicating hunger and poverty; ensuring food and nutritional security, access to affordable, safe, efficacious and quality medicines as well as to safe drinking-water and sanitation, employment and decent work and social protection; protecting environments and delivering equitable economic growth through resolute action on social determinants of health across all sectors and at all levels;

Welcoming the discussions and results of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011),

1. ENDORSES the Rio Political Declaration on Social Determinants of Health adopted by the World Conference on Social Determinants of Health,¹ including as a key input to the work of Member States and WHO;

2. URGES Member States:

- (1) to implement the pledges made in the Rio Political Declaration on Social Determinants of Health with regard to (i) better governance for health and development, (ii) promoting participation in policy-making and implementation, (iii) further reorienting the health sector towards reducing health inequities, (iv) strengthening global governance and collaboration, and (v) monitoring progress and increasing accountability;

¹ Document A65/16.

- (2) to develop and support policies, strategies, programmes and action plans that address social determinants of health, with clearly defined goals, activities and accountability mechanisms and with resources for their implementation;
- (3) to support the further development of the “health-in-all-policies” approach as a way to promote health equity;
- (4) to build capacities among policy-makers, managers, and programme workers in health and other sectors to facilitate work on social determinants of health;
- (5) to give due consideration to social determinants of health as part of the deliberations on sustainable development, in particular in the Rio+20 United Nations Conference on Sustainable Development and deliberations in other United Nations forums with relevance to health;

3. CALLS UPON the international community to support the implementation of the pledges made in the Rio Political Declaration on Social Determinants of Health for action on social determinants of health, including through:

- (1) supporting the leading role of WHO in global health governance and promoting alignment of policies, plans and activities on social determinants of health with those of its partner organizations in the United Nations system, development banks and other key international organizations, including in joint advocacy, and in facilitating access to the provision of financial and technical support to countries and regions, in particular developing countries;
- (2) strengthening international cooperation, with a view to promoting health equity in all countries, through facilitating transfer on mutually agreed terms of expertise,

technologies and scientific data in the field of social determinants of health, as well as exchanging good practices for managing intersectoral policy development;

- (3) facilitating access to financial resources;

4. URGES those developed countries that have pledged to achieve the target of 0.7% of gross national product for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard, and also urges developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help to achieve development goals and targets;

5. REQUESTS the Director-General:

- (1) to duly consider social determinants of health in the assessment of global needs for health, including in the WHO reform process and WHO’s future work;
- (2) to provide support to Member States in implementing the Rio Political Declaration on Social Determinants of Health through approaches such as “health-in-all policies” in order to address social determinants of health;
- (3) to work closely with other organizations in the United Nations system on advocacy, research, capacity-building and direct technical support to Member States for work on social determinants of health;
- (4) to continue to convey and advocate the importance of integrating social determinants of health perspectives into forthcoming United Nations and other high-level meetings related to health and/or social development;
- (5) to report to the Sixty-sixth and Sixty-eighth World Health Assemblies, through the Executive Board, on progress in implementing this resolution and the Rio Political Declaration on Social Determinants of Health.

WMA Luncheon on Women’s, Maternal and Girls’ Health

Every year during the World Health Assembly, the WMA organises a reception for Ministers of Health and Heads of Delegations of the Assembly. This year the Honorable Kathleen Sebelius, the U.S. Secretary of Health and Human Services, was the key note speaker on the topic of *Women’s, Maternal and Girls’ Health – Their Futures in Our Hands* (see p. 95).

Secretary Sebelius emphasised the need for universal access to care in general, and the benefit in investing in health care. Furthermore, she highlighted that while women play a key role as health keepers for families, many health care systems failed to consider the unique health needs of women. Dr. Mukesh Heikerwal accentuated the vision and engagement of the WMA in emphasizing the special situation of women in health care. The reception was very well attended with more than 200 participants.

WHA’s Results related to the WMA Advocacy Priorities

Non-communicable diseases

The Political Declaration of the UN High Level Meeting on NCDs in 2011 urged WHO and the member states to develop a global monitoring framework with targets and indicators on NCD before the end of 2012. At the 65th WHA a discussion on

this framework took place with limited opportunities for the member states to reach agreement. Thanks to the initiative of several countries, finally the 193 member states adopted the resolution to reduce preventable deaths from NCDs by 25% by the year 2025, with the remaining targets to be agreed at a formal Member State consultation before the end of October 2012.

WHO Reform

At the 65th WHA member states endorsed reforms to the management and priority setting processes at WHO.

It was agreed that WHO should become more transparent, result-focused, accountable and effective. As the five priorities for future WHO activity, the member states defined: communicable diseases; non-communicable diseases; health through the life-course; health systems; and preparedness, surveillance and response. Furthermore, the delegates emphasized that WHO should increase its focus on the social, economic and environmental determinants of health.

One critical point of the reform process was not discussed— how to make WHO's future governance more inclusive and participatory by involving external stakeholders such as philanthropic bodies and industry. This topic is too controversial for many countries. It raises many questions, starting with the question of mandate and not ending with the fact that some foundations contribute more to global health than many countries do.

Another core reform issue that wasn't discussed was how WHO finances its operations. The organization is suffering a financial crisis due to several factors, including reduced government funding. Last year, it slashed its annual budget of \$US4.5 billion by nearly a quarter.

A New Role for WHO in Complex Humanitarian Emergencies

One of the items on the agenda of the last World Health Assembly related to the role of WHO as the health cluster lead in meeting the growing demands of health in humanitarian emergencies. A draft resolution was submitted to the Assembly for adoption.

With the resolution, the Member States called on WHO Director-General: *"...to provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies, in coordination with other relevant United Nations bodies, other relevant actors, and intergovernmental and nongovernmental organizations, avoiding duplication of efforts"*.

From the start, the initiative had been actively supported by the Safeguarding Health Coalition¹, in which the WMA is an observer. The proposal had been first submitted to the Executive Board in January. The Coalition and other organisations concerned had sent an open letter to the attention of Dr. Margaret Chan and made an oral statement in support of the initiative.

Similarly, last May at the World Health Assembly, numerous organizations joined

the coalition in a statement encouraging the WHO member states to adopt the resolution so that the work of developing methods to collect data and report on attacks can commence. The statement was made on behalf of the World Health Professional Alliance, and was supported by the American Public Health Association, CARE, the Center for Public Health and Human Rights at the John Hopkins Bloomberg School of Public Health, Doctors for Human Rights, International Health Protection Initiative, International Federation of Health and Human Rights Organisations, International Medical Corps, International Rehabilitation Council for Torture Victims, International Rescue Committee, Intra Health International, Management Sciences for Health, Medact, Merlin, Physicians for Human Rights, Women's Refugee Commission and World Federation of Public Health Associations.

Going forward, the coalition will advocate for effective implementation of the World Health Assembly resolution.

The resolutions adopted by the World Health Assembly can be downloaded from WHO's following website:

http://apps.who.int/gh/e/e_wha65.html

*Ms Clarisse Delorme,
WMA Advocacy Advisor*

¹ The **Safeguarding Health in Conflict** coalition promotes respect for international humanitarian and human rights laws that relate to the safety and security of health facilities, workers, ambulances and patients during periods of armed conflict or civil violence. The founding members include Intra Health International, Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health, Doctors for Human Rights, International Council of Nurses, International Health Protection Initiative, Karen Human Rights Group, Medact, Merlin – UK and Physicians for Human Rights.

Statement of World Health Professional Alliance addressed to World Health Assembly

On behalf of the World Health Professional Alliance, which includes:
World Medical Association
International Council of Nurses
International Pharmaceutical Federation
World Confederation for Physical Therapy
World Dental Federation.

These organizations speak on behalf of millions of health workers worldwide. This statement is also supported by the following organizations:

American Public Health Association
CARE
Center for Public Health and Human Rights of the John Hopkins Bloomberg School of Public Health
Doctors for Human Rights
Human Rights Watch
International Health Protection Initiative
International Federation of Health and Human Rights Organisations
International Medical Corps

International Rehabilitation Council for Torture Victims
International Rescue Committee
IntraHealth International
Management Sciences for Health
Medact
Merlin
Physicians for Human Rights
Women's Refugee Commission
World Federation of Public Health Associations

Health care workers are on the frontline during complex humanitarian emergencies. Health providers and those they serve deserve protection. Indeed, the strength and performance of the health system require it. Yet, in crises where health needs are most urgent, health care workers are at greatest risk of assault, arrest, obstruction of their duties, kidnapping and death. Health facilities and ambulances are also at risk of attack. The health community must mobi-

lize to assure adherence to the principle of impartiality of health care in humanitarian emergencies.

At the 64th Assembly, and again at the Executive Board, WHO's Director General, Dr. Margaret Chan, spoke eloquently of the need for WHO to respond.

The foundation of protection and prevention is information. WHO has a unique role to play in collecting and disseminating data on attacks. For that reason, we support resolution EB130.R14 (see below), in particular, paragraph 8, calling on the Director General:

"...to provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies..."

We call on the WHO Member States to adopt the resolution. This will be a strong affirmation of the Member States commitment to protect health workers, services and patients.

WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies

The Executive Board,

Having considered the report on WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies,¹

RECOMMENDS to the Sixty-fifth World Health Assembly the adoption of the following resolution:

The Sixty-fifth World Health Assembly,

Having considered the report on WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies;

Recognizing that humanitarian emergencies result in avoidable loss of life and human suffering, weaken the ability of health systems to deliver essential life-saving health services, produce setbacks for health development and hinder the achievement of the Millennium Development Goals;

Reaffirming the principles of neutrality, humanity, impartiality and independence in the provision of humanitarian assistance, and reaffirming the need for all actors engaged in the provision of humanitarian assistance in situations of complex humanitarian emergencies and natural disasters to promote and fully respect these principles;

Recalling Article 2(d) of the Constitution of the World Health Organization on the mandate of WHO in emergencies, and reso-

¹ Document EB130/24.

lutions WHA58.1 on health action in relation to crises and disasters and WHA59.22 on emergency preparedness and response;¹

Recalling United Nations General Assembly resolution 46/182 on the strengthening of the coordination of humanitarian emergency assistance of the United Nations and the guiding principles thereof, confirming the central and unique role for the United Nations in providing leadership and coordinating the efforts of the international community to support countries affected by humanitarian emergencies, establishing, inter alia, the Inter-Agency Standing Committee, chaired by the Emergency Relief Coordinator, supported by the United Nations Office for the Coordination of Humanitarian Affairs;

Taking note of the humanitarian response review in 2005, led by the Emergency Relief Coordinator and by the Principals of the Inter-Agency Standing Committee aiming at improving urgency, timeliness, accountability, leadership and surge capacity, and recommending the strengthening of humanitarian leadership, the improvement of humanitarian financing mechanisms and the introduction of the clusters as a means of sectoral coordination;

Taking note of the Inter-Agency Standing Committee Principals' Reform Agenda 2011–2012 to improve the international humanitarian response by strengthening leadership, coordination, accountability, building global capacity for preparedness and increasing advocacy and communications;

Recognizing United Nations General Assembly Resolution 60/124, and taking note of WHO's subsequent commitment to supporting the Inter-Agency Standing Committee transformative humanitarian agenda and contributing to the implementation of the Principals' priority actions designed to strengthen international humanitarian response to affected populations;

Reaffirming that it is the national authority that has the primary responsibility to take care of victims of natural disasters and other emergencies occurring on its territory, and that the affected State has the primary role in the initiation, organization, coordination, and implementation of humanitarian assistance within its territory;

Taking note of the 2011 Inter-Agency Standing Committee guidance note on working with national authorities, that clusters should support and/or complement existing national coordination mechanisms for response and preparedness and where ap-

propriate, government, or other appropriate national counterparts should be actively encouraged to co-chair cluster meetings with the Cluster Lead Agency;

Recalling resolution WHA64.10 on strengthening national health emergency and disaster management capacities and resilience of health systems, which urges Member States, inter alia, to strengthen all-hazards health emergency and disaster risk-management programmes;

Reaffirming also that countries are responsible for ensuring the protection of the health, safety and welfare of their people and for ensuring the resilience and self-reliance of the health system, which is critical for minimizing health hazards and vulnerabilities and delivering effective response and recovery in emergencies and disasters;

Recognizing the comparative advantage of WHO through its presence in, and its relationship with Member States, and through its capacity to provide independent expertise from a wide range of health-related disciplines, its history of providing the evidence-based advice necessary for prioritizing effective health interventions, and that the Organization is in a unique position to support health ministries and partners as the global health cluster lead agency in the coordination of preparing for, responding to and recovering from humanitarian emergencies;

Recalling WHO's reform agenda and taking note of the report in 2011 by the Director-General on Reforms for a healthy future,¹ which led to the creation of a new WHO cluster, Polio, Emergencies and Country Collaboration, aimed at supporting regional and country offices to improve outcomes and increase WHO's effectiveness at the country level, by redefining its commitment to emergency work and placing the cluster on a more sustainable budgetary footing;

Welcoming the reform in 2011 transforming the WHO cluster Health Action in Crisis into the Emergency Risk Management and Humanitarian Response department as a means of implementing these reforms, ensuring that the Organization becomes faster, more effective and more predictable in delivering higher quality response in health, and that the Organization holds itself accountable for its performance;

Recalling resolutions WHA46.39 on health and medical services in times of armed conflict; WHA55.13 on protection of medical missions during armed conflict; and the United Nations General Assembly resolution 65/132 on safety and security of humanitar-

¹ Resolutions WHA34.26, WHA46.6, WHA48.2, WHA58.1, WHA59.22 and WHA64.10 reiterate WHO's role in emergencies.

ian personnel and protection of United Nations personnel, considers that there is a need of systematic data collection on attacks or lack of respect for patients and/or health workers, facilities and transports in complex humanitarian emergencies,

1. CALLS ON Member States and donors:

- (1) to allocate resources for the health sector activities during humanitarian emergencies through United Nations Consolidated Appeal Process and Flash Appeals, and for strengthening WHO's institutional capacity to exercise its role as the Global Health Cluster Lead Agency and to assume health cluster lead in the field;
- (2) to ensure that humanitarian activities are carried out in consultation with the country concerned for an efficient response to the humanitarian needs, and to encourage all humanitarian partners, including nongovernmental organizations, to participate actively in the health cluster coordination;
- (3) to strengthen the national level risk management, health emergency preparedness and contingency planning processes and disaster management units in the health ministry, as outlined in resolution WHA64.10, and, in this context, as part of the national preparedness planning, with the Office for the Coordination of Humanitarian Affairs where appropriate, identify in advance the best way to ensure that the coordination between the international humanitarian partners and existing national coordination mechanisms will take place in a complementary manner in order to guarantee an effective and well-coordinated humanitarian response;
- (4) to build the capacity of national authorities at all levels in managing the recovery process in synergy with the longer-term health system strengthening and reform strategies, as appropriate, in collaboration with WHO and the health cluster;

2. CALLS ON the Director-General:

- (1) to have in place the necessary WHO policies, guidelines, adequate management structures and processes required for effective and successful humanitarian action at the country level, as well as the organizational capacity and resources to enable itself to discharge its function as the Global Health Cluster Lead Agency, in accordance with agreements made by the Inter-Agency Standing Committee Principals; and assume a role as Health Cluster Lead Agency in the field;
- (2) to strengthen WHO's surge capacity, including developing standby arrangements with Global Health Cluster partners, to ensure that WHO has qualified humanitarian personnel to be mobilized at short notice when required;

- (3) to ensure that in humanitarian crises WHO provides Member States and humanitarian partners with predictable support by coordinating rapid assessment and analysis of humanitarian needs, including as a part of the coordinated Inter-Agency Standing Committee response, building an evidence-based strategy and action plan, monitoring the health situation and health sector response, identifying gaps, mobilizing resources and performing the necessary advocacy for humanitarian health action;
- (4) to define the core commitments, core functions and performance standards of the Organization in humanitarian emergencies, including its role as the Global Health Cluster Lead Agency and as Health Cluster Lead Agency in the field, and to ensure full engagement of country, regional and global levels of the Organization to their implementation according to established benchmarks, keeping in mind the ongoing work on the Inter-Agency Standing Committee transformative humanitarian agenda;
- (5) to provide a faster, more effective and more predictable humanitarian response by operationalizing the Emergency Response Framework, with the performance benchmarks in line with the humanitarian reform, and to ensure the accountability of its performance against those standards;
- (6) to establish necessary mechanisms to mobilize WHO's technical expertise across all disciplines and levels, for the provision of necessary guidance and support to Member States, as well as partners of the health cluster in humanitarian crises;
- (7) to support Member States and partners in the transition to recovery, aligning the recovery planning, including emergency risk management as well as disaster risk-reduction and preparedness, with the national development policies and ongoing health sector reforms, and/or using the opportunities of post-disaster and/or post-conflict recovery planning;
- (8) to provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies, in coordination with other relevant United Nations bodies, the International Committee of the Red Cross, and intergovernmental and nongovernmental organizations, avoiding duplication of efforts;
- (9) to provide a report to the Sixty-seventh World Health Assembly, through the Executive Board, and thereafter every two years, on progress made in the implementation of this resolution.

Speech given by the US Secretary of Health and Human Services *Kathleen Sebelius* at the WMA Luncheon in Geneva, Switzerland, May 22, 2012



Kathleen Sebelius

Every country in the world recognizes the huge benefits of investing in health. Healthy children are better students. Healthy adults are more productive workers. Healthy families can make greater contributions to their communities. And when we live longer, healthier lives, we have more time to do our jobs, play with our children, and watch our grandchildren grow up.

And yet, in too many countries, including my own, we fall short when it comes to the health of women.

One reason for this is that women are more likely to depend on a male partner to access health care. And they're often less likely to have the resources they need to get care on their own.

Another obstacle is health systems that too often fail to consider the unique health needs of women.

In the United States, it wasn't until the 1980s that women were even included in clinical trials.

As a result, we had no idea what treatments or medicines were particularly effective for women. We didn't know what might happen when a drug that had been tested on a 180-pound man, was given to a 110-pound woman.

Despite the progress we've made since then, disparities persist to this day. Women in America often pay more for health insurance, just because they're women. And to add insult to injury, these plans often don't even cover the basic care they need. In my country, just one out of 8 plans for those who buy their own insurance cover maternity care – as if getting pregnant were some very rare condition.

The result is that far too many women, who often serve as the health care gatekeepers for their families, go without care themselves.

Of course, we see the same thing around the world. Every two minutes, a woman dies from complications related to pregnancy or childbirth. The risks are even greater if you live in the developing world – where three out of every four women needing care for complications from pregnancy do not receive it.

Even in places where care is available, the demand is so great that it often stretches resources to their limits.

Last year I visited the maternity ward of the MnaziMmoja Hospital in Zanzibar, Tanzania. There were so few beds and nurses that some women had to share beds in the postnatal room. And others were discharged just hours after giving birth. The hospital was doing heroic work. And the women who were able to deliver there, were among the lucky ones. Yet, so much need still went unmet.

We know that when we under-invest in women's health, whole families pay the price. When a mother dies the chance of her child dying within 12 months, increases seven fold.

So under President Obama, we're putting a new focus on women's health – at home and abroad. In the United States, the key to those efforts is the Affordable Care Act, our most important women's health legislation in years.

The health care law starts by ending discrimination against pre-existing conditions. Insurers are already prohibited from denying coverage to children because they have asthma or diabetes. And beginning in 2014, all women will be protected from being locked out of the market because they're a breast cancer survivor, or gave birth by c-section, or were a victim of domestic violence.

In the past – because they were worried about losing their health coverage – too many women didn't have the freedom to make important decisions like changing jobs, starting a new company, even leaving a bad marriage. Now that women know they can't be turned away because of their health status, we're taking those choices back from the insurance companies and returning them to the women where they belong.

Next, the law prohibits insurers from charging women more just because they're women. To put it another way: this means that being a woman is no longer a pre-existing condition.

And the law helps women get the preventive care they need to stay healthy, from mammograms to contraception to an annual check-up where you get to sit down and talk with your doctor, as a basic part of any insurance plan.

These improvements are happening across the lifespan. Young girls now have access to the vaccinations they need stay healthy without their parents worrying about additional costs. And seniors are getting better care to help manage their chronic conditions.

Put all these changes together and they represent the most important and comprehensive American law affecting women's health in decades.

Now, we've also made women and girls a priority for our Global Health Initiative – a new approach to coordinating the US government's global health work around the world.

With a focus on collaboration, and innovation, this initiative – launched by President Obama – allows us to maximize America's own strengths and support other nations as they work to improve their people's health.

We are integrating our programs across the U.S. Government so they can work together more effectively. And we are looking for new and better ways to work with international partners, multilateral organizations, NGOs and foundations to meet our common goals.

Through it all, we've made women's health a key priority – and that includes family planning. We know that access to contraception allows women to space their pregnancies and have children during their healthiest years. And delaying pregnancy beyond adolescence can reduce infant mortality and dramatically improve a child's long-term health. Providing a woman the tools to plan how many children she has, and when she has them, is essential to her health and her family's health.

Now, just as important is making sure that, when women are pregnant, they get the care and support they need to have a safe and healthy pregnancy and delivery.

The Global Health Initiative's 'Saving Mothers Giving Life' campaign is a great example of these efforts. We know that for mothers and children at risk, the first 24 hours postpartum are the most dangerous. That's when two out of every three maternal deaths, and almost half of newborn deaths occur.

So we're working together with groups like Merck for Mothers, the American College of

Obstetricians and Gynecologists, Every Mother Counts, and the Government of Norway, to make sure mothers get the essential care they need during labor, delivery, and those crucial first 24 hours, so they can survive and thrive.

We're focusing on countries with the political will to bring about change. And with more than \$90 million in generous support from our non-governmental partners, we have begun selecting pilot sites in the regions of Uganda and Zambia where women are facing some of the highest maternal mortality ratios in the world.

'Saving Mothers Giving Life' is just one example. But it illustrates an approach that runs throughout the Global Health Initiative. It starts by identifying the most urgent health challenges affecting some of the world's poorest nations. Next, we identify the best people in the world with the specific expertise to solve these problems. Then we bring them together, and make sure they have the tools, resources and flexibility to take action.

For too long, too many women and girls have had their lives marred by illness or disability, just because they didn't have access to health services. When we deprive women of the care and support they need to stay healthy or get well, we're also robbing them of hope for the future.

That's the moral argument for making women's health a priority. But there's a strategic argument too.

Women are gateways to their communities. Around the world, women are primarily responsible for managing water, nutrition, and household resources. They're responsible for accessing health services for their families. Many of them are closely involved in actually providing health care for those around them. So by improving the health of women, we can improve the health of communities too.

Consider the story of Jemima, a woman living with HIV in rural western Kenya. At

one point, the effects of her HIV got so bad she had wasted to 77 pounds. That's when a volunteer brought Jemima, her husband, and her sick grandchild to a U.S. government-supported health clinic.

They went home with what is called a "Basic Care Package" – a bundle of low-cost health interventions, developed by public health researchers from our CDC Global AIDS Program to prevent the most debilitating, opportunistic infections among people living with HIV.

Jemima bounced back. She regained a healthy weight. And today she is a health leader in her community. She founded a group that offers emotional support and small loans to families touched by HIV. She sells health products to help support the eight sick and orphaned children she has adopted. And she has referred more than 100 HIV-infected men, women, and children to receive care at the same facility where she got help.

In Jemima, our investment saved not only a life, but a mother, a community leader, an entrepreneur and a health advocate.

What we know from our work with partners around the world is that improving the health of women and girls, unleashes powerful new opportunities – not just for them or their families – but for their communities and countries.

If we want to improve education, we should be giving our young women the healthy start they need to succeed in school. If we want to boost productivity, we can make sure women have access to health care, including family planning and other reproductive health services. If we want to build stronger communities, let's enable women to teach their neighbors how to prevent disease and stay healthy.

Around the globe, our nations face many challenges. And investing in women's health is one of the best ways we can address them together.

World Medical Journal



“To Run and Not Grow Weary”

**Jeremy A. Lazarus, MD, President,
American Medical Association
Inaugural Address, American Medical Association,
2012 Annual Meeting,
June 19, 2012, Chicago, Illinois**



Jeremy A. Lazarus

Thank you for this profound honour. As you know, the summer Olympics start soon in London.

I mention this because my journey to this stage has been – for me – something of an Olympic race itself.

I love watching athletes compete. And at the Olympic level, they inspire a pride of accomplishment in each of us, and each of us feels part of their success.

When an American athlete wins, we cheer. When they stand on the podium with a medal on their chest, as the national anthem plays, we share their tears of joy.

Now some of you may know that I've run a race or two in my time, but I can tell you, running 13 marathons or completing 13 triathlons is something completely differ-

ent than becoming the 167th president of the AMA.

This was much harder.

The truth is, I've learned we all need each other's support to make great things happen.

Tonight, there are many people to thank – those who supported me and encouraged me to keep on going. You are the ones who didn't think I was completely crazy to keep on going race after race...well, most of you.

I'm reminded of what Olympic marathoner Don Kardong said: “No doubt a brain and some shoes are essential for success, although if it comes down to a choice, pick the shoes. More people finish marathons with no brains than with no shoes.”

Rest assured I've laced up my sneakers for the start of my run as AMA president.

And I look forward to making great strides together with you, who represent the best of our profession.

Just like the Olympic athletes, when one of us wins, we all win. It's all of us on that podium, wearing the medal.

Now, my path into this profession may have been different than that chosen by many of you.

It turns out that my high school, here in Chicago, was named for Nicholas Senn, who happened to be the AMA's 49th president.

Say what you will about foreshadowing or fate, but given my skill set at the time, it was probably for the best that I didn't go someplace named for another prominent Chicagoan – say, Michael Jordan Prep, or Mike Ditka Magnet School.

Could've been a disaster.

For me, medicine and then psychiatry became a calling. When I was in college, my brother died in an accident.

That tragedy fueled my desire to do something that made a difference to help people. To become a physician.

I wanted to help repair shattered minds – to guide people through the minefields of depression, or personality disorders – or crushing changes in circumstance.

I wanted to help someone who was troubled – lead a fulfilling, normal and healthy life.

I wanted to pull a profoundly depressed person back from the ledge of a potential suicide, and watch him grow from a troubled adolescent – to a productive adult.

In 40 years as a psychiatrist, I've been fortunate to help many people. For me, that's what it's all about.

For our specialty, taking a person whose mental health is in jeopardy – and helping them toward recovery – is like watching someone walk again, or curing cancer.

When something is wrong in the brain or the mind, it affects the whole person. The challenge is in how we determine what's really going on – whether it's psychological or neurochemical or both.

It's no coincidence the words, psychiatrist, and psychic, are in some way connected. We are trained to listen both to what is said out loud – and what isn't said at all.

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Listen to all sides – and then help people find their own path.

By listening – and working to find common ground, I want to bring greater unity to our AMA.

And while we can be thoughtful and deliberative and not act in haste, we recognize also that we stand at a healthcare crossroad.

Our patients cannot afford the luxury of indefinite time for us to simply talk about the issues.

In the 21st century, we can advance and grow only by incorporating the insights of physicians from all specialties, cultures, practice settings, states and regions, and ideologies.

There's a real opportunity, regardless of the political paralysis in Washington, for us to unify to promote the practice of medicine – to AMA members and non-member physicians alike – around the country.

But any success will materialize only if we are unified on the issues that matter most to us, and our patients.

Ask a random physician about what the AMA does and how it represent physicians . . . chances are you would get a variety of responses.

So we're working to harness the legacy of the AMA – what was – in a way that helps us all define what the future of the AMA can be.

You've heard a lot about the "AMA equation" this week.

But it bears repeating: The AMA is the sum of many parts: Our House of Delegates, with more than 185 physician groups represented.

Membership – in which physicians engage each other – and learn from each other.

The tools and expertise we provide to help physicians manage practices.

Our pacesetter work in ethics – our efforts to end disparities – and our crown jewel publication JAMA and others – that make us a leader in research and education.

And advocacy – giving voice to physicians in courthouses, statehouses, the media and in Washington, DC.

We are proof that those with opposing views can see the bigger picture and do what's best for physicians and patients. That's how we all win.

One recent example is the 200 million dollars returned to physicians because of AMA leadership in the United Health settlement. Or the needed delays the AMA won in implementing costly and confusing ICD-10 measures.

In these ways, the AMA touches the vast majority of physicians in this country – members and non-members – in tangible ways.

And the AMA is well-positioned to influence an uncertain future.

Nonetheless, to improve health outcomes, accelerate change in medical education and shape health care delivery and payment systems so they work better for physicians – are not modest ambitions.

To meet these challenges we sometimes go over them. Or go under them, or around them. Sometimes we ask for help – ask for a hand up to clear the obstacle. That's what achievers do.

I've been with the AMA and in the medical profession long enough to understand and respect the differences we have.

But I've been witness to our mutual interests. And how powerful we are when we

work together to fulfil them. I ask you to help me explore that aspect – and expand it.

This year, the AMA celebrates its 165th birthday. Since our founding, we've been a player on the national stage.

But great organizations with a long history do not need to live in the past. Respecting tradition does not mean we can't create – and pursue – our future.

The years ahead are a new race to be run – and to finish we'll need more than just talented physicians.

The AMA has shown both courage and a willingness to face what's ahead – to shape it – confront it – and when sensible, to conform to it.

To succeed is to evolve. It reminds me of when Woody Allen compared a relationship to a shark – that it has to move forward or it dies.

It's not enough for the AMA merely to act, but to keep at it. To refuse to quit. To face challenges and rise above them.

One of the most important lessons I have learned in medicine, in my pursuits – in my life – is the value of persistence.

As I mentioned, competing in marathons and triathlons has been a passion for me.

I enjoy the challenge and pushing myself beyond what some may find reasonable. And running 26.2 miles or finishing a 140.6-mile triathlon is no cakewalk.

Mary Wittenberg of the New York Road Runners Club described it this way. She said: "Virtually everyone who tries the marathon has trained for months. That commitment, physical and mental, gives it its meaning, be the day's effort fast or slow. It's all in conquering the challenge."

World Medical Journal



This persistence – this effort – helps give meaning to what the AMA accomplishes on behalf of physicians and patients, every day.

This is what we have in common. Each of us has already run a marathon.

You completed medical school. Or you run a medical practice – a small business. Or make split-second treatment decisions where life and death are in the balance. Sometimes all of these.

You, like me, want a positive outcome even when the unexpected happens.

An example. In one triathlon, I was on the bicycle leg of the race going over Vail Pass in Colorado.

I rounded a curve and came upon a woman who had wrecked her bike. She was sprawled on the ground, injured, exhausted, dazed from a concussion.

With her was a fellow competitor – also a physician (and fortunately an ER doc) – administering first aid. I stopped as well – and when I could not be of further help, went on my way.

But the doctor who stopped first ultimately suspended his race. He stayed with his new patient for two hours – and sacrificed his chance to complete an event for which he'd trained for months. Why? Because he'd trained for years to be a physician.

The well-being of the patient always comes first – even when it isn't our own patient.

This selfless service has been a hallmark of who we are, as physicians, since the dawn of time.

And it's one of the valuable lessons I've learned from my own encounters with the hard ground. Not to give up.

In this most contentious time in our country, the AMA will do more than step up to a podium.

We will run – we will win the race to provide medical and mental health care services to all, and we will hear the cheers of those too often silent.

The AMA rejects the idea of media 'spin doctors' – who hold no medical degree – attempting to dictate our future. We'll stand with physicians and take back our message.

The AMA rejects the idea that bowing to the policies of government and insurance industry bureaucracies are simply inevitable costs of doing business.

The AMA rejects the notion that legislators can impose themselves into the patient-physician relationship and legislate how we practice –

Whether it concerns what we can ask or say to our patients – or what tests and procedures are appropriate.

We fight for the interests of physicians. Sometimes we have prevailed, sometimes we haven't, but we've been on the course, pushing our limits, testing our endurance.

Not always winning – but always being heard and always finishing.

The documentary filmmaker Bud Greenspan, who chronicled the Olympic Games for almost 60 years, once described a moment he believed best captured the Olympic ideal of perseverance and commitment.

In Mexico City in 1968, the Tanzanian runner John Ahkwari finished last in the marathon.

Midway through the race, he had fallen and torn a deep gash in his leg. In agony, he limped into the stadium 90 minutes af-

ter the winner, his leg bruised, bandaged and bleeding. For everyone else, the race was over. The stadium was nearly empty, the lights dimmed.

Bud Greenspan was still there, his cameras still rolling. He asked John Ahkwari why on earth he kept going with such a serious injury, with no hope of winning.

He replied, "My country did not send me 5,000 miles to start a race – they sent me to finish it."

That thought will guide me as AMA president.

Training for medicine was much like training for a marathon or triathlon. You learn your strengths, focus on what you do best, do it – and don't quit.

If you get off course on the swim, adjust your stroke. (Unless you're fortunate enough to see Dr. Cecil Wilson's sailboat in the distance)

If you get tired on the bike, shift to a lower gear.

If you can't run, walk. If you can't walk, take a break and try again.

That is an approach we can take to address the newest challenge we face – health system reform.

It means changes for those previously without coverage, changes in payment methods, changes in how care is delivered.

The Affordable Care Act will soon cover 32 million people without health insurance, provided neither the Supreme Court nor a new president overturns the law.

It requires insurance market reforms.

It invests in quality, prevention and wellness.

World Medical Journal



And it does something else – it starts us down the road to a very different system of payment and delivery.

We're hearing jargon like "Accountable Care Organization," and "medical home," and "integration."

We've come far since the days of a family doctor with a black bag holding the tools of his trade.

Today, a physician may text a patient on an iPad while viewing their medical history and coordinate care among a team of physicians and other health care professionals.

Such physician-led teams are crucial components of medicine's future.

As more patients live longer and accumulate more complex medical conditions, their care will require more coordination, more use of clinical data, and professionals working together.

To be part of a team – and following guidelines and best practices – doesn't mean you've lost your ability to think, to create, to act on behalf of your patients.

In the mental health field, a good example is the DIAMOND Initiative in Minnesota.

Psychiatrists are paid to consult with primary care practices on the best way to manage patients with depression. It's resulted in dramatic improvements in patient outcomes.

The current system discourages this, since specialists are paid for face-to-face visits with patients, but not when they advise the primary care physician.

In 2008, this House of Delegates adopted principles that support this approach.

The AMA has also backed the medical home model for mental illness and the prin-

ciple of parity for mental health coverage – and is part of the Coalition for Fairness in Mental Illness. We've made tremendous progress, but we can do more.

As AMA president, I will note the need to better integrate mental health care into other aspects of medical care – to provide more resources to treat more people.

Because you can no more separate the heart from the mind of a person any more than you can separate the heart from the lungs and expect them still to function.

I'll also want to highlight the impact of violence on both the mental and physical health of those abused...

Just like we'll need you to make a concerted effort through our Joining Forces Initiative to help our returning troops, veterans and their families who suffer with traumatic brain injury, post-traumatic stress disorder or post-combat depression.

The wounds of those who have borne the battle are not always visible.

We're not just playing defence. Just like in football, you need a good offense, too. We're being proactive, not just reactive.

Education on exercise, preventive health and nutrition starting in early childhood that continues through a lifetime will help create a healthier society.

One with less obesity, cancer and the other illnesses that debilitate the very people we care about – and which exact a staggering societal and financial cost.

For them, physicians must be the role models for our patient's health – and for each other's.

We have a duty to care not only for our patient's health, but for our own, both physical and psychological.

That's hard for many physicians to admit – that they, too, may sometimes need help or guidance.

When we treat our patients – especially our youngest ones – remember that you might be treating or inspiring a future physician.

Our family internist, Dr. Lerner, who suffered from poor circulation in his legs, nonetheless would climb four flights of stairs to make a house call.

The doctor I saw was the doctor I knew, and to me, he represented the profession and as Dr. Carmel would say, he was my hero.

To me, his actions said: Treat people the way you want to be cared for, because too often, this is an uncaring world.

As physicians, as AMA members, we are the face of this profession, this organization. We are also its voice.

Let's be willing to sing from the same page. Those of you who have sung in choirs know how a collection of varied but trained voices can lift a crowd to their feet. When the AMA combines our many voices in harmony – we can do just that.

For me, it's not just a metaphor. I paid my way through college and medical school by directing synagogue choirs.

There, you have to combine many disparate voices – and help them sing in harmony.

As director, you work with sopranos and tenors, altos and baritones, contraltos and basses. And in some choirs you have to designate a section called the "lip synchers".

But even if a voice is out of tune, or the pipes rusty – I learned that even a monotone can learn a second note.

So we need to rise up – raise our voices – and sing out for medical liability reform, to end

frivolous lawsuits, to end the fear of being dragged into court for no good reason, and to slow spending on defensive medicine.

Sing out, and demand the Sustainable Growth Rate be scrapped – and be replaced with a system that recognizes reality – and reflects the actual costs of medical care – in all its effective forms.

Sing out for private contracting legislation, and physician-led delivery and payment reforms.

Sing out our commitment that Americans need health insurance coverage and that we finally end health care disparities.

Sing out – for an equitable health care system. Where all its elements exist in harmony.

We trained all of our adult lives to be the best physicians we can be. Now is the time to combine our voices and make a joyful noise. Rise to this occasion. Be persistent. And keep going no matter how rough the terrain, or how tiring the course.

I'll be alongside AMA staff, every physician, and this House of Delegates. Together, we can finish this – and we can win.

Among the most inspirational words I've ever seen were at the 130-mile marker of

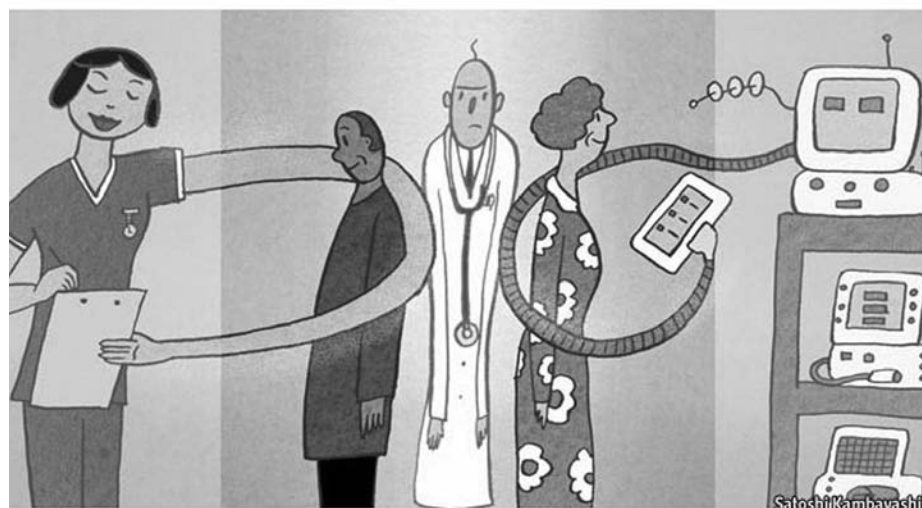
a triathlon course, in the 100-degree lava field in Kona, Hawaii. They were from Isaiah, and it read: "They that hope in the Lord will renew their strength. They will soar like wings on eagles. They will run and not grow weary – walk and not grow faint."

And to that I will add: we will rise up and be heard. We will run this race, together. We will persist. And together, we will cross the finish line.

Thank you.

Squeezing Out the Doctor

The role of physicians at the centre of health care is under pressure



In a windowless room on a quiet street in Framingham, outside Boston, Rob Goudswaard and his colleagues are trying to unpick the knottiest problem in health care: how to look after an ageing and thus sickening population efficiently. The walls are plastered with photographs of typical patient—here a man who exercises occasionally, there

a woman with many chronic ailments. Big sheets of paper chart each patient's course from the hospital back to a comfortable life at home, with divergent lines showing all the problems that might arise and ways to handle them. To map the many paths to health in this way Mr Goudswaard's team interviewed a lot of patients and nurses.

But this war room does not belong to a hospital. It belongs to Philips, a Dutch electronics company. Mr Goudswaard, the head of innovation for Philips's home-monitoring business, has no medical training. His speciality is the consumer.

In this section

The past 150 years have been a golden age for doctors. In some ways, their job is much as it has been for millennia: they examine patients, diagnose their ailments and try to make them better. Since the mid-19th century, however, they have enjoyed new eminence. The rise of doctors associations and medical schools helped separate doctors from quacks. Licensing and prescribing laws enshrined their status. And as understanding, technology and technique evolved, doctors became more effective, able to diagnose consistently, treat effectively and advise on public-health interventions such as hygiene and vaccination that actually worked.

This has brought rewards. In developed countries, excluding America, doctors with no speciality earn about twice the income of

the average worker, according to McKinsey, a consultancy. Americas specialist doctors earn ten times Americas average wage. A medical degree is a universal badge of respectability. Others make a living. Doctors save lives, too.

With the 21st century certain to see soaring demand for health care, the doctors star might seem in the ascendant still. By 2030, 22% of people in the OECD club of rich countries will be 65 or older, nearly double the share in 1990. China will catch up just six years later. About half of American adults already have a chronic condition, such as diabetes or hypertension, and as the world becomes richer the diseases of the rich spread farther. In the slums of Calcutta, infectious diseases claim the young; for middle-aged adults, heart disease and cancer are the most common killers. Last year the United Nations held a summit on health (only the second in its history) that gave warning about the rising toll of chronic disease worldwide.

But this demand for health care looks unlikely to be met by doctors in the way the past centuries was. For one thing, to treat the 21st centurys problems with a 20th-century approach to health care would require an impossible number of doctors. For another, caring for chronic conditions is not what doctors are best at. For both these reasons doctors look set to become much less central to health care process which, in some places, has already started.

Make do and mend

Most countries suffer from a simple mismatch: the demand for health care is rising faster than the supply of doctors. The problem is most acute in the developing world, though rich countries are not immune (see article). It does not help that health care is notoriously inefficient. Whereas Americas overall labour productivity has increased by 1.8% annually for the past two decades, the

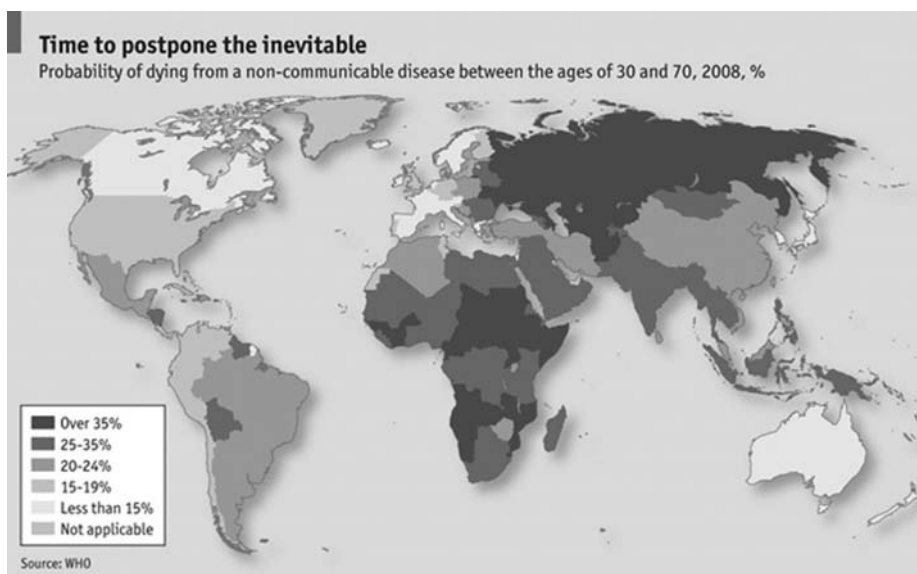


figure for health care has declined by 0.6% each year, according to Robert Kocher of the Brookings Institution and Nikhil Sahni, until recently of Harvard University. But it is in poor countries that interest in alternative ways of training doctors and in alternatives to doctors themselves has produced the most innovation.

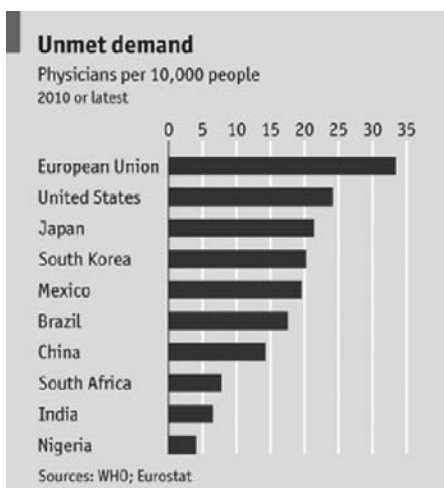
One approach to making doctors more efficient is to focus what they do. India is home to some of the worlds most exciting models along this line, argues Nicolaus Henke of McKinsey, who leads the consultancys work with health systems. Britain has 27.4 doctors for every 10,000 patients. India has just six. With so few doctors, it is changing the way it uses them.

Your correspondent recently watched Devi Shetty, chief executive of Narayana Hrudayalaya hospital in Bangalore, making careful incisions in a yellowed heart, pulling out clots that resembled tiny octopuses. It looked difficult. Some of the other tasks at Narayana Hrudayalaya hospital do not, and are not. Dr. Shettys goal is to offer as many surgeries as possible, without compromising on quality. To do that, he ensures that his surgeons do only the most complex proce-

dures; an army of other workers do everything else. The result is surgeries that cost less than \$2,000 each, about one-fifteenth as much as a similar procedure in America.

The trick is repeated in other areas of health care. Indias LifeSpring hospitals slash the price of childbirth by augmenting doctors with less expensive midwives. The costs are about one-sixth of those in a private clinic. The Aravind Eye Care System offers surgery to about 350,000 patients a year. Operating rooms have at least two beds, so surgeons can swivel from one patient to the next. Most important, for every surgeon there are six eye-care techniciansyoung women recruited and trained by Aravindwho perform the myriad tasks in the operating room that do not require a surgeons training.

Other problems have inspired other solutions, with technology filling gaps in the labour force. The Bill and Melinda Gates Foundation supports a programme that uses mobile phones to deliver advice and reminders to pregnant women in Ghana. In December the foundation and Grand Challenges Canada, a non-profit organisation, announced \$32m in grants for new mobile tools that will help health-care workers di-



agnose various ailments. In Mexico, worried patients can phone Medicall Home, a telehealth service. If a patient needs care, Medicall Home can help to arrange a doctors visit. But about two-thirds of patients concerns can be addressed over the phone by a doctor (often one only recently qualified).

These programmes are expanding. Medicall Home is rolling out its service in Colombia and plans to be operating in Peru by the end of the year. Aravind has exported its training model to about 30 developing countries. Dr. Shetty already has 14 hospitals in India. He plans to add 30,000 hospital beds in big health complexes and small hospitals there over the next seven years, as well as build a hospital in the Cayman Islands.

Technology does not just allow diagnosis at a distance it allows surgery at a distance, too. In 2001 doctors in New York used robotic instruments under remote control to remove the gall bladder of a brave woman in Strasbourg. Robots allow doctors to be more precise, as well as more omnipresent, making incisions more neatly than human hands can. As yet they are enhancements for surgeons more than they are replacements, but that may change in time. Military drones started off being flown by officers who had gone through the expensive rigours of flight school; these days other

ranks with far less exhaustive training can take the controls.

Team effort

Less flashy technology, though, could make the biggest difference by reducing the number of crises which require a doctors intervention. Marta Pettit works on a programme to manage chronic conditions that is run from Montefiore Medical Centre, the largest hospital system in the Bronx, a New York borough. Ms Pettit and a squadron of other care co-ordinators examine a stream of data gathered from health records and devices in patients homes, such as the Health Buddy. Made by Bosch, a German engineering company, the Health Buddy asks patients questions about their symptoms each day. If a diabetics blood sugar jumps, or a patient with congestive heart failure shows a sudden weight gain, Ms Pettit calls the patient and, if necessary, alerts her superior, a nurse.

Other tasks are simpler, but no less important. Montefiore noticed that one old woman was not seeing her doctor because she was scared of crossing the Grand Concourse, a busy road in the Bronx. So Montefiore found a new doctor on her side of the Concourse. Together, such measures make a difference. Diabetics trips to hospital plunged by 30% between 2006 and 2010; their costs dropped by 12%.

Similar programmes will become even more sophisticated as monitors evolve. Patients are much happier to monitor themselves at home with gadgets bought online than they used to be, and gadget-makers think there is a huge potential for growth in taking the trend further. Philips, General Electric (GE) and others are all upping their investments in home health, and widening the markets in which they sell their existing products (Philips is trying to crack Japan with emergency-alert devices for the elderly). GEs design gurus predict that a patients

overall condition will soon be measured as easily as a thermometer measures his temperature.

Such technologies have long seemed promising; recently the promise has begun to be borne out. Britain has completed the worlds biggest randomised trial of telehealth technology, including gizmos from Philips. The study examined 6,000 patients with chronic diseases. According to preliminary results of a study by Britains health department in December 2011, admissions to the emergency room dropped by 20% and mortality plummeted by 45%.

Nursed back to health

Changing health systems is tortuous. Reformers are stymied by medical lobbies, nervous patients and heaps of regulations about who may do what and where. But there is movement, particularly in the lower ranks of the labour market. Indias health ministry has proposed a new three-and-a-half-year degree that would let graduates deliver basic primary care in rural areas. Dr. Shetty thinks his hospitals could benefit from a broader range of training programmes, to create workers with a wider array of skills.

Workers with a lot less training than doctors can still be highly effective. Physician assistants in America can do about 85% of the work of a general practitioner, according to James Cawley of George Washington University. A pilot programme of rural health-care workers in India the type that the health ministry wants to expand found that the workers were perfectly able to diagnose basic ailments and prescribe appropriate drugs. In some areas non-doctors actually look preferable. A review of studies of nurse practitioners in Britain, South Africa, America, Japan, Israel and Australia, published in the *British Medical Journal*, determined that patients treated by nurses were more satisfied and no less healthy than those treated by doctors.



But expanding the supply of non-doctors is not, in itself, enough. America has led the world in developing the roles of nurse practitioners and physician assistants. Other, less trained workers are proliferating there too. The number of diagnostic medical sonographers, who have two years of training, is expected to jump by 44% between 2010 and 2020, according to the Bureau of Labour Statistics. Yet productivity still falls.

This seems to be because new ways of doing things, and of managing health teams, have not kept pace and are still under the control of doctors.

The doctors power rests on their professional prestige rather than managerial acumen, for which they are neither selected nor trained. But it is a power that they wish to keep. The Confederation of Medical Associations in Asia and Oceania, a regional group of doctors lobbies, wants task-shifting limited to emergencies. Japan's medical lobby has vehemently opposed the creation of nurse practitioners. India's proposal for a rural cadre outraged the country's medical establishment, and legislation to create the three-and-a-half-year degree has gone nowhere.

In 2010 America's respected Institute of Medicine (IOM) called for nurses to play a greater role in primary care. Among other barriers, nurses face wildly different constraints from one state to another. But any change will first require swaying the doctors. The American Medical Association, the main doctors lobby, greeted the IOM's

report with a veiled snarl. Nurses are critical to the health-care team, but there is no substitute for education and training, the group said in a statement.

As doctors become scarcer and health costs continue to rise, more and more systems will seek to innovate, and the successes they have will become ever more widely known. Already, programmes such as Montefiore are becoming the paradigm for keeping patients healthy. In December America's health department chose Montefiore for a pilot to improve care and lower costs for the old.

All this should be cause for excitement. Resources are slowly being reallocated. Nurses and other health workers will put their training to better use. Devices will bolster care in ways previously unthinkable. Doctors, meanwhile, will devote their skill to the complex tasks worthy of their highly trained abilities. Doctors may thus lose some of their old standing. But patients will clearly win.

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50 Years of Cardiothoracic Surgery

As early as the 4th and 5th century BCE, the heart, lungs, veins, and arteries were known to be critically important organs in the human body – although it would be a few more centuries before dissection allowed scientists of the time to better understand how these parts worked to pump blood and give life. When modern medicine emerged in the 19th century, a new understanding of microbiology and bacteriology greatly reduced infection rates and the use of anesthetics such as ether and chloroform also became more common. These two advancements set the stage for the astounding medical innovations of the next century.

And yet, surgery of the heart and lungs presented special problems because the heart performed the important task of carrying blood to the brain. A beating heart would lead to excessive blood loss, and a heart that wasn't beating resulted in a brain-dead patient after only four minutes.

The devastation of World War II led to more progress in the field of surgical medicine. Doctors on the battlefield, desperate to help save the lives of injured soldiers, pioneered new advancements in antibiotics, anesthesia, and blood transfusions. Army surgeon Dr. Dwight Harken suc-

cessfully removed shrapnel from the hearts of wounded soldiers during the war, proving that the heart could in fact be operated upon. Soon after the end of the war, Harken and Dr. Charles Bailey of Philadelphia used the same technique to repair defective heart valves, a condition known as mitral stenosis. However, this type of closed-heart surgery had its limitations, and patients with more serious heart conditions had few options.

Solving this problem became a defining issue in the mid 20th century. Doctors from all over the world worked furiously to resolve the conundrum. One solution came when Dr. Wilfred Bigelow discovered that cooling the body's core temperature slows

the heart rate and allows a longer time in which to operate—ten minutes as opposed to four. Drs. John Lewis and Walton Lillehei of the University of Minnesota used the hypothermia method to close an atrial septal defect in 1952, and Dr. Henry Swan perfected the procedure, eventually performing hundreds of open-heart surgeries with relatively low mortality. This rather cumbersome method was ultimately short-lived, however, when it became clear that more complex heart conditions would require more time than the cooling of the body allowed. It was evident that a better approach was needed.

Heart surgeons of the time understood that a successful heart-lung machine – that is, a machine that would bypass the heart and lungs and take over circulation of the blood during the surgery—had to not only pump blood, but also resupply oxygen to the red blood cells and pump blood at sufficient pressure to supply all the organs in the body, all without damaging blood platelets in the process. Anticoagulation was also necessary to prevent bleeding out during surgery. The latter problem had been earlier solved by the discovery of heparin in the early 1900s. The heart-lung machine had several prototypes, but it wasn't until the 1950s that surgeons were able to use such a device to repair the hearts of patients.

From 1950–2000, the following timeline describes some of the important milestones in cardiothoracic surgery that followed the development of cardiopulmonary bypass, a revolutionary advancement that has since saved thousands of lives.

1951 – Dr. Clarence Dennis of the University of Minnesota performed the first open-heart surgery using a heart-lung machine. The patient is a six-year-old girl suffering from an atrial septal defect. She does not survive.

1952 – Dr. Forest Dodrill and colleagues use a mechanical pump (developed with

General Motors) to perform the first successful total left-sided heart bypass on a 41-year-old man in Detroit. The patient's own lungs were used for oxygenation.

1952 – Dr. Paul Zoll applies electrical charges to the outside of a patient's chest to successfully restart his heart.

1953 – Dr. John Gibbon performs the first successful intercardiac surgery of its kind using a heart-lung machine he developed with IBM. The patient is an 18-year-old girl with congestive heart failure due to an atrial septal defect. Unfortunately, the next two patients to receive surgery with the machine do not survive. Gibbon declares a one year moratorium on further surgeries using his machine.

1955–1956 – A team led by Dr. John Kirklin of the Mayo Clinic uses a heart-lung machine based on Gibbon's model to perform intercardiac surgery on eight patients, four of whom survive.

1958 – Swedish surgeon Dr. Ake Senning places the first implantable pacemaker in a patient with Stokes-Adams syndrome.

1960 – The first aortic valve replacements are placed by Dr. Dwight Harken and Dr. Lowell Edwards, both of whom use a caged ball valve. In the next seven years, 2000 of these valves are implanted.

1960 – Dr. Robert Goetz performs what appears to be the first coronary artery bypass operation on a human. He receives criticism for attempting the experimental surgery, and never performs another.

1963 – An artificial left ventricle assist device is successfully used to help wean a patient from cardiopulmonary bypass after heart valve surgery.

1964 – Dr. Charles Dotter performs the world's first percutaneous transluminal angioplasty in Oregon.

1967 – A South African surgeon, Dr. Christiaan Barnard, transplants the heart of a 23-year-old woman into a middle-aged man. He survives for 18-days before dying of pneumonia brought on by powerful anti-rejection drugs.

1968 – Dr. Norman Shumway of Stanford University performs the first heart transplant in the United States. The patient survives for 14 days. Following the sensation of this first operation, several more transplant surgeries take place, but with high mortality.

1974 – Dr. Andreas Gruentzig performs the first peripheral human balloon angioplasty

1981 – Shumway performs the first successful heart-lung transplant with colleague Dr. Bruce Reitz.

1982 – American surgeon Dr. William DeVries implants a permanent artificial heart into a patient at the University of Utah

1998 – Dr. Friedrich Wilhelm Mohr and Dr. Alain Carpentier perform the first robot-assisted mitral valve repair and coronary bypass surgery in France.

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Provided by
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<http://www.surgicaltechnologist.net>

Israeli Torture Doctors: Medical Ethics Betrayed

Summary

In the recent report 'Doctoring the Evidence, Abandoning the Victim' the Israeli Public Committee against Torture accuses several Israeli medical doctors of medical complicity in torture. When analyzing the report's outcomes, the author pleads for a strong condemnation by the Israeli medical association of these illicit practices. What's more, in line with the report, urging Israel to restructure its medical system of checks and balances and recommending the ratification the Optional Protocol of the Convention against Torture aimed at preventing torture and thus strengthening the rights of the detained.

Introduction

The alarming report 'Doctoring the Evidence, Abandoning the Victim' of the Israeli Public Committee against Torture accuses Israeli medical doctors of medical complicity in torture.¹ These allegations are not new and have been mentioned before.² What's new is the figures and systematic approach of these human rights violations. Based on a series of testimonies and other evidence, such as medical files of over 100 victims of torture since 2007, the report demonstrates that several doctors are (in)directly involved in torture or cruel and degrading treatment

of Palestinian detained persons in Israeli detention centres.

Report Outcomes

According to the report, physicians willingly take part in, facilitate or allow torture by failing to report clinical evidence of it to the relevant authorities. Evidence of active involvement includes falsification of medical records and disclosure of medical information to the interrogators of the security services. Information that is relevant to the interrogation techniques to be used by the intelligence services.³ As such Israeli medical doctors failed to protect detainee's human rights, violated the basic principles of medical ethics and ignored the basic tenets of medical professionalism.

More common is passive engagement including: the failure to oppose, accurately document, report (suspicion of) torture, and return the detainees they examined or treat to their interrogators.⁴ As such, these doctors remain silent of what they see and hear, offering moral license for torturers.

International Law and Ethics

International law and international medical ethics are very clear about the prohibition of torture.⁵ Torture violates the essen-

tial ethical obligation on all physicians to "first do no harm" and human dignity.⁶ The same international standards condemn all forms of torture and inhuman or degrading treatment at any time and in any place whatsoever and can thus never be justified.⁷ All States are obliged to ensure fully the implementation of the absolute prohibition of torture, for instance by means of criminalizing all acts of torture, never requesting medical personnel to commit any act of torture and respecting the professional independence and duties of health personnel, as well as respecting the doctor's duty to report or denounce acts of torture without fear of retribution or harassment, and not punishing or intimidating medical personnel not obeying orders or instructions to

information for a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with consent or acquiescence of a public official or other person acting in an official capacity'.

Apart from UNCAT, the international community has developed various instruments condemning torture and other forms of ill-treatment, such as the Art. 7 of the International Covenant on Civil and Political Rights of December 19, 1966 and Art. 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms of November 4, 1950; UN Human Rights Council. Resolution on torture and other cruel, inhuman or degrading treatment or punishment: The role and responsibility of medical and other health personnel, 2009, A/HRC/10/L.32.

6 WMA International Code of Medical Ethics. Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949, latest revision: the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006.

7 The UN Istanbul Protocol (1999): A manual for the efficient investigation and documentation of torture and other cruel, inhuman or degrading treatment; WMA Declaration of Tokyo (1975) – Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment <www.wma.net/publications>

1 Public Committee against Torture in Israel en Physicians for Human Rights, 'Doctoring the Evidence, Abandoning the Victim. The Involvement of medical professionals in torture and ill-treatment in Israel', in collaboration with Physicians for Human Rights, October 2011, <<http://www.stoptorture.org.il/en/>>.

2 Eg, J.S. Yudkin, "The responsibilities of the World Medical Association President", Comment, the Lancet, 373 (2009) 1115-6.

3 See note 1, pp. 28–40.

4 Ibid, pp. 43–45.

5 According to the United Nations Convention against Torture (UNCAT 1984, Art. 1 section 1), torture is defined as 'any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person

commit, facilitate or conceal acts amounting to torture.¹

Vague National Standards

Despite these clear international standards, the gap between the national norms and practice remains too wide. Israeli law and ethical guidelines on this matter are overly vague in asserting the duty of the doctor to the patient's well-being. What is worse, misinterpret international standards by including a 'national security' exception allowing the doctor to compromise the patient's health in the face of the security services.² As such, prison doctors are being trapped by the so-called "dual loyalty" conflict: confronted with a patient who happened to be an Arab detained in medical need, and their duty towards their employer security services fighting a war on terrorism. Balancing these interests has led to blatant breaches of human rights.

Unfortunately, this 'dual loyalty' situation is not unique for Israeli doctors. In the past several colleagues have been struggling with that dilemma.

"Healers" as Torturers: International Experiences

Extreme cases of torture doctors occurred in Nazi death camps during World War II.³ The report considers incidents of medical complicity in torture in several countries (the former USSR, South and Central America, Sri Lanka, etc.).⁴ More recently

there is participation in the so-called 'water boarding' interrogation techniques in the US 'war on terror' performed in Guantanamo Bay and the Abu Ghraib prison in Iraq.⁵

These cases show a clear ignorance of physicians towards international ethics and law. Educating doctors on human rights, humanitarian law and medical ethics appears therefore an essential element in the medical curriculum. Inadequate training in human rights is part of the problem, but alone it cannot justify the actions or inactions of the prison medical personnel. Similar as in the Abu Ghraib prison, the Israeli medical system failed to protect the detainee's health and failed to accurately report witnessed or suspected abuse.⁶ These failures of the Israeli (prison) medical system illustrate a more fundamental problem: the absence of functioning checks and balances and being subject to professional discipline.⁷

Role of the International Community

What can the international community do to raise its voice against this? Efforts to eradicate torture should first and foremost be concentrated on prevention. Therefore, Israel should be invited to adopt the Optional Protocol to the Convention against Torture.⁸ This Protocol introduces a system of regular visits to places of detention, aimed at preventing torture and thus strengthening the rights of the detained. By ratifica-

tion, each State shall allow these visits by an independent committee, granted with extended powers, including access to all relevant information, the opportunity having private interviews with detained persons, and submitting proposals for legislation.

Apart from prevention, the World Medical Association (WMA) as the world's largest association representing the international medical community, should urge the Israeli member association to speak out in support of the fundamental principle of medical ethics and to investigate any breach of these principles by their members.⁹ More important, the voice of the international medical profession should urge the Israeli medical association to bring its ethical guidelines in line with international standards, which means rejecting the security exception as a justification for torture. The message should be univocal: respecting this core principle is nothing less than is a condition sine qua non for the WMA-membership.

Conclusion

The report made painfully clear that there is a fundamental need for improvement and enforcement of the checks and balances in the Israeli medical system. In a way, this is one of the recommendations made by the Israeli Public Committee against Torture suggesting the introduction of independent board of inquiry to examine the full nature of these abuses.¹⁰ International pressure from both UNCAT and the WMA could be effective to realize these changes.

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1 Examples based on the United Nations Convention against Torture (CAT, 1984) and the United Nations' Human Rights Council recommendation against torture, A/HRC/10/L32, 20 March 2009.

2 Ibid note 1, pp. 19-26.

3 Eg, M. Lippman, "The Nazi Doctors Trial and the International Prohibition on Medical Involvement in Torture" *Loy. L.A. Int'l & Comp. Law J.* (1992-3) 395-441.

4 Ibid note 1, pp. 47-51.

5 S.H. Miles, *Oath Betrayed: America's Torture Doctors* (2nd ed. Univ. of California Press, 2009).

6 Compare: P.A. Clark, "Medical Ethics at Guantanamo Bay and Abu Ghraib: The Problem of Dual Loyalty", *Journal of Law, Medicine & Ethics* Fall (2006) 570-580: 573.

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10 Ibid, note 1, p. 55.

Violence in the Health Care Sector — an Updated Look



Malke Borow

In October 2010, the Israeli Medical Association (IMA) first proposed a statement for adoption by the WMA on the subject of violence in the health sector. The statement was the result of the worrying trend of increasing violence against health professionals by patients and their family members. Since the initial proposal, this trend has not abated, and if anything, has worsened.

Some statistics: According to the US Bureau of Labor Statistics, in 2007 there were 670,600 injuries and illnesses in the health care and social assistance industry, with an injury and illness rate of 5.6 per 100 full-time workers compared with 4.2 for all of private industry. Nearly half (45.3%) of these injuries and illnesses required days away from work, job transfer, or restriction [1].

In an updated study conducted by the British Medical Association (BMA) and published in 2008, almost half of those surveyed, both GPs and hospital doctors, reported

violence to be a problem in the workplace, with a third reporting experiencing violence or abuse in the workplace in the preceding year. The majority reported cases of verbal abuse, but almost a third reported (instead or in addition) physical violence or abuse [2].

Finally, the 2011 summary of violent incidents in Israeli healthcare workplaces showed a total of 752 reported cases of physical violence and another 2406 cases of verbal abuse, a rise from 2010, although lower than in 2008–2009. More cases were reported in hospitals than in ambulatory clinics, and the department with the most reported cases was the emergency department [3].

The effects of violence, as we reported previously [4], are devastating and include physical and emotional stress, anger, helplessness and anxiety [5], lost work days, low worker morale, increased turnover and direct and indirect effects on work ability [6].

In a personal complaint by a Chinese medical student following the fatal stabbing of an intern, she reports her own regret in choosing medicine as a career and asserts that many of her fellow students do not know whether to continue to study medicine or not [7]. Besides the direct effects of violence, in an era of workplace shortages, this is a byproduct we cannot afford to accept.

Israel has introduced a series of reforms over the last several years in an effort to combat this worrisome phenomenon, including financial, legal and social initiatives. The IMA, in particular, initiated several important actions, including an emergency hotline for physicians, a professional security company that accompanies

physicians perceived to be in danger, and an ad campaign, including posters and a video clip that was broadcast on cable television. In addition, we partnered with certain hospitals on a pilot “emergency call button” program.

On the legal front, the IMA proposed two bills that were subsequently passed into law. These bills were developed, in part, on the basis of a successful action plan implemented in England in 2000 in order to reduce violence against medical staff.

In 2011, the law preventing violence in healthcare institutions in Israel was passed [8]. This law allows a hospital or clinic to warn family members or accompanying persons of patients, who previously engaged in verbal or physical violence against hospital/clinic personnel or destroyed institutional property, that if they repeat such an act they will not be permitted on the hospital/clinic grounds for a period of 3–6 months unless they themselves need medical care.

The second law was an amendment to the Penal Code that lengthens the punishment for one who attacks medical personnel in the ER or while they are trying to treat someone in serious danger from three years to five years [9].

The legal system also, indirectly, helped reduce some of the pressures that lead to violence when, in June 2008, the district court in Tel Aviv ruled that doctors are not allowed to include budgetary considerations in their medical decisions [10]. It is hoped that this decision will restore the doctor's professional autonomy and minimize the tension between doctor and patient.

As we noted in our previous article, verbal aggression is more insidious and no less problematic than physical aggression. Although the results may be less dramatic — clearly a fatal or disfiguring attack has more immediate and dramatic consequences

than verbal attack – because verbal aggression is more prevalent, over time it erodes worker confidence, morale and feelings of safety in the workplace. In these types of cases, training to deal with aggressive patients can be especially effective [11], perhaps because it is easier to equip people with tools to handle verbal aggression than physical aggression.

One issue that was hotly debated among the National Medical Associations (NMAs) was the issue of violence among psychiatric patients. It was recognized that this is a unique problem that cannot be addressed in the same way as other violent events. In a study conducted in Egypt, 80% of workers in psychiatric departments reported exposure to one or more violent incidents in the previous year as compared to 23% of workers in internal medicine departments. In both departments, verbal violence was the most common type reported, followed by threat and then physical violence. Also, in both departments doctors and nurses were exposed to more violence than social workers or psychiatrists [12].

It does appear that mental illness raises the likelihood of violent behavior. This is necessary knowledge not to further stigmatize the community of mentally ill patients but in order to give health workers a realistic understanding of the risk and the precautions they should take. One survey showed a 5% lifetime risk of schizophrenia among people convicted of homicide, a prevalence that exceeds the rate of schizophrenia in the general population. Nonetheless, it is important to note the difficulty of establishing an accurate profile of people committing acts of workplace violence, and to acknowledge the risks associated with generalization and stereotyping in this area.

Conclusion

A key motive in preparing the statement for adoption by the WMA was to raise aware-

ness of the issue among the NMAs and to build greater understanding among health care professionals of the causes and associated risks of workplace violence.

There was general consensus among the NMAs as to the importance of such a statement and the need for action on the part of NMAs, medical institutions and governments, including the allocation of appropriate funds to combat the problem.

Prevention is as important as the provision of tools and strategies to deal with violence when it occurs. Effective reporting mechanisms are also crucial in order to keep tabs on the scope and characteristics of the problem.

It is hoped that the adoption of this statement by the General Assembly in October will lead to renewed commitment among governments and health care workers to address the problem on all levels and slowly reverse the worrisome trend that leads to physical and emotional debilitation and eventual attrition of the healthcare workforce.

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Report on MedicReS World Congress 2012 on Good Medical Research MedicReS International Conference on Good Biostatistical Practice



E. Arzu Kanik

The main themes at the MedicReS World Congress June 6–9, 2012, at Hofburg Palace in Vienna, were Good Medical Research and Good Biostatistical Practice which had been introduced to the medical literature by MedicReS for the first time at the MedicReS International Conference 2011 in Istanbul [1].

At the MedicReS World Congress 2012, these themes were made open for contributed discussions for all medical scientists working at different stages of medical research. This is the first time that authors, editors, reviewers, ethical board members, research education professionals, publishers, clinical research organizations and management teams of medical sector were brought together to discuss the concept of “Good Medical Research”.

20 invited and 30 contributed speakers and more than 50 presentations from 37 different countries took part in the Scientific

Table 1. *MedicReS Good Biostatistical Practice (GBP) Guide (GBRS release 1.2)*

Main Parts	Subtitles
Part I “Design – Good Planning”, consisting of 20 subtitles in the form of Expanded PICOS (E-PICOS); E-PICOS	<ul style="list-style-type: none"> • 7P: Purpose & Population & Patients & Participants & Power & P value & Protocol (7 subtitles) • 2I: Intervention & Interpretation (2 subtitles) • 4C: Comparators & Controls & Covariate & Confounding (4 subtitles) • 2O: Outcomes & Outputs (2 subtitles) • 5S: Study Design, Sample Size, Summary Statistics, Statistical Software and Submitting (5 subtitles)
Part II “Analysis – Good Executing”, this part of GBP consists of 12 subtitles of 4D (Data Collecting, Data Control, Data Analysis, and Data Interpretation)	<ul style="list-style-type: none"> • Data Collection (2 subtitles): Validity, Reliability • Data Control (2 subtitles): Missing values, Outliers • Data Analysis (4 subtitles): Preparing data for analysis, Calculating summary statistics, controlling assumptions, deciding statistical methods for testing hypothesis • Data Interpretation (4 subtitles): Parameter estimating, Interpretation of p values, Clinical significance vs. statistical significance, Small sample size vs. large sample size
Part III “Publication – Good Reporting and Reviewing”, consisting of 8 main parts from the MedicReS Good Biostatistical Reviewing Standards, GBRS. GBRS also endorse Good Reporting Guidelines from Equator Network	GOOD BIostatistical REVIEWING STANDARDS (GBRS release 1.2)

Program of the MedicReS World Congress. Discussions about ethical issues and global ethics training, handling with bias, creating good evidence, turning evidence to good policy, publication policies for medical jour-

nals, good publication practice measurements, the future of electronic publishing, statistical consulting, and differences between peer review systems of journals have been discussed.

Table 2. *MedicReS Good Biostatistical Reviewing Standards (GBRS release 1.2)*

GBRS Subtitles	GBRS Questions ?
1. Study Design	Was a suitable design used to achieve the objective?
	Was/Were reporting guideline(s) suitable for the study design used? (GBRS also endorse Good Reporting Guidelines from <u>Equator Network</u>)
	Was an appropriate control group used?
	Were any efforts made to avoid potential sources of bias?
2. Sample Size	Was the minimum sample size needed calculated?
	If calculated, was the pre-study calculation of the sample size reported?
3. Participants	Were the socio-demographic characteristics of participants and those who didn't wish to participate reported in the study?
	Were withdrawals from the study independent of the study groups and/or doses?
	Was a flow diagram of participants given for all stages of the study?
4. Summary Statistics	Were the validity and reliability of the measurement methods used reported in the study? (Gold standard, inter-rater agreement)
	Was the analysis of randomness of missing values and outliers made?
	Were appropriate summary statistics used?
	Were there any misuses of standard error?
	Were confidence intervals calculated for all of the summary statistics used in the study?
	Were the terms 'relation', 'correlation', 'difference' and risk terms used correctly?
5. Statistical Analysis	Were statistical methods compatible with the study design and variables, used in this study?
	Were any assumptions of statistical methods violated?
	Was the choice of parametric or nonparametric test correct?
	Were all statistical methods used in the study reported in the methods section of the paper?
	Was it stated in the study which statistical method was used for which hypothesis?
	Were a covariant and the effect of mixing variables considered during the analysis? If necessary, was a multiple data analysis conducted?
	Was a multivariate analysis necessary? If necessary, was it used correctly?
	Were subgroups constituted during the data analysis?
	Were the method and the aim of subgroup analysis correct?
	Were cutoffs used for quantitative tests? If used, how were they determined?
	Were subjective criteria used for qualitative tests? If used, how were they determined?
	Was the sample size sufficient for subgroup analysis?
6. Tables and Graphics	Was the number of significant digits in the tables used correctly?
	Were the graphics selected compatible with the data analysis?
	Were the indications and interpretations of ratios and percentages in the tables in accordance with the content?
	Were both significant and non significant p-values given in the tables? (to avoid publication bias)?
7. Statistical Interpretation	Were the indication, interpretation of p-values in the study and generalizations made correctly?
	Were both statistical and clinical significance values of the results discussed?
8. Statistical Ethics	Was the statistical or commercial software used? If commercial, was this usage legal?
	Was there a statistical expert contribution in the material? If so, was this contribution valued?

At the MedicReS World Congress, the subject “ethics” was handled within the frame of showing respect to humans, animals, women, child, patients, and their relatives in the planning stage. Ethics in the analyzing stage of data collecting, analyzing and interpreting processes was considered within the frame of respect for science and self-respect. Subjects on research ethics and biostatistical ethics were discussed and new concepts were put forward related to electronic publishing in the publishing stage. In the sessions discussing the structures of global and local ethics boards the time, place and way of training on ethics in undergraduate and graduate levels were also debated [3].

Another important issue that was highlighted at the Congress was the importance of guidance of researchers, ethical board members, referees, and editors who are in charge of practice and publishing. One of the most important results of the MedicReS World Congress was certification of researchers. As to the programs the following were certified: Good Medical Researcher Certificate program and Good Ethical Practice, Good Biostatistical Practice, and Good Reviewing Practice Certificate. These programs should be offered locally in small interactive classes and should be controlled by the center as well. It is advised that trainings on good medical research should be updated every five years because of their dynamic methodological infrastructure. The aim of these certificate programs is to maintain the reliability of medical research in the eyes of the media and the readers.

The Lancet wrote that “MedicReS aims to educate researchers and provoke discussion about good scientific method, statistics, ethics, publication, and education. Faced with stifling bureaucracy, competition for funds, and employer pressure to deliver results, finding the time and space to produce the best research can seem an arduous process” (9 June 2012 issue [2]).

According to MedicReS, researchers should have sufficient knowledge not only in their own disciplines but also on ethical, biostatistical and methodological principles while conducting their research. MedicReS also aims at putting into practice Good Medical Research philosophy and its components, namely, good planning, good analyzing, good reporting, good reviewing and good publishing, creating good evidence, turning evidence to good policy, developing a curriculum for good medical research education, defined not only as ethical and unbiased, but also powerful.

MedicReS Guide for Creating Evidence was named as Good Biostatistical Practice (GBP) and introduced into the medical literature for the first time by MedicReS when it opened for discussion all the items at the contributed sessions at the MedicReS World Congress. The ratio of the three main parts of GBP are as follows: Design – Good Planning (50%), Analysis – Good Executing (30%), Publication – Good Reporting (20%) (Table 1). This guide contains three main parts: Part I is “Design – Good Planning”, consisting of 20 subtitles in the form of Expanded PICOS (E-PICOS); E-PICOS includes the follow-up *From Purpose to Submitting*; Part II is “Analysis – Good Executing” which consists of 12 subtitles of 4D (Data Collecting, Data Control, Data Analysis and Data Interpretation); the last part, Part III is “Publication – Good Reporting and Reviewing”, consisting of 8 main parts from the MedicReS Good Biostatistical Reviewing Standards, GBRS (Table 2).

One of the new themes that will be featured in the Third MedicReS World Congress on Good Medical Research which will take place in Vienna next year is clinically significant range for outcomes. Clinically significant range for primary outcomes is an input required for estimating the sample size of research, yet it does not have a standard. Although this subject is the most important tool for a powerful research, there is no

guide for determining clinically significant effect sizes based on diseases and populations.

We hope to meet medical researchers from all over the world next year June 13–15 in Vienna for the Third MedicReS World Congress.

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The First Global Climate and Health Summit



Dong Chun Shin

The First Global Climate and Health Summit was held on 4th December 2011, in Durban parallel to the UNFCCC climate negotiations. The summit was organized by Health Care Without Harm (HCWH) in partnership with more than 10 major health organizations from around the world including the World Medical Association (WMA) to raise awareness of health risks of climate change and urge delegations to take immediate and bold action to tackle the climate change issue.

The summit was very successful with a high turnout of over 250 participants mostly from the health sector and from more than 40 countries. Speakers at the summit warned that climate change will be a disaster to health crises if governments don't take immediate strong action and stressed that ambitious commitments have many health benefits. In a panel discussion following the keynote speeches, ways to commit to mitigating the climate change were discussed from various viewpoints from green management of health sectors to dietary changes. As a result of all the discussion, the

participants issued the Durban Declaration urging substantial progress in governmental talks, and A Global Call to Action (www.climateandhealthcare.org) urging the health sector to play increased roles in advocacy and capacity building in addressing the issue. The voices collected at the summit were delivered to the participants of the UNFCCC meeting at a press conference of the UN meeting with a performance of doctors taking the temperature of a model earth and finding that it was overheating.

Representing the WMA, I had an opportunity to introduce the WMA's commitments to tackling health impacts of climate change including the Delhi Declaration and a lobbying action with the NMAs to make health an inherent component of governmental climate talks. I approached the issue especially focusing on the role of the organized medicine and leadership: encouraging the NMAs to press their governments to fully consider the issue, getting physicians and patients involved in the commitment for a healthy climate, fostering studies and research on the burden of disease caused by the climate change and impact of the climate change on the most vulnerable population, strengthening collaboration with other health organizations and NGOs.

As strategies to effective action plans, I pointed out strengthening professional education on environmental health and physicians' obligation and responsibilities for the commitment, getting physicians engaged in networks and groups that can work together, and raising physicians' involvement in the development of policies to protect the health from the climate change. The participants expressed high hopes in the WMA's further commitments and leading roles as the only body representing physicians over the world.

Although governmental delegations to the UNFCCC meeting in Durban reached a consensus to extend the Kyoto Protocol and draft a universal legal agreement to be adopted and come into force by 2020, it failed to take an immediate action to save the burning planet. This slow progress gives organizations in the health sector around the world the responsibility to collaborate and strengthen their voices.

Realizing the responsibilities, at a post-conference strategy meeting, the participants agreed to establish a network among the organizations that attended the summit and work on follow-ups to promote awareness in the health sector on the health and climate change and continue to urge governments to make substantial progress in reducing greenhouse gas emissions, capitalizing on collective influences of the network. Along with political pressure, the network can step up research on co-benefits of the climate change mitigation and adaptation. Gathering momentum on the initiative, the hosting organizations plan to continue the global climate and health summit annually in parallel to the UNFCCC meeting.

Exchanging ideas and experiences with other participants representing various medical professionals, I felt the WMA needs to draft a second phase action plan for the health and climate change, if we call the adoption of the Delhi Declaration as the first phase. Organized medicine through the WMA and NMAs can effectively raise individual physician's interests and involvement in protecting health from the climate change. Collective knowledge and action can achieve far better results than separate efforts. Participating in the network is also important for the WMA to move its initiatives on the health and climate change to the next level. It will widen its horizon in drafting future plans and strengthen collectivity.

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Asia-Pacific Influenza Summit

Experts at inaugural Asia-Pacific Influenza Summit warn that annual influenza vaccination levels are too low

Bangkok, 12th June 2012 – A group of more than 200 leading international influenza experts will meet in Bangkok during 12 & 13 June for an information sharing exercise, the first of its kind for the region. Concerned about the low influenza vaccination levels in the region, the experts will discuss the need to improve awareness and implement influenza control policies to protect those at greatest risk for serious complications. They will also underscore the importance of annual influenza vaccination to control the disease and improve influenza pandemic preparedness.

Each year, approximately 5 to 10% of adults and up to 30% of children worldwide will suffer from seasonal influenza, resulting in medical visits, hospitalization and death, as well as millions of lost work and school days. It is estimated that seasonal influenza causes up to 1 million deaths annually but many of these go undiagnosed or misdiagnosed leaving the influenza that underlies other conditions unrecognized. Health authorities, scientific institutions and professional organizations worldwide undertake a variety of seasonal influenza vaccination initiatives. Despite these efforts, vaccine coverage rates vary greatly between countries and between different targeted groups.

What's more, it has been shown that robust annual influenza vaccination programs are an important foundation for pandemic vaccination capabilities, while also helping to protect against annual epidemics. "Pandemic influenza poses an ongoing threat to global public health and the Asia-Pacific region is not immune to it." – says Prof Prasert Thongcharoen, Chairman of the Influenza Foundation Thailand. "Vaccination is the best way to fight this risk. However,

vaccinating large populations during a pandemic is highly challenging and requires robust vaccine production, distribution and administration capabilities. Seasonal vaccination can provide an important foundation for this infrastructure, while also helping to protect against annual epidemics", he added.

Experts are concerned that not enough is being done to protect those most at risk for serious complications. "Vaccination levels among the Asian-Pacific population, including health care professionals, are still much too low", says Prof Jennings, Chairman of the Asia-Pacific Alliance for the Control of Influenza (APACI). "We hope the meeting will stimulate policy and advocacy approaches to improve influenza vaccine uptake in high-risk groups and healthcare workers in the region", he went on to say.

The Summit is modeled on the successful European (ESWI) and United States (CDC/AMA) Influenza Summits held in 2011. Key aims of the Summit are to review the current state of official seasonal influenza control policies in Asia-Pacific countries, and to establish collaborative relationships to promote best practices for the control of influenza. "Even though awareness of the burden of influenza on public health continues to develop in the Asia-Pacific region, there is presently no consensus on the best way to prevent and treat the disease", – added Prof Lance Jennings. "A meeting such as this one will help to ensure that policies for the use of seasonal influenza vaccines and specific treatments are in place" he also said.

APACI is leading a partnership with the Influenza Foundation of Thailand (IFT)

and the Department of Disease Control (Thailand), to present the Inaugural Asia-Pacific Influenza Summit.

Thailand is one of the countries in Asia that has developed an effective influenza control program that communicates the health and economic impacts of influenza as well as the benefits of prevention to healthcare workers and high risk groups, including children, the elderly and those with chronic diseases. However the program had not been without its challenges in particular in relation to acceptance of vaccination among healthcare workers.

Dr. Porntep Siriwanarangsun, Director General at the Department of Disease Control in the Ministry of Public Health of Thailand added: "In view of all the challenges there is no doubt that continuous studies about influenza, including policy development, are important. No one can do it alone. We need networks' and partners' collaboration to brainstorm, share experience and support each other. This summit is a perfect occasion for this and its work will serve not only Thailand, but the whole Asia-Pacific region."

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Effective Fight Against Influenza Starts in Our Daily Practice and Hospitals!



Lance Jennings

There are more than 59 million health workers worldwide and the nature of our work leaves us exposed to a complex variety of health and safety hazards every day. Yet, as our job is to care for the sick we sometimes fall into the trap of not thinking about ourselves and believing that we are “immune” to illness. We live and work by the adage that the patient comes first. However, influenza does not share this point of view. It is a risk to us as well as our patients. Furthermore, if we do not protect ourselves, then we increase the risk to our patients. So, in fact, the fight against influenza in health care settings starts with us.

According to the World Health each year, approximately 5 to 10% of adults suffer from seasonal influenza [1]. At the same time, rates of 11–59% have been reported in healthcare workers caring for infected patients [2]. What it means in clinical practice is that we can get influenza from patients and coworkers, as well as from family and other contacts outside the workplace. Some of us are also at risk of the more severe ef-

fects of influenza, such as pregnant healthcare professionals or those with underlying medical conditions. We get sick and then we pass it on!

Healthcare professionals can act as vectors for influenza viruses. Some dedicated professionals actually avoid taking sick leave thinking that they cannot stop providing support to their patients. In fact, they are also likely to pass the disease to their patients. However, influenza may be asymptomatic while still posing a transmission risk. In one study, 23% of healthcare workers tested positive for infection following a mild season, while 59% of these workers did not remember having influenza and 28% did not recall any respiratory illness [3, 4]. Therefore, as well as staying home when they are sick, health care workers need to make sure they don't get infected themselves, if they are to protect their patients.

Sickness comes first to our mind when we think about influenza. Yet, the infection has also a potentially serious impact on the health care services and related costs. In extreme cases, it forces medical centers to limit or stop admissions. This was the case described in a study where an influenza outbreak in a 19-bed internal medicine unit prevented emergency admissions for 11 days and led to the postponement of eight scheduled admissions [5].

Although influenza presents a major challenge, there is substantial evidence for its control. Vaccination is safe and the most effective way to prevent influenza [6]. The WHO estimates that vaccination can prevent 70–90% of influenza illness in healthy adults.

Several studies have also associated healthcare worker immunizations with enhanced

patient outcomes. A US study found that increases in healthcare worker vaccination from 4% to 67% were associated with significant reductions in both the relative frequency of influenza cases among staff and the proportion of hospitalized patients acquiring nosocomial infections. In this particular study, nosocomial influenza represented 32% of cases amongst the patients at the beginning of the study period and subsequently fell to 0% [7, 8].

Robust annual influenza vaccination programs are also an important foundation for pandemic vaccination capabilities. In the case of the healthcare workers, they help ensure the continuity of the health services during pandemics.

Yet, despite all this evidence, many people, including us – those involved in caring for others, the healthcare workers – do not get vaccinated.

Stakeholders around the globe are increasingly aware that in order to succeed in the fight against this disease, we need to increase the seasonal influenza vaccination levels among the general public and especially among the most vulnerable and health-care workers. This is consistent with the recent recommendations of the WHO Strategic Advisory Group of Experts as well as with the conclusions of high level influenza summits held in different regions of the world, the most recent being Asia Pacific Influenza Summit in Bangkok, which built on successful European and US summits from 2011.

As far as healthcare workers are concerned the experts advising healthcare policy makers suggest different approaches to preventing influenza and increasing vaccination levels – from the use of declination forms, to providing free or subsidized vaccines to the priority groups or more drastic measures such as mandatory vaccination. Regardless of the preferred policy approach, there seems to be one point that

resonates strongly with all experts – the need to raise awareness, communicate and educate healthcare workers on the necessity of vaccination not only for themselves but more importantly for their patients. Part of this process should also include listening to healthcare workers concerns and responding to false beliefs that might prevent them from both getting vaccinated and recommending influenza vaccination to their patients.

I have been dealing with influenza for many years now and I strongly believe that vaccination among healthcare workers is a necessary and effective way forward in fighting this disease as well for preventing and controlling future pandemics. As healthcare workers, responsible both for our own and our patients' health, we must get vaccinated.

We should also be at the forefront of raising the awareness among patients as to why influenza vaccination is the best option for them and their families as well as for the society at large.

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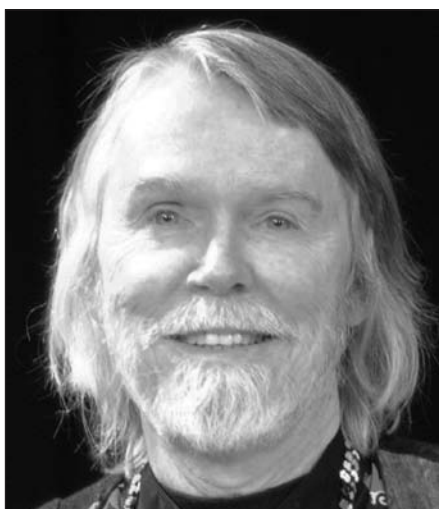
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What does Professionalism in Health Care Mean in the 21st Century?



Ames Dhai

Central to health care practice and the moral contract between the public and the profession lies professionalism and professional integrity. The purpose of health care practice



David J McQuoid-Mason

is to always care for the ailing and the sick, promote health interests and well-being and strive towards healing environments. Professionalism, which sets the standard

of what a patient should expect from his or her health care practitioner, is an ideal that should be sustained [1]. Health care practitioners are important agents through which scientific knowledge is applied to human health, thereby bridging the gap between science and society. But health care practice goes beyond just clinical or technical excellence. It is more than just knowledge about disease. It is also about experiences, feelings, and interpretations of human beings in often extraordinary moments of fear, anxiety and doubt. In this very vulnerable position, professionalism underpins the public's trust in health care practitioners [2] and professional integrity and honesty should be a measure of the extent to which the professional's reputation and credibility remains assured and untainted.

Political, social and economic factors together with advances in science and technology have reshaped attitudes and expectations of the public and health care practitioners, whose roles and professional responsibilities up till now were clear and unequivocally well understood. In addition,

several notorious failures of professionalism, including avaricious pursuits, with concomitant adverse media coverage have undermined public trust in health practice and have led to a questioning of traditional values and behaviour, challenging characteristics that were once seen as the hallmark of health practice [2]. Professional integrity can easily be tainted when the nature of the practitioner-patient relationship starts to become transactional and patients are viewed as customers and health care as a commodity. Moreover, we have progressed to an era where professional autonomy has had to give way to accountability. Perceptions of practitioners as healers have also been eroded by error and iatrogenic injury [3]. What's more, an emphasis on litigation as a tool in social justice has led to a greater level of public awareness of the harms that practitioners can be guilty of [4]. Without doubt, trust is critical to successful care and where patients cannot trust their practitioners, the quality of their care could be seriously jeopardised. It is not because practitioners have special knowledge and technologies that they should be trusted. They are trusted only if this knowledge and technology is firmly attached to values that are explicit, understood and altruistic. The principal objective of practitioners is to treat their patients well. Unfortunately, survey data over decades reveal that the level of confidence and trust that was accorded the profession several decades ago has been substantially eroded [5].

Compassion, competence and autonomy are judged to be core foundational values in the practice of health care. Understanding and concern for a person's distress is essential in this context. An extremely high degree of competence is expected and required of practitioners. This is not limited to scientific knowledge and technical skills, but also includes ethical knowledge, skills and attitudes, and an understanding of human rights and health law. As new ethical issues arise with changes in practice and its social and political environment, it is im-

portant that knowledge and skills are regularly updated and maintained in this arena. Autonomy has changed the most over time, with practitioner autonomy being moderated by governments and other authorities and patient autonomy gaining widespread acceptance [6].

The ethical and moral duties accorded to health practitioners impose an obligation of effacement of self-interest on the practitioner that distinguishes health practice from business and most other careers or forms of livelihood [7]. Pellegrino states that there are at least three things specific to health practice that have led to this position. Firstly, it is the nature of illness itself with patients being in a uniquely dependent, anxious, vulnerable and easily exploited state, being forced into a position of trusting the practitioner in a relationship of relative powerlessness. Furthermore, when practitioners offer to put knowledge at the service of the sick, they invite that trust. Hence, a health need in itself constitutes a moral claim on those equipped to help. Secondly, the knowledge gained by the practitioner is not proprietary as it is acquired through society sanctioning certain invasions of privacy, e.g. experimenting with humans and allowing for financial subsidisation of health education. The practitioner's knowledge is therefore not individually owned and should not be used primarily for personal gain, prestige or power. Finally, the oath that is taken at graduation is a public promise that the practitioner understands the gravity of her/his calling and promises to be competent and use that competence in the interests of the sick [8].

Professionalism in health practice matters just as much in the 21st century as it did at the time of Hippocrates over 2 500 years ago. It has its roots in almost all aspects of modern health care. Practitioners must accept that financial and personal gain are not all-important and need to look at other ways to think about what else matters. Moreover, social responsibility, social

conscience and a resilience to external pressures, political or otherwise, that interfere with the 'best interests' principle are more important now than ever before. Core values, principles and competencies must be reflected upon and the question of what it means to be a health care professional and what is required to claim all privileges granted by society to health professionals should be re-appraised.

The South African Journal of Bioethics and the Law has been launched to provide a forum for experts and health care practitioners to engage with their colleagues in debate about the pressing ethical and legal issues confronting the medical world during the 21st century.

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The Uniform Codes of Ethics in the Focus of Physicians and Dental Surgeons of ECOWAS after Harmonization



Kroo Florent

With the institutional support of the regional communities of the Economic Community of West African States (ECOWAS) and particularly its department responsible for health – the West African Health Organization (WAHO) – the Orders doctors in the region that regroup 15 countries including Anglophone, Francophone and Portuguese countries, started in 2008 and in 2011 resulted in the finalization of the harmonization of the codes of ethics.

While elaborating two harmonized codes, one for the French-Portuguese space and the other for the English-speaking, it has been found that the major ethical principles were similar in the respective national codes.

Differences, particularly between the English-speaking and French-Portuguese concern details; indeed, the inspiring ethical codes of France are enunciative but not limitative. The actions, even if they are not specifically detailed in the articles, are amenable to disciplinary actions if they go against the customs and practices of physicians.



Map of ECOWAS (15 countries – population around 275 million)

Managers of medical Orders, in reality pioneers, showed consensual spirit undeniable to harmonize and to finalize the 02 codes in the common area. We should pay homage to Professor Odu-sote Kayode, former director of the Department of Health and Professor Diallo Abdoulaye, current director, who have consistently demonstrated selflessness and dedication in their tasks to arrive at the conclusion of this harmonization. The difficulty for recognizing the harmonized codes could have come from Franco-Portuguese dental surgeons most of whom have separate codes of physicians while the English doctors and dental surgeons have the same code.

The political leaders of ECOWAS welcomed this advance which resulted in this harmonization, and stating that teachers in medical schools have managed to develop a common curriculum of general medical training, it was ordered to continue working at integration for attaining the WAHO objective – the realization of a unified code of ethics. This is an exciting and a more difficult challenge because the final objective is to ensure that doctors and dental surgeons both Anglo-phone and French-Lusophone recognize and incorporate the provisions of the new unified code.

The ad-hoc committee composed of Dr. Salah, Tapsoba, Abdulmumini, and Ekra and chaired by Dr. Aka Kroo Florent has a challenge. The task will be facilitated by the fact that it is based on harmonized codes that will be developed in the Uniform Code by retaining the similarities while taking into account the specific differences to be adapted.

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*The pioneers of harmonized codes with the ends and standing.
Prof. Abdoulaye Diallo left and Prof. Kayode Odu-sote right.*

Junior Doctors Network

Background

The World Medical Association (WMA) Junior Doctors Network (JDN) represents the world's first international body of junior doctors, operating under the auspices of the organization recognized as the voice of physicians worldwide. It provides junior doctors with a global forum to exchange ideas, collaborate, and conduct research relevant to issues they face in their training and career development, while providing them the opportunity to participate and contribute to the wider policy and advocacy work of the WMA.

Founded in 2010 after acceptance at the WMA General Assembly in Vancouver, the JDN's Draft Terms of Reference were subsequently accepted at the 188th Council Meeting in April 2011 in Sydney, Australia. This groundwork allowed the growth of a number of initiatives and culminated in the successful inaugural JDN meeting, held in conjunction with the 2011 WMA General Assembly in Montevideo, Uruguay.

What is the Junior Doctors Network?

The JDN is made up of junior doctors who independently join the World Medical Association as Associate Members. Any junior physician may join and participate. As the representative voice of young doctors worldwide, the JDN attracts many members who also hold leadership positions in the resident or junior doctor sections of their respective National Member Associations.

The JDN founding members were largely alumni participants from the International Federation of Medical Students' Asso-



From the left : Thorsten Hornung, Lawrence Loh, José Luiz Gomes Do Amaral, Xaviour Walker

ciations (IFMSA) alumni. Other notable founding members included junior doctors from the Korean Interns and Residents Association, Australia Medical Association Doctors-in-Training Council, Doctors-in-Training New Zealand Medical Association, American Medical Association, British Medical Association, Canadian Interns and Residents Association, Brazilian Medical Association Junior Doctors, Singapore Medical Association, and the Permanent Working Group of European Junior Doctors.

Why the Junior Doctors Network?

The JDN acts as a forum for experience sharing, policy discussions, and resource development putting focus on issues pertaining to junior doctors. Before the JDN, there was no global forum directly voicing

the concerns and views of junior doctors, interns, residents, and fellows at a global level. This left a void in representation in the middle of young physicians' continuum of training, since the interests of medical students were represented by the IFMSA, with the WMA representing physicians globally.

The development of the JDN now provides a natural progression, further developing the existing relationship between the IFMSA and the WMA. It fulfills the very important role of representing junior doctors at a global level. Recognized in official relations, the JDN also supports the IFMSA by strengthening the recruitment and development of the IFMSA alumni network. Finally, the JDN offers participants an opportunity to make an impact and to contribute to the many levels of global health via policy change at the WMA and with the WMA's partner organizations, such as the WHO.

Defined functions and objectives

The Junior Doctor Network has the following functions and objectives:

1. Participate, advocate, and consult with Constituent and Associate members of the WMA on issues of interest to junior doctors.
2. Collaborate with Constituent and Associate members of the WMA and other stakeholders to increase the number of junior doctors registered as Associate members of the WMA.
3. Develop reference materials on issues of interest to junior doctors, including (but not limited to) literature reviews, surveys, reports, and policy papers.
4. Communicate information on emerging issues of interest to junior doctors internationally, in collaboration with the National Medical Associations of the WMA and other stakeholders.
5. Organize professional development activities and develop resources for junior doctors
6. Coordinate and disseminate information on global health research and clinical elective opportunities and resources for junior doctors worldwide.
7. Develop and implement relevant junior-doctor led projects and programs.

Current projects and work

The JDN identified social media as an initial area of interest and expertise among junior doctors, and one of the first projects undertaken was the development of a white paper to provide additional scientific detail for the WMA Policy on the Professional and Ethical Use of Social Media. Subsequent projects are focused on other issues of concern to junior doctors and trainees, and include reviews of physician well-being and the ethical considerations surrounding global health training. The JDN also works in concert with other WMA workgroups on identified issues of

interest to its members, such as the current WMA workgroup on the ethics of physician strikes.

The JDN members participate as representatives of the WMA at a number of high profile conferences worldwide as well. Members of the JDN have been actively involved in working with the WMA team at the World Health Assembly and other conferences such as a recent patient centered conference in Geneva, Switzerland.

Where to from here?

The JDN continues to grow and adapt to the increasing interest and commitment from members all over the world. The organization is presently undergoing a structural review to improve its capacity and workflow as the network grows. An important structural change concerns focusing on regional growth, particularly related to the WMA meeting venues in different continents. The

JDN hopes to support the development of a website, as well as electronic resources and virtual participation for its members. The JDN also hopes to inspire and support the growth of new national junior doctor bodies as part of national medical associations, to ensure that those residents, interns, and trainees have a voice during this critical phase in their career. Recently the JDN was identified as a potential resource for two new junior doctor bodies in the Asian region.

The JDN is working hard to develop sustainable structures prior to the WMA October General Assembly in Bangkok, where the current committee is targeting to increase the involvement and contribution level of Asian junior doctors to wider activities of the WMA.

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The Position of the Romanian College of Physicians Regarding the Attempts to Violate the Professional Independence of Doctors

Over the past weeks, we have witnessed the intimidation of two prestigious Romanian doctors, who were heard for 7 hours at the National Anticorruption Directorate (DNA), regarding the interception of the dialogue between the doctors and the patient's family. At the same time, the patient's diagnosis was made public and the whole case had unallowable media coverage.

The context

The background of this national situation relates to the case of the former Prime Minister of Romania, Adrian Năstase, and his suicide attempt. Mr. Năstase was sentenced to two years in prison (after 8 years of trial).

On the night the Police came to his house to arrest him, the former Prime Minister tried to commit suicide by firing a bullet into his head. To prevent it, one of the policemen grabbed his hand and the bullet passed through his neck. He was taken to Floreasca Hospital where he was hospitalized.

Doctors' intervention in the case

The next day, both Dr. Șerban Brădisteanu (cardiologist at Floreasca Hospital and the performer of the first human heart transplant in Romania), and professor Ioan Lascar (famous surgeon and Chairman of the Bucharest College of Physicians) were part of the multidisciplinary team that operated on Mr. Năstase after his suicide attempt.

The leader of the surgical team Dr. Bradisteanu said after the surgery that the patient is under medical treatment and psychologi-

cal counseling at Floreasca Hospital, presenting a high heart attack risk. The doctors said that the former Prime Minister needed 14 days of hospitalization.

Dr. Bradisteanu was intercepted by the DNA while telling to the patient's family that he was in a good condition. The doctor is suspected of covering up the real condition of Adrian Năstase and of emphasizing it for the media and for the public opinion. Giving the context, the state institutions accused the doctors that they kept Mr. Năstase in Floreasca longer than it was needed. They wanted to transfer him to the penitentiary immediately after the surgery. Mr. Năstase remained in Floreasca Hospital only 4 days.

In this case, the doctors who provided him medical assistance were summoned to the DNA. Thus, the DNA started the prosecution against Dr. Șerban Bradisteanu because of the absence of a medical expertise with a conclusion on the real state of health of Mr. Năstase. Furthermore, Prof. Dr. Ioan Lascar, Chairman of the Bucharest College of Physicians, was summoned to be a witness in this case.

On the second day after the admission to the hospital, MEP Monica Macovei said publicly that she did not trust the diagnosis because Dr. Bradisteanu is a former PSD senator. Also, Prosecutor General Codruta Kovesi voiced suspicions concerning the diagnosis made by the doctors. One day before the experts of the Institute of Legal Medicine made their expertise, the doctors from Floreasca were forced to sign the release of Adrian Năstase, so that he could be moved to the penitentiary at 11 p.m. This is

the most clear-cut case in which the doctors are intimidated and threatened by the DNA, but it is not the only one.

Official position of the Romanian College of Physicians

The Romanian College of Physicians draws attention to the extremely severe situation of the medical professionals whose independence is affected by the national investigating committees.

In doing so, the investigators impose to the medical professionals an illegal attitude, unconformable with the doctor's role in society. The violent action, extensively propagated through the media, does anything but passes to the physicians the message that whenever a medical act in the authorities' view might have an impact on public interests, the respective doctor is likely to be summoned and stigmatized.

In this particular case, the patient's rights were infringed, the physician-patient-family confidentiality relationship (according to the law on patients' rights) was violated. The diagnostic communication and the dialogue between the doctor and the patient or his family, without the consent of the patient, violate the privacy stipulated by law.

All these happenings constitute serious violations of human rights.

It has become a practice in Romania that "incommodious" doctors are threatened with criminal cases. The Romanian doctors consider that such practices are unacceptable in a European country. Therefore, the Romanian College of Physicians requested the Superior Council of Magistracy to begin an investigation in the matter.

Luminița Vâlcea
Romanian College of Physicians

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