

World Medical Journal



Official Journal of The World Medical Association, Inc.

Nr. 2, August 2018

vol. 64

Contents

Editorial	1
209th WMA Council Session	2
WMA Council Resolution on the Prohibition of Nuclear Weapons	13
End of Life Seminars	13
Junior Doctors Meeting	14
World Health Professions Alliance Regulation Conference 2018	15
World Health Assembly Side Events – May 2018	18
Intellectual Property: who owns the right to good health?	20
Physicians’ Role in the Management and Leadership of Health Care	22
Policy Analysis Ottawa Declaration on Child Health	25
CMA Thousand Talents Cultivation Program for County Hospitals	28
Universal Medical Esperanto Association	30
Competence Drift in Professional Practice: a Psychological Perspective	33
Workforce of Healthcare Professionals in Rural Nigeria	36
International Congress on Medical Ethics, a Risk Worth Taking?	38
Multi-Media Educational Tool Created to Help Children Cope with Cancer	40

World Medical Association Officers, Chairpersons and Officials

Dr. Yoshitake YOKOKURA

WMA President
Japan Medical Association
2-28-16 Honkomagome
113-8621 Bunkyo-ku,
Tokyo, Japan

Dr. Ketan DESAI

WMA Immediate Past-President
Indian Medical Association
Indraprastha Marg
110 002 New Delhi
India

Dr. Leonid EIDELMAN

WMA President-Elect
Israeli Medical Association
2 Twin Towers, 35 Jabotinsky St.,
P.O. Box 3566
52136 Ramat-Gan
Israel

Dr. Ardis D. HOVEN

WMA Chairperson of Council
American Medical Association
AMA Plaza, 330 N. Wabash,
Suite 39300
60611-5885 Chicago, Illinois
United States

Dr. René HÉMAN

WMA Chairperson of the Finance
and Planning Committee
P.O. Box 20051
3502 LB, Utrecht
Netherlands

Dr. Joseph HEYMAN

WMA Chairperson
of the Associate Members
163 Middle Street
West Newbury, Massachusetts 01985
United States

Dr. Heidi STENSMYREN

WMA Chairperson of the Medical
Ethics Committee
Swedish Medical Association
(Villagatan 5) P.O. Box 5610
SE - 114 86 Stockholm
Sweden

Dr. Otmar KLOIBER

Secretary General
World Medical Association
13 chemin du Levant
01212 Ferney-Voltaire
France

**Prof. Dr. Frank Ulrich
MONTGOMERY**

WMA Vice-Chairperson of Council
Bundesärztekammer
Herbert-Lewin-Platz 1 (Wegelystrasse)
10623 Berlin
Germany

Dr. Andrew DEARDEN

WMA Treasurer
British Medical Association
BMA House, Tavistock Square
London WC1H 9JP
United Kingdom

Dr. Miguel Roberto JORGE

WMA Chairperson of the Socio-
Medical Affairs Committee
Brazilian Medical Association
Rua-Sao Carlos do Pinhal 324,
CEP-01333-903 Sao Paulo-SP
Brazil

www.wma.net

Official Journal of The World Medical Association

Editor in Chief

Dr. Pēteris Apinis, Latvian Medical Association, Skolas iela 3, Riga, Latvia
Phone +371 67 220 661
peteris@arstubiedriba.lv, editorin-chief@wma.net

Co-Editor

Prof. Dr. med. Elmar Doppelfeld, Deutscher Ärzte-Verlag, Dieselstr. 2, D-50859 Köln, Germany

Assistant Editor

Maira Sudraba, Velta Pozņaka; lma@arstubiedriba.lv

Journal design by

Pēteris Gricenko

Layout and Artwork

The Latvian Medical Publisher, "Medicīnas apgāds", President Dr. Maija Šetlere, Skolas street 3, Riga, Latvia

Publisher

The Latvian Medical Association, "Latvijas Ārstu biedriba",
Skolas street 3, Riga, Latvia.

ISSN: 2256-0580



Opinions expressed in this journal – especially those in authored contributions – do not necessarily reflect WMA policy or positions

Editorial

Regular reviewing of rigid assumptions is the prime task of the 21st century medicine. Undoubtedly, first and foremost it refers to medications and it is vital to assess anew whether the particular medication is appropriate for the specific illness or syndrome or the risks might exceed the expected result; is it really so that polypragmasia – administration of 6–10 medications to a patient at the same time – is the best practice for concurrent treatment of several diseases.

It would be purposeful to revise the indications of any medication at least once in ten years. It would be even better if it were done without involving the pharmaceutical industry. It should be investigated on what grounds using of a certain medication or applying some diagnostic or manipulative treatment has been refused now. Quite often it is because a new, more effective medication has entered the market, but we are unaware of its real side effects and long-term impact in a ten year period.

Treatment is vital, however, not the most important part of health care – there is also prevention, diagnostics, treatment and rehabilitation. Still, treatment includes not only the use of medications, but also physical medicine (heat, electricity), surgery, psychotherapeutic treatment, radiation therapy and non-traditional methods of treatment.

During the last 30 years the role of physical therapy and surgery has diminished due to new medications.

It would also be wise to reconsider an evidence-based opinion that has been formulated as a result of serious research. For example, anti-bacterial therapy was developed on the basis of definite findings and it treated easily different infectious diseases. Today, when we understand that the microbiome is an important part of human physiology and how it is damaged by antibacterial therapy, it is sensible to review our considerations about treating not so serious and also very serious infectious diseases.

It is time to review the physician–pharmacist relationship on a global scale. There is a strong tendency in the world to associate medicine with doctors, but the pharmaceutical industry – with pharmacists

and druggists. Doctors are often blamed publicly as soon as anything has been done wrong either by the nurse or nurse assistant or hospital registrar. Pharmacists are made responsible for medications being expensive, for prescribing them too much and that quite often medicine seems to be an appendix to the pharmaceutical industry.

Civil service and politics have largely promoted pharmacy to take the lead position on a global scale. Under the auspices of civil service the usage of medications is focused on in guidelines, recommendations and funded health care. There is extensive and fruitful research worldwide about the beneficial effect of movement (walks, trainings) on the progress in treatment, but in the prepared documents it is substituted by bed regime and a handful of tablets because politicians and financiers are unable to calculate the costs of indirect care, treatment of psychosomatic disorders, holistic treatment (and even more incapable of calculating the cost of non-conventional medicine).

Politicians and civil servants are incapable of understanding science; they cannot perceive man as a whole and they demand to treat a specific illness, not a patient, moreover, they demand to treat, but not to heal. Globalization associates with the consumer philosophy which propagates two slogans – “the more medications, the better your health” and “expensive medicine is better than cheap medicine”. The consumer philosophy leads to the situation when a sick man is equated with a broken car. The greatest lobbyists of the consumer philosophy are rich people – politicians and civil servants as they always manage to get public or insurance funds to pay for the health care services they have received.

Thus, polypragmasia and bureaucracy poison medicine globally. The only remedy against this policy and red-tapism is regular revising of the long-standing assumptions. The World Medical Association is the structure which is capable of undertaking the leadership in these activities and, moreover, it will be obliged to do it.

*Dr. med. b. c. Peteris Apinis,
Editor-in-Chief of the World Medical Journal,
President of the Latvian Medical Association*

209th WMA Council Session, 26–28 April, 2018, Riga

The 209th WMA Council meeting was held at the Radisson Blu Latvija Conference & Spa Hotel from April 26–28 in the year of Latvia's 100th anniversary. Around 150 delegates from 40 national medical associations attended.

THURSDAY APRIL 26

Council

The proceedings were opened by Dr. Ardis Hoven, Chair of the WMA, who thanked the Latvian Medical Association for their hospitality. She spoke about the importance of everybody participating in the meeting and listening to one another.

President's Report

Dr. Yoshitake Yokokura, in his Presidential report, reported on his activities in the past six months and his mission to advance the initiative of Universal Health Coverage (UHC), as well as to strengthen health systems around the world. He referred to the various meetings he had attended. These included the 2017 Global Health Forum in November 2017 hosted by the Taiwan Health Ministry and Foreign Affairs, and the UHC Forum 2017 held in Tokyo in December organized by the Japanese Government, World Bank, United Nations, WHO and UNICEF. One of the highlights of the latter meeting was the agreement between the WMA and WHO to agree an official Memorandum of Understanding on collaboration for establishing the UHC on a global level and for the strengthening of disaster preparedness. This Memorandum was signed in Geneva on April 5 and he believed this agree-

ment was a milestone and would further enhance the presence of the WMA in the global community.

Secretary General's Report

Dr. Otmar Kloiber, Secretary General, tabled a detailed written report, setting out the Secretariat's activities since the last meeting. In his oral report he said that since the Chicago Assembly further end of life seminars had been held at the Vatican in Rome and in Abuja, Nigeria, and a session with the Arab Medical Union had been addressed by Dr. Hoven.

Chair's Report

Dr. Ardis Hoven, in her written report for Council, mentioned that in writing a foreword on Women's Health in Global Perspective, she was reminded of the barriers to health care and clinical needs that constituted threats to adequate health care for women. With increasing migrant streams caused by war, climate change and economic disruption, women had become targets of abuse, violence and deprivation. She said gender based health disparities intensified the need for the WMA's role in the Social Determinants of Health globally.

"As leaders in medicine, we have the opportunity and the responsibility to lay aside our politics and concentrate on the needs of patients and our health care colleagues. As we enjoy the hospitality of Riga, I encourage honest dialogue around what we might consider difficult topics. Respect for, and encouraging, the minority opinion will be very desirable. We are diverse in many ways and we must celebrate that diversity".

Emergency Resolution

An emergency resolution on nuclear weapons was submitted for debate by the Japan Medical Association and the International Physicians for the Prevention of Nuclear War. The Council agreed that this should be considered by the Socio Medical Affairs Committee.

The Council meeting was adjourned.

Finance and Planning Committee

Dr. René Héman (Netherlands) took the chair.

Financial Statements for 2016 and 2017

Dr. Andrew Dearden, the Treasurer, gave an oral report on the Association's financial accounts and interim statement. He said there were no surprises, but several very good messages. They had finished 2017 with a surplus, their equity was good, expenses were well regulated and membership dues had increased. These achievements allowed the Association to increase workload as necessary. In short, the Association's finances were in a good position.

The committee recommended that the Council approve the interim Financial Statement for 2017, as well as the report on Membership Dues Payments for 2018

WMA Strategic Plan

Dr. Kloiber gave an oral report on the Association's draft Strategic Plan, explaining that it was being separated into two parts – one reflecting the principles upon which the plan was based and a second part articulating an action plan. The revised draft would be reported to the Council in October in Reykjavik.



WMA Statutory Meetings

The Committee considered arrangements for future WMA Statutory Meetings and heard about offers from three Constituent Members to host the 2020 General Assembly – the Rwanda Medical Association to host in Kigali, the British Medical Association to host in London and the Consejo General de Colegios Médicos de España to host in Cordova.

The Conseil National de l'Ordre des Médecins (France) also presented an invitation to host the 2022 Council Session in Paris.

The Committee recommended to Council that the 218th Council session be held from 22–24 April 2021, that the 72nd General Assembly be held from 13–16 October 2021 and that the 221st Council session be held from 7–9 April 2022.

It recommended that the invitations from Rwanda, the UK, and Spain be postponed to the next Council session in Reykjavik and that the invitation from CNOM France for Paris to host the 221st Council Session in April 2022 be accepted.

WMA Special Meetings

The Committee received an oral report from the Secretary General, about several forthcoming events:

- Ethics Conference, Reykjavik, 2–4 October 2018: This year's scientific session at the General Assembly would be integrated on the second day of the three-day Ethics conference and this could be a model for future meetings. Dr. Snædal (Iceland) said the programme would include the Declaration of Helsinki, the Declaration of Lisbon, the Declaration of Taipei and other core WMA policies. External participants would be invited to join the discussions.
- UNESCO World conference: This meeting would be held in Israel, 27–29 November 2018.

- World Health Assembly, 21–26 May 2018. The WMA was planning multiple side events during the WHA.
- The World Health Professions Alliance Regulation conference would be held before the WHA, 19–20 May 2018 in Geneva.

Associate Membership

Dr. Joe Heyman, Chair of the Associate Members, said that at the end their meeting in Chicago, 85 members had joined a Google group set up to debate online draft policy documents. He told the committee that they now had around 200 members in what had become a very active group.

Dr. Kloiber thanked Dr. Heyman for his efforts managing the online group. He said it was a very lively group, involved in a very high quality discussion about draft policies.

Junior Doctors Network

Dr. Caline Mattar, Chair of the Junior Doctors Network, reported on the group's work on antimicrobial resistance, UHC and health workers. They had held a one-day meeting in Latvia that included a capacity building and a leadership workshop attended by some NMAs.

In her written report, she said that there was now an active group of junior doctors in Latin America and new members from the Eastern Mediterranean were joining the Network.

Past Presidents and Chairs of Council Network

Dr. Jon Snædal (Iceland) gave a report on the group's activities. He thought the title of the group was rather cumbersome and suggested that perhaps it might be renamed the Senate or the House of Lords of the WMA! He told the committee that the group had started en-

gaging in the dialogue related to the 40th anniversary of Alma-Ata Declaration.

Governance Review

Dr. Mark Porter, Chair of the Review Committee, gave an oral report. He reminded delegates that the committee had been set up to receive and review proposals for new business and to assist in considering items for consideration. The committee had made a good start in helping to improve Council business.

Nominating Process

A proposal to introduce a self-declaration statement to the nominating process for WMA Presidency was discussed. It was explained that this would be an additional layer of governance.

The Committee agreed to recommend that the proposal should be circulated for comment.

World Medical Journal

In his written report, the editor in chief of the Journal, Dr. Peteris Apinis, said the Journal turned 64 this year and much had changed during this time. He thanked those who had assisted him since he took over the editorship in 2008. He said the Journal was essentially a newsletter meant for the leaders of medical associations all over the world, to inform them about key events, documents, movements and the direction in which the WMA was going. The Journal was published four times a year and for the past two years had also been publishing in digital form, with printed copies going to the world's leading libraries.

Public Relations

The Committee was told that after the General Assembly in Chicago last year, there was very strong international publicity, including

on social media, generated by the revision of the Declaration of Geneva and its immediate publication in the Journal of the American Medical Association. Ms Magda Mihaila, WMA Communications and Information Manager, was now coordinating social media on Twitter and Facebook. There had been a highly successful social media campaign during the early part of 2018 in support of the arrested Turkish doctors.

Socio Medical Affairs Committee

Dr. Miguel Roberto Jorge (Brazil) took the chair.

Health and Migration

Dr. Poonam Dhavan, Migration Health Programme Coordinator at the International Organisation for Migration, gave an oral report about the work of her organisation. She emphasized the critical role of health for migrant populations and referred to the increasing development of international policies on migration. She spoke about the importance of the role of health professionals in providing care to all migrants in need, in line with medical ethics principles. She concluded by expressing her organisation's aspiration to collaborate with the WMA in the area of health and migration.

Monitoring Report

Dr. Kloiber reported on the new Memorandum of Understanding between the WMA and the World Health Organisation signed in April between Dr. Tedros Adhanom Ghebreyesus, WHO Director-General, and WMA President Dr. Yoshitake Yokokura. The Memorandum identified four areas for the organisations to focus on – fostering the development of Universal Health Coverage with specific attention on the role of physicians, strengthening the world health workforce, inequalities in health and emergency

preparedness. Dr. Kloiber said that as a result of the agreement the WMA would have to deliver more on how physicians were involved in these processes. One example was the situation facing African countries of doctors being imported from Cuba. He said he had already started by bringing together various NMAs to discuss this issue.

Health and Environment

The Co-Chair of the Environment Caucus, Dr. Lujain Al-Qodmani (Kuwait), reported on the meeting the Caucus had held the previous day. It had discussed the opportunity to review and analyze the WMA's existing environmental policies to make them more concise, coherent and current and had decided to set up an informal working group to look at those policies and make recommendations to the Council. The Caucus had also agreed to set up a green mailing list to facilitate and promote exchange of information within the WMA membership on issues related specifically to health and the environment. The list would be open to any NMA members and interested Associate members.

Plastic Bags, Ecological Issues & Environmental Degradation

The Committee considered a proposed revision of the WMA Statement on Environmental Degradation and Sound Management of Chemicals, originally submitted by the Latvian Medical Association. It was argued that the current policy should be widened to include plastic pollution.

The Committee agreed to recommend that the draft revision should be circulated to constituent members for comment.

Medical Tourism

The committee considered the proposed WMA Statement on Medical Tourism.

Delegates were reminded that the paper was first brought to the committee two years ago by the Israel Medical Association. Concerns were raised then about parts of the document and the new proposed Statement was a revised version, taking into account those concerns. The argument of the Israeli Medical Association was that at the moment this activity was going on and the WMA did not have a firm policy or any regulations.

During the debate that followed, several members expressed continuing concerns about the definition of medical tourism and thought that the word "tourism" suggested something leisurely, when, what it was really about was cross border medical treatment. Delegates agreed several amendments. One called on governments to consider all the implications of medical tourism to the healthcare system of a country by developing comprehensive, coordinated national protocols and legislation. Another, relating to confidentiality, made it clear that interpreters, and other administrative staff with access to health information of the medical tourist should sign confidentiality agreements.

The committee recommended that the proposed Statement, as amended, be approved by the Council and forwarded to the General Assembly for adoption.

Gender Equality in Medicine

The Israel Medical Association submitted a revised Statement on Women in Medicine. An earlier draft had been debated, amended and circulated among members for comment. The committee was told that the revised paper attempted to bring together physicians from different parts of the world, with different cultures and different work environments. An attempt had been made to address all the concerns raised. The challenge was that in one part of the world, particularly northern Europe, they were

dealing with a quite equal society, where it might be problematic to talk about special concerns for women. However, there were other parts of the world where there was no equality in the medical workplace and no equal opportunities. These countries needed more protection to encourage employers to allow women to achieve their true potential in medicine.

A lengthy debate followed, with several amendments being put forward and debated. The committee agreed to change the title of the document from “Women in Medicine” to “Gender Equality in Medicine”.

The issues of flexible working hours and work-life balance were debated. One proposal, to encourage employers to ensure women were able to access all their rights and entitlements, and to ensure that men had equal opportunities to take parental leave, was rejected.

Delegates debated whether or not to include a reference to female physicians facing significant levels of mental illness and suicide. Some delegates questioned the accuracy of the reference, and many speakers said that suicide and mental illness affected both women and men. The committee decided to omit any reference to this issue.

The committee then approved the whole document as amended.

Professional Autonomy of Physicians

Clarisse Delorme, the WMA’s Advocacy Adviser, explained that as part of the Association’s annual policy review process, the Council had decided that the *Statement on Professional Responsibility for standards of Medical Care* be rescinded and archived, and that the Declaration of *Seoul* on Professional Autonomy and Clinical Independence and the Declaration of *Madrid* on Professionally-led Regulation be merged in a single document. Sections could then be

incorporated into that merged document from the *Statement on Professional Responsibility for standards of Medical Care*. However, the Council later reversed its decision and decided that the Declarations of Seoul and Madrid be kept separate and revised individually to incorporate the relevant missing sections from the *Statement on Professional Responsibility for standards of Medical Care*, which would then be rescinded and archived.

During a debate on the Declaration of Seoul, the issue was raised of other professions, particularly in Africa, moving into areas traditionally undertaken by physicians. It was argued that the document did not satisfactorily address this. Dr. Kloiber responded by saying that other professions were in fact trying to occupy parts of the physician’s traditional scope of practice. In some places there might be a good reason for this, but in general it was a problem. There was a big problem in different health care systems with the density of health professions. There were parts of the world where there was no physician and patients had to rely on health care workers or nurses. Dr. Kloiber said current WMA documents did not address this situation and he had been asked by the Executive Committee to look into this issue and build alliances with other groups, such as WoNCA.

The committee went on to recommend to the Council that the revised Declaration of Seoul be approved and forwarded to the Assembly for adoption.

Declaration of Madrid on Professionally-led Regulation

The committee then considered the revised Declaration of Madrid on Professionally-led Regulation. Members pointed out that many countries no longer had professionally-led regulation, having moved to statutory regulation. However, it was pointed out that in a recent WMA survey of members, it was

shown that 46 countries had professionally-led regulation.

After a brief debate the committee decided to recommend to the Council that the revised Declaration be recirculated among members for comment.

Sustainable Development

The Japan Medical Association introduced a proposed Statement on Sustainable Development. It was explained that two years ago it had been decided to set up a working group on sustainable development with the mandate to develop a proposal for a WMA policy on the topic and to define a proposed strategy for sustainable development at international and national level. The Council meeting in Chicago decided to circulate the document among members for comments.

The committee recommended that the revised Statement be approved and forwarded to the Assembly for adoption.

Avian and Pandemic Influenza

A proposed revision of the WMA Statement on Avian and Pandemic Influenza was considered. Delegates were reminded it had been decided that this Statement should undergo a minor revision under the 10-year review process. Concerns had been raised about the scientific content of an early revision of the document. Those concerns had now been addressed. The committee agreed to amend the document to say that a new pandemic virus could develop if a human became simultaneously infected with avian and human influenza viruses, resulting in gene swapping and a new virus strain for which there may be no immunity.

The committee recommended that the whole document as amended should be approved by the Council and forwarded to the Assembly for adoption.

Nuclear Weapons

A revised Statement on Nuclear Weapons was presented jointly by the Japan Medical Association and the International Physicians for the Prevention of Nuclear War.

Dr. Bjørn Hilt, chair of board of the IPPNW, said there were two important amendments to the previous WMA Statement on nuclear weapons. The first was the so-called modernization of nuclear weapons. Nuclear weapon states wanted to use a perverse amount of money to modernize their nuclear arsenals. They wanted to use trillions of US dollars, pounds and roubles to modernize their nuclear weapons and to keep them for infinity. This meant making these weapons more usable and this was very dangerous and disturbing.

The other amendment was that 122 UN members on July 7 last year adopted the text of the Treaty on Nuclear Weapons. The secretariat of the WMA, ICN and IPPNW had published a joint statement in September. But to make this statement the official policy of the WMA it needed the approval of the Council. They had a common interest to use this new window of opportunity of the Treaty to educate the public and for WMA members to put pressure on their own governments.

He said that critics of the Treaty argued that the Treaty as such would not eliminate a single nuclear weapon. But once the Treaty had been ratified by 50 states it would enter into force and become international law. That would strengthen the legal and moral pressure on nuclear states to fulfil their existing obligations according to the non-proliferation Treaty to negotiate for the elimination of all nuclear weapons. Dr. Hilt said they could still prevent another catastrophe of nuclear weapons happening.

Delegates agreed several minor amendments to the Statement and the committee agreed to recommend to the Council that

the Statement be forwarded to the General Assembly for adoption.

The committee also agreed the emergency resolution on nuclear weapons and recommended to the Council that it be approved.

Maternal and Child Health

The Japanese Medical Association presented a proposed Statement on the Development and Promotion of a Maternal and Child Health Handbook. The Statement was based on a booklet developed by the Japanese Medical Association in 1948. The committee was told that the booklet had contributed to improved health for the mother and child in Japan. Today there were 40 different versions of the handbook in various countries. There was also an electronic format. The Japanese Medical Association said the WMA should be collaborating on this with the WHO, and NMAs should help in developing and promoting the handbook globally.

The Committee agreed to recommend to Council that the booklet be circulated to constituent members for comment.

Pseudoscience

A proposed Declaration on Pseudoscience, Pseudotherapies, intrusion and sects in the field of health was submitted by the Spanish Medical Association. It argued that there was concern over the proliferation of these practices with their negative consequences. There was a whole group of disciplines of pseudo practices intruding on the medical profession and trying to trespass on the scope of conventional scientific based medicine. But in most countries there was no regulatory framework.

The committee recommended that the document be circulated to constituent members for comment.

Latvian Reception

During an evening reception, hosted by the Latvian Medical Association for all WMA delegates, Dr. Ilze Aizsilniece, Vice President of the LVA, welcomed the WMA, and talking about the changing weather in Riga and the change in democracy that had occurred in her country.

'Nuclear weapons, detention of medical doctors for expressing publicly their concerns about the impact of war on humans' health, autonomy of the medical profession, the way the research is conducted: these are only a few of problems discussed during the 209th Council of the WMA.

'Maybe someone will say that medical doctors should not be concerned about such matters, they should only focus on clinical practice and research. I want to oppose.

'I lived in a country where travel to another country was a dream. We needed special permission from authorities to cross the border. Only books approved by the authorities were available. Reading other books was a very dangerous. I lived in a country where people not agreeing with the system were imprisoned in psychiatric hospitals. Can you be a good medical doctor in such situation? Can you follow the principles of medical ethics in such circumstances? I doubt it.

'I would like to take this opportunity to thank the World Medical Association for the courage to tackle inconvenient topics, to take action in support of the national medical associations, to discuss internationally the problems related to environment and other factors affecting human health.

'I do believe that working together we can make this planet peaceful and healthy. Thank you for the work you are doing every day at the national and international level'



FRIDAY APRIL 28

Socio Medical Affairs Committee (continued)

Classification of Documents

Nine policies that were 10 years old were considered for review:

- The Committee recommended that the following documents should undergo a major revision:
- Resolution on the Access of Women and Children to Health Care and the Role of Women in the Medical Profession
- Statement on Reducing Dietary Sodium Intake
- Statement on Resistance to Antimicrobial Drugs
- Statement on Violence and Health
- The following Statements should undergo a minor revision
- Resolution on Collaboration Between Human and Veterinary Medicine
- Statement on Reducing the Global Burden of Mercury
- The following documents should be rescinded
- Resolution on Poppies for Medicine Project for Afghanistan
- Resolution on Economic Crisis: Implications for Health
- The following policy should be reaffirmed
- Resolution Supporting the Ottawa Convention on the Prohibition of the Use, Stockpiling, Production, and Transfer of Anti-Personnel Mines and on Their Destruction

Disaster Preparedness

The Japanese Medical Association submitted a paper on disaster medicine and raised the issue of whether the WMA should establish a network for disaster medicine.

The paper argued that the time had come for WMA to establish such a disaster-response and assistance scheme on the global level. This would involve the WMA in bringing together UN agencies, international organizations, governments, military forces, NGOs and others to work for disaster relief in a bilateral manner. Medical association members in each country would actively participate in such a network.

The Committee agreed to recommend that the proposal to set up a WMA Network on Disaster Medicine be approved by Council and forwarded to the General Assembly for adoption.

Artificial Intelligence

The American Medical Association presented a white paper on Artificial/Augmented Intelligence and Considerations for Use of Health Care. The paper asked how the WMA should position itself on this issue. Computing power had a broad impact in many areas of life and would have a great impact on medicine. This could be positive, but there needed to be a dialogue with other stakeholders. Clinical decision making could be enhanced by this, not replaced by it. However, there were downsides, for instance on liability issues and protection of health data. The AMA said it would be discussing this topic at its meeting in June and might return with proposals at a future WMA meeting.

Autonomy of Doctor's work

The Finnish Medical Association made a presentation to the Committee on ethical guidelines it had drawn up to support doctors acting in unclear situations. The guidelines were thought necessary because it was felt that professional autonomy was not clear to all doctors and particularly to junior doctors. Yet the pressure on the profession was very strong, from politicians, the

media, patients and the pharmaceutical industry. So the Finnish Medical Association had collected what it called "10 Commandments" from WMA policy documents and its own policies to help doctors understand what their obligations were.

Medical Ethics Committee

Dr. Heidi Stensmyren (Sweden) took the chair.

Dr. Kloiber, the Secretary General, highlighted two important emerging issues that impacted on the medical profession. The first was artificial/augmented intelligence. In many countries ethical questions were being discussed. The WMA needed to have an ethical position on this and would be helped by knowing more about what NMAs were doing in this area.

The second issue was nano-technology, where more questions were being asked. It was being widely introduced in many areas of our lives, and regulatory authorities with whom the WMA worked were already working on these issues. This would have regulatory consequence and there would be ethical ramifications. The WMA should look into this and he invited NMAs to share their work with the Association.

Finally, he said that the Pontifical Academy for Life had issued a White Paper on Global Palliative Care Advocacy, and the WMA had been invited to participate in this process.

Turkey

The Committee heard a report on the situation in Turkey and, in particular, how it affected the Turkish Medical Association. They were reminded that the Turkish Medical Association had no ties to any Government bodies and received no financial support from Government. It had authority to

take disciplinary action over violations of professional conduct and was on the side of prioritising disadvantaged groups and the oppressed. It also tried to keep channels of dialogue open with the government. On January 24, after Turkish armed forces started a military campaign in Afrin, the Turkish Medical Association had issued a press release saying that war was a public health problem. After this press release, Turkish authorities accused the TMA of assisting terrorists. A criminal complaint was filed against TMA leaders for making propaganda in favour of a terrorist organisation. The Ministry of Health filed another law suit saying that the TMA engaged in activities incompatible with its mandate. Central committee members of the TMA were then detained for a week. Delegates were told that the TMA had fulfilled the professional duty of physicians and the WMA and NMAs around world had responded in support.

Dr. Kloiber said the WMA had organised a highly successful social media campaign in defence of the TMA.

Istanbul Protocol

Clarisse Delorme, WMA Advocacy Advisor, reported that the WMA had been invited to participate in the development of a supplement to the Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, commonly called the Istanbul Protocol.

Therapeutic Abortion

As part of the annual policy review process, the Committee continued its revision of the WMA Declaration on Therapeutic Abortion. It considered a draft document that had been circulated among members, and received an oral report from the workgroup set up to work on the document.

In the debate that followed it was argued that it should be made clear in the preamble what this document was not about. It was proposed that the following wording be added: "This Declaration does not include or imply any views on termination of pregnancy carried out for any reason other than medical indication". This wording was approved.

It was also suggested that the document should be renamed WMA Statement on Medically-Indicated Termination of Pregnancy. This was also approved.

After a further debate, during which other amendments were approved, the Committee recommended that the Statement, as amended, be approved by Council and forwarded to the General Assembly for adoption.

Ethics of Telemedicine

The revised *WMA Statement on the Ethics of Telemedicine* was considered. *It had been agreed that the document should* undergo a major revision and the South African Medical Association volunteered to undertake that work. The document before the committee explained that telemedicine was the practice of medicine over a distance, in which interventions, diagnoses, therapeutic decisions, and subsequent treatment recommendations were based on patient data, documents and other information transmitted through telecommunication systems. The committee was told that the document addressed a number of issues, including cross border regulation. However, the Statement as revised still highlighted the importance of face to face medicine and doctors' autonomy in their responsibilities in telemedicine.

A brief debate followed about the phrase in the document that "the patient-physician relationship must be based on a prior personal examination". The committee agreed

that this should be amended, along with other changes.

The committee then recommended that the proposed Statement, as amended, be approved by the Council and forwarded to the General Assembly for adoption.

Fleeing Physicians

The committee considered the proposed revision of the WMA Statement on Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences. During the debate that followed, a number of questions were raised. It was explained that this document was about physicians fleeing prosecution. But what was meant by serious offences? Some people talked about serious allegations, some about offences and some about crimes. Should they be talking about physicians who had not yet been prosecuted? And what was meant by serious offences? Should it be up to the host country to decide?

The committee approved one amendment, making it clear that physicians who had been convicted of serious criminal offences, in particular of genocide, war crimes or crimes against humanity, should be denied a licence to practice medicine elsewhere.

However, speakers argued that further consideration should be given to the definition of serious or outrageous offences and it was agreed to recommend to Council that the document be recirculated to members for comment.

End of Life Questions

The committee heard reports about the four regional end of life conferences that had been held around the world, as part of the WMA's review of its policy on physician assisted suicide and euthanasia. Four written reports were submitted (see p. 13) and oral

reports were also given about the discussions in Nigeria and in Rome.

Dr. Kloiber explained that this issue would be brought back into an international discussion to be started in Reykjavik at the medical ethics conference before the General Assembly in October.

A brief debate took place about how to reconcile current WMA policy that euthanasia was unethical with the fact that in some countries euthanasia was now legal. The committee was told that there would be ample time to discuss this matter further at the medical ethics conference in Reykjavik.

The Canadian Medical Association gave notice that together with the Royal Dutch Medical Association it would be bringing a draft revised paper for consideration in October, to see if they could accommodate all the divergent views among members.

Dr. Kloiber said that one message he took from the regional conferences was that there was a very strong need for the WMA to look again at its policies relating to ending futile treatment, respecting patient will and the use of living wills, as well as palliative care.

Genetics and Medicine

The Danish Medical Association proposed that the WMA initiate a major revision of its Statement on Genetics and Medicine. The main reason for this was that the current version of the Statement did not deal sufficiently with the ethical issues that arose through the development and use of next-generation sequencing in personalized medicine. It was proposed that a working group be set up to carry out the revision.

The committee agreed to recommend to Council that a major revision take place and

that a working group be set up to do this, with the aim of producing a revised Statement to be considered by the meeting in Reykjavik.

Biosimilar Medicinal Products

The Israeli Medical Association proposed a Statement on Biosimilar Medicinal Products. Delegates were told that biological pharmaceuticals had been around for some time. This had allowed new methods of treatment, but these were extremely costly and were hard to access. The high pricing was because of the complexity of manufacturing and production, but also because these pharmaceuticals were under patent. Now some of these patents were starting to expire. This would reduce prices considerably, allowing more patients and countries to access these therapies. But identical active substances could not be created because there might be a difference in the dosages. The challenge was to know when a drug was a biosimilar or not. In Europe biosimilars had been regulated since 2005. In the US they had only allowed this in 2015. In Israel they were not allowing it, but difficult regulatory issues were involved. One of the ethical challenges to be faced was that insurers, employers and maybe governments might be inclined to encourage or demand physicians to switch to biosimilars because of lower prices, posing a risk to patients. It was therefore thought important for the WMA to have some guidance on this issue.

The committee agreed to recommend to Council that the proposed Statement be circulated to members for comment.

Classification of 2008 Policies

The committee recommended that the Resolution on Physician Participation in Capital Punishment and the Resolution on the Prohibition of Physician Participation in Capital Punishment be merged.

It also recommended to Council that the Resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel, Inhuman or Degrading Treatment of Which They are Aware should undergo a major revision and that a workgroup be set up to undertake this.

The committee recommended that the International Code of Medical Ethics should undergo a long-term major revision and that a working group be set up to undertake this.

Female Foeticide

The committee was informed that the Swiss Medical Association, with the support of the Swedish Medical Association, would submit a revision of the WMA Resolution on Female Foeticide at the General Assembly in Reykjavik in October.

SATURDAY APRIL 29

Council (continued)

Dr. Hoven took the chair for the reconvened meeting of the Council and delegates stood to recite the Physicians' Pledge.

The Council considered reports from the three committees that had met on the previous two days.

Report of the Medical Ethics Committee

Medically-Indicated Termination of Pregnancy

A proposal was put forward to amend the proposed Declaration to add to the preamble the words: "The medical profession retains its respect for all human life, born and unborn". However, after a brief debate,

the proposed amendment was defeated, and the Council agreed that the Declaration as submitted should be approved and forwarded to the General Assembly for adoption.

Telemedicine

The Council agreed to forward to the General Assembly the Statement on the Ethics of Telemedicine.

Fleeing Physicians

The Council agreed to recirculate the proposed Statement on Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences for comment.

Genetics and Medicine

The Council agreed to set up a work group to develop a Statement on Genetics and Medicine and to circulate the document for comment, with the aim of producing a revised Statement to be considered by the meeting in Reykjavik.

Biosimilar Medicinal Products

The Council agreed to circulate the proposed Statement on Biosimilar Medicinal Products for comment.

Classification of Documents

The Council agreed:

- that the Resolution on Physician Participation in Capital Punishment be merged with the WMA Resolution to Reaffirm the WMA's Prohibition of Physician Participation in Capital Punishment, which will constitute a minor revision as there is no change to the content of either document

- that the resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel, Inhuman or Degrading Treatment of Which They are Aware undergo a major revision
- that a workgroup be set up to undertake a long term major review of the International Code of Medical Ethics

Report of the Finance and Planning Committee

Financial Statement

The Council approved the interim Financial Statement for 2017.

Future Meetings

It agreed the following dates for future meetings:

- the 218th Council session to be held from 22–24 April 2021
- the 72nd General Assembly to be held from 13–16 October 2021
- the 221st Council session to be held from 7–9 April 2022
- that no additional invitations be accepted for the 2020 General Assembly, 2021 Council Session, and 2023 Council Session and General Assembly, and that the decision regarding the existing invitations from Rwanda, the UK, and Spain be postponed to the next Council session in Reykjavik.
- the invitation from CNOM France to host the 221st Council Session in Paris in April 2022 be accepted.

Nominating process for WMA Presidency

The Council agreed that the proposal to introduce a self-declaration statement to the nominating process for WMA Presidency be circulated to members for com-

ment and for further discussion at the next meeting.

Report of the Socio-Medical Affairs Committee

Plastic Bags, Ecological Issues & Environmental Degradation

The Council agreed to circulate for comment the proposed Statement on Environmental Degradation and Sound Management of Chemicals

Policies for Adoption

The Council agreed that the following documents be approved and forwarded to the General Assembly for adoption:

- Statement on Medical Tourism
- Statement on Gender Equality in Medicine
- [Declaration of Seoul on Professional Autonomy and Clinical Independence](#)
- Statement on Sustainable Development
- Statement on Avian and Pandemic Influenza
- Statement on Nuclear Weapons

Emergency Resolution

It was agreed that the proposed emergency Resolution on the Prohibition of Nuclear Weapons be approved for immediate release (see p. 13).

Documents to be Circulated

The Council agreed that three documents be circulated among members for comments:

- [Declaration of Madrid on Professionally-led Regulation](#)

- Statement on the Development and Promotion of a Maternal and Child Health Handbook
- Declaration on Pseudoscience, Pseudo therapies, Intrusion and Sects in the field of health

Classification of Documents

The Council agreed that the following policies should undergo major revision:

- Resolution on Access of Women and Children to Health Care and the Role of Women in the Medical Profession
- Statement on Reducing Dietary Sodium Intake
- Statement on Resistance to Antimicrobial Drugs
- Statement on Violence and Health

It was agreed that the Resolution on Collaboration Between Human and Veterinary Medicine and the Statement on Reducing the Global Burden of Mercury be reaffirmed with minor revision and that the Resolution Supporting the Ottawa Convention on the Prohibition of the Use, Stockpiling, Production, and Transfer of Anti-Personnel Mines and on Their Destruction be reaffirmed.

Finally, it was agreed that the Resolutions on Poppies for Medicine Project for Afghanistan and on the Economic Crisis: Implications for Health be rescinded and archived.

Disaster Medicine

The Council agreed that the proposal to set up a WMA Network on Disaster Medicine be approved.

Advocacy Panel

Dr. Ashok Paul, Chair of the Advocacy Panel, presented an oral report from the group. He said that despite the fact that the

WMA had a very small permanent staff, the Association had a fairly wide reach and high brand name recognition, well above what might be expected based on size alone. He said the prime focus of increasing the WMA's visibility, reach and influence should be concentrated on NMAs. He suggested that briefings should be arranged for new participants to WMA meetings to inform them about available WMA resources. Another way to raise the Association's profile would be to consider relaxing the rule that matters under discussion should not be discussed in public fora. And he said that there could be more engagement with non-member NMAs.

World Health Organisation

The Council heard reports on the WMA's work with the WHO on a number of issues, including supporting the development of Universal Health Coverage, engagement on the health workforce and emergency preparedness.

The 71st World Health Assembly, in May, was due to discuss two high level meetings on NCDs and TB arranged for later in the year.

Together with the other health professions in the World Health Professions Alliance, the WMA was holding the 5th Regulation Conference. And there was also due to be a side event during the World Health Assembly on the 100th anniversary of the Spanish flu outbreak.

The WMA would be sponsoring a lunchtime event during the week on Healthcare in Danger and the issue of strengthening national frameworks for the protection of health care.

Dr. Kloiber then spoke about some of the political undercurrents currently going on about the 40th anniversary of the Alma Ata Declaration. This Declaration had put the

focus on primary care and this had led to Health for All for 2000. But the Declaration had had only a limited success. However, a 2008 report on primary care had emphasised the value of primary care as the core part of comprehensive health care and the necessity for family physicians as part of it.

He said there was a clear role for the physician as a leading part of the primary care team. But in a further document that was currently being discussed as part of the follow up to Alma Ata, the focus had been put on other health professionals and not on family physicians. There was a strong trend to change the scope of practice towards nurse specialists and pharmacists, not only concerning prescribing rights, but also to be the first point of contact in primary care provision. This was something about which the WMA was extremely critical. However, it was no longer enough to simply say "no" to this development. The WMA had to have scientific evidence. So it was now building a coalition of organisations with the same views and was looking for what evidence there was to support its case on family physicians. It was important that those NMAs that had already done work on scope of practice came forward with the necessary material to help the WMA's case.

Dr. Kloiber's report led to a lengthy and wide-ranging debate, that turned out to be one of the most important discussions of the meeting.

Speakers from Israel, Denmark, India and South Africa were among those who supported Dr. Kloiber and reported about similar pressures in their countries. In Israel, these pressures were leading to tensions between physicians and nurses. There was agreement that the WMA needed to work on its arguments about the importance of family physicians. It needed to counter the argument that nurse practitioners were more cost effective. Some speakers talked about patients preferring to see family physicians, while others referred to the risk to

patient safety and quality of care by moving away from family physicians. What was required was less complexity in delivering primary care, not more complexity from more independent contractors.

It was reported that in India this issue was a huge problem. Thousands of medical centres were being opened by the Government, manned by non-doctors. The medical profession was fighting this, but it needed evidence to bring the community onside.

It was argued that this was essentially a political problem, in part caused by a lack of doctors, encouraging other professions to trespass on the medical profession. In France they referred not to doctors but to

health professionals. One speaker said doctors should not talk about delegating tasks to nurses, but about collaborating with nurses.

Several speakers said there was a need to recognise that the delivery of health care had changed with time and the role of doctors was changing as well. This required thinking about who was the most appropriate person to deliver a particular type of care. But it was also said that patients would always need medical practitioners and non-medical practitioners should be augmenting physicians' job and not replacing them.

Speakers from Brazil, France, Britain, Germany, Canada and Malaysia, all referred to

similar problems in their own countries. There was general agreement that this was an extremely important issue and that the WMA needed to engage with governments as well as with the community as a whole.

The Council approved a proposal for the secretariat to prepare urgently an advocacy plan for the Council Executive on how to respond to this issue.

The meeting ended with a round of thanks from Dr. Kloiber for all those who had contributed towards a highly successful meeting.

*Mr. Nigel Duncan,
Public Relations Consultant, WMA
E-mail: nduncan@ndcommunications.co.uk*



Remembrance from Riga 26.– 28. April, 2018. 209th WMA Council Session
With greetings from Latvian Medical Association and President Pēteris Apinis



WMA Council Resolution on the Prohibition of Nuclear Weapons

Adopted by the 209th Session of the Council, Riga, April 2018

The duties of physicians are to preserve life and safeguard the health of the patient and to dedicate themselves to the service of humanity.

Concerned about current global discussions on nuclear proliferation and given the catastrophic consequences of these weapons on human health and the environment, the World Medical Association (WMA) and its Constituent Members consider that they have a responsibility to work for the elimination of nuclear weapons worldwide.

The WMA is deeply concerned by plans to retain indefinitely and modernize nuclear arsenals; the absence of progress in nuclear disarmament by nuclear-armed states; and the growing threat of nuclear war.

The WMA welcomes the Treaty on the Prohibition of Nuclear Weapons, and joins with others in the international community, including the Red Cross and Red Crescent movement, International Physicians for the Prevention of Nuclear War, the International Campaign to Abolish Nuclear Weapons, and a large majority of UN member states. Consistent with our mission as physicians, the WMA calls on all states to promptly sign, ratify or accede to, and faithfully implement the Treaty on the Prohibition of Nuclear Weapons;

Emphasizing the devastating long-term health consequences, the WMA and its Constituent Members urge governments to work immediately to prohibit and eliminate nuclear weapons.

End of Life Seminars

The Socio Medical Affairs Committee received reports about the four end of life conferences that had been held in Latin America, Asia, Europe and Africa, as part of the WMA's review of its policy on physician assisted suicide. Four written reports were submitted and oral reports were also given on each conference. A summary of the written reports follows.

[BACK TO CONTENTS](#)

Brazil Symposium

A written report was submitted by the Brazilian Medical Association about the Symposium it hosted in Rio de Janeiro in March 2017. This referred to the advances in medicine as well as the increase in life expectancy which had led to times of suffering, useless treatments and the solitude of patients. Against this background, palliative care must be a right or at least an attainable service for all patients. The report spoke about the need to protect patients' dignity and added 'if the doctor is prepared not only to cure but also to kill, the ethics of medical practice and the trust that the patient must have in his doctor will be very battered'.

The report referred to the pressure that some patients might face if euthanasia was allowed and the fact that the request for euthanasia might be reduced by improved training of professionals in palliative care. It said societies should be aware of the 'slippery slope' risks of legislation allowing euthanasia.

It concluded: 'The sick at the end of life need a helping hand not to precipitate their death, nor to prolong their agony with the therapeutic obstinacy, but to be with them and relieve their suffering with palliative care while their death arrives'.

Japan Symposium

The meeting on End-of-Life Questions in Japan was held on September 14 and 15, 2017, with the participation of the Confederation of Medical Associations in Asia and Oceania members, the Chinese Medical Association and the Israel Medical Association. A report, prepared by Professor Tatsuo Kuroyanagi, the legal adviser of the Japan Medical Association, said the main purpose of the symposium was to investigate different opinions that existed among the WMA Asia-Pacific members and their home countries/jurisdictions with regard to the three WMA policies, namely WMA Declaration on Euthanasia, WMA Statement on Physician-Assisted Suicide, and WMA Resolution on Euthanasia.

A questionnaire survey was sent to 21 NMAs, and 19 submitted their answers. At the symposium, 17 NMAs presented their reports by further elaborating or partially modifying their answers. At the meeting NMAs were divided into four groups based on the similarities in legal systems and religions.

Based on the survey and the group discussions, all of the NMAs opposed euthanasia and physician assisted suicide. With the exception of Australia and New Zealand, there was no significant desire in the civil society of the Asia/Oceania region to discuss the concept of euthanasia and PAS. However, all the NMAs supported the creation of Advanced Directives and advanced care planning with physicians for the terminally-ill patients.

Rome Symposium

The WMA together with the German Medical Association and the Pontifical Academy for Life organized a two-day Conference at the Vatican's Aula Vecchia del Sinodo on 16 and 17 November 2017.

The meeting was attended by around 150 participants, including WMA leaders and members, experts in palliative care, ethicists, lawyers and religious leaders. The presentations and the views expressed covered the full spectrum of opinion.

In an address prepared by Pope Francis and read by Cardinal Peter Turkson, the Pope said it was clear that not adopting, or else suspending, disproportionate measures, meant avoiding overzealous treatment. From an ethical standpoint, this was completely different from euthanasia, which was always wrong, in that the intent of euthanasia was to end life and cause death.

Throughout the meeting, proponents of right-to-die policies emphasised that their intention was to protect physicians in their own countries who are acting within the law, not to change or influence policies in other countries. They based their arguments on the concepts of patient self-determination, dignity and compassion. Those who were opposed to euthanasia and PAS, representing the majority of attendees, rejected these procedures as being diametrically opposed to the ethical principles of medicine and expressed concern that they could lead to misuse or abuse, e.g. in the case of mentally or psychologically incapacitated people. They also expressed concern that these procedures could cause damage to the complete trust which characterises the patient-physician relationship or lead to social pressure for the elderly or those with chronic illness to end their lives.

The majority of attendees ultimately advocated for the retention of the existing policies of the WMA on euthanasia and PAS.

But participants were united in their support for high-quality, accessible palliative care and their belief that PAS and euthanasia should never be seen as a cost-saving measure.

Nigeria Symposium

The African Symposium was hosted by the Nigerian Medical Association in Abuja, Nigeria on February 1 and 2 2018.

Attendees included Presidents and delegates of National Medical Associations from Nigeria, Zambia, Kenya, South Africa, Cote D'Ivoire and Botswana.

Among the resolutions at the conclusion of the meeting were that NMAs in Africa are unanimously opposed to euthanasia and physician assisted suicide in any form. They supported policies and legislations permitting and strengthening palliative care. There was a

need for improved political will and commitment to palliative care by African Governments. There was agreement on the need to orientate governments, policy makers and the public on the importance and availability of palliative care.

And there was great need for the strengthening of African health-care systems, universal health coverage, improved budgetary allocation to health, and integration of palliative care and other chronic medical conditions into the health care financing/health insurance schemes of African countries.

Junior Doctors Meeting

The Junior Doctors Network held a meeting prior to the 209th WMA Council Meeting. This brought together 20 young doctors from across the world to discuss issues important to the WMA's work and to gain skills important for their work and future roles as health leaders. The event served as an opportunity to meet with a number of Latvian junior doctors as well a representative from the European Junior Doctors Association.

The day started with a meeting with the WMA leadership – Dr. Yoshitake Yokokura, WMA President, Dr. Ardis Hoven, WMA Chair of Council, and Dr. Otmar Kloiber, WMA Secretary General. There were discussions on leadership within the WMA and within National Medical Associations, as well as current issues important to the WMA.

The morning session included important internal work for the JDN reviewing the proposed terms of reference for JDN Working Groups, and a discussion on the structure of JDN meetings and approaches to membership of the network.

Concluding the morning, a scientific workshop on climate change policy and health summarized WMA work in this field at the international level. It highlighted future opportunities for JDN involvement and familiarized participants with how national commitments are defined. This allowed them to reflect how they could contribute to the implementation of the WMA Declaration of Delhi on Health and Climate Change in their own contexts.

During the afternoon, selected JDN working groups were discussed with important advances made with respect to planning the work of the recently created group on Working Conditions. Finally, for the first time at any JDN meeting, there was a leadership training section, led by two external speakers, Drs Paul Jones and Greg Radu. This elaborated on different leadership theories and their application in the healthcare context.

*Yassen Tcholakov
JDN Socio-Medical Affairs Officer*

World Health Professions Alliance Regulation Conference 2018

Geneva 19–20 May



Nigel Duncan

The Fifth World Health Professions Regulation Conference was held at the Crowne Plaza Hotel, Geneva on May 19 and 20. An audience of almost 150 attended from 36 countries. They included members of the five professions that make up the World Health Professions Alliance – physicians, nurses, pharmacists, dentists and physical therapists, as well as a number of economists and regulators. Over the two days, 20 expert speakers addressed the theme of the conference, ‘Facing challenges to acting in the public interest’, and engaged in high level debates with participants.

Dr. Ardis Hoven, Chair of the WMA, who chaired the first day’s debates, said in advance of the conference, that regulation of the health professions was increasingly perceived as an economic issue or as a question of power. Some professionals saw regulation as a means to limit their professional freedom. Others, such as insurers and managed care companies, viewed it as an unwelcome expense, since obeying rules costs time and money.

‘Regulation necessarily means ... setting limits and demanding checks and balances,’ she said. ‘Striking a balance between personal choices ... and obligations towards safety, highest quality and equity is difficult and requires justification’. Dr. Hoven added ‘Standards can help to provide a level playing field for all involved, including both fair and appropriate processes’.

The first session of the conference looked at the barriers to implementing regulatory standards. Dr. Hoven said such barriers included political and commercial interference, inadequate understanding of professional autonomy and regulation and a high degree of resistance to change.

Three speakers addressed different aspects of professional autonomy and regulation.

Professor Zubin Austen, Professor of the Koffler Chair in Management at the University of Toronto, spoke about setting standards and how these could be got right. He gave a history of the word ‘competence’ and looked at what competency assessment models had been tried – including the secret shopper methodology involving actors disguised as patients visiting clinicians. He emphasised the importance, when creating assessment models, of getting ‘buy in’ from both the public and the profession.

Andrew Gray, from South Africa, vice President of the International Pharmaceutical Federation, talked about autonomy, with reference to the WMA’s Declaration of Seoul on Professional Autonomy and Clinical Independence. He said that as the working environment had changed for many health professionals, so professional autonomy had also been seen as under threat, or at least subject to change. On the positive side, collaborative practice had blurred the boundaries between

professions and between professionals. However, health professionals needed to guard against the negative consequence of dual and divided loyalties.

David Benton, CEO at the National Council of State Boards of Nursing, asked who regulated the regulators. He said there was currently a lot of critical commentary about regulation. However, it was right that regulators should be held to account, and they were already being held to account in various ways. But which of the ways was effective and had the biggest impact – the external ones or the self imposed ones? The formal processes or the informal processes? He concluded that they needed to get better in managing the performance of regulators.

During the following panel discussion, participants debated whether there was too strong an alignment between the professions and the regulators. It was said that regulators in many parts of the world were enriched by their interaction with the professions. More than one speaker warned about the risk of politicians leaning on regulators.

An example of the barriers to implementing the right standards was given by Dr. Andrew Wetende, President of the Kenyan Dental Association, who spoke about Kenya’s experience with the Minamata Convention on Mercury, the international *treaty* designed to protect human health and the environment from the releases of *mercury* and mercury compounds. Barriers to success in implementing this included lack of resources and involvement of key stakeholders, professionals who refused to embrace the regulations and a lack of operational guidelines.

Dr. Barry Dolman, President of the International Society of Dental Regulators,

from Montreal, talked about the importance of regulation to ensure evidence-based care. He spoke about four trends impacting regulation – from governments, the new patient, social media and disruptive technology.

He said new patients were more educated, looking at ways where they wanted to direct treatment rather than relying on physicians and others. They had now trained patients to find their own answers.

He said that regulators also had no ability to control social media information. They were facing catch up and were powerless to stop this this phenomenon. But hopefully they could moderate its impact.

Agnes Waudo, a director of Emory University Kenya Projects, continued on the theme of barriers to implementation of regulatory standards as they affected Africa. These included a lack of resources to support implementation and enforcement, a lack of capacity building, political influence subverting standards, conflicting mandates and non-compliance. Finally, there was the problem of the shortage of health workforce.

During the panel discussion, Dr. Mark Sonderup from the South African Medical Association, said that in South Africa the medical profession felt isolated from regulators. He asked what role regulators should have in the world of social media, where professionals were pushing out information. The answer he received was that there was a major role for regulators to play.

Dr. Otmar Kloiber, Secretary General of the WMA, said that in his view people were turning more and more to regulators to ask questions and get advice. He said that almost half of the WMA's national medical association members were also regulators. He questioned the perception that physician regulators were less tough on the profession and thought the oppo-

site might be the case and that they were in fact tougher. He also said that the profession was not lagging behind governments on the issue of regulation. It was ahead of governments in thinking about regulation. He was particularly critical of governments that blamed the health profession when things went wrong because of a failure of the legal system, adding to applause 'We are not the sheriffs'.

The second day's proceedings opened with a warning that the health professions were facing many challenges on regulation. The meeting was told that today's skills and culture needed to change to be fit for tomorrow. The professions were standing on shifting sands.

Dr. Jacques de Haller, President of the Standing Committee of European Doctors (CPME), in his presentation, spoke about global standards and how much local adaptation was needed. The medical profession was a profession that loved to travel, to learn and to practice. It needed to travel. But although it was a truly global profession, there was no global regulation or global rules with legal effect about the health professions.

He spoke about the situation in Europe, where there were some supra-national regulations. The Professional Qualifications Directive set rules about what was to be recognised by different member countries. It dealt with rules for temporary mobility, introduced a system of mutual recognition of diplomas and defined minimum educational requirements, although it did not harmonise education requirements.

A survey carried out by the CPME showed that regulations to practice and the implementation of regulations to practice were different in each country. His conclusion was that although the global profession did not have global regulation, it probably did not need it because the current systems worked well. They shared a common goal, providing safe and high quality care.

He said it was commonly thought that a doctor should be 'the same' anywhere. However, such a concept, if considered desirable, could only be achieved with bottom up educational initiatives by the medical profession itself and sharing best regulatory practice examples, enabling regulators to select requirements best suited to their local needs.

Luke Slawomirski, an OECD economist, delivered a presentation on patient reported outcome measurements. These were based on the question 'What was the goal of health care?'. If it was to improve the wellbeing of individuals and society, health systems knew very little about whether or not they were successful in this endeavour. He spoke about how the OECD was measuring health outcomes. There was an information gap they were trying to fill and collecting patient reported indicators would improve policy and practice.

Emmanuel Jo, Manager Analytics at Health Workforce New Zealand Ministry of Health said big data analysis improved care and patient safety. We were now living in a big data environment with electronic health records, electronic human resources data, registration data for regulated health workers and claims data. He talked about how analytics were now being used in New Zealand, in both primary and secondary care.

Dr. Margot Skinner, vice President of the World Confederation for Physical Therapy, talked about her experiences of the Trans-Tasman Mutual Recognition Arrangement that had allowed health professionals in Australia and New Zealand to practise in either country without the need for further study or assessment. The agreement enabled each country's professional workforce to come from a bigger pool. Professionals were also able to undertake courses and post graduate qualifications without the usual barriers. The arrangements had generally worked well for Australia and New Zealand because the two countries had similar standards for health and wellbeing.



‘The bigger challenge is for countries where standards for education of health professionals are not the same’, she said.

In the panel discussion that followed there was a lively discussion, when one participant asked whether regulation had lost its identity. Panellists were quick to emphasise the importance of the patient in the process. The primary purpose of regulation, it was said, was to secure protection for the public, to ensure that practice did meet requirements. Regulators had to be effective, efficient and ethical. But there was a big danger when regulation lost the human touch.

The last session of the conference looked at continuing professional development, what it meant and how it served patients. This led to a debate about whether measurements and accreditation were useful tools. Dr. Kloiber said it was political pressure that had driven medical associations and regulators to accreditation.

One of the final panel discussions related to the WHPA’s slogan ‘Teaming up for better health’. What did it mean? Panellists said this had to start within the professions. Key players needed to team up, and this was happening. But Janet Grant, an educational psychologist, said that the evidence on inter professional education was not good. The evidence was it was a waste of time unless teams learned together in practice.

Dr. Kloiber said that in a lot of circumstances a non-team approach to learning was not constructive.

He explained that the phrase started with the global organisations working together as the WHPA. He said the five health professions were not far apart in what they had to say. But each group on its own was not being heard. So they had come together as the WHPA, as they thought they could contribute to better health. They could produce more together than apart, and he had not seen any evidence to the contrary.

The conference ended with a closing summary from Ema Paulino, Interim CEO of the International Pharmaceutical Federation. She reminded the meeting that these WHPA conferences aimed to shape the future of health professional regulation within the context of global health systems via multi-disciplinary and multi-stakeholder approaches. She said that regulation should be an enabler and a facilitator of the practice of all healthcare professionals, with a prime objective of ensuring the safety of the delivery of healthcare services.

‘Too often, there is a lack of knowledge about systems of regulations and only a few comparisons are available to describe such systems internationally. We observed that although globalization is rapidly advancing in all spheres of human endeavour, regulatory systems controlling the health professions are very disparate.’

She said the conference had illustrated that health professional regulation faced many challenges in a world characterised by political, social, economic and technological change. Widespread reform of health professional regulation reflected policy initiatives by many governments to ensure sustainable, efficient and effective health service delivery. But what were the implications, and how did they ensure the public’s best interests were met?

‘Health professional regulation is high on the global agenda. Increasing numbers of trade agreements, a push for greater harmonisation and ease of mobility, economic pressures, privatisation and corporatisation of health and education services and health human resource challenges are all impacting the regulatory environment globally.’

She said these trends would influence the shape of regulation. The conference had noted that public scrutiny of professional work was higher than ever and that the design, implementation and execution of competence assessment were essential. Speakers

had emphasised that the central element of professional autonomy was the assurance that individual healthcare professionals had the freedom to exercise professional judgment in the care and treatment of patients without undue influence by outside parties or individuals.

The conference had agreed that professions evolved and that regulations, standards and assessment schemes should follow. They had talked about safety, quality and compliance to benefit patients, communities and populations and how right-touch regulation was targeted, transparent, agile, accountable, consistent and proportionate. They had considered migration challenges, whether adaptation to local needs was necessary, and how new ways of looking at performance and population data was changing the health landscape and how regulators ensured patient safety and quality of care.

Finally, on supporting the quality of lifelong learning, Ema Paulino said that different views had been presented on what constituted the roles and responsibilities of regulators associated with continuing professional development, and how they could ultimately ensure competency in a sector where information asymmetry was prevalent.

‘I believe we can conclude by stressing the importance of collaboration amongst healthcare professionals, the true value of working together in practice for the benefit of the patient. This can also be enhanced and translated from us looking at regulatory systems together, in these forums. In addition, I believe we can also conclude that there is a significant advantage of looking at regulation from an interprofessional perspective, given that similar challenges are met by the various professions throughout the world.’

*Mr. Nigel Duncan,
Public Relations Consultant, WMA
E-mail: nduncan@ndcommunications.co.uk*

World Health Assembly Side Events – May 2018

During the week of the World Health Assembly in May, Geneva was hive of activity, with breakfast meetings, lunchtime side events and evening conferences. WMA leaders were involved in a large number of these events. Among them were the following.

International Symposium on Universal Health Coverage

On Tuesday May 22, the second day of the Assembly, the WMA, together with the Taiwan Medical Association, hosted the International Symposium on Universal Health Coverage.

The packed meeting was addressed by both the President and the Chair of the WMA.

Dr. Yoshitake Yokokura, President of the WMA and President of the Japan Medical Association, spoke about borderlessness in a world of globalization. He said the cross-border unity of physicians worldwide was increasingly important to prepare for the spread of infectious diseases and the occurrence of natural disasters.

‘The WMA is concerned about the economic and social influence of the prevalence of rapidly expanding NCDs. The WMA also recognizes the importance of measures to be taken beyond the fields and departments at the national and global levels.’

He said the new Memorandum of Understanding with the WHO aimed to promote UHC and strengthen the emergency disaster preparedness and he added that the medical profession should return to the basis of health care, create a healthy longevity society, and continue to support it.

‘I am convinced that the system which leads Japan’s aging society, unprecedented in the world, to “the society of peace of mind” should be also supported by the “Universal health insurance”. I think that it is ideal that because of extended healthy life expectancy, the elderly people can help to create a basis of the nation as “the people who support a society”. In this sense, the significance of promoting UHC is extremely high to realize such a society. As President of the WMA, I am determined to make utmost efforts toward global promotion of the UHC.’

Dr. Ardis Hoven, Chair of the WMA, said the concept of UHC was very close to the ideas of the WMA. She said there was major inequality in health in the world and those regions with the highest need – south east Asia and Africa – had the lowest share of the health work force. It was the same with resources, which were mainly available in regions with a moderate or low burden of disease. This inequality was reflected in the life expectancy at birth. And all these inequalities existed within countries, whether they were affluent or not.

Dr. Hoven referred to the WMA’s policy on patients’ rights and UHC with its statement that every person was entitled, without discrimination, to appropriate medical care. The WMA was firmly of the view that every patient should have a chance to be seen by a physician. But there was a clear disparity between countries in the numbers of physicians per thousand people, and this had to be recognized. So the WMA had policy that where countries had a critical shortage of physicians, task shifting should be viewed as an interim strategy. But task shifting should not replace the development of sustainable, fully functioning health care

systems. If they wanted to achieve equitable access to care, political action was necessary.

Dr. Hoven concluded with these words: ‘To make Universal Health Coverage a reality will require huge investments. It will require investments in people and, let me emphasize, this includes the education of physicians. It will require investment in facilities, in safety, and quality. But there is no doubt that these investments will pay off – for healthier living, for a better society and form a stronger economy’.

A recorded video message was sent to the meeting by Ms Tsai Ing-wen, President of Taiwan. She said that Universal Health Coverage was the most unifying theme in global health. She talked about Taiwan’s introduction of National Health Insurance in 1995, under which all nationals, regardless of gender, age or wealth were equally covered for their whole life. The NHI premium accounted for less than five per cent of the individual monthly pay roll and the total national health care expenditure was less than seven per cent of GDP. The scheme was very comprehensive, covering everything from the common cold to organ transplants. The public satisfaction approval rate was recently found to be 85 per cent. The scheme safeguarded not only people’s access to health care, but also ensured financial protection. Ever since the implementation of NHI, no-one had gone broke because of medical bills. The scheme was a model to achieve UHC and she said she believed Taiwan’s experience could serve as a paradigm for the world.

Strengthening National Frameworks for the Protection of Health Care

The following day, the WMA was one of the coordinating organisations for an ICRC Health Care in Danger event. The meeting’s theme was ‘Strengthening National Frameworks for the Protection of Health Care’.

The two-hour forum was hosted by Maciej Polkowski, ICRC Head of the HCiD Initiative, who emphasised how important this project was for the ICRC.

Two keynote speakers outlined the scale of the problem of violence. Dr. Esperanza Martinez, Head of Health at the ICRC's Health Unit, spoke about the consequences of attacks on hospital and health professionals, and said the problem was not confined to war zones. However, he said there was now a very strong community of concern with a common voice that was going to be heard. Raphael Gorgea, Deputy Director of Operations from *Médecins Sans Frontières*, talked about the attacks that had been made on MSF hospitals and staff, and the impact this had had on patients and the delivery of health care. Among the ways to combat this was to advocate for the respect of international law and to promote health care as a common good.

The meeting went on to hear speakers from three countries – Nigeria, Pakistan and Peru – about how the problem of violence against the health sector was being tackled. This ranged from round table talks to engage all those involved to practical interventions for raising awareness locally, improved reporting of incidents, policies of zero tolerance and crowd control measures. The meeting concluded with general agreement that health care was a common good, that it could not be taken as a given and that it had to be promoted.

100 Years After the Spanish Flu Pandemic

The third event, on Wednesday May 23, was held to mark the 100th anniversary of the Spanish Flu Pandemic and was hosted by the WMA, the International Federation of Red Cross and Red Crescent Societies (IFRC) and the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA).

The event was opened by Thomas Cueni, Director General of the IFPMA, who said it was estimated that Spanish flu killed more people in 24 weeks than Aids had killed in 24 years. In fact, the pandemic killed up to 100 million people, more people than all the wars of the 20th century combined. In 1918 this amounted to nearly five per cent of the world's population. It served as a poignant reminder of the importance of preparedness. If a highly contagious and lethal pathogen like the 1918 influenza were to take hold today, nearly 33 million people worldwide would die in just six months. More than ever they were exposed to new biological threats, many of them yet undiscovered.

He said that in today's extremely interconnected world, with people travelling at unprecedented rates, global health security had never been more fragile or more urgent. Previous epidemics had shown that when the global health community came together, they were able to tackle infectious diseases. Going forward, they needed to design and implement pro-active preparedness, to further improve their capacity to prevent and control unpredictable disease outbreaks. Sample and data sharing were key and he said they all recognized the importance of the WHO's global influenza surveillance system.

The first of two keynote speakers was Alex Azar, *US Secretary of Health and Human Services*, who said that at the time of the outbreak of Spanish flu, the United States and the world were ill-prepared to combat a pandemic. Influenza viruses had not yet been discovered, there were no vaccines to prevent infection and no medicines to treat it, and the field of public health was in its infancy.

'Today, influenza pandemics remain one of our top infectious disease threats. We have a growing set of increasingly advanced tools to detect the emergence of a new strain of influenza virus domestically and abroad, but much work remains to be done. When it comes to the threat of pandemic flu, as

well as other infectious threats, preparedness cannot be confined within borders. The world must work together to focus on the prevention and mitigation of pandemics that pay no mind to borders and focus the work of institutions like the World Health Organization on that threat.'

He said the Trump Administration strongly supported the Global Health Security Agenda to prevent, detect and respond to infectious disease threats in collaboration with their partner countries. It also supported reforms to the WHO to ensure that future epidemics were handled more effectively than Ebola was. He outlined the work of the Centers for Disease Control and Prevention in building global flu surveillance networks with partner countries that helped to detect and respond to new and known influenza viruses. And he talked about the way in which the US was putting in place preparedness plans for responding in the event of a flu pandemic.

The country's vaccine manufacturing capacity had increased ten-fold since the 2000s. At the same time they had worked to reduce the time it took to develop a new flu vaccine in the event of a pandemic and they had invested in research toward a universal flu vaccine.

Mr. Azar concluded with these words: 'The world has come a long way since 1918, but we are still vulnerable, not just to the flu but a range of infectious threats. The United States will continue to work with our partners around the globe to build preparedness for these threats and to strengthen our preparedness at home.'

Infectious diseases remain a serious threat, but with the right level of cooperation and focus, we can look forward to marking many more World Health Days before we see another pandemic like the Spanish flu'.

The second keynote speaker was Elhadj As Sy, Secretary General of the International

Federation of Red Cross and Red Crescent Societies. He said that over the last few years the world had experienced a number of epidemics, including Ebola, which had killed around 11,000 people in three west African countries. He asked if they were really ready and prepared for another epidemic or pandemic. Had they learned the lessons of the first Ebola outbreak? He said it did not matter how far away outbreaks occurred, adding 'They are only one hand shake away from many of us. They are only one plane ride away for many of us'.

He said there were many factors involved in determining the levels of vulnerability in epidemics. But none of them would be safe until all of them were safe. The only way to contain these epidemics and outbreaks was where they were happening, right in the communities. They needed international regulations and preventive measures, but they also needed to make the necessary investment in those areas where these outbreaks were occurring. Too often they had to return to the same communities to respond to the same outbreaks. He emphasized how important it was to get the acceptance of local communities to take preventive action. Partnerships were essential and health system strengthening was vital.

There was then a panel discussion conducted by the moderator, ex-BBC journalist Claire Doole. The panel consisted of Dr. Ardis Hoven, Chair of the WMA, Dr. Marie Mazur, Vice President of Response Solutions at Seqirus, Dr. Sylvie Briand, Director of Infectious Hazards Management at the WHO and Dr. Julie Hall, Chief of Staff from the Office of the Secretary General at the IFRC. The first question the panellists were asked was whether the world was prepared for another pandemic. Dr. Hoven replied bluntly 'No'. She and the other panellists agreed that there was much more work to be done.

They went on to talk about vaccines. Dr. Hoven spoke about the scepticism surrounding vaccines, saying that the challenge was to counter the reluctance to accept immunisation of any kind. They had barriers to confront. There was information going round that was not scientific and that was discouraging individuals from being immunized. So they had to have systems in place that accelerated the way people could get immunized. She said that when physicians said they had been immunized, it was much more likely that their patients and families would be immunized. She also spoke about the WMA's influenza campaign which had

been running for five years in partnership with others.

In a discussion about Ebola, Dr. Hoven stressed the importance of strengthening health care systems and addressing the work force issue. 'If we don't have people to take care of people, it all falls apart', she said. The Ebola outbreak of two years ago had illustrated cracks in the health infrastructure. On a more general issue, she added that health care professions and their national organisations should be 'looped in' with governments, so that they were part of the planning work that needed to be done, not just when there was an emergency, but on an everyday basis. She also said that there should be a removal of barriers between agencies in order to communicate better. They had to remove the silos of information and knowledge between them.

As the meeting ended, the moderator Claire Doole tweeted: 'I had great panellists – so rare to have an all woman panel! They were a joy to moderate – succinct clear and compelling – the perfect panellists'.

*Mr. Nigel Duncan,
Public Relations Consultant, WMA
E-mail: nduncan@ndcommunications.co.uk*

Intellectual Property: who owns the right to good health?

The 71st World Health Assembly (WHA), which represents the highest decision-making body of the World Health Organisation (WHO), took place in Geneva this May. The World Medical Association was represented by a diverse delegation of both members of the Junior Doctors Networks and representatives from National Medical Associations working under the coordination of the WMA Secretariat. Amongst the many issues followed by the WMA, an

inherently contentious part of the WHA agenda was the review of the global strategy and plan of action (GSPoA) on public health, innovation and intellectual property¹. Indeed, the potential barriers of medi-

¹ World Health Organization. "Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property" 2011. Available at: <http://www.who.int/pbi/publications/GlobalStrategyPlanAction.pdf>

cines costs and procurement are central elements for achieving the ambitious goals of the SDGs Agenda by 2030 especially at this WHA focused on Universal Health Coverage. While these negotiations have taken place over previous decades, progress has been slow and there is still a long way to go before accomplishing the vision behind the work on access to medicines.

Discussion around intellectual property and access to medicines have been taking place at WHO ever since the adoption of The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement in 1994. Being party to this treaty was mandatory for participation in



Yassen Tcholakov



Lisa Murphy

the World Trade Organization (WTO) and thus countries were inherently forced to adhere to it. TRIPS set down regulation on Intellectual Property (IP) into the international trading system, which has namely impacted access to newly developed medicines. While TRIPS contains provision for a number of flexibility mechanisms² (including patent exceptions, compulsory licensing and limits on data protection) their use has been rare. Indeed, countries who have utilised them have had to face political pressure and retaliatory action. In that context, the WHO proposed the GSPoA in 2008 which was fully adopted in 2009. This year marks the 10th anniversary of GSPoA's creation, and member states were reflective on what had been achieved.

The GSPoA focuses on the 8 elements:

- prioritizing research and development needs;
- promoting research and development;
- building and improving innovative capacity;
- transfer of technology;

2 Nicol D. Owoeye O. "Using TRIPS flexibilities to facilitate access to medicines" WHO Bulletin. April 2013. Available at: <http://www.who.int/bulletin/volumes/91/7/12-115865/en/>

- application and management of intellectual property to contribute to innovation and promote public health;
- improving delivery and access;
- promoting sustainable financing mechanisms;
- establishing and monitoring reporting systems.³

This GSPoA review⁴ highlighted the slow and uneven progress in the various areas of work and some of the funding gaps. It's recommendations include WHO support for member states to utilise the aforementioned TRIPS flexibilities¹, increased transparency in the pricing of medicines, and the strengthening of non-profit based innovation models through delinkage⁵ (the process

3 World Health Organization. "The Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property". Available at: http://www.who.int/phi/implementation/phi_global_action/en/

4 World Health Organization. "Overall programme review of the global strategy and plan of action on public health, innovation and intellectual property" November 2017. Available at: <http://www.who.int/medicines/areas/policy/GSPA-PHI3011rev.pdf?ua=1>

5 Love J. "Inside Views: Delinkage Of R&D Costs From Product Prices" Intellectual Property

through which pharmaceutical research is financed through means other than medication sales).

However the review neglected some important issues, such as the creation of a research and development (R&D) treaty. Many members expressed frustration during WHA with the lack of progress on implementation and funding for this area of work. The current finance gaps are largely a reflection of WHO's wider funding challenges, with a large proportion of its money firmly earmarked according to donor interests. During these R&D discussions there was a noticeable equatorial difference in opinion. While the global south emphasized the importance of WHO facilitating the use of TRIPS flexibilities and new non-profit based innovation models, the north focused on patent driven innovation. There were calls from many low and middle income countries for international cooperation and financing to increase their R&D capacities, with support sought from WHO for country led action.

Many member states from within the high income bracket endorsed the establishment of public-private partnerships as key to driving creation of quality medicines. There was also push back against the GSPoA's recommendations for transparency of research and development costs, which is a crucial measure for preventing industry manipulation of drug costs and ensuring fair medicine pricing. This, alongside a move to a fixed price model for medicines from a market driven system, could greatly enhance medicines availability and procurement. The perceived threat to profits for the pharmaceutical industry make those recommendations contentious. The question of how much implementation the WHO will be able to drive has yet to be answered.

Watch. September 2016. Available at: <http://www.ip-watch.org/2016/09/15/delinkage-of-rd-costs-from-product-prices/>

On the agenda item on the GSPoA review, the WMA presented a statement supporting opening the GSPoA to newer essential health products, encompassing medicines, vaccines, diagnostics or biologicals and to call for intellectual property which serve the people and contribute to sustainable development.⁶ Additionally, the WMA also delivered an intervention on a different agenda item calling for the WHO to help with filling the gap in the current R&D system and address global challenges such as anti-

microbial resistance and the lack of effective treatment for dementia.⁷

Now that the review panel for priority actions have identified a number of key objectives⁸ to be achieved by 2022, it remains to be seen what achievements the global health community will be celebrating in 5 years time. In a globalized economy, inter-

national law, including intellectual property regulations, should always serve the people. If it fails to do so, the global community has a moral obligation to redress its mistakes. The current IP system has failed to deliver on its promises and it is unjustified to award corporations the privileges of a monopoly at the expense of the wellbeing of millions who still lack access to essential medications.

6 World Medical Association. "71st World Health Assembly 11.6 Global strategy and plan of action on public health, innovation and intellectual property" May 2018. Available at: <https://www.wma.net/wp-content/uploads/2018/05/11.6-WHA71-Global-strategy-public-health-innovation-and-intellectual-property-WMA.pdf>

7 World Medical Association. "71st World Health Assembly 11.5 Addressing the global shortage of, and access to, medicines and vaccines" May 2018. Available at: <https://www.wma.net/wp-content/uploads/2018/05/WMA-11.5-access-to-medicine.pdf>

8 World Health Organization. "Global strategy and plan of action on public health, innovation and intellectual property" March 2018. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_13-en.pdf

*Yassen Tcholakov, MD MIH CCFP,
McGill University (Canada)*

*Lisa Murphy, MBChB BSc, Barts
and The London NHS Trust*

E-mail: yassentch@gmail.com

Physicians' Role in the Management and Leadership of Health Care



Heidi Stensmyren

The Demographic Challenge

Long-term forecasts on demographics are similar in most rich welfare states, in the

sense that as populations are ageing and wealth is increasing, more and better health care is demanded. Since many countries finance health care largely through taxes, finding solutions to finance the welfare will put the public systems under pressure. As the workforce will consist of a smaller part of the population, either taxes or out-of-pocket payments will have to increase, the quantity or quality of publicly delivered health care will have to decrease, or a combination of the above. Any solution that simplifies the equation and releases some of the pressure on the health care system should be taken into consideration. The Swedish Medical Association sees physicians taking a more active role in the leadership of health care as crucial in making the health care more efficient.

The scarce resources would most likely be used more efficiently if the decisions on resource allocations were always based on

the medical and clinical knowledge about what creates the most substantial impact on health outcomes.

In 2017 the Swedish Medical Association commissioned a report on physicians' engagement in leadership in health care, and the effects thereof. The report, *Physicians' role in the management and leadership of health care*¹, examined the published scientific literature and found several positive effects of getting more medical doctors to engage in leadership.

The report found, among other things, that physician leadership can improve hospital performance in terms of quality of care,

1 Physicians' role in the management and leadership of health care. A scoping review. Stockholm, February 2017. Mairi Savage, MPH Pamela Mazzocato, PhD Carl Savage, PhD Mats Brommels, MD, PhD, Professor

management of financial resources and staff satisfaction. All these factors are vital to meet the increasing demands of health care for a long time to come.

The report also identified some mechanisms that seem to have a role in mediating the positive relationship between physician leadership and performance outcomes. For instance, having a medical background gives physician leaders increased credibility compared to managers without medical training. Clinical knowledge seems also to be essential for improved decision making. The knowledge acquired from a long medical education and years of working experience is obviously helpful for creating an understanding between different levels of management and performance.

While the quality of medical decisions improves, the risk of complications decreases, and costs are lowered. This might explain why there are indications that financial resources are managed in a better way when physicians are assuming a managing role.

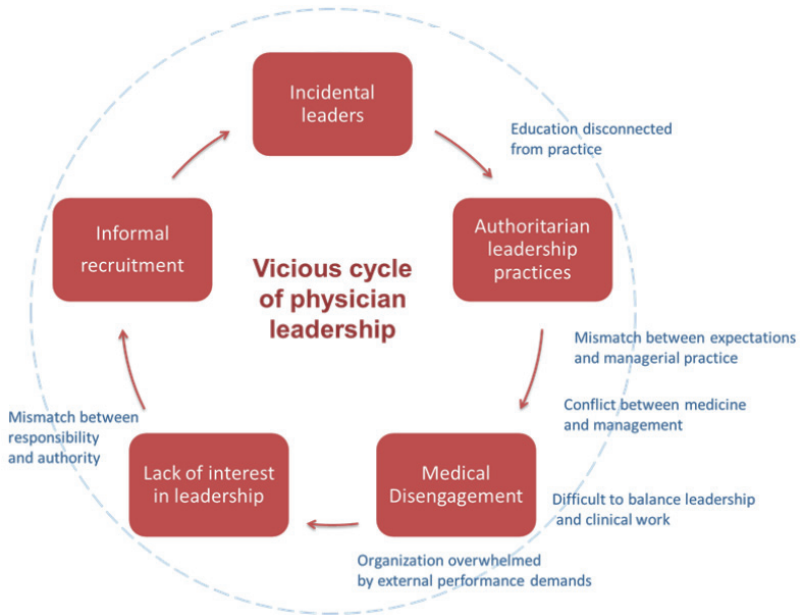
Few doctors in management

Why then, aren't physicians more engaged in management? One reason could be that most physicians already make a good earning. The financial gain from taking on more responsibility does not often add up to the amount of workload from managerial tasks. A managing role in health care is associated with a lot of responsibility and potential expressions of dissatisfaction from both employees and superiors. This is of course the case in most sectors, but certainly no less in the medical profession where decisions are literally about life and death.

In contrast, for nurses in Sweden, the wage difference between being a regular employee and a manager can be much larger, which partly could explain why many nurses are keener on engaging in management. Still, according to the Swedish Medical Association



Picture 1



Picture 2

ciation it should be the genuine interest for leadership and management, not financial benefits, that should motivate doctors to pursue a career in leadership and management in health care. If medical doctors, despite being interested, choose not to seek the managerial roles, it will benefit no one in the health care system.

Virtuous and vicious cycles

Picture 1 shows a possible virtuous cycle that can arise from better physician leadership. Medical doctors as leaders and managers create a culture and an atmosphere that invites and engages staff to participate in improving health care. The catalyst in such a process is not obvious but formal recruitment as a starting point is probably where policy makers can influence the process.

Formal recruitment can lead to positive aspects in the leadership, such as creating a broader recruitment base. It may very well be the case that persons who would not have considered becoming a leader can be made aware of the opportunity if the process is formal, and if the responsible for human resources actively seek out to those individuals. Since there is no reason to expect that persons who previously haven't considered leadership are less likely to be successful at it, such actions are likely to lead to better management in the long run.

These positive effects can hopefully be self-sustaining, giving a positive spiral upwards.

On the other hand, picture 2 illustrates the outcome if the recruitment process is done informally.

Informal recruitment can lead to a narrow base of recruitment, placing wrong persons in important management positions. Such discrepancy in the workplace is likely to lead to internal conflicts and impaired communication between the managerial level and employees.

Thus, it is obvious how important it is to engage the right persons in management and to make sure that recruitment is formal and organised.

Strong leadership for improved communication

An aspect that is sometimes overlooked is the leadership as a link from health care policies to delivering good health care. In this context, it means that effective leadership easily can communicate the intentions of upper-level decision makers to floor-level staffers. If the economic incentives points in a certain direction, but solutions to accomplish these incentives are perceived to be technical or difficult to understand, a leader with good understanding of the whole system can create an atmosphere of commitment among the staff. For this to hold, the economic incentives must of course steer towards improving health outcomes.

Policies for improved leadership

Even after finding good and promising leaders for management, the process is not nearly completed. There is a need for support throughout the career, and learning leadership skills must begin already in the early stages of education. Mandatory courses in

leadership in medical schools are important in order to establish a culture where medical professionals are encouraged to consider making a managerial career in addition to a clinical career. Better possibilities to combine clinical and managerial positions are important, not only to make management more attractive but to strengthen the connection between staff and managerial levels.

Such courses can include both traditional leadership education and more hands-on procedures such as catastrophe simulation, depending on the focus.

Putting it all together

To insure a sustainable programme for effective management and leadership in health care all the steps in different levels must be connected.

- Medical schools must supply the basic foundation of leadership knowledge
- Incentives must be in place for enough physicians to pursue this alternative career
- Recruitment processes must aim to find the most suitable candidates
- Support in place for those who choose to become managers.

If all these factors are in place there is reason to believe that physicians' leadership will provide better use of the resources in healthcare.

*Heidi Stensmyren, MD
President of the Swedish Medical Association
Chairperson of the WMA
Medical Ethics Committee
E-mail: ordforande@slf.se*

Policy Analysis Ottawa Declaration on Child Health



Elicien Ishimwe

1. Introduction

The World Medical Association (WMA) Ottawa Declaration was adopted by 50th WMA Assembly October 1998 and later substantially revised by the 60th WMA Assembly October 2009¹. According to the WMA revision cycle, the document is up for revision next year. This analysis provides an overview of the development of the declaration, its elements and their occurrence in the original and the amended version.

The Declaration of Ottawa originally aimed at improving the rights of children to health care² throughout the world. In this article we analyze and compare the above two doc-



Otmar Kloiber

uments looking for the new points added in the new version and the important points left out while amending as well as points to emphasize on.

2. Analysis

The initiative, entitled the Declaration of Ottawa, was building on the WMA Declaration of Lisbon on the Rights of the Patient (1981) and the 1989 United Nations Convention on the Rights of the Child. Among other rights³, the Declaration of Ottawa stated that:

- Parents whose children are admitted to hospital should, wherever possible, be provided with appropriate accommodation in or near the hospital at minimal or no cost. In addition parents should be allowed time off work without prejudice to their continued employment;

- parents, guardians or children of sufficient maturity should be free to change their physician or to seek a second opinion;
- the wishes of children should be taken into account in decisions involving their care;
- a competent child patient, their parents or guardians should be entitled to withhold consent to any procedure or therapy;
- the child patient is entitled to be fully informed about their medical condition.

Dr. James Appleyard himself Pediatrician who was the President of WMA by then, said at the time “that the Ottawa Declaration provides an international bench mark for children’s health care and a bench mark that many governments fail to reach.

This bench mark will empower national medical associations throughout the world to persuade their governments to value their children and improve the health of the world’s children”⁴.

Dr. Appleyard continued “The rights of children to health care need to be at the centre of our health policies and investment in the health care of children is the most cost effective measure for any government to take”⁴.

The amended Ottawa Declaration of 2009 sent a clear demand towards governments, care providers, communities and parents regarding their responsibilities by asking them to have the Ottawa principles fulfilled without any constraints. However, with the revision of 2009, the WMA split the content of the original document as well as additional, new items and information into two documents: The revised policy document⁵, the (then) new Declaration of

1 World medical association, published 22nd. March. 2017, <https://www.wma.net/policies-post/wma-declaration-of-ottawa-on-child-health/>

2 See World Medical Association Web page published 20.October.1998, <https://www.wma.net/news-post/declaration-of-ottawa-on-the-right-of-the-child-to-health-care/>

3 UNICEF. convention on the rights of the child , New York, 20 November 1989.

4 World Medical Association, pub 20 October 1998, <https://www.wma.net/news-post/declaration-of-ottawa-on-the-right-of-the-child-to-health-care/>

5 <https://www.wma.net/policies-post/wma-declaration-of-ottawa-on-child-health/>

Ottawa and a background document⁶, giving explanation to the policy revision, but not being part of the policy.

In addition, the amended Ottawa declaration⁷ stated clearly seven new important principles, which are:

1. Clean water, air and soil with a safe environment
2. Protection from injury, exploitation, discrimination
3. Health Families, homes and communities
4. Healthy Nutrition
5. Early Learning opportunities
6. Availability of drugs & immunization and
7. Research

However, there are other Principles which have been left out from the original Ottawa declaration such as,

1. **Child abuse** which could have been a duplication to the WMA Statement on Child Abuse and Neglect revised by 68th WMA assembly of 2017: There it is noted that the welfare of children is of paramount importance and that child abuse in all its forms⁸ is one of the most destructive manifestations of family violence. Moreover the United Nations convention on the rights (1989) of a child in its article 9,19 and 39 state that all forms of child abuse should be taken into consideration by states parties to prevent them⁹.

6 https://www.wma.net/wp-content/uploads/2017/02/Background_Ottawa_Declaration-Oct2009.pdf

7 See WMA, Current policies. 2017 <https://www.wma.net/policies-post/wma-declaration-of-ottawa-on-child-health/>

8 WMA statement on child abuse and neglect, 15th October 2017 <https://www.wma.net/policies-post/wma-statement-on-child-abuse-and-neglect/>

9 Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989, available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>

The amended policy mentions “protection from the child’s exploitation” however given the definition of the UNHCR in the report entitled “action for the rights of children” UNHCR¹⁰ defines abuse as “the process of making bad or improper use, or violating or injuring, or to take bad advantage of, or maltreat, the person,” while exploitation literally means “using for one’s own profit or for selfish purposes”¹⁰.

Child abuse includes the physical, emotional, or sexual mistreatment of a child, or the neglect of a child, in the context of a relationship of responsibility, trust or power, resulting in actual or potential harm to the child’s physical and emotional health, survival and development¹¹.

Exploitation of a child on the other hand refers to the use of the child in work or other activities for the benefit of others and to the detriment of the child’s physical or mental health, development, and education. Exploitation includes, but is not limited to, child labor and child prostitution; therefore child abuse should be one the principles not be left out⁸.

During Human Rights Council 2018, presenting her report, Ms. Santos Pais said that half of the world’s countries had adopted a comprehensive policy agenda on violence against children. Nevertheless, half of the world’s children experienced violence. Children were disciplined by violent means, bullied, sexually assaulted in their circle of trust, groomed online, and abused in detention centers. The 2030 Agenda provided a historic opportunity to end violence¹². In 2019 there would be an in-depth review of goal 16, including

10 UNHCR report “action for the rights of children” <http://www.unhcr.org/3bb825cd2.pdf>

11 UNHCR, Critical issues Abuse and Exploitation. March 1999, <http://www.unhcr.org/3bb81aea4.pdf>

12 <http://srsg.violenceagainstchildren.org/page/1229>

target 16.2 to end all forms of violence against children.

2. **Religious assistance:** this principle is also in the original document¹³ while amending, it was left behind. However, The Declaration of Lisbon states clearly that one has the right to receive or to decline spiritual and moral comfort including the help of a minister of his/her chosen religion¹⁴.

3. **Freedom of choice:** This principle is not mentioned in the amended policy⁵ as well although in the background document of the amended policy it no longer part of the policy.

4. **Emergency Consent:** The original documents explain that if the child is unconscious, or otherwise incapable of giving consent, and a parent or legally entitled representative is not available, but a medical intervention is needed urgently, then specific consent to the intervention may be presumed, unless it is obvious and beyond any reasonable doubt on the basis of a previous firm expression or conviction that consent would be refused in particular situation; it is not stated in the new polic¹³.

The UN convention on the rights of child¹⁵ deems the “the right to develop a healthy attachment to a parent, legal guardian, or caregiver” as necessary for its social and emotional wellbeing. And finally and in difference to the UN convention children with

13 world medical association. declaration of Ottawa on the right of the child to health care, adopted by the 50th WMA general assembly Ottawa, Canada, October 1998, <https://www.wma.net/policies-post/wma-declaration-of-ottawa-on-child-health/>

14 WMA declaration of Lisbon on the rights of the patient. 2015, <https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient/>

15 <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

Table 1. Summary of the comparison of the original and amended policy

No	Item	Old Policy	New Policy	Background document of the new policy
1	Clean water, air and soil	Left out	Present	Children shall have access to the mentioned items adequately and environments free of toxins and microbes known to harm
2	Protection from injury, exploitation, discrimination	Left out	Present	Mentioned
3	Child Abuse	Present	Left out	Item was pointed out as a sub line of the previous item
4	Health Families, homes and communities	Left out	Present	Mentioned
5	Best Possible Health at Birth	Present	Present	Mentioned
6	Health nutrition	Left out	Present	Mentioned
7	Early Learning	Left out	Present	Mentioned
8	Physical Activity	Present	Present	Mentioned
9	Education	Present	Present	Mentioned
10	Eradicate traditional practices prejudicial to health of the child	Present	Left out	Present under the item No 2
11	Health Resources Available to All	Present but renamed as Quality of care	Present	Mentioned
12	Drugs & immunization	Left out	Present	Mentioned
13	Hospitalization	Present	Present with following details missing	Present with all the details
	1. A child should be admitted to hospital only if the care cannot be provided at home	Present	present	
	2. A child in the hospital should be provided a suitable environment	Present	Left out	
	3. Every effort should be made to allow a child admitted to be accompanied	Present	Left out	
13	4. A child should be allowed as much outside contact and visiting as possible	Present	Left out	Present with all the details
	5. With relevant age a mother should not be denied the opportunity to breastfeed except if there is a medical contraindication	Present	Left out	
13	6. A child should be afforded every opportunity and facility appropriate to play, recreation and continue Education	Present	Left out	Present with all the details
	14	Rehabilitation	Mentioned in the general principal	
15	Freedom of choice	Present	Left out	Mentioned in the background
16	Dignity of the Patient	Present	Present	Mentioned in the background
17	Access to Information	Present	Left out	Mentioned
18	Consent	Present	Present	Mentioned
19	Confidentiality	Present	Present	Mentioned
20	Research	Left out	Present	Mentioned
21	Freedom of choice	Present	Left out	Present
22	No discrimination of any kind	Present	Present	Present
23	Emergency Consent (child unconscious and no guardian available)	Present	Left out	Left out
24	Health Education	Present	Left out	Mentioned
25	Religious, assistance	Present	Left out	Mentioned

Note that the background document is not part of the policy.

with disability were not given much attention in this policy.

3. Conclusion and Recommendation

As expected there are many similarities between the original Declaration of Ottawa on Child Health in 1998 and the amended policy of the 60th WMA assembly in 2009. Both list items to be considered for the good of child health, however, in the new policy which is currently being used as guidance to physicians worldwide is lacking some important principles. Some have been lost in the revision, some moved to the background document (which is not part of the policy) and some were not mentioned in the original and the revised version.

The child health was at the center of the United Nation Millennium Development Goals (MDGs)¹⁶ and it is still a of the priority in Sustainable Development Goal 3 which emphasizes among others the reduction of child mortality. Child health goes beyond SDG 3 to SDG4 (child needs a healthy diet), SDG5 (be free of any discrimination or violence) and SDG6 (clean water and hygiene)¹⁷. The above highlights the critical importance of collaboration and coordinated action across multisector to achieve improvement in chil health. There-

16 United Nations, MDG4 at: http://www.un.org/millenniumgoals/pdf/Goal_4_fs.pdf

17 United Nations, Sustainable Development Goals, 2017 available at: <https://www.un.org/sustainabledevelopment/sustainable-development-goals/>

fore The Ottawa Declaration is one of the key documents together with the Declaration of Oslo on the Social Determinants of Health to guide actions, regulations and attitudes to improve the rights of children to health and health care throughout the world. Under the light of the fulfillment of the United Nations's Sustainable Development goals the revision of the Ottawa Declaration deserves highest attention.

*Elicien Ishimwe,
Medical Doctor,
Ministry of Health, Rwanda
E-mail: ielicien@gmail.com*

*Otmar Kloiber,
General Secretary,
World Medical Association
E-mail: otmar.kloiber@wma.net*

CMA Thousand Talents Cultivation Program for County Hospitals



Kegin Rao



Yongmao Jiang



Weili Zhao

As a social organization of science and technology on the national level, the Chinese Medical Association (CMA) responds actively to the task and requirements of health poverty alleviation put forward by the Chinese government, attaches great importance to the health poverty alleviation work, and gives full play to its advantages of having extensive connections with vari-

ous industries and with all walks of life, as well as to the advantages of the experts and the active roles of scientific and technological communities in poverty alleviation work. With a view to boosting the development of medical and health services in China's poverty-stricken areas, CMA's health poverty alleviation leading group thoroughly carries out the essence of poverty alleviation docu-

ments adopted at the 19th National Congress of the Communist Party of China, reduces or exempts registration fees through academic conferences for doctors in China's west region, at the grassroots level and in poverty-stricken areas, grants transportation and accommodation subsidies to grassroots doctors, intensively patronizes clinical scientific research projects of west region, donates much-needed materials such as medical equipment to impoverished regions and counties and medical periodicals to grassroots hospitals, and launches activities such as CMA Thousand Talents Cultivation Program for county hospitals, etc.

As a typical case of the health poverty alleviation work conducted by CMA, the Thousand Talents Cultivation Program for county hospitals (abbreviated to "Thousand Talents Program") adopts approaches of "going down to grassroots to offer help" and "ushering in grassroots medical staffs for training" to improve grassroots doctors' abilities in diagnosis and medical treatment and to favour the health of impoverished masses. The following is the brief.

I. Going Down to Grassroots to Offer Help – Popularization of Medical Sciences and Technologies

In 2017, the “Thousand Talents Program” invited a total of 223 experts (205 associate seniors or higher and 18 PhDs) to popularize sciences and technologies in 7 provinces, 13 prefecture-level municipalities, 13 counties and 34 hospitals, with ward-round teaching, surgery teaching and gratuitous treatment for the rank and file serving as a platform for study, communication and sharing among grassroots doctors. In this way, the “Thousand Talents Program” set up a bridge of partnership between grassroots hospitals and major hospitals. 8 events conducted in the year attracted a total of 4914 participators, with 4800 copies of data compilations issued gratuitously and downloads of the electronic version reaching 7149.

In addition, some CMA branches secured funds from other sources or used their own funds to conduct special training courses much needed by grassroots units or poverty-stricken areas. In 2017, CMA’s pathology branch conducted the “West Bound” pathology training course in 2017 to teach 165 trainees gratuitously; the anaesthesiology branch offered the clinical anaesthesia guide training course; and the paediatrics branch launched the 11th Paediatricians’ Lecture Tour in West China, etc.

II. Ushering in Grassroots Medical Staffs for Training – Further Education and Training for Grassroots Doctors

In 2017, CMA organized two batches of core-member doctors totalling 207 from county hospitals in 10 provinces to receive a 5-month professional training at 37 provincial Class-A tertiary comprehensive hos-

pitals with a view to improving their abilities in standard diagnosis and treatment of common and frequent diseases, which provided a personnel support for reducing the referral rates from counties.

10 provinces, including Guizhou, Sichuan, Gansu, Qinghai, Jiangxi, Shaanxi, Hubei, Yunnan, Henan and Hunan, were chosen for the pilot project. The provinces were a linked aggregation of destitute areas as listed by Poverty Relief Office of the State Council, highlighting the requirement of improving health conditions for poverty-stricken areas.

The trainees came from 177 hospitals, 91.7% of which were county hospitals or hospitals at the county level (trainees from impoverished counties made up 32.27%, and those from poor cities accounted for 7.73%) while 5.8% were prefecture-level hospitals. The trainees were all honoured with the professional title of attending doctor or higher and had an educational background of college degree or above. Two-thirds of the trainees were less than 40 years old and signed the letter of commitment to promise return to their original units after training to serve continuously at the grassroots level. The pilot project accorded with the sanitation and health work guideline of the new era and observed the “Enhancing Grassroots” spirit stressed in the medical reform and complied with the requirements of establishing and perfecting the mechanism for conducting further education among grassroots health workers as well as training among core-member doctors of county hospitals as are put forward in the *National Health and Family Planning Talents Development Plan for the 13th Five-Year Plan* and the *National Health and Family Planning Professionals Training Plan for the 13th Five-Year Plan*.

The training related to 12 specialties, of which 76% were about gynaecology and obstetrics, paediatrics, intensive care medicine, emergency medicine, anaesthesiology,

psychiatric medicine, etc., which are much-needed specialties underscored in the *National Health and Family Planning Talents Development Plan for the 13th Five-Year Plan*.

To ensure the quality of the further education and training, CMA signed entrusted orientation training agreements with the said 37 Class-A tertiary comprehensive hospitals and appropriated training funds directly to the hospitals to entrust them to cultivate the trainees and issue qualification certificates to the eligible after the training. Apart from entrusting provincial medical associations to guide and appraise the training work in their provinces, CMA also organized a supervising team composed of 10 famous experts in paediatrics, gynaecology, intensive care medicine, ultrasonic medicine and medical pedagogy to launch intensified inspections from Sep. 21st through 22nd, 2017 in Sichuan where trainees were relatively concentrated. The experts went to Sichuan Maternal and Child Health Hospital and Chengdu First People’s Hospital, where they made on-site inspection over the implementation of the training system by the hospitals. In the meantime, the experts offered ward-round guidance and conducted case discussion and academic lectures, etc. CMA also invited representatives of medical associations of other 9 pilot provinces to constitute a research group to watch live demonstrations and make work discussions to enhance the implementation of the training quality requirements and the overall progress in the provinces.

CMA has formulated its “2018–2020 Work Plan for Health Poverty Alleviation Projects”. In the future, CMA will conduct its health poverty alleviation work more accurately, give more play to its advantages, adhere to the problem-oriented and demand-oriented principles, improve its participation and input efficiency and effectiveness in poverty alleviation work, and make its due contributions to the construction of a “Health China”.



Background Information: A brief introduction to the Chinese Medical Association

The Chinese Medical Association (CMA) is a non-profit national academic organization in China. It is an important social force in the development of medical science and technology and a linkage between the government and the medical professionals. Established in 1915, the CMA now has 88 specialty societies and 667,000 members in China.

Major Functions of the CMA include: developing domestic and international medical academic exchange activities; discovering, recommending and cultivating medical talents; editing and publishing 184 medical

and popular science journals including print and electronic, books and over 2,000 audio-visual products; carrying out continuing medical education projects and training specialists; implementing medical project evaluation and review and as well as science and technology decision-making demonstration; selecting and presenting awards for outstanding achievements in medical science and technology; promoting transformation and practical application of medical research results; disseminating medical and health knowledge for the general public; organizing technical appraisalment on medical malpractice and AEFI (Adverse Events Following Immunization); undertaking the functions and missions entrusted by the government, and relaying suggestions and requests from the medical professionals to the government.

The current 25th CMA council was elected in December 2015, with HAN Qide and CHEN Zhu as CMA Honorary Presidents, ZHONG Nanshan and BA Denian as CMA Consultant, and MA Xiaowei as CMA President. The Vice President and Secretary General is Dr. RAO Keqin.

Keqin Rao, Vice President & Secretary General, Chinese Medical Association

Yongmao Jiang, Director, Dept. of International Relations & Publishing House, Chinese Medical Association

Weili Zhao, Program Manager, Dept. of International Relations, Chinese Medical Association

E-mail: cmazhaoweli@163.com

Universal Medical Esperanto Association

Esperanto

Ludwik Lejzer Zamenhof (1859–1917), a Polish ophthalmologist, descendant of a family of language teachers, published his first book about the international language after years of diligent preparation in 1887 [1]. He did so under the pseudonym

Doctor Esperanto – the doctor who hopes, and Esperanto was soon adopted as the name of the constructed language itself.

Esperanto, *Bridge of Words* [2], was designed to be easily learned in much less time than ethnic languages. Word roots are taken from European languages; so many learners

will recognize them. There are no irregular forms, and an appropriate word can easily be created from a known stem by using a logical set of prefixes and suffixes. Given its regularity, no exceptions, language proficiency in Esperanto can be achieved via the internet or smartphone app. There is a well-established method of teaching Esperanto to groups of people who do not have a language in common, the so called Czech-method [3].



Christoph Klawe

According to reasonable estimates, there are about 2 million Esperanto speakers today [4]. They are well connected via international networks and the Universal Esperanto Association (UEA), founded in 1908, has a network of 1669 delegates in 102 countries [5]. The traditional close connection of Esperanto speakers is enhanced by the internet and there is a Smartphone app that locates nearby Esperanto speakers [6].

The UNESCO resolution of Montevideo in 1954 (Resolution IV. 4. 422-4224) recommended that the Director-General of UNESCO follow current developments in the use of Esperanto. In 1977, the Director-General visited the World Esperanto Congress in Reykjavík, Iceland, and in 1985 UNESCO passed a resolution recommending that member countries encourage the teaching of Esperanto.

In the 130 years of its history, Esperanto has produced a rich culture and extensive, diverse literature. The language is pleasantly sounding and can express intricate thoughts and feelings with structural simplicity. Its extensive literature includes poetry, novels, history, science, including dramas and films originally produced in Esperanto. The language has proved to be suitable for scientific exchange as well. The Red Cross supported the use of Esperanto in its humanitarian missions [7].

Brief History of the Universal Medical Esperanto Association

Doctor Ludwig Zamenhof was followed by many other physician-pioneers in the burgeoning Esperanto movement. At the 4th Esperanto World Congress, 1908, Wilhelm Róbin, a Polish doctor, proposed a medical association, subsequently founded as the Tutmonda Esperantista Kuracista Asocio (TEKA: Worldwide Association of Esperanto-speaking Physicians). Róbin edited the medical Esperanto journal *Kuracisto* (Physician) and gained the support of several influential opinion leaders.

Róbin also helped prepare the *Encyclopaedia of Esperanto* and was an important figure in his country. As early as 1893 in Warsaw he founded one of the first Esperanto groups. The first president of TEKA was Dr. Henri Dor (1835–1912), a famous Swiss ophthalmologist. He spoke eleven languages fluently and propagated Esperanto among scientists. The first yearbook of TEKA was published in 1909 with a preface by Zamenhof himself. It contained the addresses of 19 national delegates, 41 representatives in big cities and 428 members.

During the great international medical congress in Budapest (1910) TEKA organized a successful Esperanto session. World War I considerably disrupted the activities of TEKA, but by 1923 they were effectively resumed. Hungarian colleagues took the initiative (Kalocsay, Mezei, Sós, and later Bulyovszky). Other notables included Prof. Dr. Odo Bujwid (1857–1942), a Polish bacteriologist who studied with Koch in Berlin (1885) and Pasteur in Paris (1886), an honorary member of TEKA since 1927.

Prof. Dr. J. Vanverts, a French gynaecologist, was editor-in-chief of the *Internacia Medicina Revuo* (International Medical Review) for many years. This journal has been published in Esperanto from 1923 on.

Dr. Paul Kempeneers (1895–1979), a Belgian physician, orthopaedic surgeon, worked selflessly for TEKA as a chief secretary. Maximilian Blassberg, a Polish doctor (1875–1939), was an outstanding activist in the medical Esperanto movement and president of TEKA for two years. An important milestone was the first comprehensive *Esperanto Dictionary of Medical Technical Terms*, edited by Maurice Briquet (1865–1953), a French physician, in 1932. Briquet was also the editor of the *TEKA-Review* for several years.

After World War II, the centre of Esperanto medical activities shifted to Japan. Dr. Suzuki, professor at the University of Tiba, became the editor of the *Review*. Before and after the 40th World Congress of Esperanto (1955) the Japanese gynaecologist and Esperantist Dr. Hideo Shinoda presented his recently developed surgical techniques in the United States and several European countries; Esperanto was used for interpretation. Following the proposal of Dr. Shinoda at the World Congress of Esperanto in 1961, TEKA members unanimously decided to change the name of the association to *Universala Medicina Esperanto Asocio* (UMEA, Universal Medical Esperanto



Participants of the TEKA founding convention in 1908

Association). UMEA subsequently was lead by Japanese professors Hideo Yagi, Masao Suzuki, Hideo Shinoda and Seiji Kato.

The Hungarian physician Imre Ferenczy took over the presidency from Seiji Kato in 1984 and, in office until 2012, substantially shaped the character of the association [8]. The Czech Dr. Eva Kopečna had served as president of the UMEA for two years, when the author of these lines succeeded her and the head office was transferred to Trier, Germany.

Medical International Review

UMEA started publishing its own journal in 1923. It contained medical research and case reports written entirely in Esperanto. In 1964 the journal was renamed *Medicina Internacia Revuo* (MIR, Medical International Review). After moving from Budapest to Lille and Tiba, from 1994 on, MIR has been published in Krakow, Poland, in print and as an open access biannual journal [9].

As the number of authors able to submit worthy articles in Esperanto has diminished over the years due to the changing fate of the Esperanto movement itself, the editors decided to accept articles in other languages as well. If the article is not in Esperanto, the editors either provide an abstract in Esperanto or, on demand, translate the whole article. With his language policy MIR can give a voice to those who lack access to the English speaking medical community.

In December 2015, MIR was included in the list of scientific B-journals according to the ranking system of the Polish Ministry of Science and Higher Education. Publications in B-journals are acknowledged for the academic careers of Polish scientists [10]. MIR is not listed in the indexes of the US National Library of Medicine or Scopus, not so much because of the lack of quality but because the peculiar language policy did not seem appealing to the reviewers. The contents of MIR can easily be found, however, in Google Scholar.

The Universal Medical Esperanto Association today

UMEA now has members in 19 countries and special chapters of general medicine, rehabilitation, neurology, ophthalmology, psychiatry, psychotherapy, endocrinology, paediatrics, cardiology, infectious diseases, physiotherapy, Traditional Chinese Medicine, neuropsychology, pharmacology, even veterinary medicine, and the traditional Japanese massage technique Yumeiho. Since 1977 UMEA has held a conference of Esperanto speaking physicians every second year (IMEK, Internacia Medicinista Esperanto-Konferenco), which usually attracts 30–200 participants, and less formal international Skype-conferences for Esperanto speaking doctors now and then.

UMEA honors outstanding protagonists in the sphere of Esperanto in medicine with the prestigious UMEA-Shinoda-Award.

UMEA uses the Twitter-account @UMEAeo to be active in social media.

UMEA can support all who need to establish a common means of communication in multinational groups

rapidly, as may happen with humanitarian crises.

UMEA continually proves that Esperanto can be effectively used in medicine. Thanks to excellent networking between international Esperanto speakers, UMEA can effectively convey important medical information to the Esperanto speaking community, as happened on the occasion of the Ebola and Zika epidemics. UMEA has ready access to the estimated two million Esperanto speakers and is willing to support such international health organizations as WMA and WHO.

References

1. Zamenhof L L. Internationale Sprache. Vorrede und vollständiges Lehrbuch. Warschau: Gebethner et Wolff; 1887
2. Schor E. A Bridge of Words. New York: Metropolitan Books, Henry Holt and Company; 2016
3. Internacia Esperanto-Instituto, editors. Baza Cseh-Kurso kun metodikaj konsiloj. Den Haag: Internacia Esperanto-Instituto; 1992
4. Wandel A. How many people speak Esperanto? Or: Esperanto on the web Interdisciplinary Description of Complex Systems, 2015;13 (2), 318-321.
5. Universala Esperanto Asocio, editors. Jarlibro 2017, 109-249.
6. Wikipedia. <https://en.m.wikipedia.org/wiki/Amikumuro>
7. The Esperantist Movement's humanitarian activities in the two World Wars and its relationship with the International Red Cross. <https://www.icrc.org/eng/resources/documents/article/other/57jn53.htm>
8. Ferenczy I: Esperanto kaj medicino. In: Blanke D, Lins U, editors. La arto labori kune. Rotterdam: Universala Esperanto-Asocio; 2012.
9. Homepage of the Journal of UMEA. <http://interrev.com/mir/index.php/mir>
10. Journal Ranking of the Polish Ministry of Education. http://www.nauka.gov.pl/g2/oryginal/2015_12/6a011a7e5df2bc88abdea880d7f3a863.pdf

*Dr. Christoph Klarwe,
President of the Universal Medical
Esperanto-Association
Department of Neurology
and Neurophysiology
Hospital of the Brothers of Charity, Germany*

E-mail: umea@uea.org



Participants of the 20th IMEK, Nitra, Slovakia, 2016

Competence Drift in Professional Practice: a Psychological Perspective



Zubin Austin

Background

Across the health professions, there is significant interest in maintenance of competence [1]. It is an issue for regulators, practitioners, educators, employers, policy makers – and most of all, for the patients who rely upon the knowledge and skills of their care providers [1, 2, 3]. While there are no universally applicable definitions for “competence”, most stakeholders agree that facets of competence include an ability to remain up-to-date with developments in one’s profession, and a fitness-to-practice at a level commensurate with one’s peers [3, 4]. In attempt to systematize thinking about competence many regulators and educators have turned to the use of standards of practice or competence statements as a vehicle for articulating a profession’s baseline minimum competence expectations of practitioners in the field [5]. In many jurisdictions, there are requirements in place for practitioners to complete a minimum number of continuing education hours or units each year as a proxy measure for

demonstrating maintenance of competence in the field (despite the fact that there is no compelling evidence supporting this approach as an effective tool for this purpose) [4, 5]. The measurement of competence through standardized metrics (such as the use of objective structured clinical examinations or well-constructed multiple choice questions) has become a mainstay of professional education and regulation – yet concerns exists as to whether the time, effort and money invested in these approaches actually supports maintenance of competence or simply encourages practitioners to jump through regulatory hoops on a semi-regular basis [4, 5, 6]. In some fields, there is increasing use of self- and peer-assessment models, triangulated with practitioner-specific outcomes data that have shown promising results in terms of professional development; this “360 degree review” approach may be effective, but is logistically cumbersome and very costly, limiting its applicability in most health care professions [7, 8].

Framing Competence

Historically, our understanding of competence has been as a binary: one is EITHER competent or incompetent. Only these two states exist, and practitioners must demonstrate they belong to the former, rather than the latter, category [9]. Measurement of competence through standardized testing further reinforces this binary view of competence: one either “passes” tests or “meets” standards, or one “fails” them or “falls below” standards [6]. While such binary thinking may be marginally more acceptable within an educational context in which students are proving their bona fides, it becomes problematic when applied to practitioners who may have had years

or decades of experience delivering care to patients and communities. A binary model when applied to an experienced practitioner suggests there is a bright line between the two states of “competent” and “incompetent” that may be confidently articulated, measured, and defended.

Hodges and Lingard, quoting Burke, have noted that “every way of seeing is also a way of not seeing” [6]. If we define practicing physicians and other health care professionals using binary terms such as “competent” and “incompetent” what are the consequences, and what opportunities may we be missing? From the perspective of most practitioners, competence is not an either-or phenomenon, and labelling it as such can be profoundly counterproductive in motivating individuals to maintain and enhance their professional skills over a life time of practice. Simply put, how can we understand the process by which a physician – who has worked hard her whole life to first gain entry to a highly competitive medical school, who then sacrificed greatly to get through the gruelling 8–10 years of undergraduate and post-graduate education and training, and then who chooses to take one of the most demanding jobs in society – would allow herself to become incompetent? Framing competence as a binary suggests this physician made bad choices and decisions that led to her current state... and most of what we understand about human psychology and motivation suggests that this simply does not make sense. The vast majority of physicians are smart, well-intentioned, caring individuals who selected this profession to apply their skills and talents in a way that would help their societies and communities. By what process would such smart, well-intentioned, caring individuals “allow” themselves to become incompetent? And does the threat of being labelled incompetent, the use of standardized testing mechanisms, or the requirement for compulsory continuing education actually change an individual’s choices and behaviours?

Alternatives to either-or models of competence

Recently, there has been interest in “seeing” competence in a different way – not as a psychometric or measurement issue, but instead as a psychological issue reflective of lived human experience [6, 9]. While there is an abundance of literature examining the reliability and validity of competence assessment instruments and approaches (5)(6)(9), there is very limited literature examining the experiences of physicians who have failed: individuals who have been labelled by their profession as “incompetent” or who have had their registrations suspended or revoked. How did these smart, well-intentioned and caring individuals end up this way? Beyond caricatures of predatory individuals or substance-abuse problems, how does one move from competence to incompetence without first drifting through an intermediary state (a middle ground) of being somewhat competent? And what is in place to support individuals who (for whatever reason) find themselves in this intermediary state to help them regain their fullest competence?

Competence Drift in the Health Professions

Recently, we published a study examining the psychological dimensions of competence within the context of another profession – pharmacy [10]. This study explored the lived experiences and deterioration experienced by pharmacists who had been labelled by their regulatory body as “incompetent”. Longitudinal interviews [11, 12] with these individuals highlighted that, from their perspective, competence is not a binary: they did not wake up one day and suddenly find themselves incompetent, nor did they (for the most part) maliciously or intentionally choose to become incompetent. Instead, for participants in this study, the voyage from competence to incompetence was characterized as a slow drift, a series of imperceptibly small problems which over time became im-

possible for them to address by themselves. While in some cases, incompetence was the result of wilful decisions (e.g. choosing to defraud an insurance plan), the majority of participants were labelled as incompetent because of their performance on a compulsory, standardized assessment that was part of the annual registration/licensure renewal process for pharmacists. These practitioners – with a mean of 26 years clinical experience (range of 9–33 years) were deemed psychometrically incompetent due to their performance on a required and standardized objective structured clinical examination and a case-based multiple choice test [13], not because of a complaint or disciplinary procedure.

The competence drift experienced by these individuals had several important characteristics. First, there were demographic factors that may highlight who is a risk for competence drift: those in practice 25 years or more, those who worked in sole practice settings without benefit of peers, and those who were internationally educated (i.e. received their formative education and clinical training outside the United States or Canada) appeared to have a higher risk for being labelled incompetent by their regulatory body [10, 13]. Second, the vast majority of these individuals had no prior history of complaints or disciplinary issues with the regulator; their competence drift was only identified through the test that was administered as a compulsory requirement as part of an annual license/registration renewal process [13]. Third – and perhaps most relevant – all of the individuals interviewed for this study highlighted the impact of professional isolation on deterioration of their skills, even though the majority of them had complied with relevant continuing education or other requirements.

A common denominator for participants in this study was the notion of isolation and disengagement from their profession. Those who were internationally educated individuals noted that they never felt they truly “fit in” the professional community as they were,

from the start of their careers, outsiders to the schools and pre-existing professional and alumni networks that characterize professional life. Those who worked in sole-practitioner settings noted that they were in the unenviable position of never actually seeing a peer do their job, and never having the opportunity to actually benchmark themselves against a colleague. Those who had been in practice 25 years or longer noted how much the foundations of practice had changed in those years, particularly society’s and patient’s expectations of what a professional is and should be – the professional was no longer a trusted expert, but instead simply a vehicle to do whatever the patient wanted (as opposed to actually needed).

The Psychological Dimensions of Competence Drift

Competence does not switch on and off quickly – instead, participants in this study reported increasing anxiety, decreasing self-confidence, and diminishing interest in their job as a slow-and-steady precursor to finally being labelled incompetent by their regulator. With professional isolation, there was no obvious person they could ask for help, without disclosing their deficits. Without a person or organization to reach out to, these individuals felt further marginalized and disengaged from their profession. This study highlighted that competence drift may be a decade’s long process or deterioration, one with early warning signs that, if addressed, perhaps could have led to a different outcome for these individuals. Rather than “see” competence as a binary defined by psychometric properties related to tests and assessment methods, if we view competence as a psychological process in which individuals are unconsciously decoupling from their professional community, perhaps there are opportunities to prevent this drift from becoming permanent.

Across all participants interviewed, a common theme emerged: disengagement as



the root cause of competence drift [14, 15]. A psychological unfettering from one's profession, one's professional colleagues and community and ultimately one's patients were characteristics shared by all those who were ultimately found to be incompetent. Importantly, for most of these individuals there was no actual documented harm cause to patients: there were no complaints, no discipline or legal cases, and no evidence that they had done anything wrong. Yet when it came time to actually "prove" continuing competence using psychometric standardized tests, they were unable to do so. Interestingly, after the fact, most of the participants admitted they'd known for years they were sub- or incompetent, but were so psychologically disengaged by this point they had insufficient energy to overcome the inertia of simply carrying on doing what they'd always done. Many participants noted that bureaucratic regulatory requirements – ranging from compulsory continuing education attendance to maintenance of a learning portfolio, to completion of standardized competence assessment tests – all contributed to this competence drift, as they were seen as simply hurdles to be cleared and not valuable opportunities to reengage professionally with their field or their community.

While this study in one profession may have limited direct applicability to other fields because of the unique way in which "incompetence" was measured and defined, there may be lessons that could be of relevance to all health care professions. First, competence is not an either-or state, it is not a binary. Competence is a continuum and competence drift is a years- or decades-long process. Along this continuum there may be warning indicators and red flags – for example, demographic risk factors; rather than focus on maintenance of competence as a series of proxy requirements (e.g. compulsory continuing education), we would be advised to focus on these early warning indicators and intervene in a supportive way sooner. Second, a core feature of competence drift appears to be disengagement – from

colleagues, from the profession itself, and ultimately from patients. Psychological disengagement deprives an individual of the energy and motivation required to actually address competence drift on his/her own. At a certain point, a disengaged individual simply cannot see the problem or help him/herself and will require some external support to see them through to a more positive outcome. Unfortunately, after graduation and registration as a health care professional, there are few opportunities for a practitioner in competence drift to actually reach out to find such help; to whom can a disengaged, disconnected physician turn if s/he suspects s/he is experiencing competence drift? Regulators are not to be trusted due to their obligations to protect the public; disengaged individuals likely do not have peers or confidantes within the profession they can turn to and admit the need for help [15]. Continuing education has been demonstrated to have very limited value (if any) in leading to practice change. Third, psychological disengagement becomes a vicious downward spiral [15]; as competence continues to deteriorate, disengagement becomes even more of a survival and coping mechanism. Fourth – and perhaps most importantly – this vicious downward spiral is rarely if ever a conscious choice or decision made by the practitioner, and it may accelerate over time, making it even more difficult to stop the descent. Fifth, our current practices and approaches within medical regulation and education – while well-intentioned – may actually be paradoxically contributing to this downward spiral. In the name of public protection, we may be using concepts, tools and approaches that actually further irritate, isolate, and ultimately disengage practitioners from their profession. For example, framing competence as a binary concept (as we currently do) deprives practitioners of a vocabulary to describe their lived experience of competence drift. Requiring practitioners to "prove" they are competent may not actually improve practice and enhance competence if it is interpreted as simply a hoop to be jumped through and bureaucratic require-

ment enforced by those who do not realize how challenging day-to-day patient facing work actually is in today's environment.

Conclusions

We need to "see" competence in a different way, one that is more psychologically nuanced and recognizes that physicians and other health care professionals are actually like all other human beings. By seeing competence as a continuum, not a binary, and by recognizing that the psychological energy required to maintain competence comes from engagement with one's profession, not mandatory continuing education, we may have opportunities to prevent small problems from becoming bigger ones. When we see competence drift as a psychological, rather than psychometric, issue, new opportunities open for providing support and remediation in a more targeted and more nurturing manner. Psychological engagement in one's profession – a feeling of positive, energized connection to colleagues, the field itself, and the patients we serve [15] – needs to be researched further as an inoculation to competence drift. In so doing, perhaps we will find alternative ways to intervene in competence drift before small problems become big ones.

References

1. Epstein R and Hundert E. Defining and assessing professional competence (review). *J Am Med Assoc.* 2002;287(2): 226–236.
2. Ibrahim J. Continuing professional development: a burden lacking educational outcomes or a marker of professionalism? *Med Educ.* 2015;49(3):240–242.
3. Kane M. The assessment of professional competence, *Eval Health Prof.* 1992;15 (2):163–182.
4. Kogan J, Holmboe E and Hauer K. Tools for direct observation and assessment of clinical skills of medical trainees: a systematic review. *JAMA* 2009;302(12):1316–1326.
5. Accreditation Council for Graduate Medical Education (ACGME) and American Board of Medical Specialties (ABMS). *Toolbox of Assessment Methods v1.1 – September 2000.* Accessed at: <https://www.slideshare.net>



- net/pedgishih/toolbox-of-acgme-assessment-methods on August 8 2018.
6. Hodges B and Lingard L, (Eds.) (2012). The Question of Competence: Reconsidering Medical Education in the Twenty-first century. ILR Press; Ithaca NY.
 7. Sargeant J, Mann K, Sinclair D, van der Vleuten C and J. Metsemakers J. Challenges in multi-source feedback: intended and unintended outcomes. *Med Educ.* 2008; 42 (10): 1107-1113.
 8. Smither J, London M and Reilly R. Does performance improve following multisource feedback? A theoretical model, meta-analysis, and review of empirical findings, *Person Psychol.* 2005; 58:33-66.
 9. Eva K and Regehr G. "I'll never play professional football" and other fallacies of self-assessment, *J Continuing Educ Health Prof.* 2008;28 (1):14-19.
 10. Austin Z and Gregory PAM. The role of disengagement in the psychology of competence drift. *Res Social Admin Pharm* 2018 Feb 27. Accessed at: <https://www.sciencedirect.com/science/article/pii/S1551741117307775?via%3Dihub>
 11. Kratochwill T and Levin J (2014). Single-case Intervention Research: Methodological and Statistical Advances. American Psychological Association Press.
 12. Kratochwill T and Levin J. Enhancing the scientific credibility of single-case intervention research: randomization to the rescue. *Psychol Meth.* 2010; 15 (2): 124-144.
 13. Austin Z, Marini A, Croteau D and Violato C. Assessment of pharmacists' patient care competencies: validity evidence from Ontario (Canada's) quality assurance and peer review process. *Pharm Educ.* 2004;4 (1);23-32.
 14. Csikszentmihalyi M (2008). *Flow: The Psychology of Optimal Experience.* Harper Perennial Modern Classics New York NY.
 15. Schon D (1983). *The Reflective Practitioner: How Professionals Think in Action.* Basic Books New York NY.

*Zubin Austin, BScPhm, MBA,
MISc, PhD, FCAHS
Professor and Koffler Chair in Management,
Leslie Dan Faculty of Pharmacy,
University of Toronto Canada*

*Paul AM Gregory, BA, MLS
Research Associate, Leslie Dan Faculty of
Pharmacy, University of Toronto Canada*

Workforce of Healthcare Professionals in Rural Nigeria



Buowari, Dabota Yvonne

Healthcare is essential in the growth of any country though with its challenges. This article examines healthcare services and workforce in rural communities in Nigeria. This is a review article. Search for previous articles written on health care in rural Nigeria was done using Google, PubMed and Medline to search for articles on healthcare in rural areas, developing countries and Nigeria. There is dearth of

health care in Nigerian rural areas due to lack of career opportunities, lack of basic amenities, lack of training opportunities and fate in traditional medicine.

Health is the most significant ingredient to life [1] and the quality of health in any state or country is the fundamental right of its citizens [2]. This means that a healthy nation is made up of healthy citizens. In Nigeria a large percentage of the population reside in rural communities hence they are also entitled to good healthcare facilities [3]. Providing equitable access to healthcare becomes an indispensable imperative to achieving wellbeing [4]. Compared to inhabitants in Nigerian urban areas, people that dwell in rural and remote areas experience a lower life expectancy and poor health status [5]. Generally, Nigeria has a high population density but a weak healthcare system [6]. Therefore, access to healthcare should be near to where the people live as much as possible [7]. The health sector is labour intensive as it requires different professionals and precise application of knowledge to deliver quality service [8]. Good public health is vital in any country not only for the purpose of maintaining a

healthy populace but also as a matter of national security [1].

Healthcare in Nigeria

Healthcare in Nigeria is provided by both the government and private health facilities though some individuals still practice traditional medicine in the use of herbs and other traditional materials. The practitioners of this traditional medicine are herbalists, traditional bone setters, traditional birth attendants, spiritualists and faith healers. The spiritualist and faith healers use religion and conduct sacrifices as part of administering traditional healthcare to people that patronize them. In Nigeria today, the provision of healthcare facilities seems to be at low ebb as many Nigerians are vulnerably exposed to death [1]. The healthcare facilities in Nigeria are three-tier, the primary, secondary and tertiary healthcare facilities [9]. The primary healthcare centres and health posts provide primary health care services, the general, district and cottage hospitals provide secondary healthcare services while the teaching hospitals, federal medical centres and specialists' hospitals provide tertiary healthcare services [9]. The tertiary health care providers receive referrals from the primary and secondary healthcare providers.

The Nigerian government has made numerous great efforts in providing healthcare facilities for its citizens especially in the establishment of primary healthcare centres in Nigerian rural communities [10]. The private hospitals are usually expensive and mostly located in the urban areas hence individuals use their digression to choose which health facility they wish to receive healthcare.

In a study conducted in rural communities in Kogi State, Nigeria, results from the study suggested that distance to improved health facilities and the total costs of seeking healthcare needs to be reduced to enhance accessibility to improved health services by various socioeconomic groups [10]. Many countries are striving to keep pace with healthcare delivery because the sustainability and viability of any country's economic and social growth depends on the healthcare sector as a nation of sick people would certainly not live up to its basic responsibilities [1].

Healthcare Professionals in Nigeria

The healthcare workforce is made up of health workers which include all the people involved in the promotion, protection or improvement of the health of the population which play a very important role in achieving an effective healthcare delivery system [11]. The healthcare system requires a large number of health workers [8] to address the health needs such as the doctors, nurses, laboratory scientists, physiotherapists, medical technologists, medical technicians and others. The healthcare workforce is an important guide and indicator of the strength of the health system and also the quality of healthcare in a country. Though there is shortage of healthcare workers in Nigeria [11], there is too much concentration of medical personnel in the urban areas than in the rural communities [2]. Generally graduates both in medical

and non-medical professions prefer to work in the urban cities [7] where there are better amenities such as pipe borne water, electricity, telecommunication, career advancement opportunities, good schools, accommodation and communication problems if they do not understand the local language. Therefore retention of healthcare workers in these rural communities is a challenge [13]. The inadequacy of medical doctors, nurses and midwives across Nigeria in 2016–2030 is not likely to change and this would not likely affect the health indicators over the same period since healthcare workers force play a critical role in strengthening health system of any country [11].

Healthcare in Rural Areas in Nigeria

A healthy country is a wealthy country as its citizens are useful resources that will be involved in useful investments in order to move the nation to greater heights [1]. Most rural Nigerian communities do not have access to healthcare. Sometimes there are health facilities either primary or secondary healthcare facilities but the service is not utilized by the inhabitants. There are different reasons for this. While primary healthcare centres (PHC) are relatively uniformly distributed throughout the local government areas (LGA) in Nigeria, the rural people tend to underuse the service [2]. The availability of basic health services provided by the primary healthcare centres especially to rural areas in a country might be used as a yardstick to measure the extent of its level of development of healthcare [2].

Adequate and equitable distribution of healthcare facilities in rural areas is critical to human capital development [10]. Before the establishment of these health facilities, most residents in Nigerian rural settlements depended on traditional health services, but presently there exists a variety of healthcare services in Nigeria [14]. Though the primary healthcare centres were established in

both rural and urban areas in Nigeria with the intention of equity and easy access regrettably the rural populations in Nigeria are seriously underserved when compared with their urban counterparts [2]. Therefore the government should encourage public-private partnership in healthcare delivery at affordable prices to people residing in rural areas as is done in the urban areas, as this would be achieved through the provision of basic infrastructure such as accessible roads, electricity etc [10].

Challenges of Healthcare in Rural Nigeria

There are challenges facing health care delivery in rural areas. A large percentage of the Nigerian population living in rural areas have been affected with several diseases with deleterious consequences both on their health and finance [3] due to the shortage of healthcare workers in rural areas. There are many challenges to healthcare in Nigerian rural communities.

1. **Lack of good roads and other means of transportation to the health facility:** This transportation problem is a significant problem in the management of primary healthcare centres [2]. In order to overcome the barrier of distance to the utilization of healthcare facilities in the rural communities, government should establish the primary health centres in the core rural areas close to where the people live.
2. **Lack of training for healthcare workers:** There is lack of training most times available to healthcare professionals working in rural areas compared to those working in the urban for instance there is no continuous medical education/continuous professional development for medical doctors in the rural areas and this is a prerequisite for the renewal of medical doctors and dentists practising licence by the Medical Dental and Medical Council of Nigeria. Academic isolation has been identified as

one of the factors that discourage doctors from working in underdeveloped areas. Training deficiencies is a restraining factor that needs to be addressed to enable medical practitioners to deliver equitable and quality service in district and cottage hospitals which are located in rural areas [12].

3. **Lack of basic infrastructure in Nigerian rural areas:** There is lack of basic infrastructure in the rural communities. This discourages healthcare workers from staying at their duty posts when posted to the primary healthcare centres and other district, cottage and general hospitals located in rural areas. These include lack of electricity, telecommunication services, social amenities and schools for their children. Poorly equipped and managed hospitals, inappropriate training and an excessive workload are significant contributors to poor healthcare facilities in rural areas [15]. Better healthcare in the Nigerian rural communities could be achieved through the provision of basic infrastructure such as accessible roads, electricity, water, schools and essential drugs [10].

Healthcare is very important to both residents of urban and rural areas. There is shortage of healthcare workers in developing countries with Nigeria inclusive. Most of the healthcare workers in Nigeria are

concentrated in the urban communities where there are better amenities and career opportunities. There is need for government to tackle the challenges facing both the delivery of healthcare services and healthcare professionals in the rural areas in order to encourage all cadres of health workers to develop interest in working in rural areas.

References

1. Eme OI, Uche AO, Uche IB. Building a solid healthcare system in Nigeria: challenges and prospects. *Acad J Inter Stud*, 2014, 3 (6), 501-510.
2. Abdulraheem IS, Olapipo AR, Amodu MO. Primary healthcare services in Nigeria: critical issues and strategies for enhancing the use by the rural communities. *J Pub Health Epid*, 2012, 4 (11), 5-13.
3. Udoudo MGM, Umoh GS. Can government deliver quality rural healthcare? Empirics on malaria prevention and control in Nigeria. *Asian J Econ Modelling*, 2016, 4 (2), 70-81.
4. Omogbadegun Z. Development of a framework for collaborative healthcare services delivery. *Inter J Adv Comp Sci Apli*, 2013, XXX(No XXX), 1-9, www.ijacsa.thesai.org accessed 2018.
5. Strasser R, Kam SM, Regalado SM. Rural healthcare access and policy in developing countries. *Annual Rev Pub Health*, 2016, 37, 395-412, www.annualreviews.org
6. Okoli U, Eze-Ajoku E, Oludipe M, Spiekier N, Ekezie W, Ohiri K. Improving quality of care in primary healthcare facilities in rural Nigeria: successes and challenges. *Health Serv Res Manag Epid*, 2016, 1-6, doi: 10.1177/2333392816662581
7. O'Connor B, Bagg W. Encouragers and discouragers affecting medical graduate's choice of regional and rural practice locations. *Rural Remote Health*, 2017, 17, 4247, doi org/10.226051/RRH4242
8. Adindu A, Asuquo A. Training human resource for 21st century Nigerian health sector. *Global J Hum Res Manag*, 2013, 1 (3), 1-11.
9. Udoh U, Uyanga J. Housing conditions and health in rural Nigeria: a study of Akwa Ibom State. *Res Hum Soc Sci*, 2013, 3 (18), 34-42, www.iiste.org accessed 2018.
10. Awoyemi TT, Obayelu OA, Opaluwa HI. Effect of distance on utilization of healthcare services in rural Kogi State, Nigeria. *J Hum Ecol*, 2011, 35 (1), 1-9.
11. Adebayo O, Labiran A, Emerenini CF, Omoruji L. Health workforce for 2016-2030: will Nigeria have enough? *Inter J Innovative Healthcare Res*, 2016, 4 (1), 9-16.
12. Okoli U, Mohammed SA, Ejecka C, Oshin T, Okigbo A, Ekezie W. Strengthening primary healthcare services in rural Nigeria: the potential of using midwives as skilled birth attendants. *Health Systems Policy Res*, 2016, 3 (2), 18, 1-7.
13. Obembe TA, Osungbade KO, Olumide EA, Ibrahim CM, Fawole OI. Staffing situation of primary healthcare facilities in federal capital territory Nigeria: implication for attention and retention policies. *Afr J Soc Manag Sci*, 2014, 5 (2), 84-90.
14. Efe SI. Healthcare problem and management in Nigeria. *J Geo Reg Plan*, 2013, 6(6), 244-254.
15. De Villiers MR, De Villiers PJP. Doctors views of working conditions in rural hospitals in the Western Cape. *SA Fam Pract*, 2004, 46 (3), 21-26.

*Dr. Buowari, Dabota Yvonne,
Riverine Community Medical
Centre, Port Harcourt, Nigeria.*

E-mail: dabotabuowari@yahoo.com

International Congress on Medical Ethics, a Risk Worth Taking?

Introduction

The Icelandic Medical Association was one of the 27 founding members of the WMA in 1947 but in October this year the first constituent WMA meeting will be held in Iceland. The venue of the General Assem-

bly is the extraordinary music and conference centre Harpa by the harbour in central Reykjavik. For the first time, a two and a half day conference on medical ethics is planned replacing the traditional scientific day. It has been a challenge to organize a conference in parallel with the obligatory

meetings of the assembly. The last day is specifically organized around the central issues of the WMA, based on some of its most important policies such as the Declaration of Geneva and the Helsinki Declaration. We are hoping for good attendance, not only by the delegates of the assembly but by all those working on medical ethics in the respective medical associations as well as others that are interested in following the dialogue inside the WMA on medical ethics.

The medical ethics conference (MEC)

At the opening of the conference, WMA president Yokokura and the Health Minister of Iceland will address the participants in addition to the president of the Icelandic Medical Association and the President of the conference. Following the opening ceremony, the Secretary General of WMA, Dr. Otmar Kloiber will give an overview of the history of the WMA. As the conference is not only for delegates to the Assembly, this is a very good opportunity to inform of the activities of the WMA through the decades since its foundation 71 years ago and the impact it has had.

Generally, there are two parallel sessions, most of them organized with a specific theme, i.e. invited symposia. In addition, there are two sessions with free oral presentations. The general rule for a symposium is three presentations at 20 minutes each and 30 minutes of discussion. This is rather unusual but it has to be pointed out that this is not a classical scientific conference, rather a forum for dialogue and discussions. Therefore an ample time for discussions is planned for in each symposium. Another point worth mentioning is that the last day is specific for the topics that are central to the WMA even though all other topics are important in one way or another. This is the classical scientific day of a WMA General Assembly as it has been practiced for decades. The central policy documents of the WMA such as the Declaration of Geneva (DoG), the International Code of Medical Ethics (ICME), the Declaration of Helsinki (DoH) and the Declaration of Taipei (DoT) will be discussed. Some of them have recently been revised (DoG and DoT) but others are in a starting phase of the next revision (if so decided) such as the ICME that is very linked to DoG. The most known policy of WMA, the DoH was revised in 2013. There are now some ideas of changes that will be discussed at the conference. It remains to be seen if this will lead to a new



Jon Snaedal

round of revision, it is up to the formal bodies of WMA to decide.

The only social event that is planned for the participants is the reception at the City Hall, an event that is for both the MEC and the GA. In addition our travel agency, the Iceland Travel is organizing many tours for the participants.

The web site of the conference is www.medicalethicsiceland.is

A Facebook page has been created: www.facebook.com/events/33292879056658

The General Assembly (GA)

The GA will have the usual format, which is not necessary to describe for the readers of the WMJ. Every location is however unique and so it is in Iceland. This is the most northern capital in the world and the weather can be unpredictable. It will most likely be around 10°C and hopefully, the windy season has not begun but that varies from one year to the next. There might be opportunities to see the Northern lights as the autumn is the best time but the visibility needs to be good. The main hotel is not adjacent to the venue and thus transportation is provided for. There will be a city tour for

the accompanying persons on Thursday and the classical half-day tour for all the participants is scheduled on Friday. On that tour, the GA members and their accompanying persons will visit Thingvellir, the area for the oldest parliament in the world, established the year 930 and on going since then apart from 45 years in the early eighteen century. It is also a very interesting geological area as it is the most visible rift on land between Europe and America. The dinner will take place in a replica of the oldest type of houses in the country that were built by the settlers in the 8th century.

To take a risk

The Icelandic Medical Association is celebrating its 100 years anniversary in 2018. There are many special events organized through the year celebrating the profession, not only for its work and its contribution to society but also for other contributions such as in music and literature as some doctors have been quite influential in these areas. The GA and the MEC in October is however the biggest event. There are some risks taken by organizing the conference. First of all, it is to some extent parallel to the GA and that creates some difficulties and has been criticised. Another risk is on the finances. The Association is taken full financial responsibility for the event even though WMA will contribute with speakers and other support. As there is ever growing competition regarding conferences and as this is the first time an international conference focusing purely on medical ethics is organized, it is obvious that the organizers could not count on good attendance. The Association is however in good standing and the event will take place and hopefully be memorable for all of us.

*Jon Snaedal,
President of the International
Conference on Medical Ethics
2.-4. October 2018
Reykjavik, Iceland*

Multi-Media Educational Tool Created to Help Children Cope with Cancer



Brian Julius

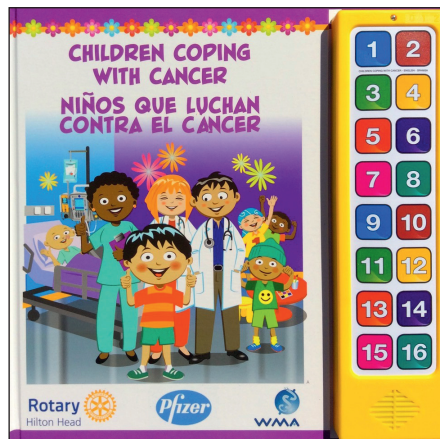
Making sense of what a cancer diagnosis means is monumental for anyone. How much more complicated and unbearable for low literacy patients and children who really don't understand their diagnosis or what is happening to them? Globally, the absence of suitable health educational material, particularly for those whose home language is not English, severely aggravates misunderstanding and treatment non-compliance.

The Speaking Book® is a multi-media educational tool developed specifically to deliver critical health information to vulnerable patients and communities in an interactive, non-threatening and culturally appropriate way. Using 16 audio buttons that follow the written text of each page of the Book allows the patient to follow the book and listen to the messages, if they are unable or unwilling to read.

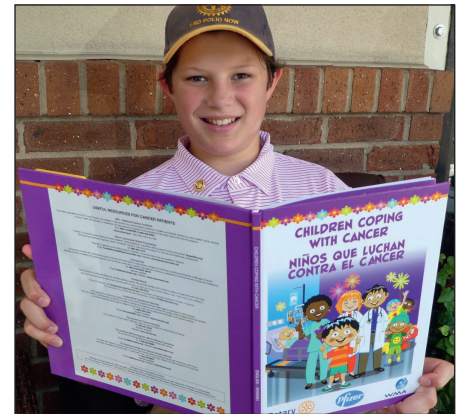
Speaking Books® has just launched a brand new book – “*Children Coping with Cancer*” – created for children in paediatric oncology wards in the USA. Written in

English and Spanish, this ground-breaking Book was developed with the input and assistance from a number of paediatric oncologists; is endorsed by the WMA, funded by Pfizer, and has the support of the Rotary Club of Hilton Head. Together with Pfizer and Rotary Clubs in the USA, the Speaking Book® *Children Coping with Cancer* will be distributed in all children's cancer centres and hospitals free of charge whilst stocks last.

“In addition”, according to Brian Julius, The President and Founder of Speaking Books®, “we have included on the back page a list of really useful resources for parents and care givers to contact for cancer related questions, financial and emotional support”



The two narrators of the Book, Cade Kris-cunas (11) and Efrain Tinoco (10) are members of The Rotary Club of Hilton Head's “Early Act Programme” for young Rotarians. Together their narration of this Book in English and Spanish delivers a message of hope and courage to children with cancer. With a push of a button, children in oncology wards (and their families) can listen to *David* telling his story about being a child with cancer; can learn about cancer; and can be entertained and distracted.



David provides an understanding and relatable voice for children. “I had cancer too. I am here to keep you company while you're in the hospital. I know you might be scared or in pain now.” He explains, in an easy to understand way, what cancer is and how children can cope. In writing the Book, research showed that many children with cancer and other life-threatening illnesses feel they are to blame for being sick or that their illness is a punishment. *David* emphasises that cancer is an illness. “You cannot catch it from someone and you cannot make anyone else sick. You did not get cancer because you were naughty or because you did something wrong.”

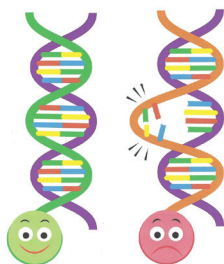
From counting flowers, to finding the squirrel hiding in the garden, to drawing pictures, *David* and *Children Coping With Cancer* distracts sick kids from the pain of treatment. The Speaking Book® is colourful and interactive. *David* chats naturally with his young audience and helps them feel less lonely and afraid.

Childhood cancers are very different in nature, cause and treatment to adult cancers. While generally childhood cancers tend to respond better to treatments that adult cancers, they require specialist paediatric treatment by a paediatric oncologist. The occurrence of childhood cancer is significantly less than that of adult cancer. To develop the expertise required, the medical team needs to see a large number of patients. This has

led to childhood cancers worldwide being treated mostly in public sector hospitals.

While the expertise is generally in a public hospital, often there is insufficient time to devote to each patient. There are waiting lists and busy staff and the environment can be all the more overwhelming for a child and for a family who may not speak English. It is for this reason that *Children Coping with Cancer* was created as a dual-language English/Spanish Book.

David explains what cancer is in a way that is engaging and comprehensible. He asks his listeners to copy a picture in the Book as quickly as they can. It isn't quite right... "When we grow, our cells and DNA split into two and make a copy of each other like the copy of your picture. Kids grow really fast and sometimes the copy isn't the way it should be. That's what cancer is." He explains that there are different types of cancer and that it can start in any part of the body. Cancer can spread but it is always named for the place where it starts.



Through the Book, *David* explains the treatment teams to the child. He reaches out to each listener, encouraging them to trust their teams and all the tests and procedures. "You have a lot of different people on your team to make sure that you will get well." One of the strengths of the Speaking Book® is that it answers questions that may not be able to be asked. Many patients who use the Speaking Book® feel like their doctor is always with them, answering their questions, and reinforcing healthy treatment compliance. For children with cancer, and for their families, having a reassuring expert at the touch of a button is incredibly powerful. *David* will tell you the same advice, will play the same games, and share the same secrets

with you every time you press the button. For people trying to grasp a diagnosis of cancer, this reassurance is comforting, educational and empowering.

"Our experience with all Speaking Books® has always been so positive, and we know this latest book will go a long way to help reduce Children's Fears and improve their understanding of Cancer, that it is not catching, was not their fault, and that they are being looked after by wonderful people dedicated to their treatment." Says Marc Chioda, Medical Director, Pfizer Oncology.



Each child is different. Some worry. Others get upset or become quiet, afraid, or defiant. Some express their feelings in words, others in actions. *Children Coping with Cancer* offers all children, across age groups, to express how they feel and connect with another child in a safe space. In the absence of fact, children use their imaginations to make up answers to unanswered questions. Answering questions honestly can be extremely challenging for families who don't have the language capacity to really grasp what is happening to their child. The Speaking Book® is dual language for exactly this reason.

David (Cade Kriscunas and Efrain Tinoco) are honest with their listeners that treatment may hurt; that they may feel scared

and sick. They also have words of wisdom for their young listeners... "We know that you want to be brave and strong and not cry or show how you feel. I used to try and pretend I was fine but I learned that being really brave means telling other people when you feel weak or sick."

It is in this spirit that this Speaking Book® is dedicated to Dr. Jack Watters, former Pfizer Vice President and Fellow and Trustee of both the New York Academy of Medicine, and Help Aged International who passed away on June 30th 2015 from Cancer. He was an invaluable supporter for public health care and a tireless advocate of health care education. He did so much to promote health care education to the most vulnerable communities, and is sorely missed.



Speaking Books® have been developed in more than 40 languages for distribution in over 30 countries worldwide. Childhood cancer is certainly not limited to the USA. While this Book has been created, with Pfizer, the WMA and the Rotary Club Hilton Head, for childhood cancer centres across the United States of America, it is the aim to offer this Book to children and families across the globe.

Brian Julius
Speaking Books, Hilton Head, USA
Website: www.speakingbooks.com
E-mail: bj@speakingbooks.com



Remembrance from Riga 26.– 28. April, 2018. 209th WMA Council Session
With greetings from Latvian Medical Association and President Pēteris Apinis

