

World Medical Journal



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Editor

In general, people are experts in three areas – educating their next-door neighbour's children, coaching their national football team and treating patients, especially if it does not directly concern themselves or their next of kin. Politicians, journalists and influencers (Internet stakeholders) seem to possess this expertise best of all, regarding health care in particular. Wherever they may be, these experts believe that medicine is no good at all, doctors should be wiser and more industrious, and that health care needs a reform. Strange as it may be, nearly in every country medical doctors, too, think that a reform is needed in health care; however, their understanding of this reform is quite different. Nonetheless, the numbers of advisers in health care reform matters keep increasing: most probably, there are billions of them.

Health care professionals and patients expect the reform to be a set of actions making health care structure more compact and targeted and capable of using human resources, material resources, technologies, facilities and transport etc. in a more efficient way. Policy makers and finance people associated with governments believe that reforms in health care mean cutting expenses in the health sector and investing the spared money in technological advancement. Those engaged in the system understand any reform as increase of collective and solidary financing from public budget or insurance.

In this aspect, it is similar all over the world – health care needs more money due to ageing population, increasing numbers of patients with chronic diseases and growing costs of medical technologies and medication. However, the opinion of governments, global associations, finance people and ministers for health is very dissimilar. We could notice that in Astana. Nevertheless, the world was able to agree that primary health care and universal coverage is the very basis of global health care.

Our goal is *health care in all policies*; however, according to the Astana Conference, there is an impression that more often than not it is rather *policy in all healthcares*. As to healthcare, the reality always is determined by the point of view from which we are looking at health care. Nevertheless, the global document has been adopted. The Global Conference on Primary Health Care in Astana, Kazakhstan in October 2018 endorsed a new declaration emphasizing the critical role of primary health care around the world. The declaration aims to refocus efforts on primary health care to ensure that everyone everywhere is able to enjoy the highest possible attainable standard of health.

My choice is to quote the part of the Astana Declaration that concerns us, leaders of national medical associations – actual stakeholders of global health care:

Align stakeholder support to national policies, strategies and plans. We call on all stakeholders – health professionals, academia, patients, civil society, local and international partners, agencies and funds, the private sector, faith-based organizations and others – to align with national policies, strategies and plans across all sectors, including through people-centred, gender-sensitive approaches, and to take joint actions to build stronger and sustainable PHC towards achieving UHC. Stakeholder support can assist countries to direct sufficient human, technological, financial and information resources to PHC. In implementing this Declaration, countries and stakeholders will work together in a spirit of partnership and effective development cooperation, sharing knowledge and good practices while fully respecting national sovereignty and human rights.

Dr. med. h. c. Peteris Apinis,
Editor-in-Chief of the World Medical Journal

Valedictory Address of WMA President Dr. Yoshitake Yokokura, October 2018



Yoshitake Yokokura

One year has passed since October 2017 when I was inaugurated the 68th WMA President.

This picture was taken after the inauguration ceremony. I feel that all these people coming from the developing and advanced countries, beyond race, are looking forward to the future of global health care with a smile. I have used it as the opening slide of my presentation to introduce the activities of WMA.

I visited various countries as WMA President and participated in many events in the past year.

In the greetings and presentations in the events I have suggested promotion of Universal Health Coverage (UHC). In the inaugural speech, I mentioned that there was a universal health insurance which pushed Japan's average life expectancy to the world's top level. I also advocated efforts in the aged society in which with healthy life expectancy extended, the society which supports the elderly is changed to the society which the elderly supports.

This graph shows historical changes in mortality rate in Japan by major five causes of death in 1947–2016. Tuberculosis, which marked 146,000 in death toll in 1947, sharply declined since 1951 when the TB control law was enacted. It can be seen that this contributed greatly to the achievement of universal health insurance in Japan in 1961.

Trends in medical expenses for TB have been declining to 27.7% in 1954, 15.7% in 1961 and as low as 0.09% in 2009. This indicates that TB control has achieved great results.

This slide shows 5 year survival rate of cancer patients in Japan. The survival rate has been improved by implementing the Cancer Basic Countermeasures Act with the joint efforts among the central government, local governments and medical community.

This graph shows the current average life expectancy in Japan. It is 80.98 for males and 87.14 for females in 2016. And for healthy life expectancy, 72.14 for males and 74.79 for females.

The JMA has been doing various efforts to extend healthy life expectancy. There are health promotion activities for the public. They are "Health Japan 21" led by the government, the Japan Health Council in which the private sector works together, and the Diabetes Countermeasures Promotion Council that the JMA is working for with specialty societies. Through these efforts, the Japanese average life expectancy stays in the world top level in 2016.

I would like to talk about the promotion of UHC.

To achieve UHC in Japan, it took about 40 years since the health insurance law was enacted in 1922.

It is clear that this system has contributed greatly to Japanese health and longevity.

In September 2015, the UN General Assembly adopted the 2030 Agenda for Sustainable Development that includes 17 Sustainable Development Goals (SDGs), built on the principle of "leaving no one behind". Goal 3 states to ensure healthy lives and promote well-being for all at all ages.

The UHC Forum 2017 was jointly organized by the Japanese government, WHO, World Bank, UNICEF and others in Tokyo. At this occasion, we invited Dr. Tedros, Director General of WHO, to dinner which was planned by the Japanese government, Ministry of Health, Labor and Welfare and Parliament members who are supporting me.

In the UHC Forum in Tokyo, the declaration for UHC was supported by many global leaders including Japanese Prime Minister Shinzo Abe, UN Secretary General Antonio Guterres, Heads of WHO, World Bank, UNICEF, WMA and a remarkable array of leaders. Through this forum, UHC became a global goal for national health policy of the countries.

As WMA President, I stated that the WMA will promote UHC together with 114 member associations.

The forum adopted the Tokyo Declaration of UHC reaffirming Health for All.

In the declaration, we call for greater commitment to accelerate progress towards UHC.

As WMA President, I exchanged the MOU with Dr. Tedros at the WHO headquarters in Geneva on April 5th this year to promote UHC and strengthen Emergency Disaster Preparedness.

Lecture of promoting UHC was made by the WHO senior advisor after the MOU exchange.

The National UHC road map was presented. He suggested the WHO supports for the WMA engagement to contribute to physician's capacity building in countries, national policy dialogue on health workforce and global advocacy for workforce investment, for example in the occasion of G20 Osaka summit in June 2019.

It was planned to hold Health Professional Meeting 20 or H20 to discuss UHC promotion with the WHO leadership, the six regional offices, and medical associations of each region of WMA.

This plan was agreed by Japanese Prime Minister Shinzo Abe, the Minister of Health, Labor and Welfare, and Parliament members.

I visited several International organizations with Dr. Kloiber at the occasion of the exchanging MOU with WHO.

I would like to talk about the United Nations General Assembly.

I attended the United Nations General Assembly held in New York last week.

I was invited to be a speaker as WMA President to the high level meeting on NCDs. The theme given to me was about mental health and well-being. I took up dementia and mentioned the importance of school health and food education in appealing the necessity of control of obesity in children.

I stressed that in order to address the issue about NCDs, it is necessary to build

a strong health care system based on physician-led primary care and a cooperative work of public and private sectors.

I was elected to JMA President for the fourth term in this June. The term of office is two years until June 2020. I will continue to support the activities of WMA led by Dr. Leonid Eidelman especially for promotion of UHC.

I am grateful for the warm support of all the member associations, Dr. Ardis Hoven, Chair and the WMA secretariat led by Dr. Otmar Kloiber.

I sincerely thank all of you that I was able to spend such a fulfilling year as WMA President.

Inaugural Address of WMA President 2018–2019 Dr. Leonid Eidelman



Leonid Eidelman

When I attended the General Assembly for the first time, 9 years ago in New Delhi, I was overwhelmed by the presence of so many prominent leaders of medicine from all over the world. Since then, every time I participate in WMA events, I feel deep appreciation and admire your sapient leadership, vision and commitment to our profession, its goals and values.

Dear distinguished delegates, your activity within WMA and everyone's participation in his or her NMA, inspires and enlightens me. I have had the great privilege of getting to know you over the last years and I hope to meet many more of you over the next year. Each one of you is shaping the future of healthcare and is furthering his or her nation's wellbeing. We all have great challenges and together we can accomplish a great deal on behalf of our patients.

It is my great honor to stand before you as the President of the World Medical Association. Before I continue, I want to acknowledge our outgoing President, Dr. Yoshitake Yokokura, who contributed greatly to the physicians of the world.

Thank you, Dr. Yoshitake Yokokura for your service to the WMA.

Over the years, I have come to realize that the WMA is one of the most important organizations for physicians worldwide, with unique strengths to meet the challenges of our medical profession as well as to help NMAs in need. In addition, the WMA assists in instructing the individual physician, and guiding him or her in this rapidly changing world.

We live in an extremely challenging period. The changes we witness daily seem incomprehensible and the pace of these changes is increasing constantly.

I believe that it is the time for WMA to take a sophisticated, scientific and innovative look to the future and to help both physicians and patients become prepared for the huge changes in medicine over the next decade.

Are we prepared for the future?

We can, and to my mind, we should, embark on a critical venture to predict how medicine will look in 2030, what will be the role of a physician, physicians' organizations and what can be done to spur significant positive changes.

I ask to dedicate my year of presidency to this agenda.

It is our mandate as leaders, since an effective leader is one who creates an inspiring vision of the future.

Working on this agenda I believe that three kinds of scenarios are to be developed: one that reflects maximal possible changes, another one for minimal changes and the third – the middle one.

The predictable societal changes, technological changes, changes in the role of

a physician, and in patients' preferences should be addressed.

The goal will be to develop a report that can help physicians and NMAs become prepared for the future.

What will be the role of a physician in 2030? In 1903, more than one hundred years ago, the future for Thomas Edison as he predicted was "The doctor ... (who) will give no medicine, but instruct his patient in the care of the human frame, in diet and in the cause and prevention of disease"

Today, we can predict that the future world of medicine will be a world of electronic health records, robots, artificial intelligence and machine learning as well as highly developed communication means.

However, moving to a future of medicine is probably like driving on a country road with its ruts, convolutions and unexpected turns rather than driving on a highway. Recent problems with the Watson supercomputer demonstrate that.

"A new study from MIT computer scientists, suggests that human doctors provide a dimension that, as yet, artificial intelligence does not". They have found that a physician's "gut feeling" plays a significant role in the intensive care unit. (Lagasse J. <https://www.healthcarefinancenews.com/news/artificial-intelligence-cant-replace-doctors-gut-instincts-mit-study-says>). As researcher Mohammad Ghassemi said: "there is something about a doctor's experience and their years of training and practice, that allows them to know in a more comprehensive sense, beyond just the list of symptoms, whether you are doing well or you are not". We can predict that physicians will provide integrated care as members of multidisciplinary teams and will perform more complex tasks in an increasingly complex work environment, although the question remains: who will be the leaders of these teams?

But there is another factor that must be addressed in order to effectively propel medicine into the next decades.

Today, at the time I am speaking on this highly-respected podium, more than 10 million physicians all over the world take

care of those in need of medical help and nearly half of them have symptoms of burnout defined as emotional exhaustion, interpersonal disengagement, and a low sense of personal accomplishment. Besides a physician's well-being, burnout negatively influences the quality of care and shortens the life-time a physician is able to practice medicine.

This is a great problem for society suffering from a shortage of physicians, which is common in most countries of the world.

In the future of universal health coverage there is a need for a growing number of burnout-free physicians.

The pandemic of physician burnout, caused, among other things, by very dynamic and changing working conditions, is a subject I believe we should address.

The quality and safety of patient care depend on high-functioning physicians. This is particularly challenging in our extremely rapidly changing world.

The wellbeing of physicians, both mentally and physically, has been on the agenda of some NMAs for several decades. Some resources have been invested to explore and move things forward on this issue; however, the real objective of combatting this blow to modern medicine has yet to be achieved. "Physicians are dealing with an incredible amount of work stress as they confront growing administrative burden, rising operating costs, new technology and an increasing patient demand for frontline care. Physician burnout is a symptom of a larger problem – a healthcare system that increasingly overworks doctors and undervalues their health needs." (Teresa Iafolla. <https://blog.evisit.com/prevent-physician-burnout>)

That is why according to the new Declaration of Geneva that was adopted by our General Assembly in Chicago a year ago, a physician pledges to attend to his own health, well-being and abilities in order to provide care of the highest standard.

While preparing for the future, there is a place to develop recommendations for physicians all over the world to keep this important part of the pledge. Physicians are

an indispensable resource of every society; burn out of this resource endangers the society.

I believe we must draw from our combined experiences and learn best practices.

An additional issue that cannot be separated from planning the future is the role of the physician in contemporary society.

Physicians have been traditionally conservative. For years the practice of medicine followed long-standing traditions. "A physician possessed a unique body of knowledge to use in the care of patients. This kind of the doctor-patient interaction was paramount and served as the foundation of a personal, caring relationship". (Wartman S.A. <http://www.aahcdc.org/Publications-Resources/Series/Nota-Bene/View/ArticleId/20829/The-Role-of-the-Physician-in-21st-Century-Healthcare>). But the forces changing 21st century society and medicine are transforming this tradition. Physicians should be prepared both mentally and technologically to meet new demands.

I believe that WMA has a capacity to help individual physicians in this challenging process.

The role of NMAs is also under significant pressure as a result of societal changes. The WMA is the only body to explore this process and develop recommendations that can help NMAs to evolve their future strategies.

Notwithstanding any future changes, patients and physicians will continue to exist, and we will continue to honor our social contract.

"Every day, we are given the great privilege of being invited into our patients' lives. We are with patients when they are born and when they die; we provide advice and comfort; we prevent illness and treat and manage disease. Our patients trust us, and we have always taken our advocacy role very seriously. It is part of the essence of our professionalism and we will keep our patients at the center of everything we do." (Dr. Chris Simpson, inaugural speech, CMA 2014)

The support of WMA is essential and I am sure, will be always provided.

WMA 2018 General Assembly Report

Reykjavik, Iceland October 3–6



Nigel Duncan

Wednesday October 3

At the invitation of the Icelandic Medical Association, delegates from more than 58 National Medical Associations and constituent member associations met at the award-winning Harpa Convention Centre, one of Reykjavik's most distinguished landmarks. The occasion was the WMA's 69th annual General Assembly to coincide with the 100th anniversary of the Icelandic Medical Association. For the first time, the General Assembly was combined with a Medical Ethics conference organized by the Icelandic Medical Association partly in parallel with our Council Session.

Council

Dr. Ardis Hoven, Chair of Council, opened the 210th Council session, welcoming delegates to Reykjavik.

Dr. Otmar Kloiber, the Secretary General, introduced several new Council members –

Dr. Tony Bartone from Australia, Dr. Grecco Aguer from Uruguay, Dr. Zion Hagay from Israel, Dr. Hokuto Hoshi from Japan, Dr. Barbara McAneny from America and Dr. Jungyul Park from Korea.

President's Report

The President, Dr. Yoshitake Yokokura, gave a brief report on his activities over the preceding six months, when he had taken up the theme of promoting Universal Health Coverage through cooperation and collaboration based on the Memorandum of Understanding between the WMA and the World Health Organisation. He had spoken at many meetings, including the High-Level United Nations meeting on the prevention and control of non-communicable diseases and the 18th MASEAN Conference, the confederation of medical associations from the South-east Asian region consisting of 10 ASEAN members. He had also attended meetings of the German, Taiwanese and American Medical Associations. He said he had been re-elected as President of the Japan Medical Association for a fourth term.

Secretary General's Report

A comprehensive report was submitted to the Assembly on the work of the Council over the preceding six months.



Otmar Kloiber

Emergency Resolution

The Spanish Medical Association (Consejo General de Médicos de España), with the support of Confemel, submitted an emergency resolution on migration, arguing that this was a problem increasing around the world.

The Council agreed that this was an issue that should be considered by the Socio-Medical Affairs Committee as a matter of urgency.

Chair's Report

Dr. Hoven spoke about the success of the previous day's medical ethics conference organised in conjunction with the Icelandic Medical Association.



Ardis Hoven

In her written report, she said she continued to be outraged by the atrocities imposed upon physician colleagues throughout the world who, when providing care for those in need, were being injured, murdered or imprisoned. The WMA had partnered with the International Committee of the Red Cross in the global project "Healthcare in Danger", which was aimed at identifying the extent of this problem and proposing interventions to mitigate the damage being done. It was imperative they continued with this activity.

In addition, the medical profession had been under growing pressure around the world from governments intent on undermining medical autonomy. In some parts of the world, politicians appeared determined to curtail the power of the medical

profession and exercise more control over their representative associations. The WMA strongly opposed any attempt to stifle the voices of physicians, because in the end it was patients who suffered. Professional self-governance was critical to the delivery of healthcare across the world.

Socio-Medical Affairs Committee

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



Miguel Roberto Jorge

Secretary General's Monitoring Report

Dr. Kloiber reported on the alarming deterioration of the health system in Nicaragua over the last few months. In response to a request from the Royal Dutch Medical Association, the WMA had issued a press release in July, condemning violent attacks on health personnel, medical vehicles and hospitals.

Network on Disaster Medicine

The Japan Medical Association reported on its proposal for a WMA Network on Disaster Medicine. A discussion on this had been held at the last Confederation of Medical Associations in Asia and Oceania (CMAAO) meeting, given the large number of natural disasters in this region. The JMA said it would report further at the next Council meeting.

Statement on Environmental Degradation and Sound Management of Chemicals

The committee considered the proposed revision of this Statement, which arose out of a proposal for a specific policy on curbing the consumption of plastic bags. The Swedish Medical Association had been asked to incorporate the issue of plastic pollution into the WMA Statement on Environmental Degradation.

A revised policy, encouraging efforts to curb the manufacture and use of plastic packaging and plastic bags, had been circulated for comment and the Committee recommended that the document be sent to the Council for forwarding to the General Assembly for adoption.

Declaration of Madrid on Professionally-Led Regulation

A proposed revision to the Declaration of Madrid was introduced, aimed at reaffirming the WMA's view that the medical profession must regulate itself if public confidence is to be maintained in the standards of care. The Committee recommended that the document should be referred back for further work and considered at the next meeting.

Maternal and Child Health Handbook

The meeting considered a proposal from the Japan Medical Association for a Statement on the Development and Promotion of a Maternal and Child Health Handbook. The Japanese Handbook, tabled by the Japanese at the previous meeting, was described as a comprehensive home-based booklet designed to provide relevant health information and include integrated mother and child health records. It covers health records and information on pregnancy, delivery, neonatal and childhood periods, and child growth and immunizations. The Handbook supports the integration of maternal, neonatal and child health services. The document had been circulated for comments and several amendments had been suggested and included.

The Committee made several further amendments to make it clear that the

WMA was supporting equivalent documents as well as the Japanese Handbook. The Committee recommended that the proposed Statement be sent to Council and forwarded to the General Assembly for adoption.

Proposed Declaration on Pseudoscience, Pseudotherapies, Intrusion and Sects in the Field of Health Pseudoscience

The proposed Declaration was submitted by the Spanish Medical Association at the last meeting, had been circulated for comment and had prompted many amendments. The meeting was told that the new draft was trying to defend scientific medical professionals and to ensure the safety of patients and the quality of health care. But several speakers questioned the language used in the document and said it was unfair to those practicing different medicine.

After a brief debate, the Committee recommended that a workgroup should be set up with the mandate to work further on this issue and develop a revised text to consider at the next meeting. The Committee agreed to recommend this to Council.

Access of Women and Children to Health Care and the Role of Women in the Medical Profession

Under the WMA's 10-year policy revision rule, a major revision was considered to the Resolution on Access of Women and Children to Health Care and the Role of Women in the Medical Profession. This reaffirmed the WMA's support for the rights of women and children to full and adequate medical care, especially where religious and cultural restrictions hindered access to such care. The revised document was submitted by the Israeli Medical Association and the Committee recommended that it be circulated to members for comment.

Antimicrobial Resistance

Similarly, a major revision of the WMA Statement on Antimicrobial Resistance was submitted. It was explained that the purpose of the revision was to recognize the impor-

tance of this issue for the future of medicine and to break down the actions needed from the WMA, NMAs and individual physicians. The document warns of the growing threat to global public health from antimicrobial resistance, threatening both the prevention and treatment of infections.

The Committee recommended that the proposed revision be circulated to members for comments.

Statement on Reducing the Global Burden of Mercury

The Committee agreed to a minor revision to this Statement and recommended that it be forwarded to the Council for adoption by the General Assembly.

Statement on Reducing Dietary Sodium Intake

A major revision to the WMA Statement on Reducing Dietary Sodium Intake was introduced. The Committee decided to recommend that the document, warning that the majority of the world consumed too much sodium, should be circulated to members for comment.

Resolution on Collaboration Between Human and Veterinary Medicine

A minor revision to the Resolution was agreed, and the Committee recommended forwarding it to the Council for adoption by the General Assembly.

Statement on Violence and health

Suggestions for major revisions to the WMA's Statement on Violence and Health were submitted by the Nigerian Medical Association. It was explained that the new document, containing a series of measures to combat violence in society, had merged different WMA policy documents on violence in the workplace, violence against women and children and family violence. The document sets out measures to safeguard health institutions. Support for the document came from the Indian Medical Association. The meeting was told that 72 per cent of Indian doctors had been subjected to physical or oral abuse and 19 prov-

inces in the country had now enacted a law against violence.

The Committee recommended that the proposed document be circulated to members for comments.

Statement on Artificial or Augmented Intelligence in Medical Care

A draft policy Statement on artificial intelligence was introduced by the American Medical Association. The paper was based on policy recently adopted by the AMA. It was argued that AI was making significant inroads into patient care and it was very important that physicians become educated about the issue and that the WMA had policy that would help shape the future of this technology so that it worked for physicians and for patients. AI offered the promise of dramatically better patient care, but that would only be accomplished if the medical profession had policy and it could engage. Several speakers said there was a sense of urgency about developing policy on this issue. They had an opportunity to influence and shape the future. AI would have a major impact on medicine and it was extremely important to get the physicians' perspective. There were a lot of dangers involved, but also considerable opportunities. The need to consider the risks to anonymisation and confidentiality from AI was also mentioned. The Committee recommended that the proposed document be circulated to members for comments.

Statement on Medical Age Assessment of Unaccompanied Minor Asylum Seekers Minor Asylum Seekers

The German Medical Association submitted a draft Statement on what it argued was an exceptionally pressing and timely matter, namely, the methods employed to assess the age of unaccompanied minor asylum seekers for the purposes of determining their legal status in the country in which they were seeking asylum. It was argued that there was a lack of definitive, internationally accepted guidelines on this matter. Children accounted for half of the world's refugees and

unaccompanied minors who had fled their countries of origin were especially vulnerable when it came to means of age assessment. The available methods of medical age assessment – ranging from X-rays of the jaw, hand, or wrist to examinations of secondary sex characteristics – raised ethical concerns because they could potentially endanger the health of those being examined, as well as violate the privacy and dignity of potentially traumatized young people. It was essential that physicians received clear guidance for dealing with cases in which they were called upon to perform medical age assessments. The Committee recommended that the proposed Statement be circulated to members for comments.

Statement on Free Sugar Consumption and Sugar-sweetened Beverages

A series of measures to combat the global consumption of sugar was proposed by the Kuwait Medical Association in a new proposed Statement.

The Committee recommended that the Statement be circulated to members for comments.

Healthcare Information for All

A proposed new Statement to address the lack of access to relevant, evidence-based healthcare information was submitted by the British Medical Association. It argued that this lack of information was a major contributor to unnecessary death and suffering, especially in low- and middle-income countries.

The Committee recommended that the Statement be circulated to members for comments.

Resolution on Migration

The Spanish Medical Association presented its emergency motion on a situation that it argued had been worsening over the last few months. It said the WMA should reaffirm the continued engagement of physicians in caring for migrants. The voice of the medical profession should be raised now because the most vulnerable people and those who

were in most need of support were suffering from this difficult situation.

During a brief debate, speakers argued that this was a global problem, and an amendment was agreed to clarify this in the Resolution. It was argued that every opportunity should be taken to reaffirm the human rights of refugees, as the political environment was getting more and more difficult.

The Committee recommended that the proposed Resolution be sent to the Council for forwarding to the General Assembly for adoption.

Medical Ethics Committee

Dr. Heidi Stensmyren (Swedish Medical Association) took the chair.



Heidi Stensmyren

Monitoring Report

In his monitoring report, Dr. Kloiber raised three topics whose developments could have implications for the WMA and its policy activities.

The first was artificial intelligence. He said that advancements in this field would have a strong impact on how physicians worked and on the way medicine was regulated, with significant ethical ramifications over the long term. He advised the Committee to be prepared to address these potential challenges.

The second was on end of life issues. He expressed concern that WMA discussions and policies on numerous end of life topics,

such as patient autonomy, living wills, substitute decision making, terminal sedation, and opioid use, had not reached large parts of the global community of physicians. He recommended that the WMA worked on identifying possible barriers and explored ways to better support physicians on these issues, particularly where national regulations did not exist.

The final issue was the Declaration of Helsinki. He noted that there were a number of issues being discussed in the international community that had important connections to and ramifications for the Declaration of Helsinki. The WMA was currently working on two of these issues – healthy volunteers and vulnerable populations – as part of their participation in the CIOMS (Council for International Organizations of Medical Sciences) working groups. Dr. Kloiber said that at the next Council Session in Santiago he would recommend reopening work on the Declaration of Helsinki.

Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences

As part of the WMA's annual policy review process, it had been decided that the Statement on Licensing of Physicians Fleeing Prosecution for Serious Criminal Offence should undergo a major revision and the French Medical Association (CNOM) volunteered to undertake that work. An early draft revision was sent round for comment, was amended, further circulated and now a second draft proposal was being submitted. However, delegates were told that while there was general agreement on what were very serious offences, such as war crimes, genocide and crimes against humanity, there was less agreement on what were serious crimes.

This led to a lengthy debate and several amendments were agreed about the scope and definition of the paper.

The Committee agreed to change the title of the document to Statement on Physicians Convicted of Genocide, War Crimes or Crimes Against Humanity and it recommended that the revision be

approved by the Council and forwarded to the General Assembly for adoption.

Genetics and Medicine

An oral report was received from the work group in charge of revising the Statement on Genetics and Medicine. A key goal of the group was to update the WMA Statement regarding the increasing use of genetic analyses and large-scale genome sequencing, both for treatment and research purposes. Other central goals were to provide recommendations regarding the ethical sensitivity of genetic information, the handling of secondary findings from genetic testing and the cost of introducing genetic analyses as standard procedure in treatment. The workgroup reported that it was not in a position to finalise a proposed revision, but expected to have a draft ready for the next meeting in Santiago. It had already reached one key conclusion – that the revision should not aim to provide detailed guidelines for every single ethical problem in the medical use of genetics. Instead it would try to provide general principles for the use of genetics. Another workgroup session was scheduled for December 2018 in Copenhagen.

The Committee unanimously agreed to a proposal from the American Medical Association to name the future revised Statement on Genetics and Medicine the 'Declaration of Reykjavik', as an acknowledgement of the essential involvement of the Icelandic Medical Association.

Biosimilar Medicinal Products

A proposed Statement on Biosimilar Medicinal Products was submitted by the Israeli Medical Association. Its various recommendations result from the expiry of patents for original biotherapeutics and the subsequent development and approval of copies, called 'similar biological medicinal products' or biosimilars that are highly similar to a previously approved biological product. The document had been circulated among members and amended where necessary. It was explained that the paper was

principally designed to protect the autonomy of the physician. However, the Committee agreed that this point should be backed up in the document by adding the words ‘There should be no substitution between biosimilars and other drugs without the attending physician’s permission’.

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

International Code of Medical Ethics (ICoME)

The Committee received an oral report from the workgroup on plans to prepare a comprehensive revision of the ICoME, engaging the entire WMA community as well as external experts through open consultation and public events, if possible. The intention was for the workgroup to submit a concrete workplan and timeline to the Committee at its next session in April 2019. The workgroup had met for the first time the previous day to plan its major revision to the document. Prof. Urban Wiesing, ethics advisor to the Committee, presented a brief overview of the correlations between the Declaration of Geneva and the ICoME and possible options for the revision of the latter. He reminded the committee that the Code, adopted in 1949, had been amended three times, in 1968, 1983 and 2006. It was in three parts – the duties of physicians in general, their duty to patients and their duty to colleagues. There were many topics contained in the Declaration of Geneva that were not mentioned in the Code, such as the well being of patients and physicians, and human rights. Compared with the Declaration of Geneva and Helsinki, the International Code of Ethics was largely unknown. A revised Code should be a coherent, extended and additional document to the Declaration of Geneva. It could also become a document on medical professionalism in a globalized world.

The Committee received the report and reaffirmed Prof. Wiesing’s appointment as advisor.

Assisted Reproductive Technologies

A proposed major revision to the WMA Statement on Assisted Reproductive Technologies was tabled with the suggestion that a workgroup be established to continue working on the document.

The Committee recommended that a workgroup be established.

Capital Punishment

The Committee considered a proposal to merge two WMA policy documents on capital punishment. It was agreed that the new document should be entitled Resolution on Prohibition of Physician Participation in Capital Punishment. This reiterated WMA policy that it was unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process, including its planning and the instruction and/or training of persons to perform executions.

This led to a debate about whether this unintentionally excluded prisoners on death row from receiving good medical care and attention. However, it was argued that other WMA policy covered this area. There was also a question about those countries where capital punishment was part of the law of the land and doctors employed by the state were required to be present to certify a prisoner fit to be executed. Dr. Kloiber said that in these circumstances, the NMA should call on the WMA for support and a letter could be sent to their government setting out WMA policy.

The Committee recommended that the proposed Resolution, as revised, be approved by the Council and forwarded to the General Assembly for information, and that the 2008 Resolution on Physician Participation in Capital Punishment and the 2012 WMA Resolution to Reaffirm WMA’s Prohibition of Physician Participation in Capital Punishment be rescinded and archived.

Documentation of Torture

The Danish Medical Association reported on its work undertaking a major revision of the WMA Resolution on the Responsi-

bility of Physicians in the Documentation and Denunciation of Acts of Torture and Ill-treatment. The aim of the revision was not to change the core recommendations, but to make the document more accessible. A new section had been added on protecting physicians who acted in accordance with WMA policy.

The Committee recommended that the proposed revision be circulated to members for comments.

Sex Selection and Female Foeticide

The Committee considered a proposed revision of the WMA Statement on Female Foeticide. This aimed to add to current WMA policy, stating clearly that sex determination for reasons of gender preference was unacceptable unless it was carried out to avoid a severe sex-linked medical condition.

The Committee recommended that the proposed revision be circulated to members for comments.

Euthanasia and Physician Assisted Dying

The Committee was informed that the Canadian and Royal Dutch Medical Associations had decided to withdraw their proposed Reconsideration of WMA Statement, Resolution and Declaration on Euthanasia and Physician Assisted Dying, as a result of a new document prepared by the German Medical Association. The new document, entitled ‘Proposed Statement on Euthanasia and Physician-Assisted Dying’ was a proposed consolidation and revision of the WMA Statement on Physician-Assisted Suicide and WMA Resolution on Euthanasia. Delegates were told that the new compromise document did not represent a change in WMA policy, but rather proposed a refinement of the language. It avoided using the term ‘unethical’ to refer to physicians who engaged in physician assisted suicide in accordance with the legislation in their countries. It reiterated that the WMA was opposed to euthanasia and physician assisted suicide.

A lengthy debate followed, during which a number of Associate Members from Canada outlined their opposition to changing the WMA's policy.

On a vote it was decided that the document should be circulated to members for comment.

Finance and Planning Committee

Dr. René Héman (Royal Dutch Medical Association) took the chair.



René Héman

Financial Statement

The Treasurer, Dr. Andrew Dearden, presented the Financial Statement for 2017. He was pleased to report that the WMA remained in a good financial position at year-end, with a surplus for the fourth year in a row.

The Committee recommended that the Statement be approved by the Council and forwarded to the General Assembly for approval and adoption.



Andrew Dearden

Dues for 2017 and 2018

The Committee received an oral report on the 2017 Dues Arrears. The Treasurer said that more than 99 per cent of contributions had been received.

Budget 2019

The Committee considered the proposed Budget for 2019 vs. actual 2017 expenditure.

The Treasurer said that with the repeated annual surpluses, the WMA was in a position to move forward on projects that had not been pursued due to lack of financial resources.

The Committee recommended that the Proposed Budget for 2019 be approved by the Council and be forwarded to the General Assembly for adoption.

Membership Dues Payments for 2018

The Committee recommended that the Treasurer's report be forwarded to the General Assembly for information.

Associate Membership Dues Increase

The Committee considered a proposal for a small dues increase for Associate Membership. Dr. Kloiber said that the benefits of the WMA education platform could be offered to Associate Members as a new benefit when the dues were increased. He noted that the Associate Members dues rate had not been changed in many years.

The Committee recommended that the increase be approved by the Council and be forwarded to the General Assembly for adoption.

Strategic Plan

Dr. Kloiber reported that he had begun work on the Strategic Plan, following the recommendations of the Governance Workgroup. The work had been interrupted by a number of extremely urgent requirements emerging from the upcoming Global Conference on Primary Health Care to be held in Astana, Kazakhstan on 25–26 October 2018. This conference had considerable influence on policy that

was being made on the way to Universal Health Care and the structure of primary health care and the role of physicians. There was a very clear tendency, especially by the donors, to replace physicians in primary health care by community health workers or nurses. This was of considerable concern and plans were being developed by the WMA to co-operate with other organisations to counteract these tendencies. He said the WMA would be present in Astana, led by WMA President Leonid Eidelman and Immediate Past President Dr. Yokokura, and he thanked the Japan Medical Association for its critical assistance in obtaining an invitation to the WMA. He also noted that the WMA would have to continue lobbying governments for proper primary care structures long after the Astana conference.

He also reported that in 2019, Japan would host the G20 Summit. This would provide an opportunity to host an H20 meeting, as proposed by Dr. Yokokura in Riga. An H20 meeting would create an important opportunity to lobby governments on physician-led primary health care and Universal Health Coverage.

Dr. Kloiber added that the Governance Workgroup had stressed the importance of WMA outreach to ensure that it became more active and worked to develop regional representation in areas where it had not had a strong presence. He was therefore proposing that some of the WMA surplus be used to support that outreach. In addition, there would be a proposal later during the Committee discussion regarding the possibility of establishing a new WMA region to attract members from the Eastern Mediterranean.

Statutory Meetings

The Committee considered proposed themes for the Scientific Session at the 70th General Assembly in Tbilisi, Georgia in 2019.

It recommended that the theme of 'Palliative Care' be recommended to the Council for approval by the General Assembly,

The Committee considered invitations for future meetings and recommended that:

- the invitation of the Spanish Medical Association to host the 71st General Assembly in Cordoba in October 2020 be accepted;
- the invitation of the British Medical Association to host the 72nd General Assembly in London in October 2021 be accepted;
- the invitation of the Rwanda Medical Association to host the 74th General Assembly in Kigali in October 2023 be accepted;
- the meeting dates of the 73rd General Assembly, Berlin 2022 be 5–8 October 2022.

Revision of WMA Articles and Bylaws/Rules

The Committee considered a proposal to introduce a Self-declaration Statement to the Nominating Process for WMA Presidency with a revised nomination form.

The Committee recommended that the revised nomination form be approved by the Council and forwarded to the General Assembly for information.

Regional Structure

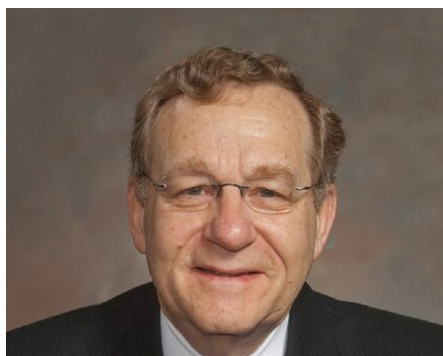
The Committee considered a proposal to set up a sixth region to the WMA's structure, an Eastern Mediterranean region. Dr. Kloiber explained that this would strengthen the WMA's outreach and would give this group of countries a seat on the Council.

The Committee recommended that the WMA Articles and Bylaws on a new WMA Region Eastern Mediterranean be approved by the Council and be forwarded to the General Assembly for approval.

Thursday October 4

Associate Members

Dr. Joseph Heyman (America) took the Chair. Dr. Heyman reported that there were 1,115 associate members, 647 from Japan and 468 from the other regions.



Joseph Heyman

Junior Doctors Network

Dr. Caline Mattar, Immediate Past-Chair of the JDN, reported on the activities of the Network since October 2017. It had participated in several policy topics, including human resources for health and anti-microbial resistance. It had also worked on a social media campaign and held a session on the Caring Physicians of the World course. The JDN had become a member of the World Forum for Medical Education Council and was also part of the young professionals' group on the Alma Ata Declaration on Primary Care. An informal meeting had taken place at the WMA Secretariat for junior doctors attending the WHA, including those participating as part of the WMA WHA delegation. They had also held a meeting in Reykjavik on Well-being and Post Graduate Education. Dr. Mattar also introduced the new JDN President, Dr. Chukwuma C. Oraegbunam from Nigeria.

Report of Past Presidents and Chairs of Council Network

A report from the Past Presidents and Chairs of Council Network was received. Dr. Kloiber reported on a key engagement of the Network in support of the WMA through the WMA Leadership Courses, social media activities, and outreach to physicians in the African region.

Declaration of Geneva (Physicians' Pledge)

A proposed Statement on Action to Stimulate use of the Physicians' Pledge of the

Declaration of Geneva was presented by Dr. Ankush Bansal (America). He argued that the pledge was not used in a lot of countries. It was not on people's minds. His resolution recommended that NMAs encouraged use of the Pledge at their annual meetings and at other medical meetings and that the Pledge should be posted in hospitals and clinics.

The meeting recommended that the proposal be sent to the General Assembly for consideration.

Policy Formulation and Consistency

Dr. Wunna Tun (Myanmar) proposed a Statement on Policy Formulation and Consistency among the World Medical Association and National Medical Associations. He argued that NMAs should take WMA policy into consideration when formulating their own policy. However, speakers raised doubts about the practicality of such a proposal and on a vote, the meeting agreed to delete the phrase that 'When an NMA has an ethical opinion that is not consistent with WMA policy, but is consistent with the law in its country and is clearly generated by benevolence toward patients, WMA may allow for national and cultural differences in formulating its own ethical policies'. However, the meeting voted to include a new sentence: 'When an NMA has an ethical opinion that is not consistent with WMA policy, it should inform the WMA about its concern with existing WMA policy'.

The Committee recommended that the Statement, as amended, be sent to the General Assembly for consideration.

Proposed Statement on Medically-Indicated Termination of Pregnancy

An attempt was made to amend the proposed Statement on Medically-Indicated Termination of Pregnancy by including provisions to allow physicians a right to conscientious objection to 'advising or performing' an abortion and that 'in all cases, proper informed consent must be provided'. But the proposed amendments were defeated.

Freedom of Conscience

Dr. Sheila Harding (Canada) said that most of the discussions at the previous day's Ethics Committee session related to freedom of conscience and its protection. She said she understood that it was too late to introduce a statement at this meeting, but she informed delegates that she would work on a proposed policy statement with the Associates on the Google Group for introduction at next year's General Assembly.

Friday October 5

Resumed Council Session

Medical Ethics Committee Report

Biosimilar Medicinal Products

An amendment was proposed to the Statement on Biosimilar Medicinal Products to change the sentence which read 'Where appropriate, national medical associations should lobby against allowing insurers and health funds to promote biosimilar and originator product's interchangeability' to read 'Where appropriate, national medical associations should lobby against allowing insurers and health funds to require biosimilar and originator product's interchangeability, and for safe regulations of interchanging biosimilar medicines where this is allowed'.

The Council agreed the amendment and recommended that the Statement be adopted by the General Assembly.

Euthanasia and Physician Assisted Dying

The Council debated the Committee's recommendation to circulate to NMAs a compromise Statement on WMA policy relating to euthanasia and physician assisted suicide. The Royal Dutch Medical Associations proposed that a work group should be set up to consider the responses from NMAs. Several speakers opposed this idea, arguing that the responses should be considered first by the Medical Ethics

Committee. It was too early to establish a work group. Following a debate, the Royal Dutch Medical Association withdrew its proposal.

The Canadian Medical Association explained to the Council the situation in Canada where the law on this issue had changed. Physicians were now concerned at being called unethical and being condemned. That was the CMA's issue with the WMA.

The Council agreed that the compromise Statement should be circulated to members for comment.

The Council agreed that the following documents be forwarded to the General Assembly for adoption.

Statement on Physicians Convicted of Genocide, War Crimes or Crimes Against Humanity

Resolution on Prohibition of Physician Participation in Capital Punishment

The Council agreed that further work be carried out on the Statement on Genetics and Medicine and that when adopted by the Assembly it should be named the Declaration of Reykjavik.

The Council agreed to recommend to the Assembly that a workgroup be established on Assisted Reproductive Technologies

The Council agreed to recommend to the Assembly that the following documents be circulated for comment:

- Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture and Ill-treatment
- Sex Selection and Female Foeticide
- Euthanasia and Physician Assisted Dying

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

- Financial Statement for 2017
- Proposed Budget for 2019
- Associate Membership Dues Increase
- Revision of WMA Articles and Bylaws/ Rules on a Self-declaration Statement to

the Nominating Process for WMA Presidency

- WMA Articles and Bylaws on a new WMA Region Eastern Mediterranean

The Council agreed to recommend to the Assembly that the theme for the Scientific Session at the 70th General Assembly in Tbilisi, Georgia in 2019 be 'Palliative Care'.

The Council agreed to recommend to the General Assembly that:

- the invitation of the Spanish Medical Association to host the 71st General Assembly in Cordoba in October 2020 be accepted;
- the invitation of the British Medical Association to host the 72nd General Assembly in London in October 2021 be accepted;
- the invitation of the Rwanda Medical Association to host the 74th General Assembly in Kigali in October 2023 be accepted;
- the meeting dates of the 73rd General Assembly, Berlin 2022 be 5–8 October 2022.

Oral reports were given on the Associate Members group, the Junior Doctors Network, the World Medical Journal and Public Relations.

Socio-Medical Affairs Committee Report

The Council agreed to forward the following documents to the General Assembly for adoption:

- Resolution on Migration
- Statement on Environmental Degradation and Sound Management of Chemicals
- Statement on the Development and Promotion of a Maternal and Child Health Handbook
- Statement on Reducing the Global Burden of Mercury
- Resolution on Collaboration Between Human and Veterinary Medicine

The Council agreed to recommend that the following documents be circulated for comment:

- Access of Women and Children to Health Care and the Role of Women in the Medical Profession
- Statement on Antimicrobial Resistance
- Statement on Reducing Dietary Sodium Intake
- Statement on Artificial or Augmented Intelligence in Medical Care
- Statement on Medical Age Assessment of Unaccompanied Minor Asylum Seekers
- Statement on Free Sugar Consumption and Sugar-sweetened Beverages
- Healthcare Information for All
- Statement on Violence and Health

The Council agreed to recommend to the General Assembly that a workgroup be set up on Proposed Declaration on Pseudoscience, Pseudotherapies, Intrusion and Sects in the Field of Health Pseudoscience.

The Council agreed to recommend that the Declaration of Madrid on Professionally-Led Regulation should be referred back for further work and considered at the next meeting.

Advocacy Report

Dr. Ashok Paul, Chair of the Advocacy and Communications Panel, reported on the work of the group. He spoke about the need for effective liaison between the WMA and NMAs and the success of regional meetings of smaller NMAs. He thought that social media should be used more effectively for putting forward WMA statements on issues being discussed and said Council should consider ways of making its discussions more transparent.

Medical Ethics Conference

Dr. Jon Snædal (Iceland) reported on the conference that had been held on the previous three days.

Nicaragua

Dr. Miguel Roberto Jorge (Brazil) proposed a motion on the situation in Nicaragua. He said there had been a massive wave of violence in Nicaragua for several months, due to government aggressive repression towards street protests that started in relation to reform social security rules. The protests had been met with disproportionate use of force by police resulting in hundreds of deaths. The Government had also fired hundreds of civil servants, including teachers and health professionals, criminalizing physicians who had delivered medical care to protesters as well as to paramilitaries who were also injured. There were also reports of police and paramilitaries arresting patients inside hospitals as well as blocking ambulances in their attempts to provide emergency care to anyone injured. The Brazilian Medical Association and other NMAs from the Confemil region proposed that a strong public statement be issued by the WMA Council, urging the Nicaraguan government to stop its repression, not just against medical doctors doing their due work but also to stop using even harder violence against protesters.

The Council agreed to the motion.

General Assembly Ceremonial Session

The Session was called to order by the President, Dr. Yoshitake Yokokura.

Dr. Reynir Arngrímsson, President of the Icelandic Medical Association, welcomed delegates. He said it was an honour for the Icelandic Medical Association to welcome the WMA to Reykjavik for the General Assembly. For Icelandic physicians it was a historic moment, just as it was in 1947 when the Association that was barely able to hold its own general meetings decided to travel to Paris to join other medical associations to lay the foundations of the WMA. The Icelandic Medical Association was celebrating its 100th anniversary this year and the anniversary coincided with Ice-

land becoming a free and sovereign state in 1918. Then, the population of Iceland was around 19,000. The founders of the Icelandic Medical Association were only 34. Now the membership had grown to 1,400 and the population of Iceland was 350,000. To be able to provide high quality health care, Icelandic doctors realised very early the importance of close communication with the world outside the island and young doctors were encouraged to go abroad for specialisation in all fields of medicine. This collaboration and educational opportunities in many countries had enabled the Icelandic medical profession to provide a high quality medical service. Medical practice could not be dissociated from the ethical implications of medical procedures and they were very proud to have organised the medical ethics conference during the week.

Following a musical performance by an Icelandic choir, a welcome address was given by the President of Iceland, *Guðni Thorlacius Jóhannesson*. He said the people of Iceland had long cherished and valued those who tried to heal others. He spoke about the advances in science, saying that in today's globalised world of fake news and populism, they should strive to defend the principles of scientific method. If they lost the basis of science, then they would be in trouble.

The Assembly then rose to recite the Declaration in Geneva, after which the Secretary General conducted the roll call of delegates. Dr. Ardis Hoven, Chair of Council, paid tribute to the retiring President, Dr. Yokokura. She said he had presided with great distinction over the WMA's affairs. He had done excellent work on universal health care, leading the work on preparedness. He had represented the WMA at many venues and had been a caring and gracious President.

Dr. Yokokura then delivered his valedictory address (see box).

This was followed by the installation of the new President, Dr. Leonid Eidelman, who delivered his inaugural address (see box).

The Assembly then adjourned.

Saturday October 6

General Assembly Plenary Session

The Plenary Session of the General Assembly was called to order by Dr. Frank-Ulrich Montgomery, Vice Chair of the Council, deputising for Dr. Ardis Hoven, the Chair of Council, who had been taken ill.

Keynote Speaker

The Keynote Speaker for the morning was Unnur Anna Valdimarsdottir, Professor of Epidemiology, Faculty of Medicine, at the University of Iceland. The title of her talk was 'The human health response to major trauma and life adversities'. She spoke about her research on the effect of trauma on life expectancy, and illustrated this by reference to the national bankruptcy that hit Iceland 10 years ago. This led to an increase of attendances at emergency departments, particularly an increase in stress levels among women. She also looked at the effect of natural disasters on health, as well as the loss of family members. She said her data showed that there was an opportunity for the medical profession to intervene with people who had suffered severe trauma, and the numbers were not small. Eighty to 90% of people would experience some sort of a trauma event in their lives and this required co-operation across disciplines in order to give appropriate intervention and screening. Most people got over these traumas with the help of friends and families. But there was a considerable proportion who needed treatment.

President's Inaugural Address

Dr. Chris Simpson, Past President of the Canadian Medical Association and a member of the Canadian Medical Association delegation, rose on a point of personal privilege. He said he was shocked to hear the words he had written for his 2014 inaugural speech plagiarised by Dr. Eidelman in his inaugural address the previous day. Multiple other parts of Dr. Eidelman's speech had also been taken word for word from various blogs and

websites. In the light of this, he called on Dr. Eidelman to resign. The Canadian Medical Association then formally moved a motion demanding Dr. Eidelman's resignation as he had failed to meet the ethical standards expected of an elected officer of the WMA.

Dr. Montgomery suspended the Assembly for a meeting of the Council executive committee to examine the allegation. This was followed by an emergency meeting of the Council, when Dr. Montgomery confirmed that parts of Dr. Eidelman's speech had been taken from Dr. Simpson's speech and from other sources.

Dr. Eidelman then addressed the Council, saying: 'My speech was comprised from many available sources. I worked for many months on these remarks. I have reviewed the literature in many journals, websites and court cases. This specific remark that was mentioned was based on a cornerstone case in Supreme Court in Israel which specified the trust between a patient and a doctor and the idea was incorporated in my speech. My speech was originally written in Hebrew and was translated with a help of English speech writers. I was totally unaware if any English phrases were taken from other sources. And I am really sorry.

'Certainly if I would know, I would quote as I did with Thomas Edison's citation. If our Canadian colleagues would mention it to me, I would gladly have an opportunity to check it with my speech writers and immediately give required credits. I fully accept the responsibility and express my sincere regret and apology. I would like to stress that everything that I said yesterday reflects my views and beliefs in what I advocate and struggle for years in Israel and outside'.

After a brief debate, the motion to demand Dr. Eidelman's resignation was defeated by 15 votes to one, with six abstentions.

When the Plenary Session of the General Assembly resumed, Dr. Eidelman repeated the statement he gave to Council.

Election of the President for 2019–20

Four candidates put their name forward for election – Dr. Miguel Roberto Jorge (Bra-

zil), Dr. Peteris Apinis (Latvia), Dr. Louis Francescutti (Canada) and Dr. Osahon Enabulele (Nigeria).

However, the acting chair Dr. Montgomery announced that the Secretary General had just received an e mail from the Canadian Medical Association announcing their resignation from the WMA. As a result, Dr. Francescutti was no longer eligible to stand for President.

The three remaining candidates each addressed the Assembly for five minutes.

Dr. Jorge said he was presenting his candidacy mainly based on the work he had been developing with the WMA for about 10 years and to keep diversity present in the Executive Committee. He went on: 'Since I became a physician, I have been involved in many different organizations, always devoted to build conditions for excellence in medical education and training, a continuous updating of medical knowledge and skills, a high standard on ethics, an integrated work with other health professionals, and also promoting public campaigns on health issues as well as fighting for governmental policies that allow better access to good health services. I am sure that all these actions are fully coincident with the objectives of the World Medical Association'.

He went on: 'I am seeking the Presidency of our Association aiming to bring to its higher leadership a strong voice coming from our low and middle income countries' physicians, and echoing medical issues not always present in the World Medical Association everyday agenda. I am very confident that I can help to enhance our strengths when facing difficult challenges to improve medical care and ethics worldwide. I hope to count on your votes in order to place the needs of every physician – and of our most vulnerable people – higher in the Association. You can be sure that will be really a pleasure and an honor for me to serve the best interests of our membership'.

Dr. Apinis, in his speech, talked about the issue of climate change, pollution and over population. The WMA, together with its

NMAs, had the mandate and the ability to champion the planet's cause. He also referred to the restrictions being put on physicians' autonomy by bureaucrats around the world and the need for the WMA to join forces to resist this.

The final speaker, Dr. Enabulele, Past President of the Nigerian Medical Association, said he had been attending WMA Assemblies since 2006. Since that time he had been espousing the aspiration for better health care across the globe and supporting patients' rights and physicians' rights. If elected, he said he would harness the potential of the WMA to ensure that the Association was really about all national medical associations.

In a vote, Dr. Jorge was elected in the first round as President for 2019–20.

Dr. Jorge thanked the Assembly for its support.

Council Report

The Assembly then considered the report of the Council.

Medical Ethics Committee

Medically-Indicated Termination of Pregnancy

Prof. Pablo Requena (Vatican) explained why his association could not support this document. He said the revised policy statement had lost some important aspects from the previous policy, namely the reference to the value of all life, including the unborn, and the possibility of conscientious objection, not only for carrying out abortion but also for giving advice. He said they had lost an opportunity in this document to recall the importance of life, including unborn life, as most abortions that took place were on healthy fetuses and healthy women. If doctors did not send out a clear message about the value of human life and pre-natal human life, no-one would.

The Assembly agreed to adopt the Statement on Medically-Indicated Termination of Pregnancy. ([see. p. 28](#))

The Assembly went on to adopt the following documents from the Medical Ethics Committee:

- Statement on Physicians Convicted of Genocide, War Crimes, or Crimes Against Humanity (revised) ([see. p. 24](#))
- Statement on Biosimilar Medicinal Products ([see. p. 18](#))
- Statement on the Ethics of Telemedicine (revised) ([see. p. 31](#))

Socio-Medical Affairs Committee

The Assembly adopted the following documents from the Committee:

- Statement on Medical Tourism ([see. p. 26](#))
- Statement on Gender Equality in Medicine ([see. p. 23](#))
- Declaration of Seoul on Professional Autonomy and Clinical Independence (revised) ([see. p. 19](#))
- Statement on Sustainable Development ([see. p. 30](#))
- Statement on Avian and Pandemic Influenza (revised) ([see. p. 17](#))
- Statement on Nuclear Weapons (revised) ([see. p. 30](#))
- Statement on Environmental Degradation and Sound Management of Chemicals (revised) ([see. p. 20](#))
- Statement on the Development and Promotion of a Maternal and Child Health Handbook ([see. p. 25](#))
- Resolution on Migration ([see. p. 29](#))

The Assembly agreed that the following policies be rescinded and archived:

- Resolution on Poppies for Medicine Project for Afghanistan
- Resolution on the Economic Crisis: Implications for Health
- Statement on Professional Responsibility for Standards of Medical Care be rescinded and archived.

The Assembly received for information two revised policies:

- Statement on Reducing the Global Burden of Mercury
- Resolution on Collaboration Between Human and Veterinary Medicine

Finance and Planning Committee

The Treasurer, Dr. Andrew Dearden, gave a financial report and the Assembly adopted the following documents:

- Audited Financial Statement for the year ending 31 December 2017
- Budget for 2019
- Revision of WMA Articles and Bylaws/ Rules on a Self-declaration Statement to the Nominating Process for WMA Presidency
- WMA Articles and Bylaws on a new WMA Region Eastern Mediterranean
- Associate Membership Dues Increase

The Assembly approved the following future meetings:

- that the invitation of the Spanish Medical Association to host the 71st General Assembly in Cordoba in October 2020 be accepted;
- that the invitation of the British Medical Association to host the 72nd General Assembly in London in October 2021 be accepted;
- that the invitation of the Rwanda Medical Association to host the 74th General Assembly in Kigali in October 2023 be accepted;
- that the meeting dates of the 73rd General Assembly, Berlin 2022 be 5–8 October 2022.

The Assembly agreed that the theme of the scientific session of the 70th General Assembly in Tbilisi, Georgia in 2019 be 'Palliative care'.

The Assembly received the following documents for information

- Membership Dues Payments for 2018
- Dues Categories 2019

Associate Members

Dr. Ankush Bansal gave a report from the Associate Members meeting.

He presented two proposed Statements of Action to Stimulate Use of the Physicians'

Pledge of the Declaration of Geneva and on Policy Formulation and Consistency among the World Medical Association and National Medical Associations. The Assembly agreed to forward both proposed Statements to the Council for consideration.

Dr. Dainius Puras

Dr. Dainius Puras, UN Special Rapporteur on the Right to Health, Office of the United Nations High Commissioner for Human Rights, gave a talk entitled 'Presentation on Opportunities and challenges on the way to realization of the right to physical and mental health'. He spoke about his work, which he said was very challenging. He was the first medical doctor to become rapporteur. He said that good primary care and the work of GPs was absolutely crucial, although some countries had tried to avoid primary care and this was not good practice. He spoke about mental health and said it needed much more investment. He said this year was the 70th anniversary of the Declaration of Human Rights and this coincided with attacks on human rights globally. It was important for the medical profession to stand on the side of protecting and promoting all human rights. But also the evidence based approach was under attack with fake news and post truth. This was an important time for all in the health field to unite to protect what was achieved in 1948 when people had a better understanding of why the Declaration was needed. Now the world was in danger of forgetting what happened in the past and it was the medical profession's duty to remind politicians and the general public what human rights were about.

Dr. Poonam Dhavan

Dr. Poonam Dhavan, Senior Migration Health Policy Advisor at the International Organization for Migration, gave a presentation on Health and Migration. She said her organisation had 10,000 people working around the world, 1,200 of them

on health. There were 60 health assessment centres worldwide. She said that migration was a determinant of health. They faced many challenges, among them the issue of monitoring. There was a lack of evidence on issues of financing and attacks on health workers. She said there was a need to change the perceptions about migration and a need to bring out positive migration stories. Migration health was about shared responsibilities and about wanting to work together. Migration was not about us and them. It was about all of us.

Susannah Sirkin

The next presentation was given by Susannah Sirkin, Director of International Policy and Partnerships, at the Physicians for Human Rights. Her address was entitled 'The criminalization of healthcare', which she described as an 'alarming situation crying out for your attention and response' and 'a global emergency that threatens not only health for many, but the preservation and protection of the profession of medicine altogether'. She said that the core ethics of the medical profession were under threat in dozens of countries in situations of armed conflict and civil unrest and in an undefined and unending and undefinable war on terrorism that had affected the medical profession in a perverse and threatening way.

The insecurity of access to health care in these contexts was a fundamental threat to the right to health. The neutrality of medical care had been violated over the years in Somalia, El Salvador, in Kosovo, Iraq and Chechnya, and in the past decade they had witnessed the utter erosion of respect for the duty of the doctor to treat the sick and wounded without discrimination.

In the past 10 years, they had seen an alarming increase in outright and apparently intentional attacks on health facilities and personnel in armed conflicts in direct violation of the Geneva Convention protections. They were war crimes, and when they were widespread and systematic, they were crimes against humanity.

What they were seeing in Syria and Yemen had virtually no precedent in the last half-century. In Yemen there had been a horrific, utter destruction of the health system and in Syria deliberate, intentional attacks carried out with total impunity.

People were calling this 'the new normal' but it was aberrant and should be highly abnormal, and it was up to the doctors of the world to make sure this condition was completely unacceptable. They could not stand by this outright assault on the practice of medicine.

Dr. S.M. Johnson Chiang Dr. Johnson Chiang, President of the World Veterinary Association, spoke about the co-operation between the WVA and the WMA over several years. Joint press releases had been issued, most recently on the elimination of rabies.

Open Session

Dr. Sinan Adiyaman, President of the Turkish Medical Association, addressed the Assembly on the situation in his country. Following a press release issued by the Turkish Medical Association stating that 'War is a Public Health Issue, members of the Association's central committee had been detained for eight days. The WMA had issued a press release in their support. But TMA members were still on trial for making propaganda in favour of terrorist organisations. Criminal action was still pending against voluntary health workers and the TMA. He thanked the WMA and NMAs for their continued support.

The Assembly was then brought to a close after the Secretary General thanked the Icelandic Medical Association for their hospitality.

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WMA Statement on Avian and Pandemic Influenza

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006 and amended by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Preamble

1. Pandemic influenza occurs approximately three or four times every century. It usually occurs when a novel influenza A virus emerges that can easily be transmitted from person-to-person, to which humans have little or no immunity. Infection control and social distancing practices can help slow down the spread of the virus. Vaccine development can be challenging as the pandemic strain may not be accurately predicted. Adequate supplies of antivirals are key for treatment of specific at-risk population and controlling further spread of the outbreak.
2. Avian influenza is a zoonotic infection of birds and poultry, and can cause sporadic human infections. Birds act as reservoir and shed the virus in their feces, mucous and saliva. In addition, 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. Humans are infected if they are exposed through the mouth, eyes, or from the inhalation of virus particles. Limited evidence of human to human transmission has been reported as well.
3. This statement alongside with WMA Statement on Epidemics and Pandemics provides guidance to National Medical Associations and physicians on how they should be involved in their respective country's pandemic influenza planning and how to respond to Avian Influenza or pandemic influenza.

Recommendations

Avian Influenza

In the event of an avian influenza outbreak, the following measures should be taken:

- Sources of exposure should be avoided when possible as this is the most effective prevention measure.
- Personal protective equipment should be used and hand hygiene practices emphasized for personnel handling poultry as well as members of the healthcare team.
- All infected/exposed birds should be destroyed with proper disposal of carcasses, and rigorous disinfection or quarantine of farms.

- Stockpiles of vaccines and antivirals should be maintained for use during an outbreak.
- Antiviral medications such as neuraminidase inhibitors may be used for treatment.

Pandemic Influenza Preparedness

WHO and National Public Health Officials:

- The coordination of the international response to an influenza pandemic is the responsibility of the World Health Organization (WHO). The WHO currently uses an all-hazards risk based approach, to allow for a coordinated response based on varying degrees of severity of the pandemic.

The WHO should:

- Offer technical and laboratory assistance to affected countries if needed and continuously monitor activity levels of potential pandemic influenza strains continuously, ensuring that the designation of "Public Health Emergency of International Concern" is done in a timely manner if needed.
- Monitor and coordinate processes by which governments share biological materials including virus strains, to facilitate the production of and ensure access to vaccines globally.
- Communicate available information on influenza activity of concern as early as possible to allow for a timely response.
- National governments are urged to develop National Action plans to address the following points:
- Ensure that there is adequate local capacity for diagnosis and surveillance to allow continuous monitoring of influenza activity around the country.
- Consider the surge capacity of hospitals, laboratories, and public health infrastructure and improve them if necessary.
- Identify legal and ethical frameworks as well as governance structures in relation to the pandemic planning.
- Identify the mechanisms and the relevant authorities to initiate and escalate interventions to slow the spread of the virus in the community such as school closures, quarantine, border closures etc.
- Prepare risk and crisis communication strategies and messages in anticipation of public and media fear and anxiety.
- Governments are also urged to share biological materials namely virus strains and others, to facilitate the production and ensure access to vaccines globally.
- Ensure that diagnostics and surveillance efforts are continued and that adequate vaccine and antiviral stockpiles are established.
- Establish protocols to manage patients in the community, carry out triage in healthcare facilities, provide ventilation management, and handle infectious waste.
- Allocation of vaccine doses, antivirals and hospital beds should be coordinated with experts.

- Priority for vaccination should be given to the highest risk groups including those required to maintain essential services, including health care services.
- Guidance and timely information to regional health departments, health care organizations, and physicians.
- Preparation for an increase in demand for healthcare services and absences of health care providers especially if clinical severity of the illness is high. In such cases prioritization and co-ordination of available resources is essential. This may include tapping into private sector capacity where state resources are insufficient.
- Ensure adequate funding is allocated for pandemic preparedness and response as well as its health and social consequences.
- Make sure that mechanisms are in place to ensure the safety of healthcare facilities, personnel and the supply chains for vaccines and antivirals
- Promote and fund research to develop vaccines and effective treatments with lasting effects against influenza.
- Encourage collaboration between human and veterinary medicine in the prevention, research and control of avian influenza.
- National Medical Associations are urged to:
 - Delineate their involvement in the national pandemic influenza preparedness plan, which may include increasing capacity building amongst physicians, participating in guideline development and communication with healthcare professionals.
 - Help educate the public about avian and pandemic influenza.
 - When feasible, coordinate with other healthcare professionals' organizations as well as other NMAs to identify common issues and congruent policies related to pandemic influenza preparedness and response.
- Consider implementing support strategies for members involved in the response including mental health services, facilitation of health emergency response teams, and locum relief.
- Advocate before and during a pandemic, for allocation of adequate resources to meet foreseeable and emerging needs of healthcare, patients and the general public.
- Encourage health personnel to protect themselves by vaccination.
- Develop their own organization-specific business contingency plans to ensure continued support of their members.
- Physicians:
 - Must be sufficiently knowledgeable about pandemic influenza and transmission risks, including local, national and international epidemiology.
 - Should implement infection control practices and vaccination, to protect themselves as well as other staff members during seasonal and pandemic influenza outbreaks.
 - Must participate in local/regional pandemic influenza preparedness planning and training.
 - Should develop contingency plans to deal with possible disruptions in essential services and personnel shortages.

WMA Statement on Biosimilar Medicinal Products

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Preamble

4. The expiry of patents for original biotherapeutics has led to the development and approval of copies, called 'similar biological medicinal products' or 'biosimilars' that are highly similar to a previously approved biological product, known as the originator or reference product.
5. In light of the fact that biosimilars are made in living organisms, there may be some minor differences from the reference medicine, as minor variability is a characteristic attribute of all biological medicines. The manufacture of biosimilars is generally more complex than the manufacture of chemically derived molecules. Therefore, the active substance in the final biosimilar can have an inherent degree of minor variability. Innovator biologics also have inherent batch-to-batch variability, and for that reason biosimilars are not always interchangeable with the reference products, even after regulatory approval.
6. Biosimilars are not the same as generics. A generic drug is an identical copy of a currently licenced pharmaceutical product that has an expired patent protection and must contain the 'same active ingredients as the original formulation'. A biosimilar is a different product with a similar, but not identical, structure that elicits a similar clinical response. As a result, biosimilar medicines have the potential to cause an unwanted immune response. Whereas generics are interchangeable, biosimilars are not always interchangeable.
7. Biosimilars have been available in Europe for almost a decade following their approval by the European Medicines Agency (EMA) in 2005. The first biosimilar was approved by the Food and Drug Administration (FDA) for use in the United States in 2015.
8. Biosimilar medicines have transformed the outlook for patients with chronic and debilitating conditions, as it is possible to obtain similar efficacy as that of the reference product at a lower cost.
9. Biosimilars will also increase availability for patients without access to the bio-originator. Greater global access to effective biopharmaceuticals can reduce disability, morbidity, and mortality associated with various chronic diseases.
10. Nonetheless, the potentially lower cost of biosimilars raises the risk that insurers and health care providers may favor them over the originator product, even when they may not be appropriate for an individual patient or in situations when they have not demonstrated adequate clinical equivalence to an original biological product. The decision to prescribe biosimilars or to

switch patients from reference medicine to a biosimilar must be made by the attending physicians, not by health insurance companies.

Recommendations

1. National medical associations should work with their governments to develop national guidance on safety of biosimilars.
2. National medical associations should advocate for delivering biosimilar therapies that are as safe and effective as their reference products.
3. National medical associations should strive to ensure that physician autonomy is preserved in directing which biologic product is dispensed.
4. Where appropriate, national medical associations should lobby against allowing insurers and health funds to require biosimilar and originator product's interchangeability, and for safe regulations of interchanging biosimilar medicines where this is allowed.
5. Physicians must ensure that patient medical records accurately reflect the biosimilar medicine that is being prescribed and taken.
6. Physicians shouldn't prescribe a biosimilar to patients already showing success with the originator product, unless clinical equivalence has been clearly demonstrated and established and patients are adequately informed and have given consent. There should be no substitution between biosimilars and other drugs without the attending physician's permission.
7. Physicians should seek to improve their understanding of the distinctions between biosimilar products that are highly similar to or are interchangeable with an originator product; raise awareness of the issues surrounding biosimilars and interchangeability; and promote clearly delineated labelling of biosimilar products.
8. Physicians should remain vigilant and report to the manufacturer, as well as through the designated regulatory pathways, any adverse events suffered by patients using originator biological products or biosimilars.

WMA Declaration of Seoul on Professional Autonomy and Clinical Independence

Adopted by the 59th WMA General Assembly, Seoul, Korea, October 2008 And amended by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

The WMA reaffirms the Declaration of Madrid on professionally-led regulation.

The World Medical Association recognises the essential nature of professional autonomy and physician clinical independence, and states that:

1. Professional autonomy and clinical independence are essential elements in providing quality health care to all patients and populations. Professional autonomy and independence are essential for the delivery of high quality health care and therefore benefit patients and society.
2. Professional autonomy and clinical independence describes the processes under which individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue or inappropriate influence by outside parties or individuals.
3. Medicine is highly complex. Through lengthy training and experience, physicians become medical experts weighing evidence to formulate advice to patients. Whereas patients have the right to self-determination, deciding within certain constraints which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations.
4. Physicians recognize that they must take into account the structure of the health system and available resources when making treatment decisions. Unreasonable restraints on clinical independence imposed by governments and administrators are not in the best interests of patients because they may not be evidence based and risk undermining trust which is an essential component of the patient-physician relationship.
5. Professional autonomy is limited by adherence to professional rules, standards and the evidence base.
6. Priority setting and limitations on health care coverage are essential due to limited resources. Governments, health care funders (third party payers), administrators and Managed Care organisations may interfere with clinical autonomy by seeking to impose rules and limitations. These may not reflect evidence-based medicine principles, cost-effectiveness and the best interest of patients. Economic evaluation studies may be undertaken from a funder's not a users' perspective and emphasise cost-savings rather than health outcomes.
7. Priority setting, funding decision making and resource allocation/limitations processes are frequently not transparent. A lack of transparency further perpetuates health inequities.
8. Some hospital administrators and third-party payers consider physician professional autonomy to be incompatible with prudent management of health care costs. Professional autonomy allows physicians to help patients make informed choices, and supports physicians if they refuse demands by patients and family members for access to inappropriate treatments and services.
9. Care is given by teams of health care professionals, usually led by physicians. No member of the care team should interfere with the professional autonomy and clinical independence of the physician who assumes the ultimate responsibility for the care of the

patient. In situations where another team member has clinical concerns about the proposed course of treatment, a mechanism to voice those concerns without fear of reprisal should exist.

10. The delivery of health care by physicians is governed by ethical rules, professional norms and by applicable law. Physicians contribute to the development of normative standards, recognizing that this both regulates their work as professionals and provides assurance to the public.
11. Ethics committees, credentials committees and other forms of peer review have long been established, recognised and accepted by organised medicine as ways of scrutinizing physicians' professional conduct and, where appropriate, may impose reasonable restrictions on the absolute professional freedom of physicians.
12. The World Medical Association reaffirms that professional autonomy and clinical independence are essential components of high quality medical care and the patient-physician relationship that must be preserved. The WMA also affirms that professional autonomy and clinical independence are core elements of medical professionalism.

WMA Statement on Environmental Degradation and Sound Management of Chemicals

Adopted by the 61st WMA General Assembly, Vancouver, Canada, October 2010 and amended by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Preamble

1. This Statement focuses on one important aspect of environmental degradation, which is environmental contamination by domestic and industrial substances. It emphasizes the harmful chemical contribution to environmental degradation and physicians' role in promoting sound management of chemicals as part of sustainable development, especially in the healthcare environment.
2. Unsafe management of chemicals has potential adverse impacts on human health and human rights, with vulnerable populations being most at risk.
3. Most chemicals to which humans are exposed come from industrial sources and include, toxic gases, food additives, household consumer and cosmetic products, agrochemicals, and substances used for therapeutic purposes, such as drugs and dietary supplements. Recently, attention has been concentrated on the effects of human engineered (or synthetic) chemicals on the environ-

ment, including specific industrial or agrochemicals and on new patterns of distribution of natural substances due to human activity. As the number of such compounds has multiplied, governments and international organizations have begun to develop a more comprehensive approach to their safe regulation. The increasing amount of plastic waste in our environment is another serious concern, that needs to be addressed.

4. While governments have the primary responsibility for establishing a framework to protect the public's health from chemical hazards, the World Medical Association, on behalf of its members, emphasizes the need to highlight the human health risks and make recommendations for further action.

Background

Chemicals of Concern

5. During the last half-century, the use of chemical pesticides and fertilizers dominated agricultural practice and manufacturing industries rapidly expanded their use of synthetic chemicals in the production of consumer and industrial goods.
6. The greatest concern relates to chemicals, which persist in the environment, have low rates of degradation, bio-accumulate in human and animal tissue (concentrating as they move up the food chain), and which have significant harmful impacts on human health and the environment (particularly at low concentrations). Some naturally occurring metals including lead, mercury, and cadmium have industrial sources and are also of concern. Advances in environmental health research including environmental and human sampling and measuring techniques, and better information about the potential of low dose human health effects have helped to underscore emerging concerns.
7. Health effects from chemical emissions can be direct (occurring as an immediate effect of the emission) or indirect. Indirect health effects are caused by the emissions' effects on water, air and food quality as well as the alterations in regional and global systems, such as red tide in many oceans, and the ozone layer and the climate, to which the emissions may contribute.

National and International Actions

8. The model of regulation of chemicals varies widely both within and between countries, from voluntary controls to statutory legislation. It is important that all countries move to a coherent, standardized national legislated approach to regulatory control. Furthermore, international regulations must be coherent such that developing countries will not be forced by economic circumstances to accept elevated toxic exposure levels.
9. Synthetic chemicals include all substances that are produced by, or result from, human activities including industrial and house-

hold chemicals, fertilizers, pesticides, chemicals contained in products and in wastes, prescription and over-the-counter drug products and dietary supplements, and unintentionally produced byproducts of industrial processes or incineration, like dioxins. Furthermore, nanomaterials may need explicit regulation beyond existing frameworks.

Strategic approach to international chemicals management

10. Worldwide hazardous environmental contamination persists despite several international agreements on chemicals, making a more comprehensive approach to chemicals essential. Reasons for ongoing contamination include persistence of companies, absolute lack of controls in some countries, lack of awareness of the potential hazards, inability to apply the precautionary principle, non-adherence to the various conventions and treaties and lack of political will. The *Strategic Approach to International Chemicals Management* (SAICM) was adopted in Dubai, on February 6, 2006 by delegates from over 100 governments and representatives of civil society. This is a voluntary global plan of action designed to assure the sound management of chemicals throughout their life cycle so that, by 2020, chemicals are used and produced in ways that minimize significant adverse effects on human health and the environment. The SAICM addresses both agricultural and industrial chemicals, covers all stages of the chemical life cycle of manufacture, use and disposal, and includes chemicals in products and in wastes.

Plastic waste

11. Plastic has been part of life for more than 100 years and is regularly used in some form by nearly everyone. While some biodegradable varieties are being developed, most plastics break down very slowly with the decomposition process taking hundreds of years. This means that most plastics that have ever been manufactured are still on Earth, unless they have been burnt, thus polluting the atmosphere with poisonous smoke.
12. Concerns about the use of plastic include accumulation of waste in landfills and in natural habitats, terrestrial and marine, physical problems for wildlife resulting from ingestion or entanglement in plastic, the leaching of chemicals from plastic products and the potential for plastics to transfer chemicals to wildlife and humans. Many plastics in use today are halogenated plastics or contain other additives used in production, that have potentially harmful effects on health (e.g. carcinogenic or promoting endocrine disruption).
13. Our current usage of plastic is not sustainable, accumulating waste and therefore contributing to environmental degradation and potentially harmful effects on health. Specific regulation is therefore needed to counter the harmful distribution of slowly degradable plastic waste into the environment and the incineration of such waste which often creates toxic byproducts.

World Medical Association (WMA) Recommendations

14. Despite national and international initiatives, chemical contamination of the environment due to inadequately controlled production and usage continues to exert harmful effects on global public health. Evidence linking some chemicals to some health issues is strong, but far from all chemicals have been tested for their health or environmental impacts. This is especially true for newer chemicals or nano materials, particularly at low doses over long periods of time. Plastic contamination of our natural environment, including in the sea where plastic decomposes to minute particles, is an additional area of serious concern. Physicians and the healthcare sector are frequently required to make decisions concerning individual patients and the public as a whole based on existing data. Physicians therefore recognize that they, too, have a significant role to play in closing the gap between policy formation and chemicals management and in reducing risks to human health.
15. The World Medical Association reaffirms its commitment to advocate for the environment in order to protect health and life, and recommends that:

Advocacy

16. National Medical Associations (NMAs) advocate for legislation that reduces chemical pollution, enhances the responsibilities of chemical manufacturers, reduces human exposure to chemicals, detects and monitors harmful chemicals in both humans and the environment, and mitigates the health effects of toxic exposures with special attention to fertility for women and men and vulnerability during pregnancy and early childhood.
17. NMAs urge their governments to support international efforts to restrict chemical pollution through safe management, or phase out and safer substitution when unmanageable (e.g. asbestos), with particular attention to developed countries aiding developing countries to achieve a safe environment and good health for all.
18. NMAs facilitate better inter-sectoral collaboration between government ministries/departments responsible for the environment and public health.
19. NMAs promote public awareness about hazards associated with chemicals (including plastics) and what can be done about it.
20. Modern medical diagnosis and treatment relies heavily on the single use of packaged clean or sterile materials with various plastic components, whether the device itself or its packaging. NMAs should encourage research and the dissemination of practices that can reduce or eliminate this component of environmental degradation.
21. Physicians and their medical associations advocate for environmental protection, disclosure of product constituents, sustainable

development, green chemistry and green hospitals within their communities, countries and regions.

22. Physicians and their medical associations should support the phase out of mercury and persistent bioaccumulative and toxic chemicals in health care devices and products and avoid incineration of wastes from these products which may create further toxic pollution.
23. Physicians and their medical associations should support the Globally Harmonized System of Classification and Labelling of Chemicals (GHS) and legislation to require an environmental and health impact assessment prior to the introduction of a new chemical or a new industrial facility.
24. Physicians should encourage the publication of evidence of the effects of different chemicals and plastics, and dosages on human health and the environment. These publications should be accessible internationally and readily available to media, non-governmental organizations (NGOs) and concerned citizens locally.
25. Physicians and their medical associations should advocate for the development of effective and safe systems to collect and dispose of pharmaceuticals that are not consumed. They should also advocate for the introduction worldwide of efficient systems to collect and dispose of plastic waste.
26. Physicians and their medical associations should encourage efforts to curb the manufacture and use of plastic packaging and plastic bags, to halt the introduction of plastic waste into the environment, and to phase out and replace plastics with more biocompatible materials. These efforts may include measures to enhance recycling and specific regulations limiting the use of plastic packaging and plastic bags.
27. Physicians and their medical associations should support efforts to rehabilitate or clean areas of environmental degradation based on a "polluter pays" and precautionary principles and ensure that moving forward, such principles are built into legislation.
28. The WMA, NMAs and physicians should urge governments to collaborate within and between departments to ensure coherent regulations are developed.

Leadership

The WMA:

29. Supports the goals of the Strategic Approach to International Chemicals Management (SAICM), which promotes best practices in the handling of chemicals by utilizing safer substitution, waste reduction, sustainable non-toxic building, recycling, as well as safe and sustainable waste handling in the health care sector.
30. Cautions that these chemical practices must be coordinated with efforts to reduce greenhouse gas emissions from health care and other sources to mitigate its contribution to global warming.

31. Urges physicians, medical associations and countries to work collaboratively to develop systems for event alerts to ensure that health care systems and physicians are aware of high-risk industrial accidents as they occur, and receive timely and accurate information regarding the management of these emergencies.
32. Urges local, national and international organizations to focus on sustainable production, safer substitution, green safe jobs, and consultation with the health care community to ensure that damaging health impacts of development are anticipated and minimized.
33. Emphasizes the importance of the safe disposal of pharmaceuticals as one aspect of health care's responsibility and the need for collaborative work in developing best practice models to reduce this part of the chemical waste problem.
34. Encourages environmental classification of pharmaceuticals in order to stimulate prescription of environmentally less harmful pharmaceuticals.
35. Encourages local, national and international efforts to reduce the use of plastic packaging and plastic bags.
36. Encourages ongoing outcomes research on the impact of regulations and monitoring of chemicals on human health and the environment.

The WMA recommends that Physicians:

37. Work to reduce toxic medical waste and exposures within their professional settings as part of the World Health Professional Alliance's campaign for Positive Practice Environments.
38. Work to provide information on the health impacts associated with exposure to toxic chemicals, how to reduce patient exposure to specific agents and encourage behaviors that improve overall health.
39. Inform patients about the importance of safe disposal of pharmaceuticals that are not consumed.
40. Work with others to help address the gaps in research regarding the environment and health (i.e., patterns and burden of disease attributed to environmental degradation; community and household impacts of industrial chemicals; the effects, including on health, of distribution of plastic and of plastic waste into our natural environment; the most vulnerable populations and protections for such populations).

Professional Education & Capacity Building

The WMA recommends that:

41. Physicians and their professional associations assist in building professional and public awareness of the importance of the environment and global chemical pollutants on personal health.

42. NMAs develop tools for physicians to help assess their patients' risk from chemical exposures.
43. Physicians and their medical associations develop locally appropriate continuing medical education on the clinical signs, diagnosis, treatment and prevention of diseases that are introduced into communities as a result of chemical pollution and exacerbated by climate change.
44. Environmental health and occupational medicine should become a core theme in medical education. Medical schools should encourage the training of sufficient specialists in environmental health and occupational medicine.

WMA Statement on Gender Equality in Medicine

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Preamble

1. The WMA notes the increasing trend around the world for women to enter medical schools and the medical profession, and believes that the study and the practice of medicine must be transformed to a greater or lesser extent in order to support all people who study to become or practice as physicians, of whatever gender. This is an essential process of modernization by which inclusiveness is promoted by gender equality. This statement proposes mechanisms to identify and address barriers causing discrimination between genders.
2. In many countries around the world, the number of women studying and practicing medicine has steadily risen over the past decades, surpassing 50% in many places.
3. This development offers opportunities for action, including in the following areas:
 - Greater emphasis on a proper balance of work and family life, while supporting the professional development of individual physicians.
 - Encouragement and actualization of women in academia, leadership and managerial roles.
 - Equalization of pay and employment opportunities for men and women, the elimination of gender pay gaps in medicine, and the removal of barriers negatively affecting the advancement of female physicians.
4. The issue of women in medicine was previously recognized in the WMA Resolution on Access of Women and Children to Health Care and the Role of Women in the Medical Profession which, among other things, called for increased representation

and participation in the medical profession, especially in light of the growing enrolment of women in medical schools. It also called for a higher growth rate of membership of women in National Medical Associations (NMAs) through empowerment, career development, training and other strategic initiatives.

Recommendations

Increased presence of women in academia, leadership and management roles.

5. National Medical Associations/Medical Schools/Employers are urged to facilitate the establishment of mentoring programs, sponsorship, and active recruitment to provide medical students and physicians with the necessary guidance and encouragement necessary to undertake leadership and management roles.
6. NMAs should explore opportunities and incentives to encourage both men and women to pursue diverse careers in medicine and apply for fellowships, academic, senior leadership and management positions.
7. NMAs should lobby for gender equal medical education and work policies.
8. NMAs should encourage the engagement of both men and women in health policy organizations and professional medical organizations.

Work-Life Balance

9. Physicians should recognize that an appropriate work-life balance is beneficial to all physicians, but that women may face unique challenges to work-life balance imposed by societal expectations concerning gender roles that must be addressed to solve the issue. Healthcare employers can show leadership and help tackle this imbalance by:
 - Ensuring women who go on maternity leave are able to access all their rights and entitlements;
 - Introducing programmes which encourage men as well as women to take parental leave, so that women are able to pursue their careers and men are able to spend important time with their families.
10. Hospitals and other places of employment should strive to provide and promote access to high quality, affordable, flexible childcare for working parents, including the provision of onsite housing and childcare where appropriate. These services should be available to both male and female physicians, recognizing the need for a better work-life balance. Employers should provide information on available services which support the compatibility of work and family.
11. Hospitals and other places of employment should be receptive to the possibility of flexible and family-friendly working hours, including part-time residencies, posts, and professional appointments.

12. There is a need for increased research on alternative work schedules and telecommunication opportunities that will allow flexibility in balancing work-life demands.
13. NMAs should advocate for the enforcement and, where necessary, the introduction of policy mandating appropriate paid parental leave and rights in their respective countries.
14. Medical workplaces and professional organisations should have fair, impartial and transparent policies and practices to give all physicians and medical students equal access to employment, education and training opportunities in medicine.

Pregnancy and Parenthood

15. It should be illegal for employers to ask applicants about pregnancy and/or family planning in relation to work.
16. Employers should assess the risks to pregnant physicians and their unborn children, when a physician has recently given birth and when she is breastfeeding. Where it is found, or a medical practitioner considers, that an employee or her child would be at risk were she to continue with her normal duties, the employer should provide suitable alternative work for which the physician should receive her normal rate of pay. Physician should have the right to not work night shifts or on-call shifts during the later part of pregnancy, without negative consequences on salary, employment or progression in residency.
17. Pregnant physicians should have equal training opportunities in post-graduate training.
18. Parents should have the right to take adequate parental leave without negative consequences on their employment, training or career opportunities.
19. Parents should have the right to return to the same position after parental leave, without the fear of termination.
20. Employers and training bodies should provide necessary support to any physician returning after a prolonged period of absence including parental, maternity and elder-care leave.
21. Mothers should be able to breastfeed (or be given protected time for breast pumping) during work hours, within the current guidelines from the WHO.
22. Workplaces should provide adequate accommodation for women who are breastfeeding including designated areas for breastfeeding, breast pumping, and milk storage, which are quiet, hygienic, and private.

Changes in organisational culture

23. The medical profession and employers should work to eliminate discrimination and harassment on the basis of gender and create a supportive environment that allows equal opportunities for training, employment and advancement.
24. Family friendliness should be part of the organizational culture of hospitals and other places of employment.

Workforce planning and research

25. NMAs should encourage governments to take the increasing number of women entering medicine into consideration in the context of long-term workforce planning. A diverse workforce is beneficial to the health care system and to patients. Organizations delivering healthcare should focus on ensuring systems are appropriately resourced to ensure that all those working within them are able to deliver safe care to patients and are appropriately and equitably rewarded. Governments should also work to counteract negative attitudes and behaviour, bias, and/or outdated norms and values from organizations and individuals.
26. NMAs should encourage governments to invest in research to identify those factors that drive women and men to choose certain fields of specialization early on in their medical education and training and strive to address any identified barriers in order to achieve equal representation of men and women in all fields of medicine.
27. NMAs should encourage governments and employers to ensure that men and women receive equal compensation for commensurate work and strive to eliminate the gender pay gap in medicine.

WMA Statement on Physicians Convicted of Genocide, War Crimes or Crimes Against Humanity

Adopted by the 49th WMA General Assembly, Hamburg, Germany, November 1997 and reaffirmed by the WMA Council Session, Berlin, Germany, May 2007 and amended by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Scope and Definitions

The scope of this Statement includes the following specified crimes: genocide, war crimes, and crimes against humanity, as defined by the Rome Statute of the International Criminal Court.

Preamble

- Physicians are bound by medical ethics to dedicate themselves to the good of their patients. Physicians who have been convicted of genocide, war crimes or crimes against humanity¹, have violated

¹ As defined by the Rome Statute of the International Criminal Court

medical ethics, human rights and international law and are therefore unworthy of practising medicine.

- In accordance with the principle of the presumption of innocence, only physicians who have been convicted of the specified crimes should be declared unworthy of practising medicine.

Discussion

1. Physicians seeking to work in any country are subject to the regulations of that country's relevant authorities or jurisdiction. The duty to demonstrate suitability to practice medicine rests with the person seeking licensure.
2. Physicians who have been convicted of genocide, war crimes or crimes against humanity must not be allowed to practise in another country or jurisdiction.
3. The relevant licensing authorities must ensure both that physicians have the required qualifications and that they have not been convicted of genocide, war crimes or crimes against humanity.
4. Physicians who have been convicted of the specified crimes have sometimes been able to leave the country in which these crimes were committed and obtain a licence to practise medicine from the relevant licensing authority in another country.
5. This practice is contrary to the public interest, damaging to the reputation of the medical profession, and may be detrimental to patient safety.

Recommendations

1. The WMA recommends that physicians who have been convicted of the specified crimes be denied a license to practice medicine and membership to national medical associations by the relevant regulatory and licensing authority of that jurisdiction.
2. The WMA recommends that relevant regulatory and licensing authorities use their own authority to inform themselves, in so far as is possible, if verifiable allegations of participation in genocide, war crimes or crimes against humanity have been made against physicians, while at the same time respecting the presumption of innocence.
3. National Medical Associations must be sure that a thorough investigation into those allegations is performed by an appropriate authority.
4. The WMA recommends that national medical associations ensure that there is efficient communication amongst themselves and that where possible and appropriate they inform relevant national regulatory and licensing authorities of physicians' convictions of genocide, war crimes, or crimes against humanity.

WMA Statement on the Development and Promotion of a Maternal and Child Health Handbook

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Preamble

- The WMA believes that both a continuum of care and family empowerment is necessary to improve the health and wellbeing of the mother and child. The reduction of maternal mortality ratio and infant deaths was an important objective of the Millennium Development Goals (MDGs). The reductions of the maternal mortality ratio, neonatal mortality rate and the under-five mortality rate are important targets to be achieved under the Sustainable Development Goals (SDGs).
- The maternal and child health (MCH) handbook is a comprehensive home-based booklet designed to provide relevant health information and include integrated mother and child health records. The MCH handbook covers health records and information on pregnancy, delivery, neonatal and childhood periods, and child growth and immunizations. The MCH handbook supports the integration of maternal, neonatal and child health services. The MCH handbook is not only about health education, but about creating ownership with women and families.
- In 1948, Japan became the first country in the world to create and distribute a maternal and child health (MCH) handbook, in order to protect and improve the health and wellbeing of the mother and child.
- There are now approximately 40-country versions of the MCH handbook, all adapted to the local culture and socio-economic context. There are a variety of handbooks and educational materials concerned to MCH in many countries. The use of MCH handbooks has helped improve the knowledge of mothers on maternal and child health issues, and has contributed to changing behaviors during pregnancy, delivery and post-delivery period.
- The MCH handbook can promote the health of pregnant women, neonates and children by using it as a tool for strengthening a continuum of care. Physicians can make better care decisions, by referring to the patient's medical history and health-check data recorded in the MCH handbook. The MCH handbook alone has not been shown to improve health indicators. The benefits

are maximized when women and children have access to relevant healthcare services based on information recorded in the handbook. Such benefits of the handbook could be shared globally.

- In Japan, a digital handbook is spreading progressively. The digital handbook is expected to be utilized in a way that protects confidentiality of the patient's health information. Some private kindergarten and primary schools request access to the MCH as part of their admission process, placing pressure on parents and physicians to modify the answers to questions in the handbook.

Recommendations

1. The WMA recommends that the constituent member associations encourage their health authorities and health institutions to provide accessible and easy to understand information regarding maternal and child health. The MCH handbook, or equivalents, can be an important tool to improve continuity of care and benefit health promotion for mothers, neonates and children.
2. The WMA recommends that the constituent member associations and medical professionals promote the adaptation to local setting and the utilization of MCH handbooks, or equivalents, in order to leave no one behind with respect to SDGs, especially for non-literate people, migrant families, refugees, minorities, people in underserved and remote areas.
3. When using a MCH handbook or similar documentation, in either digital or print form, the confidentiality of the individual health information and the privacy of mothers and children should be strictly protected. It should be used exclusively to improve health and wellbeing of mothers, neonates, and children. It should not be used in the admission procedures of schools.
4. The constituent member associations should promote local research to evaluate the utilization of the MCH handbooks, or equivalents, and make recommendations to improve the quality of care in the local setting.

WMA Statement on Medical Tourism

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Preamble

1. Medical tourism is an expanding phenomenon, although to date it has no agreed upon definition and, as a result, practices and

protocols in different countries can vary substantially. For purposes of this statement, medical tourism is defined as a situation where patients travel voluntarily across international borders to receive medical treatment, most often at their own cost. Treatments span a range of medical services, and commonly include: dental care, cosmetic surgery, elective surgery, and fertility treatment (OECD, 2011).

2. This statement does not cover cases where a national health care system or treating hospital sends a patient abroad to receive treatment at its own cost or where, as in the European Union, patients are allowed to seek care in another EU Member State according to legally defined criteria, and their home health system bears the costs. Also not covered is a situation in which people are in a foreign country when they become ill and need medical care.
3. If not regulated appropriately, medical tourism may have medico-legal and ethical ramifications and negative implications, including but not limited to: internal brain drain, establishment of a two-tiered health system, and the spread of antimicrobial resistance. Therefore, it is imperative that there are clear rules and regulation to govern this growing phenomenon.
4. Medical tourism is an emerging global industry, with health service providers in many countries competing for foreign patients, whose treatment represents a significant potential source of income. The awareness of health as a potential economic benefit and the willingness to invest in it rise with the economic welfare of countries, and billions of dollars are invested each year in medical tourism all over the world. The key stakeholders within this industry include patients, brokers, governments, health care providers, insurance providers, and travel agencies. The proliferation of medical tourism websites and related content raise concerns about unregulated and inaccurate on-line health information.
5. A medical tourist is in a more fragile and vulnerable situation than that of a patient in his or her home country. Therefore, extra sensitivity on the part of caretakers is needed at every stage of treatment and throughout the patient's care, including linguistic and cultural accommodation wherever possible. When medical treatment is sought abroad, the normal continuum of care may be interrupted and additional precautions should therefore be taken.
6. Medical tourism bears many ethical implications that should be considered by all stakeholders. Medical tourists receive care in both state-funded and private medical institutions and regulations must be in place in both scenarios. These recommendations are addressed primarily to physicians. The WMA encourages others who are involved in medical tourism to adopt these principles.

Recommendations

General

7. The WMA emphasises the importance of developing health care systems in each country in order to prevent excessive medical tourism resulting from limited treatment options in a patient's home country. Financial incentives to travel outside a patient's home country for medical care should not inappropriately limit diagnostic and therapeutic alternatives in the patient's home country, or restrict treatment or referral options.
8. The WMA calls on governments to carefully consider all the implications of medical tourism to the healthcare system of a country by developing comprehensive, coordinated national protocols and legislation for medical tourism in consultation and cooperation with all relevant stakeholders. These protocols should assess the possibilities of each country to receive medical tourists, to agree on necessary procedures, and to prevent negative impacts to the country's health care system.
9. The WMA calls on governments and service providers to ensure that medical tourism does not negatively affect the proper use of limited health care resources or the availability of appropriate care for local residents in hosting countries. Special attention should be paid to treatments with long waiting times or involving scarce medical resources. Medical tourism must not promote unethical or illegal practices, such as organ trafficking. Authorities, including government, should be able to stop elective medical tourism where it is endangering the ability to treat the local population.
10. The acceptance of medical tourists should never be allowed to distort the normal assessment of clinical need and, where appropriate, the development of waiting lists, or priority lists for treatment. Once accepted to treatment by a health care provider, medical tourists should be treated in accordance with the urgency of their medical condition. Whenever possible patients should be referred to institutions that have been approved by national authorities or accredited by appropriately recognised accreditation bodies.

Prior to travel

11. Patients should be made aware that treatment practices and health care laws may be different than in their home country and that treatment is provided according to the laws and practices of the host country. Patients should be informed by the physician/service provider of their rights and legal recourse prior to travelling outside their home country for medical care, including information regarding legal recourse in case of patient injury and possible compensation mechanisms.
12. The physician in the host country should establish a treatment plan, including a cost estimate and payment plan, prior to the medical tourist's travel to the host country. In addition, the

physician and the medical tourism company (if any) should collaborate in order to ensure that all arrangements are made in accordance with the patient's medical needs. Patients should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities.

13. Medical tourists should be informed that privacy laws are not the same in all countries and, in the context of the supplementary services they receive, it is possible that their medical information will be exposed to individuals who are not medical professionals (such as interpreters). If a medical tourist nonetheless decides to avail him or herself of these services, he or she should be provided with documentation specifying the services provided by non-medical practitioners (including interpreters) and an explanation as to who will have access to his or her medical information, and the medical tourist should be asked to consent to the necessary disclosure.
14. All stakeholders (clinical and administrative) involved in the care of medical tourists must be made aware of their ethical obligations to protect confidentiality. Interpreters, and other administrative staff with access to health information of the medical tourist should sign confidentiality agreements.
15. The medical tourist should be informed that a change in his or her clinical condition might result in a change in the cost estimate and in associated travel plans and visa requirements.
16. If the treatment plan is altered because of a medical need that becomes clear after the initial plan has been established, the medical tourist should be notified of the change and why it was necessary. Consent should be obtained from the patient for any changes to the treatment plan.
17. When a patient is suffering from an incurable condition, the physician in the host country shall provide the patient with accurate information about his or her medical treatment options, including the limitations of the treatment, the ability of the treatment to alter the course of the disease in an appreciable manner, to increase life expectancy and to improve the quality of life. If, after examining all the data, the physician concludes that it is not possible to improve the patient's medical condition, the physician should advise the patient of this and discourage the patient from travelling.

Treatment

18. Physicians are obligated to treat every individual accepted for treatment, both local and foreigner, without discrimination. All the obligations detailed in law and international medical ethical codes apply equally to the physician in his or her encounter with medical tourists.
19. Medical decisions concerning the medical tourist should be made by physicians, in cooperation with the patient, and not by non-medical personnel.

20. At the discretion of the treating physicians, and where information is available and of good quality, the patient should not be required to undergo tests previously performed, unless there is a clinical need to repeat tests.
21. The patient should receive information about his or her treatment in a language he or she understands. This includes the right to receive a summary of the treatment progress and termination by the treating physician and a translation of the documents, as needed.
22. Agreement should be reached before treatment begins, on the transfer of test results and diagnostic images, back to the home country of the patient.
23. Where possible, communication between the physicians in the host and home country should be established in order to ensure appropriate aftercare and clinical follow-up of the medical problems for which the patient was treated.
24. The physician who prepares the treatment plan for the patient should confirm the diagnosis, the prognosis and the treatments that the medical tourist has received.
25. The patient should receive a copy of his or her medical documents for the purpose of continuity of care and follow-up in his or her home country. Where necessary, the patient should be given a detailed list of medical instructions and recommendations for the period following his or her departure. This information should include a description of the expected recovery time and the time required before travelling back to his or her home is possible.

Advertising

26. Advertising for medical tourism services, whether via the internet or in any other manner, should comply with accepted principles of medical ethics and include detailed information regarding the services provided. Information should address the service provider's areas of specialty, the physicians to whom it refers the benefits of its services, and the risks that may accompany medical tourism. Access to licensing/accreditation status of physicians and facilities and the facility's outcomes data should be made readily available. Advertising material should note that all medical treatment carries risks and specific additional risks may apply in the context of medical tourism.
27. National Medical Associations should do everything in their power to prevent improper advertising or advertising that is in violation of medical ethical principles, including advertising that contains incorrect or partial information and/or any information that is liable to mislead patients, such as overstatement of potential benefits.
28. Advertising that notes the positive attributes of a specific medical treatment should also present the risks inherent in such treatment and should not guarantee treatment results or foster unrealistic expectations of benefits or treatment results.

Transparency and the prevention of conflicts of interest

29. Possible conflicts of interest may be inevitable for physicians treating medical tourists, including at the behest of their employing institution. It is essential that all clinical circumstances and relationships are managed in an open and transparent manner.
30. A physician shall exercise transparency and shall disclose to the medical tourist any personal, financial, professional or other conflict of interest, whether real or perceived, that may be connected to his or her treatment.
31. A physician should not accept any benefit, other than remuneration for the treatment, in the context of the medical treatment, and should not offer the medical tourist nor accept from him or her any business or personal offer, as long as the physician-patient relationship exists. Where the physician is treating the medical tourist as another fee paying patient, the same rules should apply as with his/her other fee paying patients.
32. A physician should ensure that any contract with a medical tourism company or medical tourist does not constitute a conflict of interest with his or her current employment, or with his or her ethical and professional obligations towards other patients.

Transparency in payment and in the physician's fees

33. A treatment plan and estimate should include a detailed report of all costs, including a breakdown of physician's fees, such as: consultancy and surgery and additional fees the patient might incur, such as: hospital costs, surgical assistance, prosthesis (if separate), and costs for post-operative care.
34. The cost estimate may be changed after the treatment plan has been given only in the event that the clinical condition of the patient has changed, or where circumstances have changed in a way that it was impossible to anticipate or prevent. If the pricing was thus changed, the patient must be informed as to the reason for the change in costs in as timely a fashion as possible.

WMA Statement on Medically-Indicated Termination of Pregnancy

Adopted by the 24th World Medical Assembly, Oslo, Norway, August 1970 and amended by the 35th World Medical Assembly, Venice, Italy, October 1983, the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006, and the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Preamble

1. Medically-indicated termination of pregnancy refers only to interruption of pregnancy due to health reasons, in accordance with principles of evidence-based medicine and good clinical practice. This Declaration does not include or imply any views on termination of pregnancy carried out for any reason other than medical indication.
2. Termination of pregnancy is a medical matter between the patient and the physician. Attitudes toward termination of pregnancy are a matter of individual conviction and conscience that should be respected.
3. A circumstance where the patient may be harmed by carrying the pregnancy to term presents a conflict between the life of the foetus and the health of the pregnant woman. Diverse responses to resolve this dilemma reflect the diverse cultural, legal, traditional, and regional standards of medical care throughout the world.

Recommendations

4. Physicians should be aware of local termination of pregnancy laws, regulations and reporting requirements. National laws, norms, standards, and clinical practice related to termination of pregnancy should promote and protect women's health, dignity and their human rights, voluntary informed consent, and autonomy in decision-making, confidentiality and privacy. National medical associations should advocate that national health policy upholds these principles.
5. Where the law allows medically-indicated termination of pregnancy to be performed, the procedure should be performed by a competent physician and only in extreme cases by another qualified health care worker, in accordance with evidence-based medicine principles and good medical practice in an approved facility that meets required medical standards.
6. The convictions of both the physician and the patient should be respected.
7. Patients must be supported appropriately and provided with necessary medical and psychological treatment along with appropriate counselling if desired.
8. Physicians have a right to conscientious objection to performing an abortion; therefore, they may withdraw while ensuring the continuity of medical care by a qualified colleague. In all cases, physician must perform those procedures necessary to save the woman's life and to prevent serious injury to her health.
9. Physicians must work with relevant institutions and authorities to ensure that no woman is harmed because medically-indicated termination of pregnancy services are unavailable.

WMA Resolution on Migration

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Nowadays, we are facing increased migration trends globally. This situation, far from being resolved, has worsened over the last months, exacerbated by political, social and economic events, with serious impacts on the population deteriorating the quality of life and in some cases putting people in mortal danger. This violates their fundamental right to health and in many cases forces them to abandon their countries to search for a better life.

International migration is a global phenomenon, caused by multiple factors, including demographic and economic inequalities among countries, in addition to war, hunger and natural disasters. Migration policies adopted by the majority of receiving countries are becoming more and more restrictive towards economic migrants.

The World Medical Association (WMA) considers that health is a basic need, a human right and one of the essential drivers of economic and social development. Increased migration is a phenomenon linked to progress and to the trends of the 21st century.

The WMA reaffirms its Resolution on Refugees and Migrants adopted in October 2016.

The WMA, its constituent members and the international health community should advocate for:

1. Strong continued engagement of physicians in the defense of human rights and dignity of all people worldwide, as well as combatting suffering, pain and illness;
2. The prioritization of the care of human beings above any other consideration or interest;
3. Providing the necessary healthcare, through international cooperation, directed to countries that welcome and receive large number of migrants.
4. Governments to reach political agreements to obtain the necessary health resources to deliver care in an adequate and coordinated manner to the migrant population.

The WMA emphasizes the role of physicians to actively support and promote the rights of all people to medical care based solely on clinical necessity, and protest against legislation and practices contrary to this fundamental right.

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.

WMA Statement on Sustainable Development

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Preamble

1. The WMA believes that health and well-being are dependent upon social determinants of health (SDHs), the conditions in which people are born, grow, live, work and age. These social de-

terminants will directly influence the achievement of the United Nations Sustainable Development Goals (SDGs). Many of the SDG goals, targets and indicators that have been developed to measure progress towards them, will also be useful measures of the impact of action is having on improving the SDH and, in particular, on reducing health inequities.

2. This statement builds upon WMA policy on Social Determinants of Health as set out in the Declaration of Oslo, and upon the basic principles of medical ethics set out in the Declaration of Geneva.
3. The WMA recognizes the important efforts undertaken by the United Nations with the adoption on 25 September 2015 of the resolution “*Transforming our world: the 2030 Agenda for Sustainable Development*”. The Sustainable Development Agenda is based upon five key themes: people, planet, prosperity, peace and partnership and the principle of leaving no one behind. The WMA affirms the importance of global efforts on sustainable development and the impact that they can bring to humanity.
4. SDGs are built on the lessons learned from successes and failures in achieving the Millennium Development Goals (MDGs), including inequity in many areas of life. While there is no overarching concept unifying the SDGs, the WMA believes that inequity in health and wellbeing encapsulates much of the 2030 Agenda. The WMA notes that while only SDG 3 is overtly about health, many of the goals have major health components.
5. The WMA recognizes all governments must commit and invest to fully implement the goals by 2030, in alignment with the Addis Ababa Action Agenda. The WMA also recognizes the risk that the SDGs might be considered unaffordable due to their estimated potential cost of between US\$ 3.3 and US\$ 4.5 trillion a year.
6. The WMA emphasises the need for cross and inter-sectoral work to achieve the goals and believes that health must be addressed in all SDGs and not only under health specific SDG 3.

Policy priorities:

7. Recognition of Health in All Policies and the Social Determinants of Health / Whole of Society approach.
8. Policy areas that are essential to achieving the SDG 3:
 - Patient Empowerment and Patient Safety
 - Continuous Quality Improvement in Health Care
 - Overcoming the Impact of Aging on Health Care
 - Addressing Antimicrobial Resistance
 - The safety and welfare of Health care staff
9. Ensuring policy alignment among all the UN Agencies and the work of regional governmental organizations such as EU, African Union, Arab League, ASEAN, and Organization of American States.

10. The WMA commits to support implementation of the other three global agreements regarding the sustainable development process:
 - The Addis Ababa Action Agenda as the mechanism that will provide the financial support for the 2030 Agenda.
 - The Paris Agreement is the binding mechanism of the sustainable development process that sets out a global action plan to put the world on track to avoid dangerous climate change by limiting global warming to well below 2°C above pre-industrial levels.
 - The Sendai Framework for Disaster Risk Reduction as the agreement which recognizes that the State has the primary role to reduce disaster risk but that responsibility should be shared with local government, the private sector and other stakeholders.

Recommendations and Commitments

11. The WMA commits to work with other intergovernmental organizations, including the UN, the WHO, healthcare professionals' organizations and other stakeholders, for the implementation and follow-up of this Agenda and related international agreements, and for policy and advocacy alignment.
12. The WMA commits to collaborate with its constituent member Associations to support their work at regional and national levels, and with their governments on the 2030 Agenda implementation.
13. The WMA recommends that NMAs create strategies regarding data collection, implementation, capacity building and advocacy, to enhance policy coherence and to maximise the 2030 Agenda implementation at national and global levels.
14. The WMA also recommends that NMAs collaborate with development banks, NGOs, intergovernmental organisations and other stakeholders who are also working to implement of the 2030 Agenda, especially in their own countries.
15. The WMA encourages the UN and the WHO to develop guidelines on how financing for health will be implemented to reach the targets established by the 2030 Agenda and the economic implications of NCDs, aging and antimicrobial resistance.

WMA Statement on the Ethics of Telemedicine

Adopted by the 58th WMA General Assembly, Copenhagen, Denmark, October 2007 And amended by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Definition

Telemedicine is the practice of medicine over a distance, in which interventions, diagnoses, therapeutic decisions, and subsequent treatment recommendations are based on patient data, documents and other information transmitted through telecommunication systems.

Telemedicine can take place between a physician and a patient or between two or more physicians including other healthcare professionals.

Preamble

- The development and implementation of information and communication technology are creating new and different ways for practicing medicine. Telemedicine is used for patients who cannot see an appropriate physician timeously because of inaccessibility due to distance, physical disability, employment, family commitments (including caring for others), patients' cost and physician schedules. It has capacity to reach patients with limited access to medical assistance and have potential to improve health care.
- Face-to-face consultation between physician and patient remains the gold standard of clinical care.
- The delivery of telemedicine services must be consistent with in-person services and supported by evidence.
- The principles of medical ethics that are mandatory for the profession must also be respected in the practice of telemedicine.

Principles

Physicians must respect the following ethical guidelines when practicing telemedicine:

1. The patient-physician relationship should be based on a personal examination and sufficient knowledge of the patient's medical history. Telemedicine should be employed primarily in situations in which a physician cannot be physically present within a safe and acceptable time period. It could also be used in management of chronic conditions or follow-up after initial treatment where it has been proven to be safe and effective.
2. The patient-physician relationship must be based on mutual trust and respect. It is therefore essential that the physician and patient be able to identify each other reliably when telemedicine is employed. In case of consultation between two or more professionals within or between different jurisdictions, the primary physician remains responsible for the care and coordination of the patient with the distant medical team.
3. The physician must aim to ensure that patient confidentiality, privacy and data integrity are not compromised. Data obtained

during a telemedicine consultation must be secured to prevent unauthorized access and breaches of identifiable patient information through appropriate and up to date security measures in accordance with local legislation. Electronic transmission of information must also be safeguarded against unauthorized access.

4. Proper informed consent requires that all necessary information regarding the distinctive features of telemedicine visit be explained fully to patients including, but not limited to:
 - explaining how telemedicine works,
 - how to schedule appointments,
 - privacy concerns,
 - the possibility of technological failure including confidentiality breaches,
 - protocols for contact during virtual visits,
 - prescribing policies and coordinating care with other health professionals in a clear and understandable manner, without influencing the patient's choices.
5. Physicians must be aware that certain telemedicine technologies could be unaffordable to patients and hence impede access. Inequitable access to telemedicine can further widen the health outcomes gap between the poor and the rich.

Autonomy and privacy of the Physician

6. A physician should not to participate in telemedicine if it violates the legal or ethical framework of the country.
7. Telemedicine can potentially infringe on the physician privacy due to 24/7 virtual availability. The physician needs to inform patients about availability and recommend services such as emergency when inaccessible.
8. The physician should exercise their professional autonomy in deciding whether a telemedicine versus face-to-face consultation is appropriate.
9. A physician should exercise autonomy and discretion in selecting the telemedicine platform to be used.

Responsibilities of the Physician

10. A physician whose advice is sought through the use of telemedicine should keep a detailed record of the advice he/she delivers as well as the information he/she received and on which the advice was based in order to ensure traceability.
11. If a decision is made to use telemedicine it is necessary to ensure that the users (patients and healthcare professionals) are able to use the necessary telecommunication system.
12. The physician must seek to ensure that the patient has understood the advice and treatment suggestions given and take steps in so far as possible to promote continuity of care.
13. The physician asking for another physician's advice or second opinion remains responsible for treatment and other decisions and recommendations given to the patient.

14. The physician should be aware of and respect the special difficulties and uncertainties that may arise when he/she is in contact with the patient through means of tele-communication. A physician must be prepared to recommend direct patient-doctor contact when he/she believes it is in the patient's best interests.
15. Physicians should only practise telemedicine in countries/jurisdictions where they are licenced to practise. Cross-jurisdiction consultations should only be allowed between two physicians.
16. Physicians should ensure that their medical indemnity cover include cover for telemedicine.

Quality of Care

17. Healthcare quality assessment measures must be used regularly to ensure patient security and the best possible diagnostic and treatment practices during telemedicine procedures. The delivery of telemedicine services must follow evidence-based practice guidelines to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. Like all health care interventions, telemedicine must be tested for its effectiveness, efficiency, safety, feasibility and cost-effectiveness.
18. The possibilities and weaknesses of telemedicine in emergencies must be duly identified. If it is necessary to use telemedicine in an emergency situation, the advice and treatment suggestions are influenced by the severity of the patient's medical condition and the competency of the persons who are with the patient. Entities that deliver telemedicine services must establish protocols for referrals for emergency services.

Recommendations

1. Telemedicine should be appropriately adapted to local regulatory frameworks, which may include licencing of telemedicine platforms in the best interest of patients.
2. Where appropriate the WMA and National Medical Associations should encourage the development of ethical norms, practice guidelines, national legislation and international agreements on subjects related to the practice of telemedicine, while protecting the patient-physician relationship, confidentiality, and quality of medical care.
3. Telemedicine should not be viewed as equal to face-to-face healthcare and should not be introduced solely to cut costs or as a perverse incentive to over-service and increase earnings for physicians.
4. Use of telemedicine requires the profession to explicitly identify and manage adverse consequences on collegial relationships and referral patterns.
5. New technologies and styles of practice integration may require new guidelines and standards.
6. Physicians should lobby for ethical telemedicine practices that are in the best interests of patients.

Why Euthanasia is Unethical and Why We Should Name it as Such



Rene Leiva

'Unanimously, a declaration was adopted which simply says that euthanasia is unethical.'

Thus read a brief initial note in the World Medical Journal of 1987 with reference to the key passage of a new WMA Declaration on Euthanasia adopted in the Madrid General Assembly of that year [1]. Concise as this message was, it announced the affirmation of a powerful, enduring medical dictum, and we believe it to be essential for us, today, to understand the context in which it came about.

The WMA was founded in 1947, in part to work for the highest possible standards of ethical behaviour and care among physicians. This was considered particularly important after the gross ethical violations observed, by physicians themselves during the Second World War (1939-45) [2]. In 1987, several members of the WMA, who had had personal experience with these atrocities, were still alive. One of them, Dr. Andre Wynen, who was then Secretary General, and a Nazi camp survivor himself, was a strong advocate of the formulation of the Declaration 'because protection of life was very important for him' [3]. These



Gordon Friesen

sentiments were echoed in a 1989 essay by then WMA President Ram Ishay from the Israeli Medical Association [4]. Dr. Ishay explained that the WMA had not seen the need to pass such a Declaration earlier, because it had already adopted policies laying out what it considered to be appropriate and ethical end of life care. However, given new positions emerging within some countries, it felt the need to break this silence, and passed the present Declaration unanimously. This robust vehicle was subsequently reaffirmed in 2005 and again in 2015.

The authors of this article are three Canadians – two are practicing physicians and the other a severely disabled individual – who have combined their efforts, here, in the hope of preserving, once again, the deep and timely precautions WMA has maintained all these years. We ask that the full language of the original Declaration – explicitly stating that euthanasia “is unethical” – be preserved.

The nature of euthanasia

Voluntary euthanasia, simply put, is the medicalization of suicide. The use of euphe-



Timothy Lau

misms such as Physician Assisted Death or Medical Assistance in Dying are misguided attempts to rebrand a practice which doctors have renounced for close to 2500 years. These terms should be rejected as linguistic deceptions.

The objective judgement of whether any suicide or assisted suicide is warranted is impossible because of the subjective nature of suffering. What is grievous, irremediable, or intolerable to one person, may not be so for another. And, unfortunately, the physician's opinion is no less subjective than that of the patient. An illustration of this comes from the review of psychiatric euthanasia in the Netherlands which demonstrated that, in 24% of cases, there was disagreement amongst consultants [5]. Having doctors validate and assist in suicide, therefore, is a distortion of our role as healers and makes us both accomplices and supporters – if not encouragers – of suicide.

We believe doctors should never be open to euthanasia and assisted suicide as solutions to our patients' suffering. It is our personal experience, backed up by multiple studies, that the majority number of requests for

the hastening of death are based on what we call 'existential suffering' which includes social, psychological and spiritual reasons such as loss of autonomy, wish to avoid burdening others or losing dignity and the intolerability of not being able to enjoy one's life [6,7]. Moreover, it is our position that, behind the fears caused by that existential suffering, there is also a call for help, to find meaning, even in the midst of such suffering. Hopelessness and the wish for death naturally arise in the course of human experience, but it should not be our role, as physicians, to judge of their validity (regardless of personal opinion), nor is it our role to give them satisfaction.

The scope of euthanasia in theory and practice: a stark contrast

Euthanasia was purportedly introduced as a solution for 'rare cases' involving the very end of life where unbearable suffering could, supposedly, be ended only with death. But euthanasia is not only employed for such cases.

In Canada, physicians may provide euthanasia or assisted suicide for competent adults who clearly consent, who have a grievous and irremediable medical condition (including illness, disease, or disability) that causes enduring and intolerable physical or psychological suffering that cannot be relieved by means acceptable to the individual [8]. But as stated earlier, these are entirely subjective and elastic concepts. In practice, Canadian criteria are already so broad as to have permitted the administration of lethal injections to an elderly couple who preferred to die together by euthanasia rather than at different times by natural causes [9]. Moreover, court challenges and government studies are presently underway which could soon open euthanasia access to competent minors; to people who are non-terminal (death not "reasonably foreseeable"); to de-

mentia patients by advance directive; and to those with psychiatric disorders only [10]. In Ontario, only 15% of patients euthanized had a previous relationship with the euthanasia provider [11].

Economic pressure towards euthanasia

Economics and resource management always play a critical role in health services. Dr. Wynen, as we know from his writings, definitely feared that legalised euthanasia would eventually be used to ration health care [3]. But even then, warning about the risks of abuse from euthanasia, due to financial reasons, was not new. Dr. Leo Alexander, who served as a medical consultant to the Allied prosecutors during the Nuremberg trials, wrote in his historic essay "Medical Science under Dictatorship", New England Journal of Medicine (1949):

"Hospitals like to limit themselves to the care of patients who can be fully rehabilitated, and the patient whose full rehabilitation is unlikely finds himself, at least in the best and most advanced centers of healing, as a second-class patient faced with a reluctance on the part of both the visiting and the house staff to suggest and apply therapeutic procedures that are not likely to bring about immediately striking results in terms of recovery. I wish to emphasize that this point of view did not arise primarily within the medical profession, which has always been outstanding in a highly competitive economic society for giving freely and unstintingly of its time and efforts, but was imposed by the shortage of funds available, both private and public. From the attitude of easing patients with chronic diseases away from the doors of the best types of treatment facilities available to the actual dispatching of such patients to killing centers is a long but nevertheless logical step. Resources for the so-called incurable patient have recently become practically unavailable" [12].

In Canada, a recent cost analysis concluded that 'providing medical assistance in dying

should not result in any excess financial burden to the health care system *and could result in substantial savings* [13]. It is obvious that those patients who opt for euthanasia do provide a saving to the health care system. Therefore, the danger of exerting a hidden pressure on vulnerable people is very real. For example, hospital authorities recently denied a chronically ill, severely disabled patient the care he needed, and – faced with his inability to pay – suggested euthanasia or assisted suicide instead [14]. On another occasion, a 25-year-old disabled woman in acute crisis in a Canadian Emergency ward, was pressured to consider assisted suicide by an attending physician, who called her mother "selfish" for protecting her [15].

Private financial interests are also important. Colleagues have voiced case reports where family members may be taking advantage of the law and creating vulnerable victims [16]. Elder abuse is endemic – in Canada as elsewhere – and one of the main forms of that abuse is financial. The conflict is obvious, and so is the potential for abuse.

Breaking the promise: how euthanasia destroys trust in the medical profession

At the root of euthanasia lies an assumption that some lives are not worth living. But rational people disagree, both on the principle and on the application to each individual case. Severely disabled and chronically ill individuals disagree, also, on the value of their own lives. Some become suicidal; a greater number do not. But a critical factor in the choices they make results from the attitudes of friends, family, medical professionals and society at large. As philosopher Daniel Callahan has stated, "Euthanasia is not a private matter of self-determination. It is an act that requires two people to make it possible, and a complicit society to make it acceptable" [17].

Again, both Wynan and Ishay were concerned that people caring for patients would personally side with the logic of euthanasia, thus creating new risks for the abuse of patients, and especially the most vulnerable. It is our experience that in several cases the troubles of human relationships within families become accentuated, and problems of physician error and abuse in an already stressed medical system become exacerbated. In the words of President Ishay, "The main problem is to differentiate between what is really done for the benefit of the patient, and what is done out of comfort for the family or for the caring team. Killing can occur, not because the patient is suffering, but because the person caring for the patient can not take it any more" [4].

No wonder, then, that many doctors remain unsure of correct practice. Some emergency physicians in Quebec were, for a time, actually allowing suicide victims to die even though they could have saved their lives. President of the Association of Quebec Emergency Physicians later speculated that the law, and accompanying publicity, may have 'confused' the physicians about their role [18]. Dr. Damiaan Denys, President of the Dutch Society of Psychiatrists, has also recently voiced the possibility that euthanasia is causing a frustrating new therapeutic atmosphere in psychiatric treatment, lowering many people's threshold for ending their lives and causing increased moral distress on the part of the doctor [19]. Canada's largest children's hospital has drafted a policy in preparation for the day when children could decide for themselves to be euthanized. On it, they entertain the possibility of not informing the parents until after the minor has been euthanatized [20].

We do not deny, therefore, that doctors performing euthanasia may sincerely believe themselves to be acting virtuously. But trust between doctor and patient depends, in the end, on public perception of the whole medical profession. When some doctors perform euthanasia, patients begin to worry

about the attitudes of *all* doctors, and trust is lost. In Canada, for example, we are personally aware that many patients, out of fear, are now directly asking for doctors who will not practice euthanasia. Already in 2005, it became apparent that some elderly Dutch were afraid that those around them would take advantage of their vulnerable state to shorten their lives. Having lost confidence in Dutch practitioners, they either went to German doctors or they settled in Germany, as reported in the 2008 French government report to the National Assembly [21]; or they carry cards with them stating that they don't want to be euthanatized when seriously ill [22]. In a recent survey among Quebec physicians caring for patients with dementia, between 14% to 43% of doctors would provide access to euthanasia to patients with advanced or terminal stage dementia respectively even if no a prior written request existed [23].

The true physician's role

At the heart of modern medical practice, we expect to find the survival, welfare and comfort of the patient. It is this conscious devotion to life which is so urgently required from physicians by the vast majority of patients, whether they are suicidal or not. The declaration of Geneva holds as the first consideration, the health and well-being of our patients. The respect for the autonomy and dignity of our patients which is the next line of the declaration, should not ignore the first consideration, nor the third line of the declaration which includes the utmost respect for human life. Properly understood there should be no conflict at all [24].

One of us (Friesen) knows, first hand, the mental strain of suddenly being presented, as a young man, with serious post-traumatic disabilities which took months to fully understand, years to accommodate, and decades to accept. In his own words, "it is an illusion to believe that education, family re-

lations, economic status, or present health and happiness, can effectively protect people such as myself from the risk of euthanasia, because the most ordinary chances of life – the slightest relaxation of discipline in the maintenance of my physical state – would immediately (within months at most) place me in the intended category for that lethal procedure. And so, it is, for all surviving disabled and chronically ill."

The good doctor, we believe, does not judge the value of such lives. Doctors are -- doctors must be unconditionally devoted to supporting *every* life, through all the phases of therapy and palliation.

And to conclude: "If I had not had such doctors to guide me through the first critical weeks of Intensive Care (and the long years of recovery which followed), I would not be here to write these lines today."

Euthanasia policy: a unique responsibility of the World Medical Association

Objectively speaking, nothing has changed in the facts of euthanasia since 1945. Our current debate has not been caused by real changes in the internal logic of medical ethics and practice. It is actually the result of those same political, social, and economic factors, which civilized medicine has rejected time and again: the attraction of economic savings, feared by Wynen and described at first hand by Alexander; the terrible possibility that doctors and families might choose their own convenience over the survival of the patient, as voiced by Ishay; the horrible notion that certain lives are objectively less valuable. When death becomes the answer, we as human beings – as doctors – have failed in our duty to sustain trust and hope. Amid the larger pressures we have described, a free, autonomous decision about euthanasia becomes impossible. Patient choice becomes a cruel illusion.

On the positive side, it is evident that most doctors will never be willing to personally practice euthanasia. This conclusion has emerged clearly from the four regional WMA symposia, held recently on the subject in Brazil, Japan, Rome and Nigeria [25]. From the records of these seminars, we are reminded that a majority of doctors, everywhere, wish only to foster the will to live, not to lay the seeds of suicidal despair. In those countries where it unfortunately becomes legal, law and policy should allow medical practice to remain largely unchanged. Those who support medical involvement should thus embrace the liberation of relinquishing such a painful technical monopoly for doctors and allow other 'experts' to do it.

Unwavering ethical guidance from the World Medical Association is of crucial importance in preserving this positive climate in global medical practice. Any compromising additions or modifications to existing WMA declarations can only bring harm to our patients and to our profession. A firm WMA refusal to accept euthanasia, on the other hand, will stand as a powerful aid to all doctors.

We hope the WMA will take this opportunity to make it clear that what is legal is not necessarily ethical. It is useful to note, that the WMA was recently willing to make this distinction by condemning the participation of physicians in capital punishment, even in jurisdictions where that practice is legal [26]. We believe that the WMA should also remain consistent in this principle with regard to euthanasia, and not confuse political expediency with medical ethics.

WMA policy, we hope, will continue to stand as a beacon to the world, bringing comfort to patients and physicians around the globe, proclaiming that – regardless of changing opinions from place to place – true medicine's first value is human life. Similarly, even if some particular society may devalue human life by promoting sui-

cide, medicine and medical practitioners should not.

We believe that euthanasia is, was, and will always be, unethical. The World Medical Association was *right* to say this in the past, and must continue for the future, firmly on the same path.

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Ethics and Professional Autonomy



Andy Gray

The concept of professional autonomy is core to most health professions understanding of their role, and any perceived diminution of that autonomy is always perceived and portrayed by health professionals as inimical to their status as professionals. Examples of trends that are sometimes characterised in this way include the growing use (portrayed as an imposition) of

clinical practice guidelines by insurers or governments, the growing role of managers in the health system (often not medically-qualified, but with considerable power to direct how care is delivered), and the oversight mechanisms that measure the delivery of care against a pre-determined set of process indicators or quality standards. In this sense, the concept of "autonomy" is complementary to, but also different from the well-known Beauchamp-Childress concept of respect for the autonomy of persons [1]. These principles are uniquely applicable to medical (or more broadly, health professional) practice, but the concept of professional autonomy is far more widely applied and appealed for, not always successfully.

Tracking the Concept Through WMA Declarations

The ways in which the concept of professional autonomy has evolved can be tracked when considering the evolving World Medical Association (WMA) policy positions, as expressed in a series of Declarations.

The Declaration of Madrid on Professional Autonomy and Self-Regulation was adopted by the WMA in 1987 [2]. The key statement here was that "the central element of professional autonomy is the assurance that individual physicians have the freedom to exercise their professional judgement in the care and treatment of their patients." This Declaration was subsequently rescinded and replaced by the Declaration of Seoul on Professional Autonomy and Clinical Independence, in 2009 [3]. The new WMA position emphasised the circumstances which might lead to an assault on professional autonomy, and in particular on clinical independence, stating:

"The central element of professional autonomy and clinical independence is the assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue influence by outside parties or individuals."

In particular, the Declaration went on to outline, briefly, who might be implied by such "undue influence". Point 3 targeted

“governments and administrators: “Although physicians recognize that they must take into account the structure of the health system and available resources, unreasonable restraints on clinical independence imposed by governments and administrators are not in the best interests of patients, not least because they can damage the trust which is an essential component of the patient-physician relationship.” Point 4 aimed at hospital administrators and third-party payers: “Hospital administrators and third-party payers may consider physician professional autonomy to be incompatible with prudent management of health care costs. However, the restraints that administrators and third-party payers attempt to place on clinical independence may not be in the best interests of patients. Furthermore, restraints on the ability of physicians to refuse demands by patients or their families for inappropriate medical services are not in the best interests of either patients or society.”

However, the pendulum is also swinging in the other direction, with recognition that patients and their families have a greater need for, and right to, access to sufficient information to decide whether their physicians are subject to undue influence. For example, Bauchner *et al.* have argued that “[a]s increased transparency reveals many aspects of medicine that have formerly been hidden from patients (such as conflicts of interest and costs of care), as more physicians are employed, as the economic stakes for patients and their families are greater, and as the belief that medicine should be more personalized becomes integrated into practice, it is incumbent on the leaders of medicine to re-examine the organizational, governance, and self-regulatory structure of the profession” [4]. The key statement here is about the nature of the physician as an employee, not an independent practitioner.

The 2008 Declaration of Seoul was accompanied by the 2009 Declaration of Madrid

on Professionally-led Regulation [5]. This Declaration claimed that “[a]s a corollary to the right of professional autonomy and clinical independence, the medical profession has a continuing responsibility to be self-regulating. Ultimate control and decision-making authority must rest with physicians, based on their specific medical training, knowledge, experience and expertise.” This right would include, for example, the right to define professional competencies, and thus exercise control of entry into the profession through the accreditation of educational providers and qualifications, and the requirement for continued competence. It would also include the right to exercise disciplinary powers, whereby practitioners would be subject to the judgment by their peers and no-one else. That set of rights is also under attack. Collier has written that “granting doctors complete control over their own ship is becoming a tougher sell” [6].

Concerns around professional autonomy have not been reserved to medicine. In pharmacy, one of the key schisms has been between those jurisdictions that have allowed the entry of non-pharmacists owners of community pharmacies (usually in the form of chain stores) and those that have resisted this change. In 2009, the European Court of Justice weighed in on this debate, noting: “a Member State may take the view that there is a risk that legislative rules designed to ensure the professional independence of pharmacists would not be observed in practice, given that the interest of a non-pharmacist in making a profit would not be tempered in a manner equivalent to that of self-employed pharmacists and that the fact that pharmacists, when employees, work under an operator could make it difficult for them to oppose instructions given by him. [7]”

However, the core principle cannot just be reduced to one of ownership. As the working environment has changed for many health professionals, with fewer being

self-employed solo practitioners, so professional autonomy has been seen to be under threat. Another way to consider this, is to see professional autonomy as important, but subject to change. The same challenges can be seen in government service and not only in the for-profit environment. Calnan and Williams identified “market principles and the new “managerialism” into the National Health Service by the government” as threats to autonomy in the United Kingdom, but also added “the emergence of complementary medicine and the role of the “articulate” consumer” [8]. One of their respondents cited being “put upon from above and below”.

Dual Loyalty Issues

Any time of radical change is unsettling to old perceptions and assumptions. So, when the Affordable Care Act was passed in the United States (more commonly referred to as “Obamacare”), some saw the risk of restrictions on professional autonomy [9]. Times of political strife can also pose threats to autonomy, as have been identified in the Middle East, as it was buffeted by the “Arab Spring” [10]. In combat zones, many health professionals may perceive a tussle between dual loyalties, to the the objectives of the armed forces, compared to the needs of their individual patients, who may be combatants or civilians [11].

The concept of dual loyalty has particular resonance for anyone who has served in a conscripted role, especially in a civil war setting [12]. In analysing the dual loyalties at play in the military tribunals at Guantanamo Bay, Singh pointed to the lessons from *apartheid* South Africa, where professional associations did not always stand up for their members, but were “acquiescent” to the security policies of the day [13]. However, dual loyalties are not confined to areas of conflict or the military. They have been identified in the prison health service, for example, with the advice that “Profession-

als caring for prisoners should strictly and exclusively adhere to their role as caregivers to their inmate patients, acting in complete and undivided loyalty to them, and should firmly refuse to take over any professional obligation that is outside the interest of their prisoner patients. [14]" Similar challenges have been identified in immigrant detention centres [15].

Collaborative Practice – the new Normal

The concept of the solo practitioner, accountable only to himself (and yes, there is probably a gendered element to the concept), is not only untenable in the light of the demand of respect for patient autonomy, it also runs headlong into the more compelling demand for truly collaborative practice.

In 2013, the World Health Professions Alliance issued a joint statement on interprofessional collaborative practice. The Statement defines collaborative practice as follows: "Collaborative practice happens when multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care across settings." In particular, professional regulatory systems and processes including professional competencies, practice standards, and scopes of practice should permit and facilitate effective collaborative practice. Collaborative practice should be the norm, not an exception, just as active involvement of the patient and caregivers in all decisions is imperative. Pellegrino, in outlining the linkages between the elements of medical ethics, underscored the centrality of respect for autonomy:

"Do good and avoid evil is the *primum principium* of all ethics. All ethical systems, medical ethics included, must begin with this dictum, which means that the good must be the focal point and the end of any

theory or professional action claiming to be morally justifiable. ... The good of the person served is linked ontologically to the end of the professional activity. It is not subject to change at will. With the good as the end of professional activity, autonomy becomes mandatory since to violate autonomy is to violate the dignity and humanity of the person. [16]"

Just as the working environment has changed for many health professionals, so professional autonomy has also been seen as under threat or at least subject to change. However, on the positive side, collaborative practice has blurred the boundaries between professions and between professionals.

Although health professionals need to guard against the negative consequences of dual and divided loyalties, they should never lose sight of their primary obligation, to respect the autonomy of persons, and thus to serve.

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Ten Reasons to “Go Green” in the Medical Practice



Todd Sack

The World Medical Association now offers to its members a free online service, My Green Doctor, which helps health professionals to add wise environmental practices and climate change awareness to their medical practices. WMA members in 34 countries are using My Green Doctor. They find this to be an easy way to save money as they adopt environmental sustainability. One medical group in the United States began saving money in the first month and continues to save more than \$2000 US per doctor annually.

My Green Doctor is located on the web at www.mygreendocor.org. It is a complete, simple-to-follow program that can be used in any outpatient health facility. It is peer-written, peer-reviewed, non-partisan, science-based, and uses language that can be understood by anyone working in a medical office. The office teaches how to make changes that help build healthier and more efficient workplaces. My Green Doctor offers ways to teach healthy environmental choices to the patients as well. This is another way in which

your practice improves community health outcomes. My Green Doctor will make your colleagues and you truly proud!

Share My Green Doctor with your members, free from the World Medical Association. Contact the WMA (secretariat@wma.net) to receive a short announcement that you can include in your organization's newsletter or email.

The Ten Reasons

“Going Green” means to achieve My Green Doctor's well-defined benchmarks in managing your environmental impact and teaching your patients. There are at least ten reasons why your medical practice should try this. But the most important is the tenth: to “help make environmental sustainability and climate change awareness part of everyone's life.”

Ten Reasons to “Go Green”:

1. Leads to wiser and more responsible use of resources.
2. Saves money by lowering office expenses.
3. Creates a healthier work environment.
4. Green Teams encourage team-work and finding better ways to do things.
5. Green Teams generate ideas from every member of the office or clinic.
6. Improves job satisfaction.
7. Enhances the office's public image and the trust of patients.
8. Decreases air pollution, water consumption and waste.
9. Builds a healthier community.
10. Helps to make environmental sustainability and climate change awareness part of everyone's life!

Five-to-Ten Minutes Weekly

The key principle of My Green Doctor is the Green Team, a management tool that has found success in many types of companies. My Green Doctor's “Quick Start, Now!” page (reading time: ten minutes) explains simple steps for how the office manager or director begins the Green Team process. Green Team meetings take place for 5-10 minutes as a part of your practice's usual weekly or monthly staff meeting. There is nothing to plan in advance of your Team meetings because the website's “Meeting-by-Meeting Guide” directs what to say and what to do at each meeting. There is one topic for each meeting, such as “Energy Efficiency”, “Chemicals in the Office and Home”, “Recycling”, “Healthy Foods”, or “Patient Education”. The “Meeting-by-Meeting Guide” lists for each meeting two or three specific actions that the office can choose from on that topic. In this manner, your practice will make gradual improvements. By six months, you will qualify for the World Medical Association's Green Doctor Office Certificate that can be displayed in your patient waiting room and staff lunch room.

The benefits are real and nearly immediate. Your office is likely to save electricity and water, which is real money. For example, a five-office practice in Pensacola, Florida, is saving more than \$14,000 US each year on its electric bill. In addition, your office colleagues are likely to enjoy contributing to making their workplace safer, cleaner and healthier. This builds office morale and a team approach to problem-solving.

Your patients will see the improvements: recycling bins in your waiting room, brochures or posters for them to read, a “Green Doctor Recognition” certificate from the World Medical Association on your wall, and likely other measures showing them that yours is a modern, progressive office with a broad interest in their health.

Getting Started

Start by talking with your practice's managing physicians, owners or Board of Directors. They should agree to adopt environmental sustainability as a core value for your company and to choose My Green Doctor to guide the process. You may not need these, but My Green Doctor provides a sample company environmental sustainability policy and a ten-minute Power Point talk to introduce these ideas. If you are a large practice, your company might appoint an Environmental Sustainability Committee that will meet quarterly to coordinate your progress.

My Green Doctor is free for members of the World Medical Association and National Medical Associations.

A key early step is to find someone to be the Green Team Leader. This might be a physician, an office manager, or anyone who wants to help. The leader will schedule the Team meetings, send reminders to members, and manage the meetings to be sure that each Action Step has a Champion who takes responsibility for reporting back at the next Team meeting. The position of Team leader can rotate every few months. In an organization with several offices, each Green Team will report its progress quarterly to your Environmental Sustainability Committee or to the Director.

Education Steps: Your Biggest Impact

An important purpose of My Green Doctor is to help health professionals to share wise environmental practices and climate change awareness with the patients. The program offers dozens of ideas for teaching: waiting room brochures, posters, blogs and ideas for office handouts. The "Tip-of-the-Week" section suggests a simple but powerful theme for each week that can be taught easily across the practice.

My Green Doctor teaches climate change awareness.

Green Team members often take ideas home to their families and neighbors. These include ideas about energy efficiency, wise water and chemicals uses, healthy food choices, and healthy transportation decisions. Patients look to their health providers for role models; when we recycle, keep organic gardens, bicycle to work or drive energy-efficient cars, our patients and neighbors pay attention.

Green Doctor Office Recognition

We suggest that your office allocate five to ten minutes of each regular staff meeting for the Green Team. Doing so will qualify you

for the World Medical Association's Green Doctor Office Recognition certificate in six months or less. The criteria for qualifying are found at www.mygreendoc.org. They include completing five Green Team Meetings, implementing five Action Steps, and completing five Education Steps.

Going Green, For Good

Businesses large and small have been "going green" for decades. Their motivations are as diverse as their business plans and profit margins. Like doctor offices, most start because they want to save money and most accomplish that. But many businesses report that the non-monetary advantages are the most rewarding and are gained when a business not only "goes green" but also stays green "for good". These offices have used the greening process to foster a culture of teamwork, resources conservation and mutual respect. The World Medical Association is proud to offer My Green Doctor to its members without a fee. The WMA urges you both to register your office today at www.mygreendoc.org and to share this idea with your national organization's members.

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Audit of Resident Doctors Attendance at Clinical Meeting in a Low Resource Setting

Doctors choose from a range of many specialties after qualification for further training. This further training takes different forms such as residency, masters and PhD academic programmes; postgraduate diploma, certificate and refresher (update) courses. There has been a threefold increase in the number of training facilities for Nigerian doctors in the last twenty years. This is an ex-

cellent marker of progress in Nigerian health education [1]. The primary objective of the residency-training programme in Nigeria as conceptualised by the founding fathers is to provide highly trained doctors who have acquired competence in the current practice of a given branch of medicine in a manner relevant to the healthcare needs of Nigeria [2]. Consultants as leaders, teachers, role models,

and mentors are to guide, train and impart knowledge to residents.

The most competent doctor needs to assess him/herself periodically and make improvements on his/her performance [1]. Continuing education is a term used to describe the process of continuing to learn once a career has begun.

Continuous medical education (CME) has long been recognised as the key to updating and maintaining the knowledge and skill of



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health professional [3] continuous medical education also known as continuous professional development is a process of continuous learning that begins ones the person starts practicing as a doctor as it is a way of updating the knowledge of the doctor o new developments [4–7]. Most of what is taught in medical school becomes obsolete about a decade after graduation [3; 7–8].

In-hospital continuous medical education takes different forms. One of which is clinical meeting also known as clinical conference or Grand round where health workers organise meetings, selected topics are presented and discussed, giving each participant a chance to contribute [5]. Sometimes case presentations are done. Clinical meetings play a vital role in the education and training of doctors as it provides an opportunity for patient centered clinical discussion, integration of research and best practice literature with contemporary clinical cases, demonstration of clinical leadership poor delivery of formal education [8]. Attendance at clinical meetings includes doctors, medical students, nurses and sometimes other healthcare workers such as physiotherapists and medical technicians. The clinical meeting is intended to keep the doctors abreast with current knowledge and competent and should be part of the hos-

pital schedule of activities [9–10]. World-wide, the number of medical graduates are increasing, it is important that hospitals ensure that clinical meetings remain a priority [8]. Attendance at continuous medical education is a requirement for certification and dictated by certain regulatory authorities in some countries.

This is a 29-months retrospective study from March 2009 to July 2011 at a Nigerian hospital. Names of attendees at the in-hospital continuous medical education are entered into a registers during each clinical meeting.

It is a tertiary hospital, the in-hospital continuous medical education available at the hospital studied are weekly journal club, morning review and clinical meeting in all the departments and a monthly general hospital clinical meeting

The audit was conducted in the department of anaesthesiology. The hospital is a tertiary hospital with training for residency that is specialist doctors in raining. The cadre of doctors at the hospital are consultants, medical officers, registrars, senior registrars and house-officers (interns).

Data was extracted from the clinical meeting register of the department of anaesthesiology. Residents from other departments having posting in the department of anaesthesiology when the study was conducted were included in the survey.

During this 29 months when the audit was conducted, the department held 76 sessions of clinical meetings, which was attended by 1695 doctors made up of 11.27% consul-

tants, 24.78% senior registrars, 54.93% registrars, 7.61% doctors on posting from other departments and 1.42% visitors. Residents absent from the 76 sessions of clinical meetings were 1107. The percentages of those present, absent against the total number of residents that is supposed to attend the clinical meeting are shown in *Table 1*. The residents are made of registrars and senior registrars.

Continuous describes those educational activities undertaken by physicians after completion of the basic formal undergraduate training [11]. Clinical meetings are necessary in improving and updating the doctor's knowledge of the current trends in medicine. It helps doctors and other healthcare professionals keep up to date in important evolving areas which may be outside of their core practice. It also helps those preparing for professional examinations and learns how difficult cases were managed especially in low resource centres where there is lack of current modern sophisticated equipment. Residents on posting from other departments had the least attendance at clinical meetings. They should be encouraged to attend these academic sessions. All residents should be advised to attend these academic sessions as no knowledge is ever wasted. Attendance by visitors made up 1.42% of attendees. These visitors are made up of doctors from another hospital and departments. One visitor was from the obstetrics and gynaecology department when obstetric haemorrhage was discussed and another from the department of surgery when deep venous thrombosis was discussed. Doctors still absent themselves from this crucial and very important meeting, which does not have a course fee.

Table 1. Showing number of residents absent and present at the clinical meeting

Cadre of resident	Senior registrar	Registrar	Residents on posting from other departmentsv
Attended	60.09% (420)	60.42%(931)	9.92%(24)
Absent	39.9% (279)	39.58%(610)	90.08%(218)
total	100% (699)	100%(1541)	100%(242)

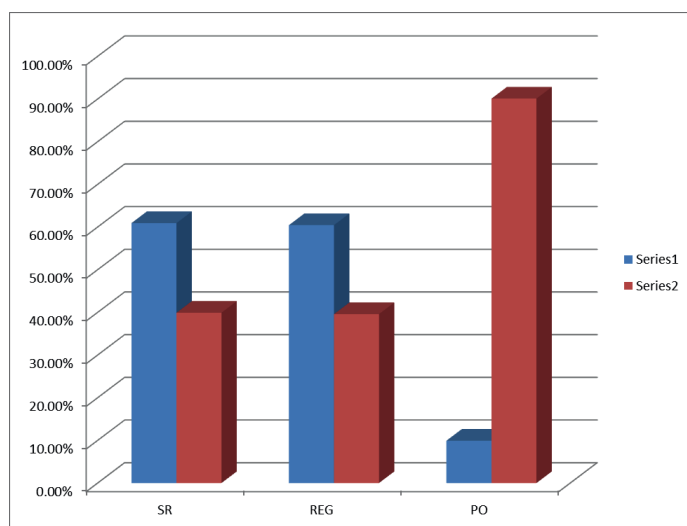


Figure 1. Showing attendance at the clinical meeting

■ Attended clinical conference ■ Absent from clinical conference
SR: Senior Registrar; **Reg:** Registrar; **PO:** Resident doctor on posting from another department

In a study conducted in the United States of America, continuous medical education consisted of 41% conference's/lectures, 20% Grand rounds, 17% online, 7% tumour boards, 4% projects, 4% case/peer reviews, 2% journal club, 2% participation in committee, 2% collaborates and 1% simulation/skill lab [12].

Continuous medical education helps increase the chances of the most positive outcome for patient care. Continuous medical education is aimed at educating practising physicians through the provision of up-to-date clinical information. Grand rounds require much effort in preparation and prolonged attention by their audience, but their purpose and effectiveness are rarely investigated or even questioned by physicians [4]. Healthcare leaders and medical educators often rely on Grand rounds to change physician behaviour and improve patient outcomes [3]. Non-medical observers have reached the conclusion that Grand

rounds are used in continuous medical education as an instructional method for maintaining and improving clinical skills of practising physicians [10].

Health care is a field with constant new developments hence continuous medical education prepares health staff for these changes. There is need to learn the latest in health care technology. Doctors should continually educate themselves to keep up to date otherwise; they would only have the education received before graduation.

Doctors have a duty to maintain personal knowledge and skills. In-hospital academic programmes are important to upgrade the knowledge of doctors. These clinical meetings are beneficial to the residents that is why it is been instituted by the consultants and senior doctors. All residents should be encouraged to attend all academic programmes of their departments and hospitals. Attendance registers should be provided at such meetings instead of using sheets of papers, which can easily be lost. All doctors should be encouraged to put down their names whether it is there hospital or primary department as this may be used for research in future. Topics to be discussed should be advertised at conspicuous places to the hospital community so that it can be attended by doctors, nurses and other paramedical medical staff from other departments especially if the topic is related to their discipline. Where resources are available in larger hospitals, a notice board can be dedicated to the advertisements of clinical meetings top-

ics and other in-hospital continuous medical education where that of various departments is kept. A library of all presentations of the various departments can be made for reference purposes to those who cannot attend the meeting. Interesting topics can be submitted as review articles to journals.

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Public-Private Partnership in Health Care: Case of Turkey



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The nature of neoliberal health reforms that brings market orientation to health and making it a new area of profit maximization for capital has, within the last three decades, deeply affected public hospitals in Turkey in terms of organization, financing and employment. The financing structure of public hospitals has radically changed in this process. While citizens have already taken up the burden through direct and indirect taxation, hospitals are forced to seek funds from extra budgetary resources and consequently it became necessary to have citizens to contribute to the financing of health services through social/private security contributions, cost-sharing/user fees and out-of-pocket costs.

Changing the financial and organizational structure of public hospitals is the principal approach in widening the operational sphere of capital in the field of health. In this context, the building of and service delivery by public hospitals on the basis of the model called public-private partnership (PPP) is brought to the fore in Turkey.

Historical Background

The first arrangement in Turkey relating to the building of health facilities under the public sector through “leasing” was made in 2005 by adding an article (Additional Article 7) to the Fundamental Law on Health Services No. 3359 dated 1987. Then, a new

regulation (2006) and legislation (2013) established in detail the scope and content of leasing. These arrangements were first referred to as “Integrated Health Campus”, followed by other terms including “Health Campus”, “Public-Private Partnership” and “Public-Private Cooperation.” Finally, hospitals built through public-private partnership were introduced to the public as “City Hospitals”. Presently there are 6 active city hospitals in Turkey (Yozgat, Mersin, Adana, Isparta, Kayseri and Elazig).

Opinions of neither the Turkish Medical Association (TMA) nor trade unions were solicited during arrangements related to the drafting of the law in 2015, regulation on the enforcement of the law and in establishment of the Ministry of Health Department of Public-Private Partnership.

On land allocated free by the public for city hospitals, the Ministry of Health goes out to tender for buildings whose projects were developed by the Ministry and these tenders are generally won by group of companies active in the fields of medical equipment/technology, construction and financing. According to tender specifications, winning companies have to finish hospital buildings within three years (in many contracts this condition is not met; for instance, the construction of Kayseri City Hospital tendered out in 2009 was completed only recently), and to undertake care/maintenance works throughout the leasing period (25 years).

Information available about tenders is kept limited since it is considered as “business secret.”

Contracts acted by the Ministry of Health and companies are subject to private law provisions and related disputes are to be settled by arbitration. At this point it must be recalled that Prof Alfred de Zayas, United Nations Special Rapporteur for Human Rights warned that the privatization of public services through public-private partnerships would lead to human rights violations and it would harm citizens in longer term since arbitration is but a mechanism making the powerful also rightful [1].

Decisions related to the building of city hospitals used to be taken by the High Planning Board under the Ministry of Development comprising relevant Ministers under the chair of Prime Minister. The Ministry of Development was closed with the new government system in Turkey. The decision making authority of the High Planning Board was withdrawn and at present the building of city hospitals is to be decided by the President as the sole authority. Until recently, the Board used to decide on building city hospitals on the condition that the number of beds in existing hospitals is reduced by the same amount as needed by prospective hospital or the closure of existing hospitals. Following the completion of a city hospital, state hospitals move to their new buildings, old buildings remaining

within the city are closed, and consequently no inpatient beds are added to Ministry of Health hospitals in provinces where city hospitals are built. For example, while public hospitals in Adana used to deliver services with bed capacity of 3,011, this number rose to only 3,025 after the opening of the city hospital with bed capacity of 1,550. In Ankara, the capital city of the country, the plan for the closure of 13 deep-seated hospitals of the Ministry of Health located at central town and delivery of health services by two city hospitals will radically transform health services and urban structure.

It was revealed upon lawsuits brought by the Turkish Medical Association that tender specifications prepared by the Ministry of Health also included the free transfer of land once occupied by closed public hospitals to tender winning companies for their business enterprises such as hotels, luxury housing or shopping malls though not envisaged either in Board decisions or legislative arrangements. Upon this, the Council of State decided to suspend tenders related to Ankara-Etlik, Ankara-Bilkent and Elazığ city hospitals. Then a legislative arrangement was introduced to the effect “tender specifications envisaging the transfer of hospital land to companies are not to be complied with.” In order to stand against any possible decision of annulment by the Council of State, the clause “decisions of annulment by the administrative jurisdiction are not enforced; but relevant revisions are made according to justifications given for annulment” was introduced.

“Commercial revenues” in city hospitals are left to tender winning companies and both “Clinical Support Services” and “Support Services” are also delivered by these companies. Throughout the period of contract (25 years) companies are to be paid “Availability payment” as rental and repair/maintenance, and volume based “Service payments” for clinical support services (Laboratory, imaging, sterilization and disinfection, rehabilitation, etc.) and other

support services (Linen and laundry, catering, waste management, etc.). Companies that undertake city hospital tenders in Turkey are guaranteed that hospitals will be operated by rate of occupancy of 70% in terms of volume-based care. This rate is 80% for high security forensic psychiatry hospitals.

The definition of “clinical support services” included in tender specifications is not sufficiently clear. Due to this lack of clarity branches such as physical treatment and rehabilitation and radiation oncology together with medical imaging and laboratory services are included in “clinical support services” and left to private companies. Upon an amendment made later, ambiguity went further and it was accepted that “services requiring advanced technology and high funding” may be handed over to companies. This means that all services with high rates of return may be transferred to companies upon their request.

It is agreed that availability and service payments for city hospitals is to be paid by the Ministry of Health or from revolving fund budgets of its affiliate facilities and/or by central government budget. But it is uncertain whether revolving funds can cover very high service costs. Due to neoliberal health policies, base salaries of doctors and other health workers are low in Turkey and the system of performance-based additional payment is adopted on the condition that it is covered by revolving fund. Since priority in the use of revolving fund is given to payments due to companies, there are cuts in additional payments of doctors and other health workers.

As can be understood clearly from what has been said above, public-private partnership is a model of investment and service delivery that is based on State’s long-term contractual relationship with a group of private companies. In this model, hospitals are built by private companies and leased to the State for long-term (i.e. 25 years) while the State, on its part, both pays rent and transfers all

services other than “core services” to these companies.

Public-private partnership is a privatization method and cases from many countries clearly show that public-private partnership initiatives serve not to the interest of patients but financiers. There are many studies confirming that investments in infrastructure made through public-private partnerships are costlier than others made through routine tendering procedures. In public-private partnership model, risks and costs rest with public whereas private companies enjoy means of financing through rental and income guaranteed on the basis of service transfer.

Problems Coming to the Fore in Turkey

The major problem related to city hospitals in Turkey is the high cost of hospital buildings and equipment to the public. Examining the amount of fixed investment and annual rentals in tenders arranged by the Ministry of Health we come across significantly high costs. According to a report by the Ministry of Development, for 18 city hospitals whose contract price amounts to 10.6 billion USD, an amount of 30.3 billion USD is to be paid in 25 years to companies building and operating these hospitals [2]. Given that the number of city hospitals planned is 31 (for the time being) we can foresee that Turkey will undertake a debt burden of over 50 billion USD for a period running until 2050 only as availability payments. Considering that the total investment budget of the Ministry of Health is 1.5 billion USD for the year 2018, it is understood better how high the cost of public-private partnership is in the field of health.

In case the State has its investments within the framework of a plan there will be no need to resort to methods like PPP by going into long-term debt or paying rental. Such methods are too costly and paid through

taxes collected from people. For instance, it is figured out that with 2.6 billion TL allocated from the 2018 budget of the Ministry of Health to presently operating hospitals it is possible to build 64 full-fledged hospitals each with 150 bed capacity [3]. The extremely high cost burden can be seen more clearly if it is considered that rentals will be paid for a period of 25 years and it will further increase with each new city hospital. While the exchange rate was set as 1 USD=1.5 TL in preliminary feasibility reports for hospitals, the present exchange rate is well over 1 USD=6 TL. Given that the Turkish lira is recently losing value against foreign currencies including dollar and euro in the first place, it is a great risk for the country that rentals have to be paid based on USD. Economists warn that initiatives in public-private partnership will further deepen the present economic crisis faced by Turkey.

Worldwide, suppositions that once laid the basis of arguments about the “rationality” and “legitimacy” of privatizations through public-private partnerships and other methods are collapsing while arguments and struggle for the delivery of public services publicly and for the benefit of public are getting stronger. The call made by more than 150 organizations throughout the world with a Manifesto addressed to the World Bank and IMF was an important stage in this process. Upon reactions, the World Bank had to update its criteria related to Environmental and Social Impact Assessment [4]. In the same vein, a revised text related to counselling services in initiatives supported by the International Bank for Reconstruction and Development (IBRD) and International Development Association (IDA) was issued in July 2014. The point that is emphasized in modifications made is that relevant reports should go into the essence beyond what is formal and include realistic assessments. A statement made by the World Bank openly admits the presence of manipulations in environmental and social impact assessment reports com-

ing from the field in relation to projects that it will fund and concedes that its local units have to be more meticulous on such matters.

The first one being in April 2011, tenders based on the PPP method and their legislative basis was carried out in a way closed to all relevant stakeholders. Infractions and irregularities in the process include the following: Change in companies involved in tendering process; continuation of price related discussions even after the completion of tenders; failure in making deliveries on committed dates; revision of contracts over and over again; and deeming the procedure of tendering practically non-functional through transfer of shares of the main company as a method having no place either in legislation or in relevant regulation. The essential point in any tender is to find a company best suited to perform a specific work in compliance with some specifications and award it in a way to uphold public benefit. In the method mentioned above, however, even companies not participating to tender process were awarded by moving out of the inspection of tender commissions. This is openly in contrast with the Law on Public Tendering and the Law No. 6428 on Building and Renewal of Facilities and Delivery of Services through Public-Private Partnership Model by the Ministry of Health.

In relation to PPP practices known as “city hospitals” tendered in Turkey since 2011, various consulting firms solicited the opinion of the Turkish Medical Association in the context of environmental and social impact assessment. Resulting opinions were placed on internet pages of the organization. Retrospective visits to World Bank’s project evaluation and promotion pages showed that opinions of the TMA were not incorporated into reports and the only mention of the TMA was about its lawsuit requesting the nullification of tenders.

Yet, opinions forwarded by the TMA had pointed out to many defects and irregulari-

ties in relevant procedures and processes including the following: practices, including those under the relevant legislation in the first place, totally out of public information and scrutiny; absence of Environmental Impact Assessment (EIA) in any project though it is compulsory under the existing Environment Law; development of projects out of international criteria related to efficiency; existence of building projects leading to implicit incremental costs; threat to peace in working life as a result of status differences of personnel to be employed in hospitals; negative implications on education for specialty in medicine as a result of arrangements not considering the requirements of this education; threats to medical autonomy in the absence of rules on doctor-private company relations; increased possibility of companies shifting risks to public and public employees as a result of ambiguities in risk sharing; non-compliance of preliminary feasibility reports on projects with criteria set by the World Bank, OECD, European Bank for Reconstruction and Development (EBRD) and European Investment Bank; absence of any value for money (VfM) analysis complying with international standards; and neither including nor taking the opinion of trade unions and professional organizations at any stage in the process. Hence, the process operating so far in Turkey as a whole runs counter to all environmental and social impact assessment criteria.

In Turkey there are also some technical problems associated with city hospitals such as high number of beds and large size of indoor space per bed.

The average number of beds in a city hospital in Turkey is 1,311. This number, however, may be as high as 3,704 in the case of Ankara-Bilkent City Hospital for instance. The number of beds in a hospital is accepted as an important indicator with respect to efficiency. The outcomes of a systematic study on the efficiency and optimal size of hospitals show that hospitals with bed capacity under 200 and over 600 are inefficient

[5]. The high number of beds preferred for city hospitals confronts Turkey as a source of inefficiency as proven by past experience and scientific studies. While large hospitals are being abandoned throughout the world for their inefficiency, the Ministry of Health targets launching such hospitals with thousands of beds.

In city hospitals in Turkey, the average indoor space per bed is 287 m² than can be as high as 350 m² in some hospitals. It is observed that this space is generally around 150-200 m² in new hospitals built in developed countries. This means that indoor space per bed in city hospitals in Turkey is larger by about 40 per cent than what is recently preferred in modern hospitals. The point is that larger the indoor space per bed is, higher the costs of energy, cleaning, repair and maintenance are.

As far as health workers are concerned, city hospitals first of all created problems related to their employment. While it is accepted to transfer sub-contracted workers in Ministry of Health hospitals to permanent employment status, those working in city hospitals as well as workers in public hospitals to be closed for these hospitals are excluded from this arrangement.

The practice of city hospitals that underwent auditing by the Court of Accounts for the first time in 2018 since 2005 presents a dire picture. The report by the Court of Accounts observes the following: Hospitals are delivered with yet uncompleted construction and equipment; operations favouring companies in payment schedules even when guarantees are given for changes in foreign exchange and inflation rates; deletion of records of flaws by companies that are also awarded hospital information management systems; or administrations that have to conduct inspection only on databases provided by companies; possibility of revising all contracts to the benefit of companies upon the request of companies and credit institutions; and while in legislative terms

it is only the Treasury that can undertake debts on behalf of public, top staff in the Ministry of Health committing to compensate companies in cases of termination of contracts even when companies are the breaching party and undertake the repayment of debts incurred by companies [6].

To sum up, the major problem areas related to "City Hospitals" in Turkey can be listed as follows:

- Method of financing (extremely high cost to the public, payment difficulties faced by public hospitals to move, ways to be pursued in relation to treasury guarantee and cases like bankruptcy),
- Site selection (opening of farmland to development and constructions on sites under the threat of floods),
- Problems of physical access resulting from the closure of hospitals located at city centres (geographical/economical accessibility),
- Status of sites to be vacated by public hospitals moving elsewhere (their transfer to contracting companies is at issue),
- Concessions for the delivery of both health and support services in public hospitals to move and
- Issues related to the employment and rights of health workers [7].

Stance of Turkish Medical Association

It is known that the PPP is a method of privatization creating new market opportunities in countries where it is implemented in the field of health and that its purpose is not public benefit. Hospitals operating in the context of PPP deliver private and profit seeking services that erode the system of healthcare. The focal point of service here is not human health but what accrues as profit.

The Turkish Medical Association closely follows the process of city hospitals and wages a struggle in both organizational and legal terms against public-private partner-

ship initiatives in the field of health upholding the interests of health workers and public benefit. In 2012, the TMA carried the issue of public-private partnership/city hospitals to the top of its agenda and defined it as a strategic work given that the process will eventually lead to the full privatization of healthcare and leave doctors and health workers with no other option but being employees of international consortiums. The TMA Central Council established its City Hospitals Monitoring Group in April to steer efforts and initiatives in this area.

Despite the promotion of city hospitals as new and modern buildings that public hospitals will finally enjoy, it is clear that such campuses built through public-private partnerships have in fact no ties with what is actually public. It appears that city hospitals will be the means of transferring new and large resources to global capital under the pretext of "public". The people of Turkey are now confronted in the field of health a form of privatization even more destructive than what has been experienced so far.

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Confederation of Medical Associations in Asia and Oceania (CMAAO)



Ravindran R Naidu

Welcome speech by Dr. Ravindran R. Naidu – president of the Cmaao 2018–2019

"Friends, it is an absolute honour and privilege to stand before you on this graceful occasion and utter the most awaited words "Yes, I accept to be the President of CMAAO for the year 2018–2019, an organisation with a proud past and an exciting future. A single

head achieves nothing, so I am counting on your support to achieve the growth and goals of CMAAO. This is truly a moment to be honoured and cherished. I accept this appointment with pride and will give my best efforts to make you proud. With the grace of god and the cooperation of fellow members, I will devote my time and myself to the obligations and duties of this post.

Currently comprised of 19-member National Medical Associations (NMAs), the Confederation of Medical Associations in Asia and Oceania (CMAAO) has more than 50 years of history. Its establishment was proposed in 1956 by Dr. Rodolfo P. Gonzalez, then President of the Philippine Medical Association at the third meeting of the Southeast Asian Medical Confederation. In 1959, CMAAO was inaugurated at the first Congress and Council Meeting held at the Imperial Hotel in Tokyo. There were 11-member NMAs at the time of inauguration, of which 6 were present at the first congress.

The Secretariat, which was originally in the Philippine Medical Association, moved to Malaysia (1993), Thailand (1997), New

Zealand (1999), and since 2000 it has been in Japan. The role of CMAAO Secretary General was also passed to the JMA.

This is a history that should never be forgotten, and we, the current generation of members, owe it to all the organisation's past members to keep this great organisation strong and vibrant as we face the challenges of the medical profession that confront us now and into the future.

Over the next one year we will continue to build on our strengths, but also take on new directions.

We will continue our programs that strengthen our professionalism. We will also retain our commitment to solidarity, ensuring that our members that are less resourced can have more opportunities and assistance to be part of this organisation and promoting exchange of information and activities aimed at improving the health of all in the Asia Pacific region. To ensure that all of us can perform our critical role and be a part of:

- CMAAO Resolution on Ensuring Food Safety,
- CMAAO Resolution on Ethical Frameworks for Health Databases and Health genetic databases,
- CMAAO Delhi Resolution on the Prevention of Child Abuse,

World Medical Journal



- CMAAO Taipei Resolution on Strengthening of Primary Healthcare in Asia and Oceania,
 - CMAAO Statement on Task Shifting,
 - CMAAO Resolution in Economic Crisis and Health,
 - CMAAO Declaration on Tobacco Control in Asia and Oceania,
- And this year in this General Assembly, the Malaysia Statement on Pathway to Universal Health Coverage.

For the first time this year, we have organised a concurrent JDN meeting whereby a discussion on Bullying at Workplace and Sexual Harassment will be deliberated by the Junior Doctors. This will be presented as the JDN-SCHOMOS-MMA Penang Declaration to the Ministry of Health, Malaysia and the World Medical Association.

But let's not forget we are an organisation – united by our values and rich with talent. If each of us puts in what we can, we will



become an organisation to be reckoned with and secure a place of recognition in the world.

I have noted that I will be the 36th President of CMAAO over this 59-year period, an amazing statistic that further highlights to me the great responsibility I have taken on. For those who know me well, you will know that I will always do the very best I can for

the organisation and will hopefully lead the team to continue the great work done by the people before me. I will always strive to continue the development of CMAAO, through leadership, co-operation and hard work.

I want to take this opportunity to thank the outgoing President Dr. Yoshitake Yokokura for his immense contribution to CMAAO."

The 33rd CMAAO General Assembly and 54th Council meeting was held in Shangri-La Rasa Sayang Resort and SPA, Penang, Malaysia on 12–14 September 2018. The countries represented were Malaysia, Australia, Bangladesh, Hong Kong, India, Indonesia, Japan, Korea, Myanmar, Nepal, Pakistan, Philippines, Singapore, Taiwan and Thailand. We had 120 delegates attending this event. The special guests were Dr. Otmar Kloiber, Secretary General of the World Medical Association, Dr. Miguel Jorge of the Brazilian Medical Association, Dr. Peteris Apinis and Ms Maira Sudraba of the Latvian Medical Association.

Dr. Ravindran R. Naidu, Immediate Past President of the MMA, was installed as the 36th President of CMAAO for the year 2018–2019. The outgoing President of CMAAO was Dr. Yoshitake Yokokura, President of the World Medical Association and President of the Japan Medical Association. Dr. K. K. Aggarwal was appointed as President Elect 2018–2019.

The Director General of Health of the Ministry of Health, Malaysia, Datuk Dr. Noor Hisham was the orator at the 16th Takemi Memorial Oration and his presentation was on "Global Surgery as part of Universal Health Coverage". This was then followed by a symposium on "Path to Universal Health Coverage" which was attended by all the National Medical Associations present.

The CMAAO Council passed and adopted the CMAAO Resolution, namely, "CMAAO Penang Resolution on Universal Health Coverage", which will be presented to the World Medical Association.

For the first time in the history of CMAAO, the Junior Doctors Network (JDN) together with the SCHOMOS MMA had a concurrent meeting with the CMAAO Council Meeting represented by 7 countries. The JDN themed discussion was "Leading the way towards mutual respect – The Role of Junior Doctors in preventing Workplace

Bullying & Sexual Harassment". This session was graced by the Deputy Director of the Medical Development Division, Ministry of Health, Dr. Mohd Fikri Bin Ujang. A proposal has been submitted to the Committee of the CMAAO to involve the JDN as part of the CMAAO General Assembly and Council Meeting. After a serious discussion the following resolution has been presented by the JDN – "Junior Doctors Network-SCHOMOS MMA Penang Declaration 2018" on workplace bullying and sexual harassment which will be submitted to the Ministry of Health and the World Medical Association.

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