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Editorial



Editorial

Evolution of Health Professions

Reading the national medical association (NMA) press over the last few months there appear to be a number of broad issues which appear to occupy the medical and other professions. Two of these reflect major concerns in the care of patients and are related, namely Quality of Care and Patient Safety. There has been much activity in the former for many years and action in the latter has substantially increased, notably in the World Alliance for Patient Safety movement of WHO. The issues involve all health professions and with increasing teamwork in health care and the huge increase in general access to information and the involvement of patients in decisions about their health care, these are welcome and appropriate developments.

At the same time in all health professions, knowledge and roles are constantly evolving and changing, reflecting the advances in knowledge and advances in technology. In parallel there are also changes in Healthcare provision as existing national health care systems reflect both changes in demography in the professions and in the population, as well as the economic and political climate in individual countries.

In the past few weeks such headlines as “New healthcare role will confuse patients” and “physician task force confronts scope of practice legislation” have appeared the press of the some national medical associations. Both of these are referring to the changes in field of activity of evolving health professions and suggestions of new ones both of which will impact on the traditional areas of practice, hitherto those of physicians. The first headline quoted above refers to a proposed new type of health worker to be called by suggested titles such as “medical care practitioner” or “surgical care practitioner” in the United Kingdom Health Service. The second reference is to pending legislation in a number of states in the USA to formally expand the role of 20 non-medical health professions.

As long ago as the early 1970s this topic was one of concern, at least in Europe, when the first Chairs of Nursing were being established. There have been substantial developments in that profession over the intervening years, accompanied by positive changes in attitudes, in relationships, and the increase in teamwork referred to above. Increasing technology, knowledge, training and professional co-operation have benefited both the professions and patients

But the apprehensions expressed above arise substantially from concerns related to some health professionals undertaking roles for which they are much less extensively prepared as those who have undertaken the long and rigorous medical training. Whilst it is possible to provide special training for specific activities or diseases, there is concern that patient safety could be affected. Whilst each professional has a duty to work only within their area of competence, with the introduction of extended new roles this is causing concern. It is particularly important that where new health professionals are being introduced, patients should be aware of their professional role and the limits of their training. This certainly means that the professional title should not be open to misinterpretation or imply in any way that the competence is that of a fully qualified medical practitioner. This issue is a now matter of concern to NMAs in many countries.

The role of medical and paramedical health professionals is complementary. It has been so for many years, and in many countries and within countries this has substantially increased,



with a real feeling of partnership between the professionals. With the global crisis of human health resources which will be the topic of WHO for this year, and for a decade of action "Human Resources for Health", it is vital that all the health professions work together to ensure that maximum use is made of the potential of each profession, and that roles and functions are clearly defined and adequate training provided. To

this end the health professions, faced with the changing spheres of activity, need to re-examine their own scope of practice and engage in active productive dialogue to achieve this and ensure that the resources of the health professions are used in the best way, even if this involves some change in traditional roles.

Alan Rowe

Health Professional Card

European Developments presage Worldwide Activities

Dr. med. Christoph F-J Goetz

Today it is clear to everyone that telecommunications will be the new driving force for economic and social systems worldwide. The paradigms of communication are currently evolving at an enormous pace away from paper-based methods directly towards electronic mechanisms, at all levels. This entails massive changes everywhere which can rightly be compared to the industrial revolution with all of its social and economic upheavals.

While up to now most national regulations have been dominated by regional interests, it comes as no surprise that these are becoming ever more strongly influenced by international aspects and interactions with foreign structures. Until today every physician practised as a doctor basically only within his/her own national context. Spurred on by the increasing rise in cross border traffic and telecommunications in medicine, this will no longer be the case in the foreseeable future. A World-Wide trend has been initiated.

The European Community¹ recognized this fact and has recently adopted Directive 2005/36/EC on the Recognition of Professional Qualifications. This expressly mandates "the abolition of obstacles to the free movement of persons and services" and in this context explicitly gives each professional "the right to pursue a profession, in a self employed or employed capacity, in a member state other than the one in which they have obtained their professional qualifications".

It is obvious that these regulations will also have a massive impact on the medical community. However, in a separate directive, liberalising the provision of services in other member states, the European Parliament in February this year, voted to exclude the health sector. MEP's also voted to reject article 23 of the Directive, which would have given cross-border patients guarantees of reimbursement of treatment costs. The motivation can presumably be found in differing basic premises of the various health care systems which entail major differences in health care management. In some countries enormous waiting lists already dominate medical diagnostics and therapy as a last resort to curtail rising costs, while in contrast, these services remain readily available in other countries. In this context "health tourism" is the last thing any nation wants to foster. However, the trend towards mobility of patients and providers cannot be stopped.

The technological mainstay of the secure exchange of medical data in the future will indisputably be the methods of authentication and signature as they are offered by health professional cards. Only these can achieve a sufficiently high level of security as to be usable

in the sensitive area of health care. In recognition of this fact many nations have begun the planning and development of health professional cards for their own medical community.

In the last years quite a number of national smart card projects with major impact were initiated worldwide. Compiled as part of a Trailblazer project, the White Paper on "Open Smart Card Infrastructure" (OSCIE) gives an excellent overview of activities in Europe². With a special focus on health professional cards the following projects were especially formative for current technology and trends:

- France (Groupement d'intérêt Public, Carte de Professionnel de Santé),
- Germany (Heilberufsausweise für Ärzte, Zahnärzte, Apotheker und Psychotherapeuten),
- Netherlands (NICTIZ, Nationaal ICT Instituut in de Zorg) and
- Slovenia (Profesionalna kartica, ZZZS, Zavod za zdravstveno zavarovanje Slovenije).

Early on it was recognised that functional interoperability and widespread acceptance will be crucial for this new technology, and standardisation activities initiated.

In Europe, the Technical Committee 251 "Health Informatics" (TC 251) of the Comité Européen de Normalisation (CEN) focuses its activities concerning "Security, Safety and Quality" in Working Group III. In the year 2000 this Group III put together the first version of the European pre-

¹ The European unification started 1957 with six states. Through various expansions the European Community now has 25 members since May 2004. These are: Austria, Belgium, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden and the United Kingdom. In addition, four nations are currently also planning entry to the EC: Bulgaria, Croatia, Rumania and Turkey.

² Open Smart Card Infrastructure for Europe, White Paper of the eEurope Smart Card Trailblazer 11, OSCIE, Volume 1, Part 4, March 2003. Latest version of OSCIE papers are available from "www.europe-smartcards.org" and "www.eurosmart.com".



standard ENV 13729 “Health informatics – Secure user identification – Strong authentication using microprocessor cards”. This is currently undergoing revision under the leadership of the author, with support of the KVB (Bavarian Administration of Statutory Office Based Physicians) and the BAEK (German Medical Chamber). Due to the broad range of interoperability issues foreseeable in this context, and because of national healthcare responsibilities and differing (or even currently non-existent) technical frameworks, it has been deemed necessary to gather an up-to-date and encompassing overview of salient information regarding national activities for healthcare professional cards in the member states of the EC before starting this revision.

The following aspects will be covered in this study:

- 1) Identification of institutions responsible for planning and rollout of national healthcare professional cards,
- 2) identification and enumeration of involved healthcare professions,
- 3) identification of industrial solutions and product providers,
- 4) documentation of the status of current plans and development,
- 5) identification of technical correspondents for HPC queries, and finally
- 6) collection of design frameworks and/or guides of national HPC’s.

The output of this agenda will be a technical report to support ENV 13729 and it is expected (depending on the rapidity of feedback) that the work can largely be completed within 2006. It has already been decided that the results of this European report will be shared with the corresponding Working Group 5 “Health Cards” of the Technical Committee 215 “Health Informatics” (TC 215), which is part of the International Standards Organization (ISO), so that a world-wide overview can be expected to be available by 2007.

To summarise, it is essential to recognise that in medicine, as everywhere else, standardisation enables the national and international exchange of products and services and reduces their costs by specifying

equivalent requirements and qualifications. Standardisation makes faster and easier transfer of knowledge and innovation possible, and thereby lowers cost and increases availability. These commercial truisms also hold true for medical care. It is clear that the functional interoperability of secure authentication and information transfer in medicine will be the indispensable cornerstone for future applications and deserves our unmitigated support.

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Medical Ethics and Human Rights

Avian influenza: A possible new human pandemic with old ethical problems

Prof. Urban Wiesing MD, PhD, Georg Marckmann MD, MPH

Currently nobody knows exactly whether we will face a new human pandemic with a mutated avian influenza virus or not. So far, the pandemic is mainly an animal disease and the cases of infected human beings are linked to direct contact with infected animals. But if the H5N1-virus mutates into a strain which can easily pass between human beings resulting in a new human pandemic with dramatic effects, we are sure to be confronted with serious ethical decisions, in addition to huge other problems. They can be anticipated and are not new – the coming ethical problems are well known.

First of all, a global human influenza pandemic will bind enormous capacities in the health care systems all over the world. Highly developed medical systems in wealthy countries might be able to cope with the challenges of treating an extremely high number of sick people in a more acceptable way. They might have enough human and material resources to react in a way that minimises the number of people infected and dying from the disease. But most health care systems in the world will not be able to respond adequately to the

increased health care needs. They lack the necessary reserves. Their medical capacities are already insufficient to cope with their daily health problems, let alone to cope with a new human pandemic flu. Less developed health care systems face two options, both of which pose serious dilemmas; they can either concentrate on fighting the new human pandemic at the expense of other urgent health care needs, or they can neglect the new pandemic trying to maintain the level of other health care services. In any case, the consequences will be devastating for the people involved, the avian influenza victims or those with other sicknesses. And the choice between these two options is a difficult one, with ethical implications. On the one hand the responsible health care officials have to decide under conditions of some uncertainty based on vague data about the outcome of their measures, on the other hand they have to choose the appropriate aim of their strategy: Should one follow the utilitarian goal to minimize the number of fatalities, or should other considerations govern the decisions, e.g. egalitarian considerations that give all indi-



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viduals an equal chance of treatment regardless of the overall outcome?

Even well-funded health care systems will be confronted with a shortage of antiviral drugs, vaccines, hospital beds and health care professionals for the treatment of avian influenza patients. Who should receive the available drugs, who be vaccinated first, or who get the needed hospital beds? Those who are able to pay the price – which will highly increase? Or the professionals who are responsible for the public health system and for the treatment of infected people? Should the drug be distributed by ability to pay in a free market or in a regulated way for the benefit of the greatest number? The answer is clearly in favour of maximising the overall benefits. Consequently, most pandemic plans give priority to health care workers and other professionals who help to maintain public order. Understandably, it always places a heavy burden on a physician to decide between two patients in the absence of capacities to treat both. Therefore, the World Medical Association has defined a clear priority in its “Statement on Medical Ethics in the Event of Disasters” (1994) [3] When the circumstances do not allow the treatment of every patient who under normal conditions could be treated, the “decision to ‘abandon an injured person’ on account of priorities dictated by the disaster situation cannot be considered ‘failure to come to the assistance of a person in mortal danger. It is justified when it intends to save the maximum number of victims.’” (3.3.e)

In addition to the ethical problems of allocating scarce resources *within* a health care system, there will be even more dramatic problems regarding the distribution of health services *between* health care systems. It can be expected that people in wealthy countries with highly developed medical systems will have a better chance to survive than those in low-income countries. What can be seen in the HIV pandemic will most probably also happen in a possible – and hopefully never arriving – human influenza pandemic: the survival rates will depend on the wealth of a country, region or group of people within a certain state. Only the pure chance of living in one or the other country leads to tremendous differences in the prob-

ability of surviving. A possible human influenza pandemic will show once again the unjust distribution of health services around the world.

Another set of ethical issues arises from the restriction of individual rights in the interest of the public health. During the history of medicine it has always been a problem to what extent individual rights may legitimately be restricted to protect the health of other people. Under what circumstances is it permissible to put infected or other people in quarantine? As long as the quarantine is short and does not reduce the survival rate of those infected, most people will probably agree voluntarily to quarantine. But if the restriction of individual freedom is extensive and if the restriction leads to significant financial disadvantages or even the loss of a job, the ethical balancing seems more difficult. How far can the freedom of movement be restricted, in particular if people are not infected but live in an area in which cases of avian influenza occurred? To what extent may the daily living of so far uninvolved people be restricted to prevent a human pandemic? Restrictive action for public health purposes may also include overriding the right to privacy. The Council on Ethical and Judicial Affairs of the American Medical Association set up a recommendation that tries to balance the protection of “individual rights of liberty and self-determination” and “the public health requirements”. As a general rule, “quarantine and isolation should use the least restrictive measures available that will minimize negative effects on the community through disease control, while providing protections for individual rights”. [1] In addition, any quarantine or isolation measures should be based on sound scientific evidence and the people should be informed about the rationale behind the restrictive public health interventions, which in turn will increase the likelihood that they comply voluntarily with the restraints.

Finally, what can be legitimately demanded from health care workers? On the one hand, health professionals will have an increased risk to being infected while caring for influenza patients. On the other hand, they have the professional obligation to put the

interest of their patients first and treat the patients who are most in need. Certainly, health care workers voluntarily assume a special responsibility by choosing to become a health professional, a responsibility that includes increased health risks. But do they have to take any risk no matter how threatening it is? Do they have the right to refuse to treat infected patients if they are not willing to risk a life-threatening infection themselves? The answer remains open. At least, any available precautions should be taken to minimize the health risk for health professionals by providing protective equipment, preventive immunizations and preferential access to antiviral drugs if they have been infected. Still, considerable health risks remain and so far professional codes do not provide sufficient guidance on what can be demanded from health care workers. Even the detailed recommendations of the University of Toronto's Joint Centre of Bioethics remain vague on these difficult ethical issues [2]

However some procedural ethical values are undisputed in open democratic societies: The ethical choices involved in a human pandemic of avian influenza should be discussed publicly, openly and in advance. Any measures should be based on the available scientific evidence and explicit ethical reasoning. It is better to involve the public before the crisis than during the crisis. It will increase the success of all measures if people realize that the fight against a pandemic flu is also their concern: Their contribution is necessary for successful interventions against the pandemic and they, as individuals, will benefit from these concerted actions. Apart from concrete plans for early response and containment, a broad societal discourse about the underlying ethical choices that will have to be made is probably crucial for a successful fight against a new influenza pandemic. We should rather start this public dialogue sooner than later, on a national as well as on an international level.

Literature

[1] American Medical Association, Council on Ethical and Judicial Affairs. (2005) The Use of Quarantine and Isolation as Public Health Intervention. <http://www.ama>



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“Caring Physicians of the World”

Last year’s WMA President’s project was marked during the 2006 WMA meeting in Santiago by the launch of the book “Caring Physicians of the World”. This beautifully written and illustrated book presents the sixty five “Caring Physicians of the World” selected by a WMA panel from the several hundred nominations made by National Medical Associations

In his introduction, Dr Yank Coble, while referring to the importance of individual physicians’ commitment to knowledge of medical science, its utilisation, and the observance of the principles of medical ethics, stresses the primary importance of “Caring” with the quotation “I don’t care how much you know about (science and ethics) until I know how much you care” (anon). The book also quotes Sir William Osler as also quoted in the book “The most important thing is caring, so do it first, for a caring physician best inspires hope and trust” This quality is clearly illustrated by the description of work and activities of those whose names appear in this book

The book covers a wide spectrum of individuals whose devotion and work as “Caring Physicians” encompasses not only their care of individuals, but also extends to “social leadership on behalf of the Public Health, scientific progress, society’s resources and the welfare of human kind”. It includes not only some internationally recognised names but many who are little or generally recognised, whose caring qualities have been applied to those in need in all corners of the earth, both urban and remote, isolated and sometimes otherwise uncared for.

It is little wonder that this book, honouring those chosen by their colleagues for their exemplary care, not only makes fascinating and inspiring reading, has also stimulated great worldwide interest and attention. It merits reading by both doctors and their patients alike (for details visit www.wma.net.)

Medical management of hunger-strikers

Mr. J. N. Johnson, M.D., FRCS, FRCP, FDSRCS

Doctors around the world look to the WMA for definitive guidance on professional ethics. Recent controversy over the medical management of hunger strikes, however, has not only re-opened the issue of whether doctors can ever ethically feed protesters against their will but highlighted the fact that the WMA has two different approaches, and indeed two different policies, on the issue. This is leading to some confusion and needs urgently to be addressed by the WMA.

It is widely recognized that the WMA’s 1975 Declaration of Tokyo never intended to provide guidance on the management of hunger strikes. Its remit was the prohibition

of doctors’ involvement in torture. It says that doctors should not resuscitate victims to allow torture to continue, but also says that they should not resuscitate prisoners who fast in order to end their lives in a bid to escape further torture. According to the Tokyo Declaration, which is now a key human rights text, artificial feeding should not be instated “*where a prisoner refuses nourishment and is considered by the physician to be capable of forming an unimpaired and rational judgement concerning the consequences*”.

Contrary to this clear prohibition on feeding when prisoners refuse it, the WMA’s 1991 Declaration of Malta, ambiguously leaves

to doctors the decision on whether to artificially feed hunger strikers. This Declaration which deals exclusively with hunger-strikes, resulted from South African doctors appealing for more detailed guidance on the subject. The Declaration eloquently raises, but fails to answer, the dilemma of whether “sanctity of life” or “respect of individual autonomy” should be the key issue.

Clear WMA guidance on this matter is in demand since the Malta Declaration is increasingly quoted on both sides of the debate about whether or not protesters can be force fed or artificially fed against their expressed wishes. Hunger strikes have also become more complex in the 15 years since the Malta Declaration. Distinctions between prisoners determined to fast to death and those calculating to prolong their protest but ultimately survive, was blurred by the Turkish hunger strikers of the 1990s.



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They showed that they could lengthen the protest by partial fasts. Deaths occurred, but only after extra months allowed considerably more pressure to be put on the authorities. Collective hunger strikes, such as those in Spain and Turkey, also raised questions about whether prisoners could make truly voluntary decisions in situations where there was likely to be considerable peer pressure. The WMA Declaration of Malta does not provide guidance to doctors faced with such cases.

Another problematic aspect of current WMA guidance is that it conflates artificial feeding and forced feeding. Many would argue that any medical intervention based on force, coercion or intimidation must be

clearly prohibited by the WMA. Artificial feeding without coercion can be an acceptable way to defuse a hunger strike situation.

The BMA is calling on the WMA to review and upgrade its guidance. The guidelines must be made clearer and a background document exploring the complex issues in greater depth is also needed. Doctors are hoping that the WMA will firmly uphold its commitment to promulgating consensus ethics around the world.

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The Right to Health

The Constitution of the World Health Organization states that the “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...” International statements on human rights, such as the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child, support the right to health and require signatory nations to secure its observance.

Despite the widespread, although by no means universal, acceptance of the right to health, both its meaning and its application are problematic. It cannot mean a right to be healthy, since much illness is impossible to prevent or cure. Nor can it mean that individuals have a right to all needed health care services, since the demand for such services is greater than the supply in even the wealthiest countries. There seems to be general agreement that the right to health entails a minimum requirement that individuals should be protected from actions that undermine their health. There is much disagreement as to whether individuals have a further right to equal access to needed health care in their country or elsewhere. Some

countries accept and promote this right while in others, access to health care is largely dependent on one’s financial resources.

Even where the right to health is accepted, it is often difficult to implement because of a severe shortage of resources. This is clearly the situation in many developing countries, although some of these countries (e.g., Sri Lanka) have managed to promote equitable access to their limited health care resources, with extremely positive results for the overall health status of the population.

In 2000 the Committee on Economic, Social and Cultural Rights, which was created to monitor the International Covenant on Economic, Social and Cultural Rights, issued a report on the right to health. It interpreted this right “as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important

aspect is the participation of the population in all health-related decision-making at the community, national and international levels.” According to the Committee, States have the following obligations in relation to the right to health: “The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfil. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote.... The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.”

Also in 2000 the United Nations General Assembly adopted the United Nations Millennium Declaration that includes eight Millennium Development Goals to be achieved by 2015. Five of these relate to the right to health: halve extreme poverty and hunger, reduce under-five mortality by two-thirds, reduce maternal mortality by three-quarters, reverse the spread of diseases, especially HIV/AIDS and malaria, and ensure environmental sustainability.

In 2002 the United Nations Commission on Human Rights appointed, for a period of three years, a Special Rapporteur whose mandate focuses on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The mandate was extended in 2005 for three years, and the Special Rapporteur was asked, among other things, “To gather, request, receive and exchange information from all relevant sources, including Governments, intergovernmental organizations and non-governmental organizations, on the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

Medical associations have not been particularly outspoken on the right to health in general but have tended to focus on specif-



ic rights. The WMA's principal documents in this respect are the Declaration of Lisbon on the Rights of the Patient and the Declaration of Ottawa on the Right of the Child to Health Care. In 1998 the WMA General Assembly adopted a Resolution on Improved Investment in Health Care that, while not mentioning a right to health, nevertheless urged governments and intergovernmental agencies to provide the requisite

conditions for the exercise of this right, especially access to good quality health care.

Readers are invited to provide information on other medical association or research activities related to privacy and confidentiality of personal health information to williams@wma.net

Affecting about one person in every million, the mutations that cause dyskeratosis congenita disrupt telomeres the tips of the chromosomes, rather like the plastic cap on the tips of shoelaces which keep the whole structure together. When chromosomes are copied during cell division, telomeres tend to get shorter, from which remaining life span can be predicted. In order to compensate for this winding down effect, actively dividing cells can synthesise the enzyme telomerase, which repairs telomeres. Indeed, close analysis of telomere structure can calculate when a rare inherited disorder will strike. Without telomerase, the cells will go through a certain number of divisions, as far as the Hayflick Limit, and then die.

Mutant genes, when switched on, such as that coding for telomerase, mean that chromosome repair is faulty. Tissues with rapidly proliferating cells, such as skin, gut and bone marrow, are the first to be affected. The earliest sign of accelerated wear and tear is usually abnormal skin pigmentation, followed years later by cancer, premature ageing and bone marrow failure, which often proves fatal.

But why do children's symptoms appear at an earlier age than their parents? This phenomenon is also seen in some other genetic disorders, where a 3 letter fragment of DNA multiplies in successive generations. The length of a patient's telomeres show when symptoms will first emerge – the shorter the telomere, the sooner symptoms appeared.

Ivan M. Gillibrand

Medical Science, Professional Practice and Education

Human Genetics And Biomedical Research

The human genome sequence, now almost complete, is a driving force behind research, focussing on the impact of genetic differences between people, many of which affect health. Another key theme is how genetic information is translated into biological function, whether in terms of the 'biological clock' governing cell division in tissues, or gene expression in health and disease.

Beyond the helix

It is now calculated that humans have only about 23,000 genes operating, some of which have died out or are dying out over the course of evolution. Thus our biological complexity is more likely to be related to how these genes are used, incorporating feedback to ensure maximum effectiveness, in the solution to problems of how and where the genes can be switched on and off during development. Many different mechanisms of gene control are being discovered – indeed the higher order arrangement of DNA is turning out to be particularly important. For example, it has been found that the DNA of active genes is not linear, as typically drawn in textbooks, but rather is looped, with control proteins shared between the start and end points of the gene. Such looping of the structure is essential for the activation of the gene.

Gene control

RNA interference (RNAi) is an exciting area of study, as these tiny RNAs can

silence genes very effectively. Generally they act by triggering a massive destruction of the intermediate messenger RNA as it is read from a gene. Small RNA molecules can somehow insert themselves causing tightlypacked DNA to shut down its gene action.

Premature ageing

Dyskeratosis congenita is a devastating disease that leads to premature ageing, bone marrow failure and cancer. Over the past few years, Professor Inderjeet Dokal and colleagues at Imperial College, London, have identified the genetic basis of this rare inherited disorder. They have clarified why symptoms appear earlier in successive generations.

Health Care Policy Reform – the UK National Health Service

Mr James Johnson, MD, FRCS, Chairman of Council, British Medical Association.

The substance of this paper was presented at the WMA Santiago meeting 2005.

Almost sixty years after the start of the UK's National Health Service, the NHS is in trouble. Despite unprecedented levels of investment, a massive financial deficit is

forecast for the current year. If unit costs cannot be reduced over the next two years there will be serious doubts as to whether we can sustain an NHS free at the point of use and offering comprehensive services to all. That would be a tragedy.



Medical Science, Professional Practice and Education

The NHS was founded on an assumption that once patients' "need" had been satisfied, demand and costs would fall, over time. It was introduced with the promise of universal and efficient delivery of health services. In reality, instead of demand and costs falling, there have been rising demands, costs and expectations. These are global pressures experienced by health services all over the world.

The UK's NHS is an experiment in health reform. Almost every conceivable lever has been pulled to try to influence the system, for example by reducing waiting times and increasing quality. Although when elected in 1997 the Labour Party was critical of an internal market created by the previous (Conservative) government, it is interesting that after seven years in office, the Labour government has recreated the basic model and returned to incentives as the main model of reform.

Recent NHS reforms have included a pledge to increase the numbers of health professionals, including doctors, and the modernisation of the infrastructure and services. The number of medical school places has been increased and we are attracting more doctors from other parts of the European Union and elsewhere. Nevertheless there are still shortages in some specialities and in some branches of the profession such as general practice. It's also true that in general practice the majority of the extra doctors recruited elect to work less than full time and choose portfolio careers.

Improvements in NHS infrastructure have been largely secured via the **Private Finance Initiative (PFI)** using private sector money to build and staff new hospitals which are then leased back to the NHS for a limited period, typically 30 or 35 years. Critics of PFI, and they are vociferous, say this is a very expensive way of accessing money and while it saves on capital costs it leaves Hospital Trusts with a heavy debt burden for many years. On the more positive side, clinicians have welcomed the chance to move from outdated, deficient, hospital buildings to modern purpose-designed ones, albeit often with fewer beds.

It isn't just NHS buildings which are old fashioned and in need of modernisation.

Hospitals in particular have been slow to take advantage of new technology, and in General Practice, a multiplicity of IT systems mean that we still have not got the ability to transfer patient records between practices electronically – let alone between hospital and GP.

To combat all this, the government has commissioned a National Programme for IT for the NHS (NPfIT) run by **Connecting for Health**. The initial budget for the NPfIT project was £6 billion sterling but commentators predict this will be substantially exceeded. Described as the world's largest civil computer programme, NPfIT includes a national care records system to provide a central database for the electronic health records of 50 million patients. It also includes "*Choose and Book*", a software system to allow people to select hospital appointments from a choice of dates and locations when they are referred to secondary care by their GP. Suffice to say there have been problems implementing the systems and neither is fully operational.

The British Medical Association has criticised the IT project for failing to engage with clinicians from the start. Quite late on, the Department of Health appointed clinical advisors who have been helpful, but by the time they came on board a great many doctors felt alienated.

In terms of other NHS Reforms, clinical governance was tightened and a raft of bodies brought in to implement it and to support learning activities. These included the **Modernisation Agency**, the **National Patient Safety Agency** and the short-lived **NHS University**. Hierarchical reforms to the NHS include setting national standards and targets, inspection and regulation from the centre, published information on performance and other central interventions.

The National Institute for Clinical Excellence (NICE), was set up to examine new drugs and treatment to determine whether they should be available on the NHS. **National Service Frameworks** emerged to direct clinicians towards best treatments for certain conditions, and the **Healthcare Commission** (formerly CHI, the Commission for Health Improvement) is an independent organisation which inspects health

services. Its duties include giving local Trusts and NHS bodies a rating to reflect their performance. Initially this was a star rating system which my Association has condemned as far too crude to offer any useful information to patients or to the NHS. The star ratings are being replaced by new measures which will separately look at a Trusts' financial management.

These Healthcare Commission ratings are important to NHS hospitals seeking to become **Foundation Hospitals**, which are free from the normal constraints under which the majority of NHS Trusts operate. Only three star Trusts are eligible to apply for Foundation status.

As incentives to drive these changes to the NHS, the Government has introduced choice and commissioning policies. Patient choice is to drive the reform agenda, with people given more say in how when and where they access treatments. Money will follow the patient's journey through the NHS and this will be effected via **Payment by Results**. A fixed national tariff will be payable to NHS providers – including the growing number of independent sector organisations providing NHS care – for each treatment. At present only Foundation Trusts are covered by Payment by Results but the intention is for all NHS hospitals to operate under the system from April 2006.

At the same time the government wants to take the role of commissioning services away from local NHS bodies and hand it to other commissioners, notably general practitioners under a scheme called **Practice Based Commissioning**. The hope is that by giving clinicians the commissioning role, costs will be constrained and more patients will be treated nearer to home in a community setting, rather than in expensive acute hospitals and other secondary care.

So far, take up on Practice Based Commissioning has been patchy and somewhat lukewarm. Potential commissioners are dubious about assuming the role in the face of large-scale deficits in local NHS budgets. Payment by Results has the potential to attract even more care into the hospital sector, driving up NHS costs, and the government clearly hopes that Practice Based Commissioning will contain that.



Key Changes in the UK

In future the NHS will have less emphasis on the state's role as provider and more as a purchaser of care. It will be less directive of local services and act more as a regulator, setting the framework for a competitive market in the provision of healthcare.

We will see greater devolvement of managerial responsibility, while retaining central direction through the use of financial incentives and quality standards.

Most importantly there will be plurality of provision with health care delivered by both public and private sectors, still free at the point of use. Independent Sector Treatment Centres have been introduced in secondary care to bring down waiting times and lists, amid many concerns among NHS staff that their introduction risks destabilising existing hospitals which train staff and provide round the clock NHS care in all its aspects.

General Practice is also changing. A new contract for GPs introduced in 2004 contains a Quality and Outcomes Framework rewarding GPs according to the quality of services they provide. General practice is now said to have "over-delivered" causing the contract to cost more than the government expected. GPs are able to point to the high quality care they provide for patients. Nevertheless a national shortage of GPs means that some areas are "under-doctored". The government is opening up the service to commercial providers for the first time. It is providing wider access with walk-in centres and plans to bring more care out of hospitals closer to patients' homes.

There is an ideological debate taking place in the UK over whether the "socialised" model of healthcare is being dismantled and the NHS privatised. The financing of UK healthcare has not changed. The government pledges that money will continue to come from general taxation. We are experiencing a privatisation of provision. The change is in provision and delivery of UK healthcare

Doctors see threats and opportunities in this – more providers means a choice of

employers and while there is a shortage of doctors, more freedom to move around. The future picture of health policy is uncertain, but incentives ensure that service provision will change radically.

The NHS has seen a huge increase in funding in the past five years so that by 2007/08 it will have risen to approach 10% of total GDP. Britain will by then be spending on health sums comparable to other countries of the Western world, with the exception of the USA. Certainly in recent years we have seen a marked change in the proportion of GDP we spend on health. Five years into this investment, people are questioning whether there has been commensurate improvement.

People ask where has the money gone. Rectifying the legacy of historic under-funding has absorbed some of it. New technology and new buildings account for more. New contracts for NHS staff account for half of the resources, and incentives to reach government targets have swallowed up an appreciable amount.

Despite higher numbers of doctors, the UK is still relatively low in the league table of practising physicians per 1000 population. Few westernised countries have lower ratios than the UK. Yet we face increasing pressures on the NHS resulting from an

increase in the number of elderly people in the population, many of whom will have multiple morbidity.

Challenges for policy makers

The Finance Ministry and the Department of Health have two key priorities. They must enhance productivity and they must increase self management of care. The first, they plan to tackle by changing service provision and patterns of working within the NHS. Their approach to increasing self management of care is through giving patients greater choice of care pathways outside hospital.

The current level of NHS investment growth will cease in 2008 and we will return to the relative low annual increases of around 2.5%. If the system is not working well by then, people will question whether a "free-at-the-point-of-use" model is sustainable. We have two years left to sort out the financial problems and demonstrate that the NHS can work.

Mr James Johnson
M.D., FRCS, FRCP, FDSRCS

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Collaboration with the Global Health Initiative of the World Economic Forum: Initiatives launched to address training and education needs in TB burdened countries

Nobel Peace Laureates and representatives of 20 million health care providers call on governments to fund the scale up of human resources needed to fight TB

GENEVA, 21 March 2006 – Nobel Peace Laureates Archbishop Desmond Tutu and Betty Williams joined forces with global healthcare organizations representing more than 20 million health care providers in

highlighting the need to provide the necessary human resources to fight the growing TB threat in high burden countries. They called on governments to immediately commit to fund, train and scale-up the health care workforce to combat TB and help prevent 5 000 daily deaths from this curable disease. At this special event, Eli Lilly & Company and six leading global health and relief organizations launched a number of



initiatives to tackle the human resources crisis in TB treatment.

Though 90% of the world's population live in countries that have adopted the internationally recommended strategy for controlling TB, an adequately trained health care workforce is required to fully implement control programmes and save an additional 14 million lives over the next ten years. According to the Stop TB Partnership, it is estimated that US\$250 million is needed every year to provide technical assistance to countries to provide the training and strengthening of TB control services to millions of care providers.

To address this, the International Council of Nurses (ICN), the International Hospital Federation (IHF), and the World Medical Association (WMA) their new on-site and distance learning TB training programmes for nurses, hospital managers, doctors and laboratory technicians, which are being rolled-out in the high-burden countries. The World Economic Forum and the International Federation of the Red Cross and Red Crescent Societies outlined their new programs to introduce TB prevention and treatment into the workplace and communities, so that workers and families can be diagnosed correctly and the social stigma of the disease reduced.

This event follows the announcement of the Global Plan to Stop TB 2006-2015 at the Annual Meeting of the World Economic Forum in Davos, and aims to raise awareness of the urgent need to expand and strengthen human resources to deliver the Global Plan. Tuberculosis is re-emerging as a serious global health threat that causes 9 million new cases and 2 million deaths every year. Of these new cases, 400 000 are of increasingly virulent drugresistant strains (MDR-TB), which are often spawned by improper or incomplete treatment of normal TB. In several countries of Eastern Europe and Central Asia, MDR-TB has increased to 15 % of new cases, while in several African countries with high HIV prevalence, rates of TB have tripled. According to the WHO, fewer than 1 in 50 people who develop MDR-TB currently have access to effective treatment and the vast majority die.

Archbishop Tutu, speaking from his personal experience with TB, said "I urge the G8, governments of TB burdened countries, and international donors to address this gap in funding for human resources urgently." The Archbishop, who contracted the disease as a child in South Africa, continued "Without well-trained health care providers in the field we cannot possibly combat this curable disease which kills so many so needlessly, and the Global Plan will fail. Fourteen million lives can be saved and 50 million people treated in the next 10 years if we address this crisis now and ramp-up training and education in high burden countries."

Eli Lilly and Company has committed \$70 million to a ground breaking global partnership to fight multi-drug resistant tuberculosis (Lilly MDR-TB Partnership**). Rich Pilnik, Lilly President of Europe, Africa, Middle East and CIS, comments: "The successful treatment and prevention of this silent killer is above all dependent on sufficient well trained, mobilized and motivated health providers, particularly for multi-drug resistant tuberculosis. As some of the programs launched today show, we are beginning to build the defences, but now we need to fight this war with welltrained professionals."

* **High burden countries** (the top 22 ranked by number of new TB cases) include: Afghanistan, Bangladesh, Brazil, Cambodia, China, DR Congo, Ethiopia, India, Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Pakistan, Philippines, Russian Federation, South Africa, Tanzania, Thailand, Uganda, Viet Nam, Zimbabwe.

** **The Lilly MDR-TB Partnership** is a public-private initiative led by Eli Lilly & Company to address the expanding crisis of multi-drug resistant tuberculosis (MDR-TB) The partnership is pursuing a comprehensive strategy to fight MDR-TB through increasing drug supply and discounting prices, providing training in prevention, treatment, and surveillance, and sharing drug manufacturing technology with nations most at risk. For further information www.lillymdr-tb.com.

World Economic Forum

As part of its Global Health initiative launched in January 2002, the World Economic Forum (WEF) has developed a unique TB Awareness Workplace Toolkit. The toolkit, consisting of educational materials, awareness programs, and suggested prevention techniques for teaching in the workplace, will help employees, and company health-care staff better understand symptoms of TB and seek timely diagnosis and care.

The **International Council of Nurses (ICN)**, the **International Hospital Federation (IHF)** and the **World Medical Association (WMA)**, have all produced training programmes which include detecting, planning and implementation of treatment for both TB and MDR-TB.

Heroki Minami, President of ICN stated "Nurses are usually and often the only health care professionals to see a person with TB or MDR-TB, particularly in struggling health systems in developing countries where we are seeing TB re-emerging dramatically."

The Director General of the IHF (Per-Gunnar Svensson, said, "It is vital to recognise that there is a need to include managers of hospitals and health services in planning and implementation of disease prevention and control systems. Ignorance and non-involvement/exclusion can lead to adoption and implementation of counter-productive decisions and actions"

A TB Distance-learning course is being prepared by the WMA, whose manual is being converted into a web-based course by the Norwegian Medical Association for WMA, and will provide Continuing Medical Education (CME) accreditation. While focusing on the quality of clinical care needed to treat tuberculosis Dr. Otmar Kloiber, Secretary-General of the WMA, recognising the fundamental causes of this disease and other global pandemics, said "Tuberculosis is a disease that is strongly related to social circumstances and living conditions" and explained "To improve the economic situation of the affected populations must be a central aim of any development, in other words: Fight Poverty".



WMA

WMA General Assembly, Santiago Presidential Valedictory Address, Yank D. Coble, MD, MACP, MACE, October 14, 2005

I am honored to be here, to share my perspective on some of the World Medical Association's initiatives this past year. What was accomplished where we've made progress and the work yet to be done.

Among you, I see many familiar faces. Old friends and new. I am proud to be associated with all of you, who care so much for your patients, practice medicine with such passion and who work so hard to live out and uphold the ethics of our profession.

As WMA president, I tried to be true to that mission. We want medical care everywhere to be the best care anywhere. We promote the highest standards of medical education, ethics and science. And we expect the same from the other players in our respective health care systems – be they in the private or public sectors.

And we have to expect something from our patients, as well.

We cannot speak too much, or too often, of the paramount importance of individual health. It has been said that "He who has health, has hope. And he who has hope, has everything."

In the last century, a mere instant in the timeline of human history, the rapid advance of medical progress and innovations in care has supplied that hope for thousands of millions of people in need.

Herophilus, a physician in ancient Greece, said "When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied."

You cannot put a price tag on hope, but researchers have placed a value on the economic return of investments in better health, higher quality medical care and medical research. It tells us the wealth of nations

depends on the health of nations. And it is we, as physicians, who are the instruments used to fulfill those hopes, address those needs and meet those expectations.

The Canadian physician Sir William Osler, who was a philosopher as much as he was a doctor, described the heart and soul of what we do more than 100 years ago, no matter where we live. "The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head. Often the best part of your work will have nothing to do with potions and powders, but with the exercise of an influence of the strong upon the weak, of the righteous upon the wicked, of the wise upon the foolish."

It was just these sort of ethical issues that led to the founding of the World Medical Association in 1947. It's stated purpose: "to serve humanity by endeavoring to achieve the highest international standards in medical education, medical science, medical art, and medical ethics and health care for all people of the world".

Behind its founding was a sad fact of life – that the same rapid advances in medical technology and innovations in care that has brought hope to millions could be twisted to bring suffering to millions if conducted in an ethical vacuum.

Since 1947, time and again, we've seen the importance of National Medical Associations acting in their role as nongovernmental organizations, acting together as the vanguard for medical ethics. We saw it in the aftermath of World War II, and we saw it during the dictatorship in Iraq.

As our world becomes smaller with more intertwined interests, so also, the medical associations of the world need to tighten their mutual bonds.

In this global village, we need to support each other. We need to provide a balance to a politics of scarcity that views medical care and medical professions not as a value to be cherished and protected but as a cost to be cut, and controlled.

It was in that spirit that I approached my term as president.

As you know, we sometimes cannot accomplish everything that we wish for in our organization. But while our finances may be limited, our imaginations are not, nor need our influence or example.

When I assumed the WMA presidency, my goal was to continue to communicate the unique, enduring traditions and values of the medical profession – that is **caring, ethics and science**. These three values are shared by physicians throughout the world.

As physicians we are committed to science and the life-long process of learning. It gives us a unique authority and perspective.

Ethics compel us to put the interests of the patient or the public health first.

Caring, as Osler said, "is the most important thing – so do it first. For it is the caring physician who most inspires hope and trust."

These traditions enable physicians to provide value, hope and trust to patients and society. They make us powerful advocates for our patients, our profession and the public's health. They give us a common language of action and behavior. They are, in short, what unify us.

I wanted to let the world know about the good work we do as an organization – and the great work done by physicians around the world. To remind people that there's a human face on the concept – on the act – of healing. That science, ethics and caring aren't just words but a way of life.

"Apology: We apologise for the misprint in WMJ 51(4) which, in the report of the Associates' meeting, referred to a paper by the late Dr. Doppelfeld. We are pleased to report that Dr. Doppelfeld recovered from his spell in hospital and we very much regret any distress this may have caused".



To me, that idea is represented in the Caring Physicians of the World Initiative.

With the help of the Pfizer Medical Humanities Initiative (PMHI) team, led by Director Mike Magee, we decided to produce a publication profiling physicians among those nominated by National Medical Associations around the world. These are physicians who carry on the tradition of caring ethics and science while practicing or teaching medicine in an array of circumstances, some difficult, some dangerous, all of them a challenge. And all the while, they give of themselves in service to patients or students.

Our national medical associations were interested, but assembling this book would require a lot of resources, including trips to often remote locations to photograph this international array of physicians and learn their stories. Again, the PMHI Team stepped forward with generous support. At the same time, they left all decisions on selection, writing and editing to us. We presented the idea at WMA gatherings throughout 2004, and in November of that year, requests for nominations were sent to national associations.

We asked for rapid response so we could complete the publication within one year and launch the book during the WMA Annual meeting in Santiago, Chile in October, 2005.

The response was overwhelming. Within two months, 55 national associations nominated more than 200 physicians. We heard not only from members, but from NMAs that were not yet members. We also received nominations from people outside the medical professions, particularly for physicians who performed so admirably following the South Asian tsunami of December, 2004.

Of the 200 nominees, 65 physicians were selected, interviewed, photographed in their home environments and profiled.

Physicians such as Valentin Pokrovsky, a leading expert on AIDS and the first person in Russia to describe HIV-infection and AIDS;

Otar Toidze, a neurologist and epileptologist who became a Member of Parliament in Georgia;

Emily Chan, President of the Hong Kong section of Medecins Sans Frontieres; Nanshan Zhong, China's top expert on Severe Acute Respiratory Syndrome, who played such a vital role in the SARS epidemic in 2002;

Benito Atienza of the Philippines, who created the Child Community Health Workers Foundation;

Hoang Dinh Cau, who is the chairman of the Committee for Investigation of the Consequences of Chemicals Used in the Vietnam War;

Mamphela Ramphele, who was imprisoned for her anti-apartheid political activities, and went on to become the first black woman Vice Chancellor at a South African University and then a managing director of the World Bank.

And John Awoonor-Williams from Ghana, who works in one of the remotest areas of the world as the only doctor serving a vast area.

Heroes all, immortalized not just in their work, but now in words and pictures, as well.

We made our deadline. The book cleared customs in Santiago less than 24 hours before our scheduled launch two days ago, October 12, 2005.

When we unveiled "Caring Physicians of the World," the event was attended by more than 200 people and we presented the first volumes to our hosts, the Chilean Medical Association and their nominee profiled in the book.

A separate web site was linked to the WMA web site and described in detail the purpose behind the book – how it came to be published – and why we believe it's an important glimpse into the lives of physicians the world over. All nominees and all National Medical Associations have received the "Caring Physicians of the World" book. Some of you have used the book in press conferences and meetings with government officials and related health professions and organizations.

More than 250 copies of the book were distributed to health and medical leaders in Geneva at the World Health Organization and other groups. In the United States, copies have been distributed widely among the leadership of the American Medical

Association and the leadership of national medical specialty associations, state medical associations, health related organizations, and government agencies.

If you want to read some positive reviews and widespread publicity, type the words "Caring Physicians of the World" into a Google search.

All of this – the extraordinary expressions of gratitude by the nominees – and by their associations, families and friends, suggest that physicians appreciate this sort of recognition. For some, it is what helps them persevere through often difficult circumstances.

NMA response has been equally gratifying. Two of the largest NMAs in terms of physician numbers, who are WMA members but were inactive and non dues paying for several years, nominated physicians for inclusion, subsequently paid dues, and requested presentation of the book at an annual meeting.

The WHO has requested that the "Caring Physicians of the World" book be presented on April 7 during World Health Day and presented to press conferences in London or Lusaka. For our part, the WMA will hold a press conference for the Ministers of Health of all nations participating in the WHA in Geneva in May 2006. We'll be showing off the book and making sure that the WHO delegations get a copy. Beyond that, plans are in the works to distribute the book to English language medical schools, and we're seeking new venues to get this message out.

"The Caring Physicians of the World," through photographs and words, conveys a compelling story about the impact of medical professionals on their communities and their countries. I am confident that it will continue to be a useful resource and reference for our organization and for those organizations we engage.

NMA Survey & CPWI: Outreach and Regional Meetings

But this book was only one way the World Medical Association is opening its lines of communication.

In the summer of 2004 the WMA completed a survey of its member associations that revealed that we share many of the same concerns and needs, such as diminished access to quality, safe, affordable medical care, limited patient choice, reduction of professional prestige, and appropriate autonomy and compensation. These are problems for our profession that cross all national and cultural borders.

Knowing this helps the WMA better approach our priorities and communicate better with our member national associations. It also helps us communicate better with outside organizations, and the public.

Outreach

Our Caring Physicians of the World outreach effort is striving to re-introduce the WMA to those national medical associations that have been inactive.

This included the associations from two of the most populous nations on the planet.

In the space of a single one-year period, we had four meetings with the Chinese Medical Association and other medical groups there – including the Shanghai First World Medical Summit and the Shanghai Medical University.

The World Medical Association's Caring Physicians of the World initiative also reached out to India – I spoke in February to the Indian Medical Association and Medical Council of India in Delhi, and addressed officials of their association again in December.

The initiative's outreach support also gave the new Secretary General and President the opportunity to visit jointly with NMAs, a key representation benefit that would have been otherwise impossible. These included the annual meeting of the American Medical Association, the inaugural ceremony of the Canadian Medical Association, the Confederation of Latin American Nations and the Caribbean (CONFEMEL) in Costa Rica, the Israel Medical Association, the South African Medical Association, and the Thailand Medical Association. We carried our message of the Caring Physicians of the world as well to the Hungarian Medical Association, the Taiwan Medical Association, the Colegio Medico de Mexico,

the Portuguese Medical Association, and the British Medical Association.

The WMA took part in the WHO Executive Board meetings in January and March, 2005, which focused on the tsunami response effort; and also participated in the WHO strategic workgroup on Diet, Fitness and Health.

The WMA also reached out to the World Health Assembly (WHA) in May.

Other events of note include:

- Keynoting of the WMA World Oceans Forum November, 2004 in New York;
- Chairing the WMA Ethics Manual launch in Geneva, Switzerland in January, 2005 (the ethics manual has already been translated into more than a half-dozen languages);
- Addressing the World Bank Forum on Counterfeit Drugs;
- Meetings with the World Bank leadership on Global response to AIDS, Tuberculosis and Malaria;
- Participation in formation meetings of the Iraqi Physicians Society and the Project Hope Basra, at the Iraq Pediatric Hospital;
- And addressing the US DHHS/DOD Forum on disaster response for tsunami effected countries.

Regional Meetings

The third component of the CPWL, stimulated by NMA response to our WMA questionnaire the summer of 2004, was the establishment of WMA/CPW Regional Meetings of NMAs around the world. These meetings enable WMA to listen and learn how to best serve their membership and advocate on behalf of patients and the profession, enhance exchange of information between WMA and NMAs, and among NMAs in regions, and enhance NMA's effectiveness and growth.

The concerns expressed by NMAs reflected the concerns of Physicians worldwide: diminishing access to safe, affordable medical care; limited patient choice; erosion of professional prestige, and appropriate autonomy and compensations.

The first regional meeting was among Sub-Saharan NMAs in Johannesburg, South

Africa in January 2005. The second highly successful regional meeting was among Latin American NMAs here in Santiago four days ago.

Regional meetings are planned for South East Asian NMAs in November in Bangkok, European NMAs in Prague in December 2005, and North American NMAs in Florida March 2006.

Each of these regions and each of these organizations have different needs and interests and capabilities. Each can teach us something new about the practice and value of medicine. Each can tell us more about why it is so important – to rally around the banner of science, ethics and caring.

Science, Ethics and Caring

These are the three enduring traditions. Science – ethics – caring.

We see these exemplified in the 65 of our colleagues profiled in the "Caring Physicians of the World" book. We see it practiced by physicians everywhere.

They are what make us effective advocates for patients and for our profession, no matter where we live. They give us an anchor – a sense of permanence – in an imperfect and transitory world of political upheavals, policy shifts and spasms of public opinion. Get involved – become an activist in national and international organizations that affect your patients and your calling. That way, you make an impact as an individual and as part of chorus of powerful voices, singing as one. A voice that makes entities in government and industry which may seem distant and unresponsive, sit up and take notice. Also to learn what we do, what we stand for and the values we embrace. All in the service of our patients and the public health.

We are the global face of medicine. We share a commitment to the best science – to caring and compassion – and to the highest ethical standards. We are by now familiar with those profiled as Caring Physicians of the World what they do every day to change the course of health care in their communities and in their countries.

Our challenge, each and every one of us, is to effect that change wherever we may live. Because all of us are the "Caring Physicians of the World."



The World Medical Association Statement on reducing the global Impact of Alcohol on Health and Society

Adopted by the WMA General Assembly, Santiago 2005

Preamble

1. Alcohol use is deeply embedded in many societies. Overall, 4% of the global burden of disease is attributable to alcohol, which accounts for about as much death and disability globally as tobacco or hypertension. Overall, there are causal relationships between alcohol consumption and more than 60 types of disease and injury including traffic fatalities. Alcohol consumption is the leading risk factor for disease burden in low mortality developing countries and the third largest risk factor in developed countries. Beyond the numerous chronic and acute health effects, alcohol use is associated with widespread social, mental and emotional consequences. The global burden related to alcohol consumption, both in terms of morbidity and mortality, is considerable.
2. Alcohol-related problems are the result of a complex interplay between individual use of alcoholic beverages and the surrounding cultural, economic, physical environment, political and social contexts.
3. Alcohol cannot be considered an ordinary beverage or consumer commodity since it is a drug that causes substantial medical, psychological and social harm by means of physical toxicity, intoxication and dependence. There is increasing evidence that genetic vulnerability to alcohol dependence is a risk factor for some individuals. Fetal alcohol syndrome and fetal alcohol effects, preventable causes of mental retardation, may result from alcohol consumption during pregnancy. Growing scientific evidence has

demonstrated the harmful effects of consumption prior to adulthood on the brains, mental, cognitive and social functioning of youth and increased likelihood of adult alcohol dependence and alcohol related problems among those who drink before full physiological maturity. Regular alcohol consumption and binge drinking in adolescents can negatively affect school performance, increase participation in crime and adversely affect sexual performance and behaviour.

4. Alcohol advertising and promotion is rapidly expanding throughout the world and is increasingly sophisticated and carefully targeted, including to youth. It is aimed to attract, influence, and recruit new generations of potential drinkers despite industry codes of self-regulation that are widely ignored and often not enforced.
5. Effective alcohol social policy can put into place measures that control the supply of alcohol and/or affect population-wide demand for alcohol beverages. Comprehensive policies address legal measures to: control supply and demand, control access to alcohol (by age, location and time), provide public education and treatment for those who need assistance, levy taxation to affect prices and to pay for problems generated by consumption, and harm-reduction strategies to limit alcohol-related problems such as impaired driving and domestic violence.
6. Alcohol problems are highly correlated with per capita consumption so that reductions of use can lead to decreases in alcohol problems. Because alcohol is an economic commodity, alco-

hol beverage sales are sensitive to prices, i.e., as prices increase, demand declines, and visa versa. Price can be influenced through taxation and effective penalties for inappropriate sales and promotion activities. Such policy measures affect even heavy drinkers, and they are particularly effective among young people.

7. Heavy drinkers and those with alcohol-related problems or alcohol dependence cause a significant share of the problems resulting from consumption. However, in most countries, the majority of alcohol-related problems in a population are associated with harmful or hazardous drinking by non-dependent 'social' drinkers, particularly when intoxicated. This is particularly a problem of young people in many regions of the world who drink with the intent of becoming intoxicated.
8. Although research has found some limited positive health effects of low levels of alcohol consumption in some populations, this must be weighed against potential harms from consumption in those same populations as well as in population as a whole.
9. Thus, population-based approaches that affect the social drinking environment and the availability of alcoholic beverages are more effective than individual approaches (such as education) for preventing alcohol related problems and illness. Alcohol policies that affect drinking patterns by limiting access and by discouraging drinking by young people through setting a minimum legal purchasing age are especially likely to reduce harms.

Laws to reduce permitted blood alcohol levels for drivers and to control the number of sales outlets have been effective in lowering alcohol problems.

10. In recent years some constraints on the production, mass marketing and patterns of consumption of alcohol have been weakened and have resulted in increased availability and accessibility of alcoholic beverages and changes in drinking patterns across the world. This has created a global health problem that urgently requires governmental, citizen, medical and health care intervention.

Recommendations

The WMA urges National Medical Associations and all physicians to take the following actions to help reduce the impact of alcohol on health and society:

11. Advocate for comprehensive national policies that
 - a. incorporate measures to educate the public about the dangers of hazardous and unhealthy use of alcohol (from risky amounts through dependence), including, but not limited to, education programs targeted specifically at youth;
 - b. create legal interventions that focus primarily on treating or provide evidence-based legal sanctions that deter those who place themselves or others at risk, and
 - c. put in place regulatory and other environmental supports that promote the health of the population as a whole.
12. Promote national and sub-national policies that follow 'best practices' from the developed countries that with appropriate modification may also be effective in developing nations. These may include setting of a minimum legal purchase age, restricted sales policies, restricting hours or days of

sale and the number of sales outlets, increasing alcohol taxes, and implementing effective countermeasures for alcohol impaired driving (such as lowered blood alcohol concentration limits for driving, active enforcement of traffic safety measures, random breath testing, and legal and medical interventions for repeat intoxicated drivers).

13. Be aware of and counter non-evidence-based alcohol control strategies promoted by the alcohol industry or their social aspect organizations.
14. Restrict the promotion, advertising and provision of alcohol to youth so that youth can grow up with fewer social pressures to consume alcohol. Support the creation of an independent monitoring capability that assures that alcohol advertising conforms to the content and exposure guidelines described in alcohol industry self-regulation codes.
15. Work collaboratively with national and local medical societies, specialty medical organizations, concerned social, religious and economic groups (including governmental, scientific, professional, nongovernmental and voluntary bodies, the private sector, and civil society) to:
 - a. reduce harmful use of alcohol, especially among young people and pregnant women, in the workplace, and when driving;
 - b. increase the likelihood that everyone will be free of pressures to consume alcohol and free from the harmful and unhealthy effects of drinking by others; and
 - c. promote evidence-based prevention strategies in schools.
16. Undertake to
 - a. screen patients for alcohol use disorders and at-risk drinking, or arrange to have screening conducted

systematically by qualified personnel using evidence-based screening tools that can be used in clinical practice;

- b. promote self-screening / mass screening with questionnaires that could then select those needing to be seen by a provider for assessment;
 - c. provide brief interventions to motivate high-risk drinkers to moderate their consumption; and
 - d. provide specialized treatment, including use of evidence-based pharmaceuticals, and rehabilitation for alcohol-dependent individuals and assistance to their families.
17. Encourage physicians to facilitate epidemiologic and health service data collection on the impact of alcohol.
 18. Promote consideration of a Framework Convention on Alcohol Control similar to that of the WHO Framework Convention on Tobacco Control that took effect on February 27, 2005.
 19. Furthermore, in order to protect current and future alcohol control measures, advocate for consideration of alcohol as an extra-ordinary commodity and that measures affecting the supply, distribution, sale, advertising, promotion or investment in alcoholic beverages be excluded from international trade agreements.



From the Secretary General's desk

Working together for health – Human Resources for Health World Health Day 2006

As WHO invites governments and institutions to celebrate World Health Day 2006 under the theme „Working together for health“, the people working in health care in many countries of this world may have the feeling that there is not very much to celebrate. Actually there is rather a question, “Where to go?” and the answer has already been given: “from East to West and from South to North”. The migration of health professionals is soaring and clearly follows an economic gradient from poor countries to rich countries. While in Europe the migration from East to West is partly compensated by an oversupply of physicians in East and Central Europe, and the brain drain from African countries in particular, reaches catastrophic dimensions.

But to believe that money is the only driving force for health professionals to migrate falls short of reality. There are many other reasons that make physicians (and other health professions) go or stay. Working conditions, amongst them the availability of material local items that lead to a decision whether to go or to stay. The environment in which the physician and his or her family have to live certainly is another. However, cross border migration is not the only move that is possible. Young physicians leave medicine and search other fields of work in their country, sometimes immediately after passing their final exams. Established physicians retire early or they simply discover that there is “life beyond medicine” and decide to reduce their workload at the expense of a lower income.

Countries with an emigration of physicians have to try very hard to do whatever they can to offer better conditions to physicians (and other health professions) and their families, if they wish to retain them. The expenses of educating physicians alone should make it a necessity for all countries to retain as many of the physicians they have trained as is possible. Bonding of

young physicians has been suggested. Bonding means to oblige a person to provide a service in return e.g. for the education they have received. Bonding could also be seen as part of a social contract, when physicians return a service for the state paid education they received. However there are many problems with bonding other than that young workers or college graduate students are not being paid. One could argue that the return has already been made, it is their commitment to study and not receive a salary for that work. Also, each nation that believes in equality before the law would have to demand the same bonding from every other student as well.

Yet good examples of voluntary bonding exist and bonding can serve to guarantee a workforce. For those who promise to serve in certain areas, special benefits or preferential treatment could be awarded. But that only works if there are focal shortfalls, e.g. in a certain rural area or in the military. When there is a general shortage of physicians, voluntary bonding is meaningless. In these cases a better payment and better working conditions would be the straightforward approach.

There is a decreasing willingness to accept 36 hours shifts, there is a demand for parental leave and there is a higher demand for more private time in general. To blame this trend on a feminisation of medicine is shortsighted. It is true that medicine is no longer a male domain. In many countries the majority of graduates now are female and new gender mix reaches the workplace. But a suggestion that women go off the job because they marry and have children and therefore reduce the workforce, is far too easy.

Thirty years ago the typical physician was male and provided the single income of the family. He would work 150 to 200 % of what was a normal workload and (in the western world) would receive a decent

income after specialization. Today physicians, male and female, are in relationships with spouses who have their own professional life. Burdens are to be shared between equal partners, nor do young physicians do, or want to have. The same work load as their predecessors regardless of whether they are male or female.

“Work-life balance” is a phrase that our slave-like profession is slowly learning to recognize. Although senior physicians often see it as a kind of mutiny, those who are asking for more private time and reasonable working hours, are only asking for what other professions see as their natural right since decades.

The traditional expectation of a good income in a late part of our professional life has for a long time led us to often tolerate inadequate payment and unacceptable working conditions. Often to the extent that the average salary of a young physician is lower than that of a factory worker. And with the increasing tendency of employers to be unwilling or able to pay for over-hours worked, the misery does not start, but becomes visible.

Grave as are the failures of governments, politicians, insurances, managed care organizations, hospital owners and other outsiders in regulating the health care labour market, we have to acknowledge that we made mistakes ourselves. There are certain myths and misunderstandings we have to clarify ourselves:

1. A good physician is always available. Physicians have the same physiology as other humans. There is a point when an overworked person doing a danger-prone work becomes a danger him or herself. That is what every physician would tell an employer. It's now time to tell it our employers. And when we indeed believe in the equality of men and women, and when we indeed value the family, we have to change the medical work place now.
2. The more experience you get – the more you learn – that is wishful thinking. One can have a lot of experience and still make everything wrong. Learning is primarily not a question of quantity but of

quality. Burying young physicians under work does not mean that they learn a lot – unless you take frustration as a learning experience. Those senior physicians who believe that their assistants or interns only learn when working long hours, have probably missed the most important lesson of their life, namely how to teach.

3. It is similar with our (specialist) education. Whatever is new in medicine simply adds up to medical education. Every one of us knows examples of things we learnt as being essential at the beginning of our professional career, (some of which were outdated even before we finished formal education). With an ever faster evolving knowledge, the extension of training duration is exactly the wrong strategy. Instead of prolonging our basic and specialist training ever more, we would be better off to reduce these periods and admit that we have to undergo (structured) education as part of our professional development for our whole lifetime.
4. Those responsible for the working conditions of physicians are often physicians themselves. Sometimes they are reacting to a miserable shortage of

resources management, truly earning the title of a disaster. We are in no position to blame them. But often senior physicians simply exploit young doctors for their own profit. The more hierarchical the organizational structure is the more this becomes a danger. The exploitation of physicians by senior physicians is not acceptable.

5. We don't talk about money. That is fine – as long as you have enough of it. In many countries of this world physicians are underpaid, absolutely and in relation to the general population. More and more often this happens in the western world as well. Whoever thinks that a highly valuable service can be delivered for token payment lives an illusion. Waiting lists, "under the table payments" and emigration, are the immediate answer. Whoever organizes such a system betrays both the physicians and the patients. Being silent about this is a shame.

Sir William Osler said: „The most important thing is caring, so do it first, for the caring physician best inspires hope and trust.“ Let's do our part, to give our young colleagues a chance to care.

are taking something which will make them well, when it may instead make them sicker or even kill them.

„People don't die from carrying a fake handbag or wearing a fake t-shirt. They can die from taking a counterfeit medicine," says Howard Zucker, Assistant Director General for Health Technology and Pharmaceuticals at WHO. "International police action against the factories and distribution networks should be as uncompromising as that applied to the pursuit of narcotic smuggling."

Counterfeit medicines are part of the broader phenomenon of substandard pharmaceuticals. The difference is that they are deliberately and fraudulently mislabelled with respect to identity and/or source. These products mostly have no therapeutic benefit; they can cause drug resistance and death.

Trade in counterfeits is extremely lucrative, thus making it more attractive to criminal networks. A report released by the Centre for Medicines in the Public Interest, in the United States, projects counterfeit drug sales to reach US\$ 75 billion in 2010, a 92 % increase from 2005.

The presence of fake drugs is more prevalent in countries with weak drug regulation control and enforcement. However, no single country is immune to the problem. Reports from the pharmaceutical industry and governments clearly indicate that the methods and channels used by counterfeiters are becoming more sophisticated, making detection more difficult. Measures for combating counterfeit medicines so far have included support to under-resourced drug regulatory authorities; simple, easily interpretable and cheap markers of authenticity such as barcoding; transnational surveillance for fake and substandard drugs; and education of patients, healthcare workers, and pharmacists.

"These measures need to be intensified," adds Dr Zucker. "Countries should think about ways to make the necessary technological, legislative and financial adjustments as quickly as possible to guarantee the availability of quality assured essential drugs."

WHO

Counterfeit medicines: the silent epidemic

WHO convenes stakeholders to find global solutions to a growing health threat

The World Health Organization (WHO) calls for immediate concrete action against the growing epidemic of counterfeit medicines. In a bid to accelerate the war on fake drugs, the agency pushed for stronger global cooperation, political commitment and creative solutions at a meeting in Rome 16 – 18 February, 2006.

WHO aims to create a global task force involving all major interested parties. The task force will focus on legislation and law

enforcement, trade, risk communications and innovative technology solutions, including public-private initiatives for applying new technologies to the detection of counterfeits and technology transfer to developing countries.

The counterfeiting of medicines is present in all countries and is thought to represent 10% of the global medicines trade. Particularly insidious, counterfeit medicines dupe sick people into believing they



WHO

WHO would also like to see more developments in the areas of innovative high and low tech solutions for prevention at the manufacturing stage and for detection in the distribution chain.

Simple, inexpensive methods to identify fakes can be effective. For example, simple colorimetric assays developed for artemisinins have been used successfully to identify fake artesunate antimalarials.

WHO set up the world's first web-based system for tracking the activities of drug cheats in the Western Pacific Region in 2005. The Rapid Alert System (RAS) communications network transmits reports on the distribution of counterfeit medicines to the relevant authorities for them to take rapid countermeasures. That system should be expanded to include all regions.

Radio frequency identification (RFID) and more sophisticated technologies for product tracking within supply chain management systems are being experimented with in some countries. Means must be sought to make these more sophisticated tools available and workable in developing countries.

Information on fake drug identity and distribution needs to be shared nationally and internationally between government drug regulatory authorities, customs and police organizations, pharmaceutical companies, non-governmental organizations, and consumer groups. Risk communications, involving the media, should be practised to raise public awareness.

The Rome conference was hosted by the Italian Pharmaceutical Agency (AIFA) and Italian Cooperation, and organized with the support of the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) and the German Government. Participants in the conference included experts from national governments and regulatory authorities, industry, intergovernmental organizations, and consumer and patient groups.

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Countries representing three-quarters of the world's population meet in Geneva to plan the effective implementation of the tobacco control treaty

Countries around the world are taking effective measures to curb tobacco use, including strong legislation, graphic warning labels and advertising bans. These positive changes reinforce the commitment made by the more than 110 countries who met to decide on the detailed implementation of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC).

At the opening of the first session of the Conference of the Parties (COP) to the WHO Framework Convention on Tobacco Control, in Geneva /Feb 6–17m, 2006) Dr LEE Jong-wook, WHO Director General said.

“One hundred and twenty one countries are now contracting parties to the Convention. Of these, 110 are here today, with full powers of participation. You represent nearly three quarters of the world's population. You represent nations at all levels of income and all stages of development. In this powerful gathering, we have three of the five top tobacco-leaf exporting countries, and four of the five top cigarette-exporting countries. This group of countries represents 69% of the world's cigarette consumption. It might seem astonishing that this group is also preparing to put into action the roadmap for countries to control tobacco. But this group has already changed history.

When the process began there was some scepticism over its success. The sceptics were wrong.

You are driving change forward. To name some examples: India has introduced comprehensive tobacco advertising bans. Australia, Brazil, Canada, Singapore and Thailand have introduced highly visible graphic warnings on cigarette packets. The European Union is on its way to doing the

same. In Ireland, Norway, and now in Spain, smoking has been banned in indoor public places. These, and other similar steps, will result in a major reduction in tobacco deaths.

New York State passed a smoking ban. It termed this act its “strongest public health policy ever”. Ironically, now it's said that the only place you can smoke with impunity in New York City is the United Nations Building.

Both Ann Veneman and I have said that this is wrong. Smoking should be banned in all UN premises. Also, cigarette sales should be banned in all United Nations premises. After all, the people who are smoking in the UN building sometimes are the representatives of the same Member States who have signed up to the Framework Convention. But it can be hard to put agreements into practice. We will all face this.

When we know that, in an Irish pub a smoking ban can really work, then we know that anything is possible.

Smoking is an advance contract. Those who smoke don't pay now, but will do so 30 to 40 years later, when their health fails. They pay with lung cancer, with obstructive airways disorders, with cardiovascular diseases. One in two smokers pays with their life. We have to help them stop smoking. We have to prevent them from starting. This convention is something that we all committed to. Its provisions are bold. They are based on knowledge of what is effective.

We will make it work.”

The COP is the governing body of the Treaty. It serves as the authority to oversee, monitor and evaluate progress of the Treaty, in order to reduce tobacco consumption and tobacco-related deaths globally.

Concrete measures included in the Treaty could help save 200 million lives by the year 2050 if a progressive 50% reduction in uptake and consumption rates is achieved. Many measures in the WHO FCTC have deadlines and clear guidelines. For example, from the Treaty's entry into force, countries have three years to enforce health warnings on tobacco products, and five years to implement comprehensive bans on tobacco advertising, promotion and sponsorship.

Other measures, such as those regarding illicit trade or cross-border advertising, have not yet been detailed in the Treaty. The COP could decide to develop protocols and specific guidelines and requirements for countries to implement these measures.

In February 2007, the first Contracting Parties will submit to the COP initial reports on their progress, specifying what actions they have taken to implement the tobacco control measures established in the Treaty. "This is a crucial time for people suffering the consequences of tobacco use," said Dr Yumiko Mochizuki-Kobayashi, Director of the WHO Tobacco Free Initiative. "Tobacco is still the top preventable cause of death. The goal is to see it fall from that position in our lifetime. With continued commitment from Member States, we will achieve that goal."

The conference having adopted the following decisions:

- To establish the permanent secretariat of the Treaty within the World Health Organization, located in Geneva. Delegates agreed on a budget of US\$ 8 million for its functioning during the next two years. Parties agreed to fund it through voluntary assessed contributions.
- To create working groups that will begin development of protocols (legally binding instruments) in the areas of cross-border advertising and illicit trade. To help countries establish smoke-free places and effective ways of regulating tobacco products, Parties agreed to develop guidelines (non-binding instruments).

- To allow the Conference of the Parties to assess progress made by countries in implementing the measures required by the Treaty through a pilot reporting questionnaire agreed by the Parties during the Conference.
- To establish an ad-hoc group of experts that will study economically viable alternatives to tobacco growing and production, with a view to making recommendations on diversification initiatives for those countries whose economies depend heavily on tobacco production.

The President of the Conference, Ambassador Juan Martabit from Chile said,

"The urgency of the problem of tobacco use is shared by all of us, and the commitment from countries and civil society to take action is very strong. I felt the positive spirit throughout the Conference, which clearly contributed to its success, helping countries to reach consensus quickly on the basic issues, so we can concentrate our efforts in the implementation. I am confident we are on track to save millions of lives in the near future thanks to this Treaty."

More information about the first session of the COP, including day to day overview, documents and presentations: www.who.int/tobacco/fctc/cop/en/index.html

Stop TB

WHO welcomes United Kingdom, Gates Foundation funding for global action to stop tuberculosis

New tools to fight the disease

The World Health Organization welcomed the announcement by the United Kingdom government that it will give £41.7 million (US\$ 74 million) to help fight tuberculosis (TB) in India and by the Bill and Melinda Gates Foundation that it will triple funding for tuberculosis to more than US\$ 900 million by 2015.

Announcement of the two funding commitments follows publication of the Global Plan to Stop Tuberculosis which sets out the steps that are needed to tackle the global tuberculosis epidemic. Two million people die of TB every year and eight million become infected. The plan, prepared by the Stop Tuberculosis Partnership, calls for global spending on tuberculosis to triple over the next ten years to increase access to tuberculosis control programmes and accelerate research on new tools to fight the disease.

„This funding from the UK government and from the Gates Foundation shows real, long-term commitment to the global effort to stop tuberculosis," said Dr LEE Jongwook, WHO Director-General. "The global TB action plan shows clearly what must be done to tackle the burden of TB. We must now act urgently to raise all the funds needed to put the plan into action."

Key objectives of the plan include improving access to treatment in order to prevent 14 million deaths and provide treatment to 50 million people; developing and distributing new drugs and a new, safe and affordable vaccine; and developing new efficient, effective and affordable diagnostic tests.

WHO is a partner in the Stop TB Partnership, which was established in 2000. The partnership secretariat is hosted by WHO in Geneva.



World Cancer Day, February 2006: Global action to avert 8 million cancer-related deaths by 2015

Cancer is a leading cause of death globally: an estimated 7.6 million people died of cancer in 2005 and 84 million people will die in the next 10 years if action is not taken. The World Health Organization (WHO) has proposed a global goal of reducing chronic disease death rates by 2% per annum from 2006 to 2015.

More than 70% of all cancer deaths occur in low- and middle-income countries, where resources available for prevention, diagnosis and treatment of cancer are limited or nonexistent. Tobacco use alone accounts for some 1.5 million cancer deaths per year.

WHO is actively responding to these rising levels of cancer. A World Health Assembly resolution adopted in May 2005 called on WHO and its Member States to take urgent action to prevent and control cancer. As a result, WHO has been developing a Global Cancer Strategy and the coming year will see the publication of "Cancer Control: Knowledge into Action – WHO Guide for Effective Programmes", a series of six modules aimed at supporting Member States to develop strategies to improve prevention, treatment and care of cancer patients.

"We must, first and foremost, address the tremendous inequalities between developed and developing countries in terms of cancer prevention, treatment and care," said Dr Catherine Le Galès-Camus, Assistant Director-General for Noncommunicable Diseases and Mental Health. "Despite our knowledge that many cases are avoidable, or curable when detected early and treated according to best evidence, sadly for many people tumours are detected too late and adequate treatment is not available. Furthermore, the quality of life of many patients with cancer can be improved substantially by pain control and palliative care."

It is estimated that over 40% of all cancer can be prevented. However, dramatic increases in risk factors such as tobacco use

and obesity are contributing to the rise in cancer rates, particularly in low- and middle-income countries. A rapidly changing global environment due to globalization of markets and urbanization is leading to rising consumption of processed foods high in fats, sugars and salt, as well as tobacco products; declining consumption of fruit and vegetables; and more sedentary activity levels. As a consequence the burden (incidence) of cancer and other chronic diseases is increasing. Other preventable risk factors include many environmental carcinogens and infections caused by Hepatitis B Virus and Human Papilloma Virus.

WHO is taking significant measures to prevent cancer and other chronic diseases. A key achievement has been the entry into force this past year of the first-ever WHO global health treaty. The WHO Framework Convention on Tobacco Control (WHO FCTC), is a major step towards the goal of reducing tobacco use, which is the leading preventable cause of cancer. Additionally, the Global Strategy on Diet, Physical Activity and Health has provided a multi-sectoral approach to reducing key risk factors for cancer and other chronic diseases. The Programme on Chemical Safety is a worldwide WHO-guided network aimed at reducing exposure to carcinogens, and immunization programmes against hepatitis are part of WHO global immunization strategies.

Social Healthcare

Medical costs push millions of people into poverty across the globe

Berlin/Geneva – Each year 100 million people slide into poverty as a result of medical care payments. Another 150 million people are forced to spend nearly half their incomes

To improve early detection, treatment and care of cancer patients, WHO's International Agency for Research on Cancer (IARC) is providing the scientific evidence for cancer causes and mechanisms of cancer development as well as developing strategies for early detection of cancer. Moreover, WHO acts in partnership with a range of major stakeholders in cancer control, including other UN organizations such as the International Atomic Energy Agency (IAEA), NGOs such as the International Union Against Cancer (UICC) and many national cancer institutes.

WHO advocates an integrated approach to prevention, treatment and care for all leading chronic diseases. Integrated approaches that combine cancer prevention, diagnosis, management with that for heart disease, stroke, diabetes and other chronic diseases are necessary because the diseases share common risk factors (tobacco use, unhealthy diet and physical inactivity) and require similar responses from the health system. The integrated approach is best for prevention and treatment, it is also cost-effective. It is outlined in the recently released report, „Preventing chronic diseases: a vital investment“.

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Paradoxically, people in the world's poorest countries contribute relatively more for health care than those in wealthy industrialized nations. In Germany, for example, where the average GDP per capita is US\$ 32 860 and almost everyone has social health protection, 10% of all medical expenses nationwide are borne by households. In the Democratic Republic of the Congo, by contrast, where GDP per capita is only US\$ 120 and where social health protection is scant, about 70% of the money spent on medical care is paid directly by households.

Experts from some 40 countries met in Berlin at a conference convened by the Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (GTZ), the German Federal Ministry for Economic Cooperation and Development, the International Labour Office (ILO) and the World Health Organization and laid out strategies that they and their partners can undertake to prevent such catastrophes.

"Social health protection is feasible even in the developing world, but it has not got the attention it deserves. Countries must begin now to craft well-organized schemes, and international donors will have to help. It takes years to put such a scheme into place, but if we start now, by 2015 – the target for the Millennium Development Goals – we could be well on the way to protecting people worldwide through equitable health financing," said Dr Timothy Evans, WHO Assistant Director-General for Evidence and Information for Policy.

In low-income countries, it would take an average of about US\$ 35 per person per year to finance a social health protection scheme able to provide basic health services, of which US\$ 15 to US\$ 25 would have to come from international donors.

Social health protection can do more than shield people against poverty – it can also save lives. "At least 1.3 billion people worldwide lack access to the most basic healthcare. Often it is because they cannot afford it. As a result, millions become very sick or die every year from preventable or curable medical conditions said Dr. Rüdiger Krech, Head of Social Protection

in the Division Health, Education, and Social Protection at GTZ.

"Social health protection is not only a key tool in making health care accessible to all and to free millions of people from poverty. It is also an investment in health, productivity and development – an investment that is a prerequisite for international competitiveness", said Assane Diop, Executive Director of the ILO.

Having to pay for medical treatment can cause a farmer to lose his herd or a family to lose its business. The Chinwubas and their five children used to live comfortably in Abakpa, Kenya from the earnings of a small building supply shop they owned. When Gloria needed an emergency Cesarean section they were suddenly faced with medical bills of US\$ 200 – more than

their usual earnings for a four-month period. Unable to pay the entire bill, Amos had to give his motorbike as a safety deposit to the hospital. Without it, he was unable to collect material from the wholesaler, and his business came to standstill. He had to pull the children out of school, because there was no money to pay for fees and uniforms; and the family is now subsisting on one meal a day.

A number of low-income countries – including Ghana, Rwanda and Senegal – have already experimented with innovative ways of protecting people against the financial risks of ill health. Drawing on those experiences, the GTZ, ILO and WHO are offering direct technical assistance to countries seeking to develop social health protection plans.

Foundation for Innovative New Diagnostics and WHO collaborate to improve diagnosis of sleeping sickness

The Foundation for Innovative New Diagnostics (FIND) and the World Health Organization (WHO), with a grant from the Bill & Melinda Gates Foundation, today announced that they will begin work on the development and evaluation of new diagnostic tests for human African trypanosomiasis (HAT) also known as sleeping sickness.

African sleeping sickness, a major public health threat in sub-Saharan Africa, spreads among people bitten by the tsetse fly and is fatal unless treated. Because early-stage infection produces few symptoms, it is thought that only 10% of patients with the disease are accurately diagnosed. FIND and the World Health Organization will collaborate in seeking to identify, test and implement diagnostics that will increase the likelihood of early detection of HAT and the opportunity for treatment.

"The spread of human African trypanosomiasis has reached epidemic proportions in regions of Africa. There is clearly a great need for a simple, accurate and cost-effective way to diagnose this disease so that it can be better treated and controlled," said Dr Giorgio Roscigno, CEO of FIND. "FIND is committed to identifying and implementing diagnostics for infectious diseases, and we look forward to securing partnerships and initiating field testing."

"Existing diagnostics for sleeping sickness are difficult to implement in remote, impoverished settings," said Dr Jean Jannin and Dr Pere Simarro, from the Neglected Tropical Diseases Control Department of the World Health Organization. "We look forward to working with FIND to advance new diagnostic tests that could revolutionize human African trypanosomiasis control."



“Developing point-of-care tests to direct sleeping sickness treatment will greatly simplify patient care, allowing for early case detection, simpler and safer treatment, and higher rates of cure that will improve disease management and could lead to the elimination of the disease as a public health problem,” said Thomas Brewer, M.D., senior programme officer, Infectious Diseases division, Global Health Programme, at the Gates Foundation.

Currently, diagnosis of sleeping sickness is made by serologic examinations followed by microscopy, which is laborious, insensitive and costly. FIND’s and WHO’s efforts will be focused on developing tools that will be simple to use and effective in the remote field conditions that exist where it is most prevalent. In addition to developing appropriate diagnostic technologies, the objectives of the programme include establishing field research sites for clinical studies and evaluating prototype products.

About FIND

The Foundation for Innovative New Diagnostics (FIND) was launched at the World Health Assembly in May 2003 as a non-profit Swiss foundation based in Geneva. Its purpose is to support and promote the health of people in developing countries by sponsoring the development and introduction of new but affordable diagnostic products for infectious diseases. FIND currently has established collaborations with a number of leading public and private organizations for the development of diagnostics for tuberculosis. For more information, please visit www.finddiagnostics.org

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Measles cases and deaths fall by 60% in Africa since 1999

Ted Turner Announces \$20 million Commitment from UN Foundation to Measles Initiative Over the Next Four Years

The Measles Initiative partners gathered in a TIME Magazine Global Health Summit in New York this week to announce that tremendous progress has been made in Africa in the fight against measles. Largely due to the technical and financial support of the Measles Initiative and commitment from African governments, more than 200 million children in Africa have been vaccinated against measles and one million lives have been saved since 1999. Measles cases and deaths have dropped by 60%, thanks to improvements in routine and supplementary immunization activities in Africa. The founding partners of the Measles Initiative are the American Red Cross, UN Foundation, World Health Organization, UNICEF and Centers for Disease Control and Prevention.

“This is a major public health achievement,” said Dr. LEE Jong-wook, WHO Director-General. “It is the result of the hard work and dedication of the governments of priority countries with high measles deaths and all our Measles Initiative partners to achieve a common goal – to reduce measles deaths. Let us continue to build on this momentum.”

Measles is one of the leading vaccine-preventable childhood killers in the world. In 2003, more than 500,000 people – 470,000 of them children under age 5 – died from the disease. Half of these deaths were in Africa alone. A safe and highly effective vaccine has been available for over forty years, and it costs less than US \$1 to protect a child against measles. Despite this, millions of children still remain at risk from measles.

UNICEF Executive Director Ann M. Veneman said that the Initiative’s extraordinary success against measles has brought the world closer to reaching the Millennium Development Goal (MDG) on child mortality. The results in Africa can now be replicated in Asia, the region that accounts for more than 180,000 deaths worldwide.

“The Measles Initiative and other investments in immunization not only save lives, they build economies,” said Bo Stenson of the Global Alliance for Vaccines and Immunization (GAVI). “In fact, a new study out of the Harvard School of Public Health demonstrates that in the past, development experts have generally underestimated the economic value of immunization. Investing in the health of children is not only the compassionate thing to do, it is the smart thing to do and will pay off for future generations in their educational attainment, labor productivity, income and savings.”

Next steps for the Measles Initiative include additional ‘follow-up’ vaccination campaigns in Africa, expanding vaccination campaigns into Asia and continuing the successful “integrated child health campaigns” in which health workers provide not only measles vaccines, but also insecticide-treated bed-nets (for malaria prevention), vitamin A, deworming medication, and polio vaccines.

Launched in February 2001, the Measles Initiative (www.measlesinitiative.org) is a partnership formed to reduce and control measles deaths. The Initiative is led by the United Nations Foundation, American Red Cross, Centers for Disease Control and Prevention, UNICEF and the World Health Organization. The Measles Initiative (MI) bases its success on its far-reaching partnership between public and private institutions, including key players such as the International Federation of Red Cross and Red Crescent Societies, the Canadian International Development Agency (CIDA), Becton, Dickinson and Company, The Bill and Melinda Gates Foundation, the Church of Jesus Christ and Latter Day Saints, Becton, Dickinson and Company (BD), the Global Alliance for Vaccines and Immunization (GAVI) and countries and governments affected by measles. While the Measles Initiative is focused in Africa where the majority of measles-related deaths occur, partners also work on a wide-range of health initiatives around the world, including measles control and other vaccination services outside of Africa.

Chernobyl: the true scale of the accident

20 years later a UN report provides definitive answers and ways to repair lives

Geneva, 5 September 2005 - A total of up to 4000 people could eventually die of radiation exposure from the Chernobyl nuclear power plant (NPP) accident nearly 20 years ago, an international team of more than 100 scientists has concluded.

As of mid-2005, however, fewer than 50 deaths had been directly attributed to radiation from the disaster, almost all being highly exposed rescue workers, many who died within months of the accident but others who died as late as 2004.

The new numbers are presented in a landmark digest report, "Chernobyl's Legacy: Health, Environmental and Socio-Economic Impacts," just released by the Chernobyl Forum. The digest, based on a three-volume, 600-page report and incorporating the work of hundreds of scientists, economists and health experts, assesses the 20-year impact of the largest nuclear accident in history. The Forum is made up of 8 UN specialized agencies, including the International Atomic Energy Agency (IAEA), World Health Organization (WHO), United Nations Development Programme (UNDP), Food and Agriculture Organization (FAO), United Nations Environment Programme (UNEP), United Nations Office for the Coordination of Humanitarian Affairs (UN-OCHA), United Nations Scientific Committee on the Effects of Atomic Radiation (UNSCEAR), and the World Bank, as well as the governments of Belarus, the Russian Federation and Ukraine.

"This compilation of the latest research can help to settle the outstanding questions about how much death, disease and economic fallout really resulted from the Chernobyl accident," explains Dr. Burton Bennett, chairman of the Chernobyl Forum and an authority on radiation effects. "The governments of the three most-affected countries have realized that they need to find a clear way forward, and that progress

must be based on a sound consensus about environmental, health and economic consequences and some good advice and support from the international community."

Bennett continued: "This was a very serious accident with major health consequences, especially for thousands of workers exposed in the early days who received very high radiation doses, and for the thousands more stricken with thyroid cancer. By and large, however, we have not found profound negative health impacts to the rest of the population in surrounding areas, nor have we found widespread contamination that would continue to pose a substantial threat to human health, within a few exceptional, restricted areas."

The Forum's report aims to help the affected countries understand the true scale of the accident's consequences and also suggests ways the governments of Belarus, the Russian Federation and Ukraine might address major economic and social problems stemming from the accident. Members of the Forum, including representatives of the three governments, met on September 6 and 7 in Vienna at an unprecedented gathering of the world's experts on Chernobyl, radiation effects and protection, to consider these findings and recommendations.

Major study findings

Dozens of important findings are included in the massive report:

- Approximately 1000 on-site reactor staff and emergency workers were heavily exposed to high-level radiation on the first day of the accident; among the more than 200,000 emergency and recovery operation workers exposed during the period from 1986-1987, an estimated 2,200 radiation-caused deaths can be expected during their lifetime.

- An estimated five million people currently live in areas of Belarus, Russia and Ukraine that are contaminated with radionuclides due to the accident; about 100 000 of them live in areas classified in the past by government authorities as areas of "strict control". The existing "zoning" definitions need to be revisited and relaxed in the light of these new findings.
- About 4,000 cases of thyroid cancer, mainly in children and adolescents at the time of the accident, have resulted from the accident's contamination and at least nine children died of thyroid cancer; however the survival rate among such cancer victims, judging from experience in Belarus, has been almost 99%.
- Most emergency workers and people living in contaminated areas received relatively low whole body radiation doses, comparable to natural background levels. As a consequence, no evidence or likelihood of decreased fertility among the affected population has been found, nor has there been any evidence of increases in congenital malformations that can be attributed to radiation exposure.
- Poverty, "lifestyle" diseases now rampant in the former Soviet Union and mental health problems pose a far greater threat to local communities than does radiation exposure.
- Relocation proved a "deeply traumatic experience" for some 350,000 people moved out of the affected areas. Although 116 000 were moved from the most heavily impacted area immediately after the accident, later relocations did little to reduce radiation exposure.
- Persistent myths and misperceptions about the threat of radiation have resulted in "paralyzing fatalism" among residents of affected areas.
- Ambitious rehabilitation and social benefit programmes started by the former Soviet Union, and continued by Belarus, Russia and Ukraine, need reformulation



due to changes in radiation conditions, poor targeting and funding shortages.

- Structural elements of the sarcophagus built to contain the damaged reactor have degraded, posing a risk of collapse and the release of radioactive dust;
- A comprehensive plan to dispose of tons of high-level radioactive waste at and around the Chernobyl NPP site, in accordance with current safety standards, has yet to be defined.

Alongside radiation-induced deaths and diseases, the report labels the mental health impact of Chernobyl as “the largest public health problem created by the accident” and partially attributes this damaging psychological impact to a lack of accurate information. These problems manifest as negative self-assessments of health, belief in a shortened life expectancy, lack of initiative, and dependency on assistance from the state.

“Two decades after the Chernobyl accident, residents in the affected areas still lack the information they need to lead the healthy and productive lives that are possible,” explains Louisa Vinton, Chernobyl focal point at the UNDP. “We are advising our partner governments that they must reach people with accurate information, not only about how to live safely in regions of low-level contamination, but also about leading healthy lifestyles and creating new livelihoods.” But, says Dr. Michael Repacholi, Manager of WHO’s Radiation Programme, “the sum total of the Chernobyl Forum is a reassuring message.”

He explains that there have been 4,000 cases of thyroid cancer, mainly in children, but that except for nine deaths, all of them have recovered. “Otherwise, the team of international experts found no evidence for any increases in the incidence of leukemia and cancer among affected residents.”

The international experts have estimated that radiation could cause up to about 4000 eventual deaths among the higher-exposed Chernobyl populations, i.e., emergency workers from 1986-1987, evacuees and residents of the most contaminated areas. This number contains both the known radiation-induced cancer and leukaemia deaths and a

statistical prediction, based on estimates of the radiation doses received by these populations. As about quarter of people die from spontaneous cancer not caused by Chernobyl radiation, the radiation-induced increase of only about 3% will be difficult to observe. However, in the most exposed cohorts of emergency and recovery operation workers some increase of particular cancer forms (e.g., leukemia) in particular time periods has already been observed. The predictions use six decades of scientific experience with the effects of such doses, explained Repacholi.

Repacholi concludes that “the health effects of the accident are potentially horrific, but when they are added them up using validated conclusions from good science, the public health effects are not nearly as substantial as at first feared.”

The report’s estimate for the eventual number of deaths is far lower than earlier, well-publicized speculations that radiation exposure would claim tens of thousands of lives. But the 4,000 figure is not far different from estimates made in 1986 by Soviet scientists, according to Dr. Mikhail Balonov, a radiation expert with the International Atomic Energy Agency in Vienna, who was a scientist in the former Soviet Union at the time of the accident.

As for environmental impact, the reports are also reassuring, for the scientific assessments show that, except for the still closed highly contaminated 30 kilometre area surrounding the reactor, and some closed lakes and restricted forests, radiation levels have mostly returned to acceptable levels. “In most areas the problems are economic and psychological, not health or environmental,” reports Balonov, the scientific secretary of the Chernobyl Forum effort who has been involved with Chernobyl recovery since the disaster occurred.

Recommendations

Recommendations call for focussing assistance efforts on highly contaminated areas and redesigning government programmes to help those genuinely in need. Suggested changes would shift programmes away

from those that foster “dependency” and a “victim” mentality, and replacing them with initiatives that encourage opportunity, support local development, and give people confidence in their futures.

In the health area, the Forum report calls for continued close monitoring of workers who recovered from Acute Radiation Syndrome (ARS) and other highly exposed emergency personnel. The Report also calls for focussed screening of children exposed to radioiodine for thyroid cancer and highly exposed clean-up workers for non-thyroid cancers. However, existing screening programmes should be evaluated for cost-effectiveness, since the incidence of spontaneous thyroid cancers is increasing significantly as the target population ages. Moreover, high quality cancer registries need continuing government support.

In the environmental realm, the Report calls for long term monitoring of caesium and strontium radionuclides to assess human exposure and food contamination and to analyse the impacts of remedial actions and radiation-reduction countermeasures. Better information needs to be provided to the public about the persistence of radioactive contamination in certain food products and about food preparation methods that reduce radionuclide intake. Restrictions on harvesting of some wild food products are still needed in some areas.

Also in the realm of protecting the environment, the Report calls for an “integrated waste management programme for the Shelter, the Chernobyl NPP site and the Exclusion Zone” to ensure application of consistent management and capacity for all types of radioactive waste. Waste storage and disposal must be dealt with in a comprehensive manner across the entire Exclusion Zone, according to the Report.

In areas where human exposure is not high, no remediation needs to be done, points out Balonov. “If we do not expect health or environmental effects, we should not waste resources and effort on low priority, low contamination areas,” he explains. “We need to focus our efforts and resources on real problems.”

One key recommendation addresses the fact that large parts of the population, especially in rural areas, still lack accurate information and emphasizes the need to find better ways both to inform the public and to overcome the lack of credibility that hampered previous efforts. Even though accurate information has been available for years, either it has not reached those who need it or people do not trust and accept the information and do not act upon it, according to the Report.

This recommendation calls for targeting information to specific audiences, including community leaders and health care workers, along with a broader strategy that promotes healthy lifestyles as well as information about how to reduce internal and external radiation exposures and address the main causes of disease and mortality.

In the socioeconomic sphere, the Report recommends a new development approach that helps individuals to “take control of their own lives and communities to take control of their own futures.” The Governments, the Report states, must streamline and refocus Chernobyl programmes through more targeted benefits, elimination of unnecessary benefits to people in less contaminated areas, improving primary health care, support for safe food production techniques, and encouragement for investment and private sector development, including small and medium-size enterprises.

Notes Vinton, “The most important need is for accurate information on healthy lifestyles, together with better regulations to promote small, rural businesses. Poverty is the real danger. We need to take steps to empower people.”

Answers to Longstanding Questions

How much radiation were people exposed to as a result of the accident?

With the exception of on-site reactor staff and emergency workers exposed on 26 April, most recovery operation workers and those living in contaminated territories received relatively low whole body radiation

doses, comparable to background radiation levels and lower than the average doses received by residents in some parts of the world having high natural background radiation levels.

For the majority of the five million people living in the contaminated areas, exposures are within the recommended dose limit for the general public, though about 100,000 residents still receive more. Remediation of those areas and application of some agricultural countermeasures continues. Further reduction of exposure levels will be slow, but most exposure from the accident has already occurred.

How many people died and how many more are likely to die in the future?

The total number of deaths already attributable to Chernobyl or expected in the future over the lifetime of emergency workers and local residents in the most contaminated areas is estimated to be about 4,000. This includes some 50 emergency workers who died of acute radiation syndrome and nine children who died of thyroid cancer, and an estimated total of 3,940 deaths from radiation-induced cancer and leukemia among the 200,000 emergency workers from 1986-1987, 116,000 evacuees and 270,000 residents of the most contaminated areas (total about 600,000). These three major cohorts were subjected to higher doses of radiation amongst all the people exposed to Chernobyl radiation.

The estimated 4,000 casualties may occur during the lifetime of about 600,000 people under consideration. As about quarter of them will eventually die from spontaneous cancer not caused by Chernobyl radiation, the radiation-induced increase of about 3% will be difficult to observe. However, in the most highly exposed cohorts of emergency and recovery operation workers, some increase in particular cancers (e.g., leukemia) has already been observed.

Confusion about the impact has arisen owing to the fact that thousands of people in the affected areas have died of natural causes. Also, widespread expectations of ill health and a tendency to attribute all health problems to radiation exposure have led local residents to assume that Chernobyl

related fatalities were much higher than they actually were.

What diseases have already occurred or might occur in the future?

Residents who ate food contaminated with radioactive iodine in the days immediately after the accident received relatively high doses to the thyroid gland. This was especially true of children who drank milk from cows who had eaten contaminated grass. Since iodine concentrates in the thyroid gland, this was a major cause of the high incidence of thyroid cancer in children.

Several recent studies suggest a slight increase in the incidence of leukemia among emergency workers, but not in children or adult residents of contaminated areas. A slight increase in solid cancers and possibly circulatory system diseases was noted, but needs to be evaluated further because of the possible indirect influence of such factors as smoking, alcohol, stress and unhealthy lifestyle.

Have there been or will there be any inherited or reproductive effects?

Because of the relatively low doses to residents of contaminated territories, no evidence or likelihood of decreased fertility has been seen among males or females. Also, because the doses were so low, there was no evidence of any effect on the number of stillbirths, adverse pregnancy outcomes, delivery complications or overall health of children. A modest but steady increase in reported congenital malformations in both contaminated and uncontaminated areas of Belarus appears related to better reporting, not radiation.

Did the trauma of rapid relocation cause persistent psychological or mental health problems?

Stress symptoms, depression, anxiety and medically unexplained physical symptoms have been reported, including self-perceived poor health. The designation of the affected population as “victims” rather than “survivors” has led them to perceive themselves as helpless, weak and lacking control over their future. This, in turn, has led either to over cautious behavior and exaggerated health concerns, or to reckless conduct,



such as consumption of mushrooms, berries and game from areas still designated as highly contaminated, overuse of alcohol and tobacco, and unprotected promiscuous sexual activity.

What was the environmental impact?

Ecosystems affected by Chernobyl have been studied and monitored extensively for the past two decades. Major releases of radionuclides continued for ten days and contaminated more than 200,000 square kilometres of Europe. The extent of deposition varied depending on whether it was raining when contaminated air masses passed.

Most of the strontium and plutonium isotopes were deposited within 100 kilometres of the damaged reactor. Radioactive iodine, of great concern after the accident, has a short half-life, and has now decayed away. Strontium and caesium, with a longer half-life of 30 years, persist and will remain a concern for decades to come. Although plutonium isotopes and americium 241 will persist perhaps for thousands of years, their contribution to human exposure is low.

What is the scope of urban contamination?

Open surfaces, such as roads, lawns and roofs, were most heavily contaminated. Residents of Pripjat, the city nearest to Chernobyl, were quickly evacuated, reducing their potential exposure to radioactive materials. Wind, rain and human activity has reduced surface contamination, but led to secondary contamination of sewage and sludge systems. Radiation in air above settled areas returned to background levels, though levels remain higher where soils have remained undisturbed.

How contaminated are agricultural areas?

Weathering, physical decay, migration of radionuclides down the soil and reductions in bioavailability have led to a significant reduction in the transfer of radionuclides to plants and animals. Radioactive iodine, rapidly absorbed from grasses and animal feed into milk, was an early concern and elevated levels were seen in some parts of the former Soviet Union and Southern

Europe, but, given the nuclide's short half life, this concern abated quickly. Currently and for the long term, radiocaesium, present in milk, meat and some plant foods, remains the most significant concern for internal human exposure, but, with the exception of a few areas, concentrations fall within safe levels.

What is the extent of forest contamination?

Following the accident, animals and vegetation in forest and mountain areas had high absorption of radiocaesium, with persistent high levels in mushrooms, berries and game. Because exposure from agricultural products has declined, the relative importance of exposure from forest products has increased and will only decline as radioactive materials migrate downward into the soil and slowly decay. The high transfer of radiocaesium from lichen to reindeer meat to humans was seen in the Arctic and sub-Arctic areas, with high contamination of reindeer meat in Finland, Norway, Russia, and Sweden. The concerned governments imposed some restrictions on hunting, including scheduling hunting season when animals have lower meat contamination.

How contaminated are the aquatic systems?

Contamination of surface waters throughout much of Europe declined quickly through dilution, physical decay, and absorption of radionuclides in bed sediments and catchment soils. Because of bioaccumulation in the aquatic food chain, though, elevated concentrations of radiocaesium were found in fish from lakes as far away as Germany and Scandinavia. Comparable levels of radiostrontium, which concentrates in fish bone, not in muscle, were not significant for humans. Levels in fish and waters are currently low, except in areas with "closed" lakes with no outflowing streams. In those lakes, levels of radiocaesium in fish will remain high for decades and, therefore, restrictions on fishing there should be maintained.

What environmental countermeasures and remediation have been taken?

The most effective early agricultural countermeasure was removing contaminated

pasture grasses from animal diets and monitoring milk for radiation levels. Treatment of land for fodder crops, clean feeding and use of Cs-binders (that prevented the transfer of radiocaesium from fodder to milk) led to large reductions in contamination and permitted agriculture to continue, though some increase in radionuclide content of plant and animal products has been measured since the mid-1990s when economic problems forced a cutback in treatments. Some agricultural lands in the three countries have been taken out of use until remediation is undertaken.

A number of measures applied to forests in affected countries and in Scandinavia have reduced human exposure, including restrictions on access to forest areas, on harvesting of food products such as game, berries and mushrooms, and on the public collection of firewood, along with changes in hunting to avoid consumption of game meat where seasonal levels of radiocaesium may be high. Low income levels in some areas cause local residents to disregard these rules.

What were radiation-induced effects on plants and animals?

Increased mortality of coniferous plants, soil invertebrates and mammals and reproductive losses in plants and animals were seen in high exposure areas up to a distance of 20-30 kilometres. Outside that zone, no acute radiation-induced effects have been reported. With reductions of exposure levels, biological populations have been recovering, though the genetic effects of radiation were seen in both somatic and germ cells of plants and animals. Prohibiting agricultural and industrial activities in the exclusion zone permitted many plant and animal populations to expand and created, paradoxically, "a unique sanctuary for biodiversity."

Does dismantlement of the Shelter and management of radioactive waste pose further environmental problems?

The protective shelter was erected quickly, which led to some imperfections in the shelter itself and did not permit gathering complete data on the stability of the damaged unit. Also, some structural parts of the

shelter have corroded in the past two decades. The main potential hazard posed by the shelter is the possible collapse of its top structures and the release of radioactive dust.

Strengthening those unstable structures has been performed recently, and construction of a New Safe Confinement covering the existing shelter that should serve for more than 100 years, starts in the near future. The new cover will allow dismantlement of the current shelter, removal of the radioactive fuel mass from the damaged unit and, eventually, decommissioning of the damaged reactor.

A comprehensive strategy still has to be developed for dealing with the high level and long-lived radioactive waste from past remediation activities. Much of this waste was placed in temporary storage in trenches and landfills that do not meet current waste safety requirements.

What was the economic cost?

Because of policies in place at the time of the explosion and the inflation and economic disruptions that followed the break-up of the Soviet Union, precise costs have been impossible to calculate. A variety of estimates from the 1990s placed the costs over two decades at hundreds of billions of dollars. These costs included direct damage, expenditures related to recovery and mitigation, resettlement of people, social protection and health care for the affected population, research on environment, health and the production of clean food, radiation monitoring, as well as indirect losses due to removing agricultural lands and forests from use and the closing of agriculture and industrial facilities, and such additional costs as cancellation of the nuclear power program in Belarus and the additional costs of energy from the loss of power from Chernobyl. The costs have created a huge drain on the budgets of the three countries involved.

What were the main consequences for the local economy?

Agriculture was hardest hit, with 784,320 hectares taken from production. Timber production was halted in 694,200 hectares of forest. Remediation made "clean food" production possible in many areas but led to

higher costs in the form of fertilizers, additives and special cultivation processes. Even where farming is safe, the stigma associated with Chernobyl caused marketing problems and led to falling revenues, declining production and the closure of some facilities. Combined with disruptions due to the collapse of the Soviet Union, recession, and new market mechanisms, the region's economy suffered, resulting in lower living standards, unemployment and increased poverty. All agricultural areas, whether affected by radiation or not, proved vulnerable.

Poverty is especially acute in affected areas. Wages for agricultural workers tend to be low and employment outside of agriculture is limited. Many skilled and educated workers, especially younger workers, left the region. Also, the business environment discourages entrepreneurial ventures and private investment is low.

What impact did Chernobyl and the aftermath have on local communities?

More than 350,000 people have been relocated away from the most severely contaminated areas, 116,000 of them immediately after the accident. Even when people were compensated for losses, given free houses and a choice of resettlement location, the experience was traumatic and left many with no employment and a belief that they have no place in society. Surveys show that those who remained or returned to their homes coped better with the aftermath than those who were resettled. Tensions between new and old residents of resettlement villages also contributed to the ostracism felt by the newcomers. The demographic structure of the affected areas became skewed since many skilled, educated and entrepreneurial workers, often younger, left the areas leaving behind an older population with few of the skills needed for economic recovery.

The older population has meant that deaths exceed births, which reinforces the perception that these areas are dangerous places to live. Even when pay is high, schools, hospitals and other essential public services are short of qualified specialists.

What has been the impact on individuals?

According to the Forum's report on health, "the mental health impact of Chernobyl is the largest public health problem unleashed by the accident to date." People in the affected areas report negative assessments of their health and well-being, coupled with an exaggerated sense of the danger to their health from radiation exposure and a belief in a shorter life expectancy. Anxiety over the health effects of radiation shows no signs of diminishing and may even be spreading. Life expectancy has been declining across the former Soviet Union, due to cardiovascular disease, injuries and poisoning, and not radiation-related illness.

How have governments responded?

The resettlement and rehabilitation programs launched in Soviet conditions proved unsustainable after 1991 and funding for projects declined, leaving many projects unfinished and abandoned and many of the promised benefits underfunded. Also, benefits were offered to broad categories of "Chernobyl victims" that expanded to seven million now receiving or eligible for pensions, special allowances and health benefits, including free holidays and guaranteed allowances. Chernobyl benefits deprive other areas of public spending of resources, but scaling down benefits or targeting only high-risk groups is unpopular and presents political problems.

Given significant reduction of radiation levels during past twenty years, governments need to revisit the classification of contaminated zones. Many areas previously considered to be at risk are in fact safe for habitation and cultivation. Current delineations are far more restrictive than demonstrated radiation levels can justify.

The report identifies the need to sharpen priorities and streamline the programmes to target the most needy, noting that reallocating resources is likely to face "strong resistance from vested interests". One suggestion calls for a "buy out" of the entitlement to benefits in return for lump sum start-up financing for small businesses.



Indian Medical Association

Aao Gaon Chalen – IMA launches rural health plan

The Indian Medical Association (IMA) has undertaken an ambitious project “Aao gaon chalen” to shoulder the responsibility of providing positive health to every village in the country. The project will enable medical professionals to develop a vision and undertake innovations to improve rural health as envisaged in the national health policy.

The project which was launched off by Union Textile Minister Shankarsingh Vaghela at a village in Mehsana District entails a new scheme where IMA members will adopt a most vulnerable village according to prevalent major health problems.

The first step of its kind by the IMA, in the world, aims to target the 75% of the population which lives in the villages and also the popular myth in the public mind that doctors do not want to serve in rural areas. “Under this project each state unit of IMA will adopt 5 villages to begin with and undertake promotive health camps free of cost. The idea is to slowly make the existing healthcare available in every nook and corner of India”, said Dr. Kedan Desai, Chairman of the project.

The major emphasis will be on the control of epidemics and endemics, maternal and child health, geriatric care and adolescent health. “The IMA with its reach and dedication can make a big difference to the rural health scenario and this step from the medical fraternity will amount to a giant leap for the whole country”, Dr. Desai added.

“Emphasis will be laid on increasing orientation of health professionals towards the needs of rural population and provide primary care to them on a regular basis at their doorsteps”. Said Dr. Vinay Aggarwal, Secretary General, IMA.

The Soul of India lies in the villages...

Almost 75% of our population lives in villages but 75% of the country's health infrastructure is concentrated in cities. Most of the villages still fall short of health man-

power and infrastructure. The popular myth in the public mind is that doctors do not want to serve in rural areas.

The villages are unaware of the progress the medical profession has made and the inherent potential of qualified and dedicated doctor. They accept all diseases as part of their destiny. This, coupled with poverty-generated helplessness, adds to considerable morbidity and mortality. IMA with its various branches can take the lead in this direction.

Aao Ganon Chalen: Advent of a new era in rural health

IMA has undertaken this ambitious project to shoulder the responsibility of the provision of positive health to every village in the country. The project will enable medical professionals to develop a vision and undertake innovations to improve rural health as envisaged in the national health policy. Under the project, the members of IMA will be adopting the most vulnerable villages according to prevalent major public health problems. Major emphasis will be on the control of epidemics and endemics, maternal and child health, geriatric care and adolescent health.

What the project will achieve

- Orientation of professionals to village health
- Health awareness generation
- Provision and strengthening of promotive, preventive, curative and rehabilitative services
- Community involvement and participation in health care
- Public / private partnership in rural health care
- Co-ordination to strengthen referral linkages in the health care delivery system
- An improved image of IMA and the medical profession

Proposed activities

Health awareness activities

- Community health meetings
- Debates, posters and painting competitions in schools
- Puppets shows and magic shows
- Nukkad natak

Medical and surgical facilities

- Health camps providing multi-disciplinary care
- Special clinics for expectant mothers, children and elderly people
- Cataract / sterilization camps
- Immunization services
- Adolescent guidance and counseling services
- Family welfare services
- Cancer detection clinics

Rehabilitation services

- Distribution of wheel chairs, artificial limbs and other required services to handicapped people. ...amongst a host of other welfare activities.

<http://www.imanational.com/AaoGaon.asp>
accessed on 28/2/06

Physicians speak out on prisoner forced feeding – the American Medical Association speaks out.

As reported in American Medical News, the American Medical Association (AMA) has given publicity to its condemnation of physician participation in prisoners' forced feeding. It stresses, in an editorial written by Dr. Duane M Cady (chair of AMA's Board of Trustees) passed to news outlets, the AMA's endorsement of the WMA Declaration of Tokyo, quoting “where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired, rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially”. The AMA has met the Department of Defence over the past years raising its concerns, “and to offer to provide them with relevant policies and expertise, with the goal of ensuring that US policies in detainee treatment comport with ethical standards of medicine...”

The U.S. government defends its policy “We're trying to preserve life” a spokeswoman of the Defence Dept. is reported as saying. (*American Medical News 49, 13*)

The AMA House of Delegates has asked the Council on Ethical and Judicial Affairs to develop clear guidelines for physician participation in prisoner and detainee interrogations. (*American Medical News 48, 13*)

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