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- WMA Secretary General's Report to 185th Council
- The History of the Placebo

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Emiliano Di Cavalcanti, Maternidade -
"Motherhood", 1942, Oil Painting.

Emiliano Augusto Cavalcanti de Albuquerque Melo (1897 – 1976), known as Di Cavalcanti, was a Brazilian painter. He in 1926 adopted the national issue as the main theme of his work, specially the social problems. As a defender of figurative art, in 1942 he paints the picture Motherhood. At that time he also positions himself against the abstrac art that is starting to grow in Brazil.

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Secretary General's Report (October 2009–April 2010) to 185th Council

Policy & Advocacy

1.1 Multi Drug Resistant Tuberculosis Project

During the third phase of the **Lilly MDR-TB partnership** we finalised the **TB refresher course for physicians** and launched it during the GA 2009 in Delhi. The purpose of the TB refresher course is to set the baseline for basic knowledge on the subject, with the existing Multi-Drug Resistant TB course providing more advanced knowledge. However, because the refresher course was developed *after* the more advanced MDR-TB course, the layout of the MDR-TB required some adaptation to conform more closely with the layout of the refresher course. The TB refresher course was nominated by the United States Centre of Disease Control (CDC) as educational highlight. Over time, both courses will be translated into different languages. The Georgian Medical Association kindly offered to translate the TB refresher course.

To increase the outreach of our TB and MDR TB educational activities WMA held **train-the-trainer courses in TB and MDR-TB** based on the 2 existing training materials in South Africa and India. In April of this year, WMA and the Chinese Medical Association (ChMA) organised a third workshop in Hangshuang with the help of the Chinese Thoracic Society. Thirty leaders of TB hospitals from all over China took part in the training and will pass on their knowledge to their colleagues. In China, TB hospitals and CDC Centres are the only facilities that treat TB patients. The government and the provincial health department honoured the activities of WMA and ChMA.

The WHO is in the final process of developing a **policy on ethics in the TB setting**, and will launch the policy during a conference and workshop in Athens just prior to the 185th Council Session in Evian. The WMA was invited to address the issues in the policy related to health professionals and Dr. Jeff Blackmer from the Canadian Medical Association kindly offered to draft





this part of the policy, which addresses the duty to treat, risks, and obligations to patients. It also elaborates obligations related to facilities, patient support, training and supervision as well as capacity building.

While there are many TB programmes and activities taking place in English speaking parts of Africa, there is far less involvement by French speaking areas in international

humanitarian activities related to TB. During the Lilly MDR-TB Partnership meeting in Mexico, a workshop was organized to increase activities in this part of the world and connect the partnership members with the national governments, WHO and local NGOs. During the meeting WMA, together with the International Council of Nurses (ICN), International Hospital Federation (IHF) and International Committee of the Red Cross (ICRC) decided to continue their series of **inter-professional workshops on health care worker safety and infection control in the context of drug resistant TB**. A third workshop will be organised in Benin in June 2010, involving health professionals from Burkina Faso, Mali, and Senegal. Through this workshop we hope to engage our francophone African Members more and try to connect with organisations in other countries.

1.2 Tobacco project

The WMA joined the implementation process of the **WHO Framework Convention on Tobacco Control (FCTC)** <http://www.who.int/tobacco/framework/en>. The FCTC is an international treaty that condemns tobacco as an addictive substance, imposes bans on advertising and promotion of tobacco, and reaffirms the right of all people to the highest standard of health. The first international treaty negotiated under the auspices of the WHO, the FCTC entered into force in 2005. It is the most widely embraced treaty in UN history, with 168 signatories and 154 ratifications to date.

WHO FCTC held a workshop on Article 14: "Measures Concerning Tobacco De-

pendence and Cessation" in New Zealand in February 2009 to finalise the draft article for the next Conference of the Parties in November 2010. The New Zealand Medical Organisation participated in this meeting on behalf of WMA. The working group stated again how important physicians are in the cessation, support and the education of patients. Therefore, countries should emphasize smoke free health care settings in which physicians and other health professionals can serve as role models.

1.3 Health Workforce

WMA continues its close involvement in the **Positive Practice Environment Campaign (PPE)**. This global 5-year campaign - spearheaded by World Health Professions Alliance members together with the World Confederation for Physical Therapy and the International Hospital Federation - aims to ensure high-quality workplaces for quality care. The first activities on a country level started in Uganda, Morocco, Zambia and Taiwan. A national PPE secretariat was set up to link the national member organisations and develop cooperation with the government. National researchers began conducting studies about the working conditions of health professionals. The first issue of the newsletter reporting the various activities of the campaign was circulated in February. A workshop bringing together national/local health professionals took place in Zambia last March, with others to follow in Morocco, Uganda and Taiwan. In April, a website was launched and the PPE Campaign was highlighted during the Geneva Health Forum 2010, on the occasion of the parallel session on retention strategies for health professionals.

The Dutch Royal Tropical Institute organised a conference on **Human Research for Health** in Amsterdam in March 2010. Dr. Julia Seyer was invited to present the PPE campaign. During the conference the advantages and disadvantages of decentralisation of health care and health care educa-

tion were discussed and a special focus was placed on how to assure quality of care and education. Another discussion point was the financing of national health care systems. None of the international and multilateral donors report how much money from vertical programmes is allocated to human resources in health and to education. Money that is not reported money cannot be monitored and managed.

The participants of the **Seminar in Reykjavik on Human Resources for Health and the Future of Health Care** last year defined ideas to facilitate WMA policy development in this area. The WMA Advocacy Working Group has considered the opportunity to collect best practices. Task shifting remains as a monitoring item of the Working Group.

In March 2009, WMA was invited to take part in the planning process of the next **Conference on Workplace Violence in the Health Sector**, which is scheduled to take place from 27-29 October, 2010 in Amsterdam. The event is supported by the Global Health Workforce Alliance (GHWA), WHO, International Labour Organisation (ILO), the International Council of Nurses (ICN), Public Services International (PSI) and other relevant health organizations.

WHO is in the final stage of the development of **guidelines on retention strategies for health professionals in rural areas**. The

objective is to attract and retain health care professionals in rural areas. The guidelines will be based on three pillars: educational and regulatory incentives, monetary incentives and management, environment and social support. Decision makers on the national and local levels and health facilities should receive evidence on the impact and effectiveness of various retention strategies that have been tried and tested. In November 2009 WHO, together with the **Asian-Pacific Action Alliance on Human resources for Health (AAAH)**, held a conference to discuss with governments in Asia this topic in general and, in particular, how the guidelines need to be adapted to be better accepted by governments.

WMA participates as a member of steering groups in two projects commissioned by the European Union on the **Mobility and Migration of Health Professionals**. One project is led by the European Health Care Management Association and the other by the Research Institute of the German Hartmann Bund, a private physicians organization. The general objective of the research projects is to assess the current trends in mobility and migration of health professionals to, from, and within the European Union, including their reasons for moving. Research will also be conducted in non-European sending and receiving countries, but the focus lies within the EU. This research project is a medium-scale collaborative project with a goal of facilitating informed policy decisions on health systems by developing a scientific evidence base related to the impact of mobility of health professionals.



In January 2011 the Global Health Workforce Alliance will organise the **2nd Global Forum on Human Resources in Health (HRH) in Thailand**. WMA is part of the thematic focus committee for this event. In an initial meeting, two main themes were proposed: improving quantity and quality of health workforce for equitable access to primary health care within a robust health system and financing HRH in the light of the global financial crisis.

1.4 Counterfeit Medical Products

Counterfeit medicines are manufactured which are below established standards of safety, quality and efficacy. They are deliberately and fraudulently mislabeled with respect to identity and/or source. Counterfeiting can apply to both brand name and generic products and counterfeit medicines may include products with the correct ingredients but fake packaging, with the

wrong ingredients, without active ingredients, or with insufficient active ingredients. Counterfeit medicinal products threaten patient safety, endanger public health by increasing the risk of antimicrobial resistance, and undermine patients' trust in health professionals and health systems. The involvement of health professions is crucial to combating counterfeit medical products.

WMA and the members of the WHPA developed the **"be aware" toolkit** for health professionals and patients to increase awareness of this topic and provide practical advice for actions to take in case of a suspected counterfeit medical product. WHPA is stepping up its activities on counterfeit medical issues with an educational grant of Pfizer Inc. and Eli Lilly. The toolkit will be updated based on the input of the national member organisations of the alliance. A **mission and NGO briefing** was organised in collaboration with WHO and IMPACT in March and a workshop in either Africa

or Asia is being planned. Here we would like to ask our members to inform us of possible national events where we could link in a combating counterfeit medical products event. WHPA developed a statement on counterfeit medical products, setting principles for procurement, distribution and reporting of counterfeit medical products.

1.5 Alcohol

In May 2008, the World Health Assembly adopted a resolution requiring WHO to intensify its work to curb harmful use of alcohol and to develop a **global strategy** for this purpose. The resolution requests the WHO Director-General to consult with intergovernmental organizations, health professionals, nongovernmental organizations, and economic operators regarding ways in which they can contribute to reducing the harmful use of alcohol. In January 2010, the WHO Executive Board 126th Session passed the resolution on "Strategies to reduce the harmful use of alcohol" which recommends to the 63rd World Health Assembly (May 2010) the adoption of a resolution endorsing the global strategy.

As an implementation measure of the **WMA Statement on Reducing the Global Impact of Alcohol on Health and Society**, the WMA secretariat monitors the drafting process of the WHO strategy, informs WMA members on a regular basis of developments in this area, and has developed contacts with relevant WHO officials and civil society organisations to collaborate in the process. Such activities include:

- On 23 October 2008, the WMA Advocacy Advisor,



Ms. Clarisse Delorme, moderated an **NGO briefing on reducing the global harm caused by alcohol**, organised by GAPA (Global Alcohol Policy Alliance). The objectives of the briefing were to understand the WHO process related to the strategy, to begin discussions on substantive and political proposals to promote an effective, evidence-based global strategy, and, finally, to develop further working relations between civil society actors involved in this area.

- On 24 November 2008, Dr. Otmar Kloiber and Ms. Delorme, participated in the **WHO roundtable meeting with representatives of NGOs and health professionals on ways they could contribute to reducing harmful use of alcohol**. This was an opportunity to raise, amongst others issues, WMA's desire that medical associations and individual physicians be fully involved in the WHO strategy on alcohol.
- As a follow-up to this, Ms. Delorme, together with George Hacker from GAPA, met with several Permanent Representatives (Denmark, Sweden, Norway, Chile, South Africa, US, New Zealand) in Geneva to discuss countries' positions and involvement within the WHO regional consultative process on the draft strategy.
- During the 126th Session of WHO Executive Board, Ms. Delorme made a **public statement** on behalf of the World Health Professional Alliance supporting the strategy and recommending more





and analyse their social, economic, behavioral, and political determinants; (ii) reduce the level of exposure of individuals and populations to the common modifiable risk factors; and (iii) strengthen health care for people with NCDs by developing standards and guidelines for cost-effective interventions and by orienting health systems to respond more effectively in managing NCDs. To increase the awareness and the commitment of governments and NGOs, WHO organized the **First NCDnet Global Forum in Geneva** in February 2010.

1.7 Patient safety

WHO stepped up its commitment on patient safety and defined it as a major global priority in health care. To deliver safe health care, clinicians require training in the discipline of patient safety, which includes an understanding

of the nature of medical error; how clinicians themselves can work in ways that reduce the risk of harm to patients; techniques for learning from errors; and how clinicians can harness quality improvement methods to improve patient safety in their own organizations. WHO responded to this need by publishing the **Patient Safety Curriculum Guide** for medical schools, and is now undertaking a major consultation exercise to develop a Multi-professional Patient Safety Curriculum Guide. WMA is member of the reviewing committee for the multi-professional guidelines.

1.8 Health care systems

Primary health care

The WMA advocacy workgroup plans to develop an **advocacy**

brief on Primary Health Care, as a tool to influence decision-makers at the national and international level and for raising awareness on this matter.

Global Charter on Health Data

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

Relationship between Physicians and Commercial Enterprises

The International Federation of Pharmaceutical Manufacturers and Associations **IFPMA** invited Dr. Julia Seyer to present the revised **WMA Statement concerning the Relationship between Physicians and Commercial Enterprises** during their



attention to the pivotal role that health professionals can and do play in terms of education, advocacy and research.

- WMA sponsored an **alcohol policy briefing**, which took place on 20 April in Geneva during the Geneva Health Forum. The briefing was organised by GAPA and other relevant civil society actors.
- WMA members are encouraged to support the adoption of WHO draft strategy by the World Health Assembly in May 2010.

1.6 Public Health

In 2007 Governments requested WHO to prepare a Global Action Plan on **Non-Communicable diseases** (NCD), based on the Global Strategy that was amended at the WHA in the year 2000.

The Global Strategy Action Plan aims to: (i) map the emerging epidemics of NCDs

committee meeting in February this year. IFPMA would be pleased to start a dialogue again with WMA to exchange codes of conduct and share information and experiences.

1.9 Health and the environment

The **WMA Workgroup on Health and the Environment**, chaired by the Canadian Medical Association, was established in the summer of 2008. For 2009, the workgroup agreed to focus its attention on health and climate change in view of the global United Nations conference on this topic in Copenhagen in December 2009. For 2010, the workgroup decided to continue its advocacy work on climate change in the context of the UNFCCC process and also to develop a proposed policy paper on environmental degradation and the built environment.

Climate change

In January 2009, the workgroup produced a set of recommendations, which were approved by the 182nd Council session in May 2009. A **WMA conference on health and climate change took place on 1 September, 2009 in Copenhagen**, with a view to further development of WMA recommendations, based on the contributions from invited experts. Following further revision of the recommendations after this conference, the WMA resolution was approved by the Council at its pre-Assembly meeting and then adopted (as the **Delhi declaration**) by the 2009 General Assembly.

Immediately after the General Assembly, the WMA secretariat prepared an **advocacy kit** for its national member organisations. Based on the new WMA policy adopted, medical associations were invited to lobby relevant national decision-makers for a health perspective to be included in the final official conclusions of the **UN Climate Change Conference 2009 (COP15)** which took place in Copenhagen in December 2009.

Furthermore, the Danish Medical Association represented the WMA at the COP15 – as part of the delegation headed by the Health and Environment Alliance (HEAL) and Health Care Without Harm (HCWH). The delegation, composed of health leaders and representing a diversity of medical and public health organizations, emphasized the fact that climate change profoundly impacts on human health. The DMA acted on the basis of the WMA Delhi Declaration and in cooperation with other NGOs acting in the same area.

As a **follow-up to the COP15** (Bonn and Mexico conferences in 2010), the Workgroup on Health and the Environment has developed an **advocacy strategy for WMA**, with the aim of supporting members associations in lobbying their governments to place health at the core of international climate change debate and to increase the medical community's voice as an important stakeholder in climate discussions.

Mercury

Following the adoption by the 2008 General Assembly of the WMA Statement on Reducing the Global Burden of Mercury, WMA joined the **UNEP Global Mercury Partnership** in December 2008 in order to contribute to the partnership goal to protect human health and the global environment from the release of mercury and its compounds.

With the support of Health Care Without Harm, an information session on the **Mercury-Free Health Care initiative** was held during the General Assembly 2009. Health Care Without Harm¹ and the World Health Organization are co-leading this global initiative (partnership) to achieve virtual elimination of mercury-based ther-

mometers and sphygmomanometers over the next decade and substitute them with accurate, economically viable alternatives. Mr. A.K. Sengupta, National Professional Officer (Sustainable Development & Healthy Environment) from the WHO India Country Office presented activities undertaken in this area, with a focus on activities in India. This information session constituted concrete follow-up to the adoption of WMA Statement on Reducing the Global Burden of Mercury.

In early March, Ms. Clarisse Delorme met with representatives of the Mercury Partnership to explore stronger involvement of the WMA in UNEP's mercury initiatives. Options discussed included the opportunity to make health professionals more vocal in the context of the current drafting process of a global legally binding instrument on mercury. Another strategic approach for WMA would be to target manufacturers of products that contain mercury. WMA and its members could have an impact in reducing supply of these products through lobbying and awareness-raising actions.

Chemicals management

In December 2009, the WMA secretariat was approached by the Chemicals Branch of the United Nations Environment Programme (UNEP) in the context of the **development of a Strategic Approach to International Chemicals Management (SAICM)**. The SAICM, adopted in 2006, is a multi-sectoral and multi-stakeholder policy framework aimed at promoting the sound management of chemicals and hazardous waste in the context of sustainable development. In 2009, the International Conference on Chemicals Management requested the development of a strategy for **strengthening the engagement of the health sector in the implementation of the Strategic Approach**, in consultation with WHO. The SAICM secretariat is therefore willing to engage medical associations in the process.

1. Health Care Without Harm (HCWH): Global coalition of 473 organizations in more than 50 countries working to protect health by reducing pollution in the health care sector – <http://www.noharm.org>.

Based on this resolution, the SAICM secretariat prepared a questionnaire for the health professionals' community to evaluate the engagement of the health sector in the management of chemicals. WMA secretariat circulated the questionnaire to WMA members. A summary of responses obtained were compiled and made available on SAICM website.

A consultative meeting was then organised on the **4-5 February in Ljubljana, Slovenia**. Dr. Dong Chun Shin, from the Korean Medical Association, and member of WMA workgroup on Health and Environment, represented WMA at the meeting.

1.10 Human Rights

Right to health

The WMA was actively involved in the preparation of the joint Seminar on the **"Right to Health as a Bridge to Peace in the Middle East"**, which took place on 27-30 October 2009 in Turkey. The seminar was organised by the International Federation of Health and Human Rights Organizations (IFHHRO), the Norwegian Medi-

cal Association (NMA), the Human Rights Foundation of Turkey (HRFT), the Turkish Medical Association (TMA) and the WMA. The objectives of the meeting were to discuss what role the medical profession can play in securing equal access to health care for the population and to facilitate communication among health professionals in the participating nations.

During the reporting period, the WMA secretariat maintained contact with Anand Grover, the **UN Special Rapporteur on Health** to increase the role of health professionals in the promotion of the human right to the highest attainable standard of health.

Physicians & patients in distress worldwide

In November 2009, the WMA secretariat sent to Iranian President, Mahmoud Ahmadinejad, and to the Iranian Minister of Health, the WMA Resolution adopted in Delhi supporting **the rights of patients and physicians in the Islamic Republic of Iran**. In the accompanying letter signed by WMA President Dr. Dana Hanson, the Iranian authorities were asked to take urgent actions in conformity with Medical Ethics Principles

and with International Human Rights Law principles.

During the same period, the WMA secretariat sent the **WMA Resolution on Legislation against Abortion in Nicaragua** to the President of The Republic of Nicaragua, the Minister of Health, and the President of the Parliament. In February, the WMA secretariat was made aware by Amnesty International of a case in Nicaragua in which a woman with metastatic cancer was reported to be denied adequate treatment, as she was 10 weeks pregnant. Doctors felt unable to act because of the law prohibiting abortion, although the woman gave her consent for the cancer treatment. A second letter was therefore sent to the Minister of Health reiterating the conclusions of the WMA resolution on this topic and reaffirming that health of the patient should be the priority of physicians. The letter also expresses serious concerns that doctors might be unable to proceed with treatment of their patients because of fear that the anti-abortion law could be used to prosecute them.

Prevention of torture

In November 2009, Ms. Clarisse Delorme attended as an elected member the council session of the **International Rehabilitation Council for Torture Victims (IRCT)**, which took place in Nairobi. During that session, she was elected member of the Executive Committee and therefore attended the Excom meeting in February in Copenhagen. It is hoped that this new position will allow WMA to develop more actively its work on torture prevention. It should also allow the IRCT to integrate more systematically the perspective of health professionals in its activities.

On the 9th of March 2010, the WMA and IRCT organised a **joint side-event at the occasion of the Human Rights Council, 13th Session** entitled **"Exploring sustainable ways to document torture – The role of health professionals"**. The event was



moderated by Manfred Nowak, UN Special Rapporteur on torture. Dr. Poul Jaszczak from the Danish Medical Association and members of the Danish Rehabilitation Council, presented WMA's policies and highlighted the role that physicians and medical associations can play in torture prevention. Other speakers included representatives from the Turkish Medical Association, the UN Subcommittee on the prevention of torture and the Association for the Prevention of Torture (APT). A press release "Physicians call for effective measure to document torture allegations" was issued on this occasion.

Women and health

In October 2009 in Delhi, the **WMA workgroup on violence against women and children (VAWC)** met for the first time. The workgroup is composed of the Ethiopian Medical Association (chair), the Canadian Medical Association, the British Medical Association, the American Medical Association, the Israel Medical Association, the Indian Medical Association, and the ICRC. Dr. Barbara Roberts participates in the WG activities as an advisor. During the reporting period, the group worked on a draft resolution on violence against women and girls as well as on a proposed revision of WMA resolution on family violence.

On the 5th of February, the WMA and the International Federation of Gynaecology and Obstetrics (FIGO) issued a joint press release to mark the **International Day of Zero Tolerance to Female Genital Mutilation (FGM)** on February 6. The two organisations strongly condemned the medicalisation of female genital mutilation and underlined the unique role that health professionals can play in working towards the elimination of FGM to ensure that girls and women enjoy the full extent of human rights and freedom.

Early March, the WMA was consulted on a draft **Global strategy against health care**

providers performing female genital mutilation prepared by WHO, UNICEF and UNFPA.

This strategy is part of the implementation process of the WHO resolution on the eradication of FGM adopted in 2008. WMA workgroup on violence against women and children made comments on the draft that were then forwarded to the WHO secretariat in charge.



1.11 Ethics

At the General Assembly 2008, the Declaration of Helsinki was amended. At that time the debate had a strong focus on the **use of placebo in medical research**. If a proven effective intervention exists, the Declaration of Helsinki allows the use of placebo controls, though only in very limited circumstances. However this opening raised some concerns. In order to analyze the use of placebos in medical research a **WMA working group** was installed. The working group invited a number of renowned experts to discuss the issue at a **conference held in Sao Paulo, Brazil in February this year** with the help of the Brazilian Medical Association.



During the conference it became clear that the current version of the Declaration addresses the issue of placebo controls quite well. However, recent research on placebo use provides a much broader and complex view on the role of placebos in medical research than we had before.

Furthermore it was acknowledged that the same ethical questions might arise with any control group that receives a treatment less than the "best current proven intervention" (which is currently required by the Declaration). The overriding question of the placebo controversy now appears to be: "To what ex-

tent and under which circumstances is it ethically acceptable to provide a control group with an intervention less effective than the "best current proven one" in a clinical trial. This includes a placebo control as well as a control with a second standard or no treatment. This problem is aggravated by the fact that in many circumstances we do not know for sure which is the "best proven" treatment.

This work has been scientifically supported by the WMA Cooperating Centre, Institute of Ethics and History of Medicine at the University of Tübingen, Germany.

1.12 Speaking book

The WMA launched the speaking book on clinical trials during the General Assembly in Seoul 2008. This project was a collaborative effort with the South African Medical Association, the SADAG (South African Depression & Anxiety Group)

and the Steve Biko Centre for Bioethics in Johannesburg and the publisher "Books of Hope". The speaking book on clinical trials in English-Hindi & Telugu was launched at the 2009 General Assembly in India. The purpose of the project is to provide proper information on clinical research to illiterate populations so that they can make informed decisions about participation. The project was made possible by an unrestricted educational grant provided by Pfizer, Inc.

In March 2010, Books of Hope, with the support of Pfizer, the Chinese Centre of Disease Control, the Chinese Medical Doctors Association, the Chinese Association on Tobacco Control and the World Medical Association presented a speaking book on the dangers of smoking. It targets a low literacy community, which has experienced significant increases in smoking rates over the last decades, yet cannot benefit from much of the written informational products on tobacco and smoking dangers and cessation.

Each of the impressively illustrated 16 page books, with easy-to-read text and/or voice on command, is expected to be received by around 27 people as research has shown. Thus the first 5000 books have the potential to impact 50,000 to 100,000 people. Like

the other speaking books, the newest one will also be accompanied by research analyzing its impact on health literacy.

1.13 Caring Physicians of the World (CPW) Initiative (Leadership Course)

The CPW Project began with the Caring Physicians of the World book, published in October 2005 in English and in Spanish in March 2007. Regional conferences were held in Latin America, Asia-Pacific and Africa regions. The CPW Project was extended to include a leadership course organized by the INSEAD Business School in Fontainebleau, France, in December 2007, in which 32 medical leaders from a wide range of countries participated. The second Leadership Course was held at the same place in December 2008 for one-week with 30 participants, also with continued successful results and positive feedback. The third Leadership Course at the INSEAD Business School was successfully held in Singapore, 8–13 February 2010, with 29 participants. The curriculum includes training in decision-making, policy work, negotiating and coalition building, intercultural relations and media relations. The courses were made possible by an unrestricted educational grant provided by Pfizer, Inc.

This work has been supported by the WMA Cooperating Centre at the Centre for Global Health and Medical Diplomacy in the University of North Florida.

1.14 Medical and Health Policy Development

In the past years the Centre for the Study of International Medical Policies and Practices, George-Mason-University, which is one of our Cooperating Centres, studied the need for educational support in the field of policy creation. The surveys performed with cooperation of the World Medical Association found a demand for education and exchange. Finally the Centre invited WMA to participate in the creation of scientific platform for the international exchange on Medical and Health policy development.

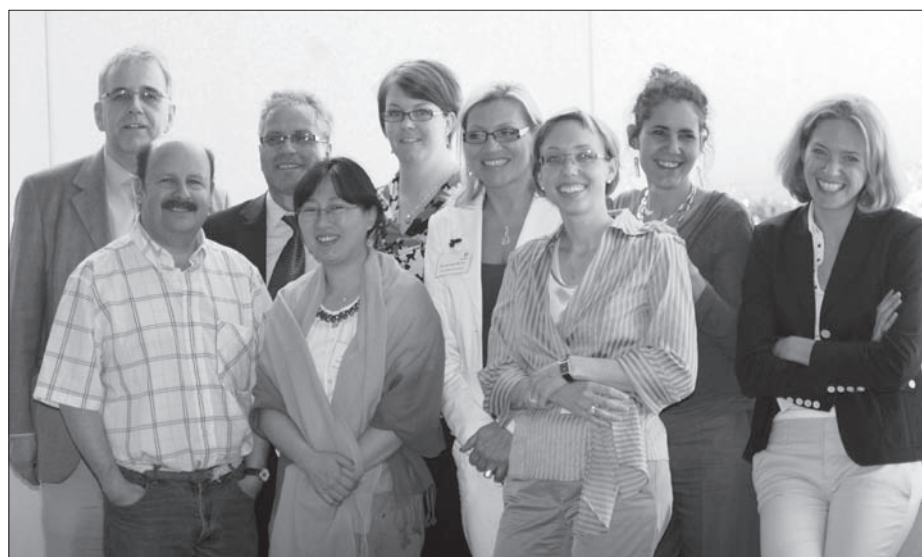
In the fall of 2009 the first issue of a scientific journal the World Medical & Health Policy was published by Berkeley Electronic Press as an online journal. It is accessible under <http://www.psocommons.org/wmhj>.

External Relations

2.1 World Health Professions Alliance

After 10 years of successful collaboration, the WHPA celebrates its anniversary at the Leadership Forum in Geneva in May in 2010. The four main health professions – physicians, nurses, pharmacists and dentists – have shown that working in collaboration instead of along parallel tracks, benefits the patient and the health care system. WHPA amplifies the policy and advocacy messages of member organisations and facilitates coherence and synergies among the messages of national member organisations.

The World Confederation of Physical Therapies WCPT was a strong and reliable partner of WHPA for several years. We are proud to announce that WCPT joined the WHPA in May.



2.3 Administration

In October 2009, the WMA re-launched its website which now provides the platform for cooperation with the members of WMA, allows online payments for meetings, books and associate membership dues, and, most of all, facilitates more timely presentation of content on the public website.

3. WMA Governance

Membership

During the reporting period, the following association applied for full membership to the WMA:

- Associação Médica de Moçambique (AMMo)

3.2 Medical organizations in Arabic Countries

The Secretariat is continuously reaching out to Medical Associations in Arabic countries.

We were pleased to have participation from Egypt, Iraq and Palestine at our conference **"Right to Health as a Bridge to Peace in the Middle East"**. We offered to visit the medical associations in Syria, Jordan and Egypt and we hope that our offer will be accepted during the year.

On the initiative of the German and Norwegian Medical Association we are exploring the possibility of holding a conference or event planned and co-organized with the Emirates Medical Association and possibly the Arab Medical Union. The current idea is to hold this event early in 2011, hopefully in Dubai. We are also exploring the possibility of holding the fourth CPW Leadership Course in the United Arab Emirates as INSEAD has its third campus in Abu Dhabi.

Acknowledgment

The Secretariat wishes to record its appreciation to member associations and inter-

national organizations for their interest in, and cooperation with, the World Medical Association and its Council during the past year. We thank all those who have represented the WMA at various meetings and gratefully acknowledge the collaboration and guidance received from the officers, as well as the Association's editors, its legal, public relations and financial advisors, and its officials.

Dr. Alan J. Rowe

The report on the 185th Council meeting will appear in the next issue WMJ 56.4.

The photographs above are those of participants at the 165th Council meeting.

Norwegian Doctor to Head WMA's Ethics Committee

Dr. Torunn Janbu, president of the Norwegian Medical Association, has been elected chair of the World Medical Association's medical ethics committee.

She was elected unopposed at the WMA's Council meeting in Evian, France in May and succeeds Dr. Jens Jensen, from Denmark, who has taken up a post with the Danish health service as medical director and CEO in one of Denmark's five healthcare regions. Dr. Jensen had been chair of the ethics committee for less than a year.

Dr. Janbu has been president of the Norwegian Medical Association since 2005 when she became the first female president in the 120 year history of the Association. Previously she was chair of the Oslo Medical As-

sociation and vice president of the Norwegian Medical Association.

She is chief surgeon and specialist in general surgery and orthopaedic surgery, presently on leave from her job at Oslo University Hospital while working full time as president. She took her medical degree at the University of Oslo in 1979.

Since taking over as President of the Norwegian Medical Association, Dr. Janbu, has been widely praised for the way she has handled several difficult issues.

She has chaired the Ethics and Professional Codes subcommittee in CPME (Comité Permanent des Médecins Européens) until it was abolished recently during the reorganisation of CPME.



Dr. Janbu emphasizes the important role of the WMA in medical ethics worldwide, and especially mentions the Declaration of Helsinki. She also said that health inequalities could be an important topic for future work in the committee.

Dr. Janbu was for several years an aerobic instructor in Oslo. She is married to politician and physician Kjell Maartmann-Moe.

Brazilian Medical Association – SOS Haiti

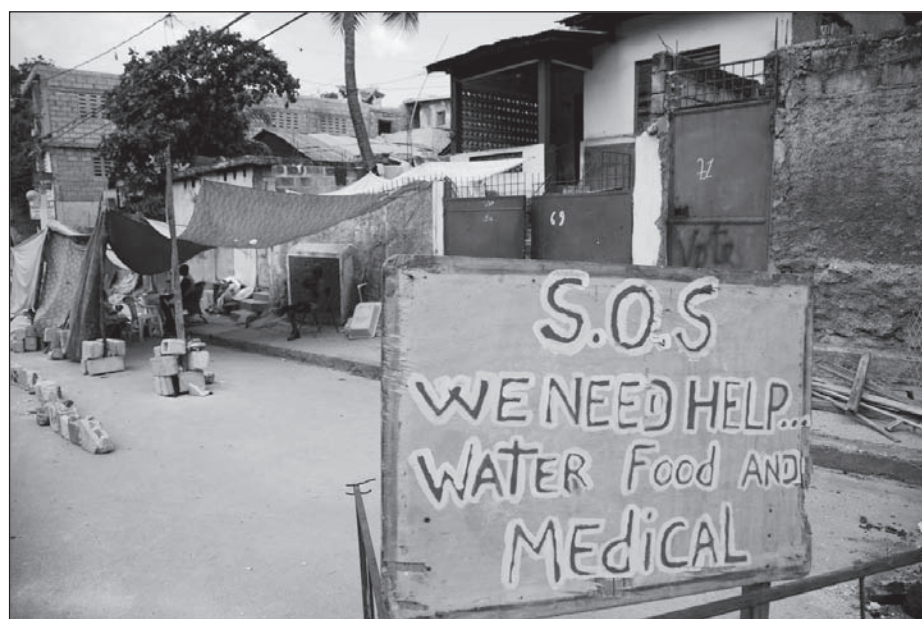
Soon after the earthquake hit Haiti on 12 January, the Brazilian Medical Association (AMB) started to receive numerous calls from doctors asking how they could help. Two days later, a cabinet crisis was installed at the AMB's headquarters to organise the available resources. On 15 January, we started an online application at our website to register all the volunteers to help the victims of the tragedy. In 15 days, we had 976 healthcare workers volunteering to go to Haiti.

While resources were being organised in Brazil, Ricardo Affonso Ferreira, leader of "Expedicionários da Saúde" (a NGO partner of the AMB), went to Haiti to access the situation. He found the Brenda Stafford Hospital, in Les Cayes, a small town situated 192 kilometres from Port au Prince that was not affected by the disaster. Within a few days the local population doubled after the arrival of 60 000 refugees. The Brenda Stafford Institute is an ophthalmology and otolaryngology hospital that later was

adapted to treat orthopaedic trauma patients.

In 45 days the AMB sent three teams to Haiti, 28 doctors (among them our president), 12 nurses and 4 radiology technicians. A lot of equipment, donated by private companies and public institutions, was carried by the three teams to treat patients. To give an idea, the second team alone, took 1500 kilos of equipment with them. The first two teams used regular commercial flights to go to Haiti, arriving at Santo Domingo, Republica Dominicana and then they travelled by bus to Les Cayes. The last team was taken straight to Port au Prince by the Brazilian Air Force.

The three teams performed 219 surgeries in 148 patients, mostly in men, the mean age was 31 years. Lower limbs were the most affected segments and the use of external fixator was the most common type of treatment. At the outpatient clinic, over 1500 people were treated.



"I consider that all three missions were successful. We felt privileged to be able to represent all physicians who could not go. The continuity of this work will be done in different ways and one of them is the creation of a task force trained for disasters", said José Luiz Gomes do Amaral, president of AMB. "We also look forward to establishing a worldwide network of physicians, national medical associations and resources ready to be used after a disaster of this proportion."

*Helena Fernandes,
Communication Department,
Brazilian Medical Association*

Burn Victims Bring Taiwan, Sao Tome Closer Together

Sao Tome is one of the world's most isolated countries, located 300 miles west of the African continent. With 160 000 inhabitants and very few medical doctors, the country has difficulty providing basic health services. This need inspired Taiwan Medical University, partly supported by the Taiwan International Corporation and Development Foundation, to send in more than a dozen health professionals since last December. Prior to their dispatch to Sao Tome, many of the Taiwan doctors and nurses did not know of this island country.

During routine rounds in local hospitals, TMU's Dr. Yu-Tai Chang was troubled by the cases of three children with burns over large areas of their bodies. He emailed photos of the burns to Taipei and asked about a timely consultation while working with his team in a shanty clinic. The chief plastic surgeon in Taipei, Dr. Cliff Chen, suggested a videoconference on treatment options in March.

However, most Sao Tome internet service was too limited to carry real-time images and voices to Taiwan. Dr. Chang persuaded

Taiwan's ambassador in Sao Tome to offer his embassy office, complete with satellite communication system, to serve as the videoconference site. During this examination, the scars over the burned areas were seen to have already contracted the children's bodies. Dr. Chen advised that the scars would continue to limit them, and recommended timely reconstructive surgery to protect the patients from irreversible lifetime deformity.

The decision to bring the children to Taiwan was a difficult one for the university and hospital doctors. The Taiwan Medical University team faced daunting financial and technical challenges in transferring the patients, but within days of publicising their cases generous pledges were made to support the children's treatment.

Dr. Chang drove to the patients' villages and helped the families with paperwork and reassured the mothers, who had never left their villages before, about the voyage of more than 10 000 miles. They had not heard about Taiwan before learning that their injured children might receive treatment here

that would enable them to lead normal lives again. Unfortunately, before they could depart the youngest patient, a 5-year-old girl, died of infection.

The two boys, both 7 years old, arrived from Sao Tome & Principe at Taoyuan International Airport on 11 April, accompanied by their mothers and a doctor from their country. They arrived exhausted and could hardly walk without assistance due to contractures from scarring over large areas of their bodies as well as 36 hours of flights and transfers from Africa via Lisbon, Amsterdam and Bangkok.

The doctors and nurses of the university's affiliated Wanfang Hospital conducted several operations and logged more than a hundred consultations and procedures to rebuild the skin over the children's scars, replacing areas from scalp to torso. One child could again close his eyelids and mouth after months when that had been impossible. Both patients' elbows could again reach normal extension, and the boys enjoyed their new freedom of motion by playing football and jumping around during their weeks of reconstruction and rehabilitation.

Now the two young burn patients are getting ready to go home. As the university and hospital receive calls from around Taiwan pledging assistance and donations, people in the African children's home villages are learning about their expected recovery and return. We salute the bravery of these injured children who came so far to stay with us. Because of their courage, hundreds of people in very different countries have shared medical knowledge and our common humanity. Everyone can celebrate this happy outcome of Taiwan's medical diplomacy.

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World Health Professions Alliance calls for increased action against counterfeits

Geneva, 18 May, 2010

The World Health Professions Alliance (WHPA www.whpa.org) today urged further action against counterfeiting of medical products, a vile and serious criminal offense that puts human lives at risk and undermines the credibility of health systems.

Speaking for more than 26 million health professionals in more than 130 countries, WHPA is extremely concerned that the infiltration and sale of counterfeit medical products in the legitimate supply chain can cause death and misery to tens of thousands of patients around the world. The only reason to combat counterfeit medicines is the protection of public health – disputes in trademark infringement and other intellectual property related crimes should never ever be the basis on which to define if a medical product is counterfeit or not.

“Falsely labelled, fake, spurious or counterfeited medical products which misrepresent an otherwise legitimate medical product pose a very serious public health threat which demands sustained and co-ordinated international action to control. Failure to act against this criminal activity would be a fundamental breach of the trust placed in public health structures by patients,” said Mr Ton Hoek, General Secretary and CEO, International Pharmaceutical Federation (FIP) and WHPA spokesperson. WHPA represents more than 26 million Health Professionals worldwide.

So that health care professionals are better equipped to combat counterfeits, the WHPA announced that it is stepping up its commitment to this issue, with the launch of the ‘Be Aware, Take Action’ campaign www.whpa.org/counterfeit_campaign.htm against counterfeiting of medical products.

This campaign focuses on public health and patient safety issues and enhances the role of health professionals and associations.

Through regional workshops dedicated to anti-counterfeiting, the WHPA aims to strengthen advocacy for appropriate investments in the education and capacity of health professionals to detect, report and prevent counterfeit medical products. In addition, the WHPA Be Aware, Take Action toolkit and other campaign resources are provided for health professionals, health-care advocates and patients

The main channels for fake medical products supply include street markets in developing countries and the Internet. The harm caused by counterfeit medicines is greatest in those communities least able to afford effective regulatory systems and quality health care.

Said Ton Hoek, “Public health and patient safety are being put at risk and now is the time to act.

Increased vigilance by health care professionals and patients can help make public and individual health safer. Health professionals need to increasingly consider counterfeit medicines as a reason for non-response or unexpected response in pharmacotherapy in the patients they care for.”

Education of health professionals is crucial for detection and prevention of counterfeit medical products and is required in order for them to educate patients and populations about the risks of buying counterfeit medical products from unknown and unreliable sources.

WHPA recognizes also that for health professionals to be able to effectively play their

role, national authorities must set up effective systems for the collection of information and increase national drug and medical device regulatory capacity to support the enforcement of pharmaceutical guidelines.

About WHPA www.whpa.org

The World Health Professionals Alliance WHPA is a unique alliance of The International Council of Nurses (ICN) www.icn.ch, the International Pharmaceutical Federation (FIP) www.fip.org,

The World Confederation for Physical Therapy (WCPT) www.wcpt.org, the FDI World Dental Federation (FDI) www.fdi-worldental.org and the World Medical Association (WMA) www.wma.net. WHPA addresses global health issues striving to help deliver cost effective, quality health care worldwide. Together, the partners of the WHPA include more than 600 national member organizations, making WHPA the key point of global access to health care professionals within the five disciplines.

Member Organisations

The International Council of Nurses (ICN) is a federation of national nurses associations, representing the more than 13 million nurses working worldwide. www.icn.ch

The International Pharmaceutical Federation (FIP) is the global federation of national organisations of pharmacists and pharmaceutical scientists representing more than two million pharmacists around the world. www.fip.org

The World Confederation for Physical Therapy (WCPT), the global voice for physical therapists / physiotherapists, has 101 national member organisations representing over 350,000 members of the profession. www.wcpt.org

The FDI World Dental Federation (FDI) is a federation of approximately 200 national

dental associations and specialist groups representing more than one million dentists worldwide. www.fdiworldental.org

The World Medical Association (WMA) is the global federation of national medical associations from around the world, directly and indirectly representing the

views of more than nine million physicians. www.wma.net

For more information about Be Aware, Take Action, please see www.whpa.org/counterfeit_campaign.htm or send an email to whpa.campaign@wma.net

The World Health Profession Alliance WHPA

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How Can Changes in Environmental Policy Help Reduce Rates of Chronic Disease?

Opportunities for prevention in the European Union



Genon Jensen

Huge potential exists to improve public health by reducing exposure to harmful environmental pollutants and through certain measures to tackle climate change, according to Génon K. Jensen, Director of the Health and Environment Alliance (HEAL). HEAL advocates changes in European policy that could reduce the burden of chronic disease in Europe.

In the world's wealthy countries, the burden of disease is dominated by chronic, long-term conditions. According to the World Health Organisation, 77% of the burden of disease in high income countries is attributable to non-



Diana Smith

communicable conditions, with only 8% of life years lost to communicable disease [1].

The incidence of certain cancers, chronic respiratory disease, diabetes and obesity is rising. Many leading European scientists say that part of this growing burden of chronic disease is due to harmful contaminants in the everyday environment.

Given that the European Union is responsible for setting about 80% of the environmental policy that is later applied in Member States, European institutions play a very significant role in public health protection.

How can changes in environmental policy reduce cancer rates?

In the European Union, one in three people will develop some form of cancer during their lifetime. Although genetics are responsible for a proportion of cancer incidence, some cancer rates are increasing so rapidly that genetics alone cannot be the driver.

Other explanations for rising rates of cancer incidence include an aging population or better screening programmes, or changes in "lifestyle" factors, such as smoking and alcohol consumption. But such explanations cannot account for all the increases. For example, the number of cancer cases among children is increasing by at least 1% every year [2].

Many researchers and policy makers increasingly point to the connection with environmental factors, at least in part.

The Health and Environment Alliance (HEAL) has brought two recent scientific reviews addressing the links between environmental chemical contamination and diseases to the attention of European policy makers. Substances known as "endocrine disrupting chemicals" (EDCs), which interfere with or damage the human hormone system, have been shown to produce "gender bending" effects in animal studies, with significant implications for human health effects.

The literature and analytical reviews link EDCs with rising rates of breast cancer and

with testicular dysgenesis syndrome (TDS) [3, 4]. TDS is a grouping which comprises male genital defects at birth (cryptorchidism, hypospadias), impaired semen quality, and a type of testicular cancer (testicular germ cell tumours). Like breast cancer, TDS has been linked with fetal exposure to EDCs. Some leading European toxicologists are convinced that breast cancer rates will not be brought down until the issue of everyday exposure to harmful synthetic chemicals is addressed.

Examples of endocrine disrupting chemicals mentioned in the reviews include: Bisphenol A – used in plastics and resins in baby bottles and can linings that may leach into drinks and foods; insecticides and pesticides, such as DDT and methoxychlor, which have been banned in Europe since 1978 and 2003 respectively, but are still found in people's bodies; UV filters, such as benzophenone and 4-MBC, which may be used in sun screens, are another example [5].

Because of concerns, France and Sweden are currently considering banning Bisphenol A for use in baby bottles as evidence increases on the need to protect biologically vulnerable groups such as babies and toddlers.

Although the EU has not yet banned Bisphenol A and many other important EDCs, some European policy is already beginning the process of protecting human health through stricter regulation of uses of harmful chemicals. In 2007, a new law on chemicals called REACH (Registration, Evaluation, Authorisation and restriction of chemical substances) was agreed to ensure that all chemicals on the EU market be registered. Those considered to be “of very high concern” to human health are gradually being put through a market authorisation process.

Two years later, the so-called “pesticides policy package” was agreed. One of its ob-

jectives was to reduce the impact of pesticides and harmful effects on human health and the environment. It will remove the sale and use of pesticides linked with cancer, DNA mutation, reproductive toxicity, and hormonal disruption. It also recommends that pesticide use in parks, schools and gardens around hospitals is minimised or avoided. For the implementation of this package the national level is crucial as EU Member States have to set up their own National Action Plans by 2012.

HEAL is currently involved in looking at how the review of the EU's biocide law can lead to better health protection. Biocides are defined as “chemical substances capable of killing living organisms, usually in a selective way”. They include rodenticides, wood preservatives, insecticides and anti-microbial, such as disinfectants. A particular concern is that the growing use of biocides is contributing to antibiotic resistance.

Recently the European Parliament passed a resolution which strongly underlines the importance of dealing with environmental factors when working to prevent cancer. The report responds to the EU “Communication” on Action against Cancer, which already acknowledged that cancer prevention should address environmental and occupational causes on an equal footing with lifestyle considerations, such as smoking, alcohol consumption and lack of exercise.

A second example: chronic respiratory illnesses

Environmental policy can also play an important role in reducing chronic health problems associated with lung disease.

Lung disease is rising worldwide and its total financial burden in Europe amounts to nearly €102 billion. Chronic Obstructive Pulmonary Disease (COPD) contributes almost one-half of this figure followed by asthma, pneumonia, lung cancer and TB.



Although air quality has improved over the past 20 years, it is still responsible for some 310,000 premature deaths within the European Union, according to a report by the European Commission [6].

Research commissioned by the Health and Environment Alliance (HEAL) and others in 2008 showed the extent to which better air quality through strong climate change policy would benefit health as a side effect [7]. This would happen because reaching climate change targets involves moving to energy sources with lower of emissions of carbon dioxide and other air pollutants, which would result in cleaner air.

The review showed that if the EU moved to a 30% target on greenhouse gas emission reductions (compared with the EU's current target of 20% by 2020), 100,000 fewer years of life would be lost to air pollution among Europeans (over 30 years of age) every year from 2020. In monetary terms, the overall public health benefits of the 30% reductions climate policy was estimated to be up to 25 billion Euros per year by 2020 [7].

The World Medical Association helped to bring the message of these health co-benefits of climate change policy to the attention of policy makers and the media, both in Brussels and at the Copenhagen climate summit at the end of 2009. WMA joined



HEAL and Health Care Without Harm (HCWH) in an initiative known as the “Prescription for a Healthy Planet”, which aims to bring health to the centre of climate change negotiations.

Looking ahead

Over the coming months there will also be opportunities to influence EU policy on REACH, biocides, the Community Strategy for Endocrine Disruptors, and the implementation of air quality legislation, which includes for the first time a requirement for governments to better inform respiratory and asthma patients on poor air quality. HEAL and HCWH Europe are also planning further research into how an ambitious greenhouse gas emission target can benefit public health in different EU Member States. We hope that the WMA and its member organisations will continue to play its effective and prestigious role in supporting advocacy work to improve public health in Europe. We very much welcome your input into our work.

The Health and Environment Alliance aims to raise awareness of how environmental protection improves health. The membership includes a diverse network of organisations of citizens, patients, women, health professionals and en-

vironmental experts across Europe. HEAL has a strong track record in increasing public and expert engagement in both EU debates and the decision-making process. The author has been a member of the WHO steering group the European Environment and Health Committee and sits on several EU expert and research advisory groups as a policy advisor.

HEAL projects

HEAL has a variety of collaborative projects running in several languages, which allow us to focus on specific areas of priority.

Chemicals Health Monitor – ensuring that scientific evidence on the links between chemicals and ill-health are translated into policy as quickly as possible. www.chemicalshealthmonitor.org

Sick of Pesticides – advocating for strong regulation of pesticide use for better health, especially to protect the most vulnerable groups in society. www.pesticidescancer.eu

Prescription for a healthy planet – bringing public health to the centre of the climate change debate, and uniting the international health community behind four principles: protect public health; set strong targets on emission reductions; promote

clean energy; and fund global action. www.climateandhealthcare.org

Healthier Environments for Children – showcasing examples of good practice projects in children’s environment and health throughout the 53 countries of the WHO European region. <http://cehpe.env-health.org>

Stay Healthy, Stop Mercury – raising awareness of the potential health risks of environmental mercury pollution. Calling on the EU to show leadership in efforts to control environmental mercury pollution by securing a global ban on mercury. www.env-health.org/stopmercury

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Re-Positioning of Service Delivery in the Nigerian Health System – the Impact of SERVICOM on Emergency and Other Services in a Tertiary Health Facility



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Introduction

At the Inauguration Ceremony of the new members of Nigerian National Assembly in Abuja, the nation's capital on 5th June, 2003, the President, Olusegun Obasanjo declared:

"Nigerians have for too long been feeling short-changed by the quality of our Public Service. Our Public offices have for too long been a showcase for the combined evils of inefficiency and corruption, whilst being impediments to effective implementation of government policies. Nigerians deserve better. We will ensure that they get what is better!" [1]

Prior to this, most of these government agencies had been pronounced inefficient

compared to their privately run counterparts, and the Federal Government had resolved to and undertook the process of privatization and commercialization of public enterprises in order to improve service delivery to the nation's citizens. The health sector was no exception.

Nigeria's peculiar health sector has been discussed at various fora over the past 30 years since the military coup of 31st December, 1983, which actually gave as one of the reasons for that putsch as *"our hospitals have become mere consulting clinics"* [2, 3]. The World Health Organization (WHO), for these past decades, has rated the Nigerian health sector very low, more so with the consistently low budgetary allocation to the sector by successive government administra-

tions. Nigeria is classed among the "Low-Expenditure, Low-Growth Health Economies", a group of underdeveloped countries which despite comprising a population of 2.6 billion people (about 40% of the world's population), is unfortunately credited with less than 5% of the world's health expenditure [4]. Countries in this group suffer from an absolute under-funding of their health sector, along with a disproportionately high disease burden.

From 1997 to 2001, Nigeria's total annual budgetary allocation to health tottered around 1.7 – 2.1% (2.1%, 2.3%, 1.7%, 1.7% and 1.9%, respectively), compared to Cameroon 4.1 – 7.9%, South Africa 10.9 – 12.4%, Namibia 12.4 – 13.1%, Canada 13.9 – 16.2%, and USA 16.8 – 17.6%, in the same period; and the WHO prescription is 15% of the Annual National Budget [5,6]. Since health equated life, it was no surprise that as the budgetary allocation to the health sector, and consequently government investment on health, dwindled, Nigeria's average life expectancy dropped from 54 years in 1998 to 43.4 years in 2004 (166th out of 177 countries). And till now, there is no evidence on ground that these indices are improving [7, 8].

The 2003/2004 Nigerian Living Standards Survey (NLSS) conducted by the Nigerian National Bureau of Statistics, with international technical assistance, documented a national poverty rate of 54.4%, implying that more than half of Nigerians live on less than \$1 per day (contrary to the WHO stipulation of \$5) [9]. Subjectively, 75.5% of Nigerians regard themselves as poor, with most of them situated in the agricultural and informal sectors particularly at the village levels. The picture could be scary

and gloomy, but more worrisome was the attitude of administrators who appeared not to be bothered by these troublesome statistics.

The poor service financing, seemingly rubs off on various aspects of the health sector, not least, the emergency care services. On most of Nigeria's highways, there are no readily available or accessible emergency care units or squads equipped and prepared to attend to road accident victims, rather, the job is left to traffic marshals whose outposts are very few and far between, and communication equipment and vehicles are acutely in short supply. The result remains that most accident victims would not make it to emergency care units even within the golden hour, and naturally, this would impact negatively on the outcome of most of the cases.

With the unavailability of basic work tools coupled with a low morale due to sub-optimal remunerations, Nigeria's public health care providers are not usually as enthusiastic in discharging their duties as would be expected of them in providing standard services to combat the constant challenge of avoidable deaths and long term debility. This attitudinal short fall, appears to affect not only the health sector but also all the other sectors of Nigeria's economy viz. law enforcement, civil service, electricity generation/supply, transportation, telecommunications, etc. and the impact on all fronts is more visible in the government sector and bureaucracy.

In December 2003, a research project was commissioned to review service delivery in Nigeria with a view to determining the institutional environment for service delivery, the citizen's views on (and experiences with) service delivery and the designing of a roadmap for a service delivery programme. Subsequently, a report titled "*Service Delivery in Nigeria: A Roadmap*" was published in February 2004, and the conclusions and recommendations therein included:

- services were not serving the people: they were inaccessible, poor in quality and indifferent to customer needs;
- public confidence was poor, and institutional arrangements were confusing and wasteful;
- services should be re-designed around clients' requirements;
- the success of the Programme would require committed leadership from the top;
- ministers should demonstrate their commitment with a leadership declaration about Service Delivery;
- there was need for a far-reaching transformation of the Nigerian society through a Service Delivery Programme as a step in the process of moving to a government that was more in touch with the people. That Service Delivery Programme should:
 - create citizens' and customers' demand',
 - instill higher expectations on public services,
 - communicate service entitlements and rights,
 - publish information about performance. [10].

In March 2004, a Special Presidential Retreat was held to deliberate on this report. The opening comment of the President was:

"This Retreat is to assert our ownership of the initiative to serve Nigerians better. We accept full responsibility for driving it to a successful end... It is also the message of leading from the front in the battle to sanitize our system morally, politically and economically. Above all, it is the message of the leadership that the Nigerian people can trust..."

And at the end of the retreat, the Federal Government on 21st March, 2004, resolved to enter into a "SERVICOM pact" (SERV-ICOM) with the citizens of our country for a commitment to their welfare and satisfaction with service delivery; and

thus, was born the SERVICOM Charter [1].

By SERVICOM, it was also agreed that all Ministries, Parastatals and Agencies and all other Government Departments will prepare and publish, not later than the First day of July 2004, SERVICOM CHARTERS whose provisions would include:

- quality services designed around the requirements of their customers and served by staff sensitive to the needs of their clients;
- set out the entitlements of the citizens clearly and in ways they could readily understand;
- list of fees payable (if any) and prohibit the demand for any additional payments;
- commitment to the provision of services (including the processing of applications and the answering of correspondence) within realistic set time-frames;
- details of agencies and officials to whom complaints about service failures may be addressed;
- publish these details in conspicuous places accessible to the public;
- periodically conduct and publish surveys to determine levels of customer satisfaction.

Under this Charter, every government establishment outlined its goals and objectives in the provision of optimal services to the satisfaction of its clients. It became an agreement with and a commitment to the clients, who were advised to report to specific officials when they get less than satisfactory answers to their enquiries or less than optimum satisfaction from services rendered to them. Such reports would be treated with seriousness, and sanctions meted out.

Nigeria's health system operates on a cash-and-carry basis whereby the client pays for every service and treatment received at any point in the hospital. However, a few years ago, a National Health Insurance Scheme (NHIS) was introduced for the benefit of government employees, that allows each

employee and four registered family members to receive care at subsidized rates for some statutorily stipulated disease conditions, but not for diseases outside the list. The NHIS does not as yet cover many disease conditions.

On 10th May, 2005, our institution fully adopted and launched the SERVICOM Charter in the provision of services to our clientele, and we began to do everything in a slightly different way. But it has been known that putting people first as the focus of service delivery reforms is not a trivial principle, as it could require significant – even if often simple – departures from “business as usual” [11].

Nnamdi Azikiwe University Teaching Hospital (NAUTH) Nnewi, was a secondary health facility (State General Hospital) in the 1970s which was upgraded to a Federal Government training institution in 1992, and since then, progressively grew into a 350-bed facility along with its five accredited outposts located in Onitsha, Neni, Ukpoka, Oba and Umunya, within Anambra State. It has facilities for service delivery and manpower training in the various specialties of Medicine and allied health professions.

Nnewi is a semi-urban community with a population of 204,000 persons located in Anambra State – one of the five states that constitute the South-East Zone of Nigeria. Anambra State has a population of 4,182,032 persons (2006 National Population Census), and our teaching hospital is the only tertiary health institution providing services to the State and some other States in the South-East Zone, as well as in parts of two other Zones (South-South and North-Central) of Nigeria. The total population of these potential catchment areas is estimated at 40.2% of Nigeria's 140million population (South-East 11.7%, South-South 15% and North-Central 13.5%) [12, 13].

This study is a prospective evaluation of the clientele turnover and outcome of

cases treated in NAUTH Nnewi after the introduction of SERVICOM in May 2005, meant to assess the impact of this Charter on the provision of services in our tertiary health institution, and determine its usefulness, or otherwise, in the improvement of the health of our catchment population.

The question is: Has SERVICOM made the desired impact on care delivery in our health institution?

Methods/Patients/Materials

Data collection for this study started prospectively as soon as the SERVICOM protocol was introduced in May 2005, using the Microsoft excel broadsheet, and collated on a monthly basis. The electronic and hardcopy registers of the Department of Health Records were used to crosscheck the collected data of the different Units and Departments. Statistical analysis was done using the *chi-square*; with the significant *p*-value taken as ≤ 0.05 .

Because SERVICOM was introduced in the second quarter of 2005, we agreed that data from 2006 represented the transition period, while 2007 onwards would more appropriately reflect the impact of this programme in the post-SERVICOM period, and 2005 would be more representative of the pre-SERVICOM status of service delivery in our Institution.

Results

By the end of 2006, numerical data began to show a change in all facets of care delivery compared to the figures in the preceding year in the hospital and quite remarkably, in the Accident and Emergency Unit, as well.

For 2005, 2006, 2007, 2008 and 2009 attendance at Consultant Out-patient Clinics were 36032, 48703, 58530, 64931 and 66831 clients, respectively (Figure 1); Gen-

eral Out-patient Clinics for the same period were 35866, 51520, 57830, 60056 and 62055 (Figure 2); Children's Out-patient Clinics 36032, 48703, 58530, 64931 and 66831 (Figure 3); Accident and Emergency Unit 3988, 7034, 10503, 12224 and 14118 (Figure 4); Hospital In-patient Admissions 4718, 6067, 11874, 13750 and 15650 (Figure 5); Laboratory Services 58039, 62007, 81196, 93300 and 115301 (Table 1); Surgical Operations in the Theatres 1001, 1321, 3706, 4142 and 5642 (Table 2), and Baby Deliveries in the Labour Room 596, 627, 1611, 2936 and 2123 (Table 3).

The gross clientele turnovers for the whole Hospital in each of these five years (2005 – 2009) were 76452, 107884, 128474, 140147 and 145127 (Figure 6), while mortalities from in-patients for the corresponding years were 284 (6% of in-patients), 221 (3.64%), 200 (1.68%), 143 (1.04%) and 127 (0.81%) (Figure 7). Within the same period, the maternal mortalities were 11 (1.84%), 9 (1.43%), 7 (0.43%), 8 (0.27%) and 3 (0.14%), respectively (Table 3).

Discussion

At the inauguration of the SERVICOM Charter, the management of our Hospital identified key areas that required re-evaluation and attention based on the submissions of every service Unit and Department, after an analysis of the Strengths, Weaknesses, Opportunities and Threats (SWOT) of each. A pre-SERVICOM workshop which was supervised by the Federal Government was held in the various institutions nationwide to enable care providers enumerate their current service capacity, and then, based on their stated ideal objectives, risks, shortcomings and strengths, identify the institutional needs that would enable them to achieve their set objectives. With the resolutions from the workshop, human and material resources were upgraded in order to address the identified risks and enhance the capacity of each institution to attain these set goals.

For example, changes employed in the Accident and Emergency Unit of NAUTH Nnewi included:

- the employment of more medical officers, nurses and other health personnel;
- procurement of more diagnostic and therapeutic equipment;
- availability of adequate supply of medications;
- appointment of a new Head of Unit with a brief to enforce discipline and compliance with all the activities in the Unit;
- daily morning audit of the clientele turn over and treatment outcome in the Unit for the preceding 24 hours, by the hospital management;
- installation of free communication lines for health personnel to easily make contact with their colleagues, superiors or hospital management round-the-clock whenever there is an urgent need arising from care delivery;
- waiver on all hospital bills for all emergency cases until resuscitation/salvage is achieved or relatives who would make payment arrive;
- direct line for feedback from the clients to the hospital management for whatever impression they make of the care they received;
- 24-hour electric power supply; structural renovation of sections of the Unit.

Following these reforms, the time lapse between the arrival of a client, in our Accident and Emergency (A&E) Unit, and review by the doctor on call in the A&E Unit was shortened to a maximum of 5 minutes compared to the previous scandalous records that got as long as 2 hours in some instances. Also, the maximum time lapse between review of the client by the doctor in the A&E Unit and arrival of any specialist Unit on call that is required to attend to the same client was statutorily fixed at 30 minutes.

For the rest of the institution itself, a log register was introduced and strictly enforced to monitor the movement of Staff right from the moment of arrival for duties

Table 1. *Laboratory services*

Year	Total Laboratory Clientele Patronage (Total No. for 2005 = 58039)	Increase over 2005
2006	62007	(3968) 6.83%
2007	81196	(23157) 39.9%
2008	93300	(35261) 60.8%
2009	115301	(57262) 98.7%

Table 2. *Surgical operations in the theatres*

Year	Total No. of Operations (Total No. for 2005 = 1001)	Increase over 2005
2006	1321	(320) 32%
2007	3706	(2705) 270.2%
2008	4142	(3141) 313.8%
2009	5642	(4641) 463.6%

Table 3. *Baby deliveries and maternal mortality*

Year	Total No. of Deliveries (Total No. for 2005 = 596)	Increase over 2005	Maternal Mortality (%) 2005 = (11) 1.84%
2006	627	(31) 5.2%	(9) 1.43%
2007	1611	(1015) 170.3%	(7) 0.43%
2008	2936	(2340) 392.6%	(8) 0.27%
2009	2123	(1527) 256.2%	(3) 0.14%

till the commencement of duty and time of departure, and appropriate sanctions were spelt out on erring Staff. Similar changes as in the A&E Unit were also introduced in the Labour Room and Children's Emergency Room, all of which we regarded as emergency flashpoints in our service delivery.

As soon as the protocols of SERVICOM were put in place, the attitude of our Staff began to change remarkably. Every employee rushed to make it to the duty post every day before the attendance register was closed, and at the various service points, clients were given timely and polite attention, medications were readily available and no client was left unattended to merely on account of lack of funds. Most importantly, people felt that they were being listened to and respected – a key aspect of what people value about health care, similar to the experience reported in 2007 from Alaska, USA

and other parts of the world where some health reforms were undertaken [14, 15, 16, 11].

With the gross annual clientele turnovers of 107884, 128474, 140147 and 145127 from 2006 to 2009 in NAUTH Nnewi, it was evident that there were geometrically increasing patronage of 41% ($p < 0.05$), 68% ($p < 0.05$), 83.3% ($p < 0.05$) and 89.8% ($p < 0.05$), respectively, over the 2005 annual figure of 76452. In the A&E Unit, the clientele attendance of 3988, 7034, 10503, 12224 and 14118 for the same period equally translated to rises of 76.4% ($p < 0.05$), 163.4% ($p < 0.05$), 206.5% ($p < 0.05$) and 254% ($p < 0.05$), respectively over the 2005 figures. Both the difference in gross clientele turnover and A&E attendance when subjected to analysis were found to be statistically significant ($p < 0.05$) in each of the years.

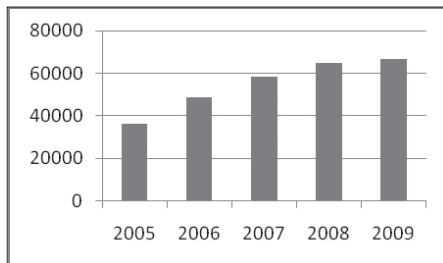


Figure 1. Attendance to Consultant Out-Patient Clinics

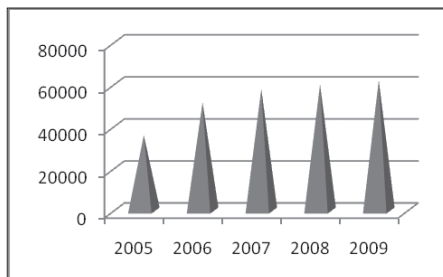


Figure 2. Attendance to General Out-Patient Clinics

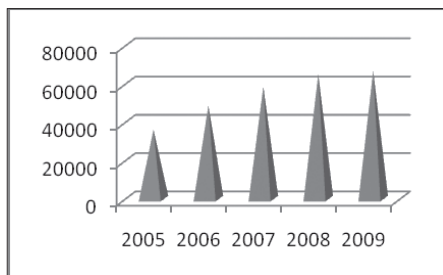


Figure 3. Attendance to Children's Out-Patient Clinics

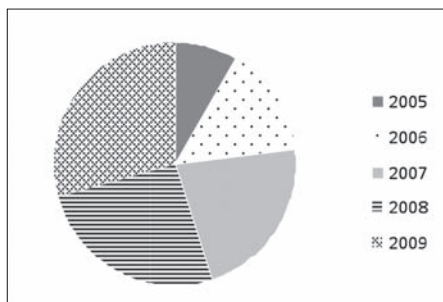


Figure 4. Accident and Emergency Cases

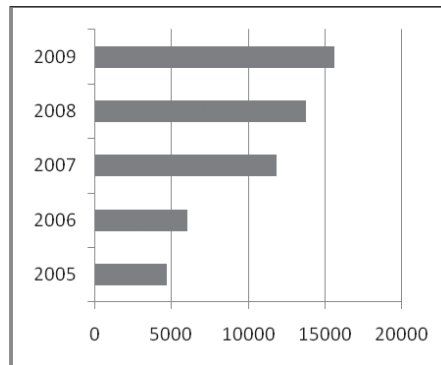


Figure 5. In-Patient Admissions

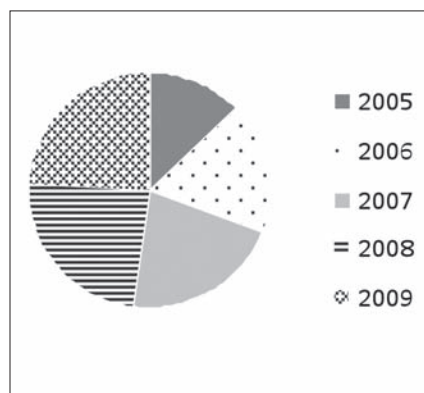


Figure 6. Gross Clientele Turnover

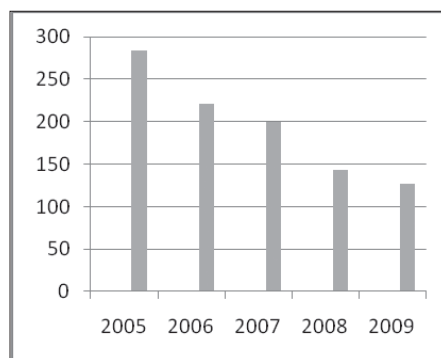


Figure 7. In-Patient Mortality

Prior to 2005, the impression of our clients and their relatives was that prompt and optimal care was more likely to be obtained in private clinics in our locality than in the Teaching Hospital; and their reasons bothered mostly on the attitude of health personnel and non-availability of medications in government-run health facilities. The WHO had noted that people are increasingly impatient with the inability of health services to deliver levels of national coverage that meet stated demands and changing needs, and with their failure to provide services in ways that correspond to their expectations [4]. As a result, patronage of our government institutions remained very low and in most cases, was confined to those clients who could not afford the bills of private facilities, or victims of accidents whose identities and relatives were not known in the immediate post-ictal period.

But, Nigeria was not alone in her inadequacies because studies by Halman, *et al*, Milenson and Davies, had shown that in many parts of the world, there were considerable scepticism about the way and the extent to which health authorities assume their responsibilities for health [17, 18, 19, 20]. Surveys have shown a trend of diminishing trust in public institutions as guarantors of the equity, honesty and integrity of the health sector because on the whole, people expect their health authorities to work for the common good, do this well, and do so with foresight [21].

The increased patronage noted after the introduction of SERVICOM appeared, therefore, to indicate a restoration of public confidence in the capacity of the hospital to provide desirable services. And this seemed to cut across the entire service points of our hospital. In the Operating Theatre, some of whose clients pass through the A&E Unit, figures rose by 32% ($p < 0.05$), 270.2% ($p < 0.05$), 313.8% ($p < 0.05$) and 463.6% ($p < 0.05$), when compared to the 2005 statistics, just as in the Labour Room where delivery of new babies rose remarkably by

170.3% ($p < 0.05$), 392.6% ($p < 0.05$) and 256.2% ($p < 0.05$), respectively for 2007, 2008 and 2009. The 5.2% rise recorded in 2006 was, however, not statistically significant on analysis ($p > 0.05$).

Perhaps, even more compelling than the absolute figures of patronage were the mortality rates of our In-patients and pregnant mothers, both which were on a persistent decline despite the rise in total clientele turnover. Mortality rates for In-patients in the five years 2005 – 2009 were 284 (out of 4718 admissions), 221 (6067 admissions), 200 (11874), 143 (13750) and 127 (15650), which translated to 6%, 3.64%, 1.68%, 1.04% and 0.81% of all admitted cases, respectively. When the post-SERVICOM mortality rates were compared to 2005 (6% of 4718), the mortality rates showed a marked progressive reduction by 39.3% ($p < 0.05$) in 2006, 72% ($p < 0.05$) in 2007, 82.7% ($p < 0.05$) in 2008 ($p < 0.05$) and 86.5% ($p < 0.05$) in 2009, respectively, all of which were statistically significant.

After an assessment of the available data, we discovered that from 2006, when compared to the pre-SERVICOM era, there was:

- a progressive increase in clientele patronage / turnover in all our service sectors – A&E, Out-patient, In-patient, Operating Theatre, Labour Room, Laboratories, etc;
- a progressive decrease in absolute mortality rates of the In-patients per annum;
- a progressive decrease in maternal mortality rates per annum;
- a much greater decline in relative mortality rates for all the in-patients and pregnant mothers per annum.

These findings strongly supported the fact that the introduction of the SERVICOM Charter stimulated several positive changes, and thereby, re-positioned our tertiary health institution towards a much better

satisfaction of the demands of our clientele. They provided the answer to the question, thus: SERVICOM has made the desired impact on care delivery in our health institution; even though it should be stated unequivocally that there is still a lot of room for more improvement.

It is worth noting that beyond attitude, the role of quality personnel, modern diagnostic and therapeutic equipments, and adequate remuneration of workers, would never be over-emphasized. Attitude alone may not be enough to sustain these massive gains for too long because it is only a portion of the whole armamentarium for a successful health care delivery system. Increasing Nigeria's annual budgetary allocation to health from the present 2% to the WHO recommended 15% as affirmed at the Abuja Accord holds the surest key.

Regular quality assurance of the human and material resources should be a complementary aspect of the project of better service delivery in all sectors of the Nigerian economy, most importantly, the health sector. More so, a host of other fairly low-cost policies (e.g. enhanced provision of water, medical drugs, or AIDS education/care) have been reported to lead to dramatic improvements in life expectancy in developing countries, and these should be given priority by the various governments in Nigeria, as well [22].

Conclusion

It is obvious that the structural and attitudinal changes introduced by SERVICOM, brought a very significant improvement in all our performance indices, and thus, contributed to the improved care delivery to our clients. Perhaps, one of the most likely handicaps that could stall or reverse these gains is the non-sustenance of the current momentum, but if this is sustained and introduced changes improved upon, health care delivery despite its various challenges would most likely continue to improve, and

the life expectancy of the average Nigerian would record a change, from the appalling 43.4 years.

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The History of the Placebo¹



Robert Jütte

Etymology

The term "placebo" has not been part of medical usage for very long, but the phe-

1. This historical study is part of a larger project on the placebo effect undertaken by a group of experts on behalf of the Wissenschaftlicher Beirat der Bundesärztekammer (Scientific Board of the German Medical Association)

nomenon we refer to as the "placebo effect" has been known in medical as well as lay circles for a long time. The French philosopher and writer Michel de Montaigne (1533-1592) described the powerful effect of imagination on the human by using the example of a patient who received regular

non-medical enemas given by his doctor and experienced the same effect from them as from enema that actually contained medicinal substances rather than just warm water [38]. It was not until the second third of the 18th century that the phenomenon, or at least a partial aspect of it, was first referred to as "placebo". It was the Scottish physician and pharmacologist William Cullen (1710-1790) who coined the expression. In 1772 he demonstrably used the term for the first

*I gave him a medicine that has been sup-
posed to be of that kind viz the mustard the stimu-
lant power of that you are well acquainted with
and the singular circumstance of its being taken in
entire and unbiassed, is supposed to give it its virtues
as its action is not over in their stomachs but proves pur-
gative, diaphoretic &c and in short proves a stimu-
lant that is alleged to be useful in paralytic affections.
I own that I did not trust much to it, but I gave
it because it is necessary to give a medicine, and
as what I call a placebo. If I had thought of any
internal medicine it would have been a dose of the
Powder powder*

time in his *Clinical Lectures* in connection with a patient to whom he gave an external application of mustard powder although he was not convinced of its specific effect: "I own that I did not trust much to it, but I gave it because it is necessary to give a medicine, and as what I call a placebo. If I had thought of any internal medicine it would have been a dose of the Dover's powders." [10]. In another case that he considered to be hopeless he also prescribed a medicine that was ineffective in his view and justified his decision as follows: "I prescribed therefore in pure placebo, but I make it a rule even in employing placebos to give what would have a tendency to be of use to the patient" [9].

Cullen's "placebo" was not yet an inert substance. He tended to use low doses of drugs which he thought to be ineffective given the severity of the disease. His main concern was not what to prescribe but how to fulfil the patient's desire for a medicament, even though he did not personally believe in its pharmacological effectiveness (according to the state of knowledge at the time) [28].

At the time when Cullen introduced the term "placebo" into medicine it had a different meaning in the English language. Since the 14th century "to sing a placebo" had meant as much as "flattering a person of high rank" [7]. It was an ironical application of a medieval antiphon from the mass for the dead. An antiphon is a short, memorable response in the liturgy, in this case the last verse of psalm 116, which in the original Hebrew reads: *אֶפְתָּחַ יְהוָה יִפְתָּח יְהוָה אֶפְתָּח יְהוָה יִפְתָּח* [24, 3, 40, 2]. In the King James Bible it is translated as "I will walk before the Lord in the land of the living". This version corresponds to the Latin translation by the church father Jerome (Vulgate) which follows the Hebrew text (Ps 114.9): "Deambulabo coram Domino in terram viventium". In the Septuagint, the classical Greek translation of the Old Testament, the Hebrew verb for "go" or "walk" is not rendered literally but figuratively as *εὐαρεστίσω*. Jerome's

Latin translation (the Gallicana version) of the Greek correspondingly uses the verbal phrase "placebo". Translated into English the verse then reads: "I shall be pleasing in the sight of the Lord in the land of the living" [21].

Early uses of placebo

Next to the Scottish physician and pharmacologist William Cullen it was a German doctor who used the placebo effect in his own practice: Samuel Hahnemann (1755–1843), the founder of homeopathy. He translated Cullen's *Materia Medica* into German which gave him the idea for his famous experiment with Peruvian Bark. Hahnemann was obviously not familiar with the term "placebo" although he knew the principle which for him meant giving "something non-medicinal" such as raspberry juice or lactose. Early on in his homeopathic practice he encountered the problem that his patients were used to taking medicine on a daily basis as was customary in orthodox medicine at the time, while in homeopathy it was important, in his view, to allow the remedies to fully unfold their action. In an essay that was printed in the *Allgemeine Anzeiger der Deutschen* in 1814 Hahnemann offered the following recommendation to his colleagues: "In the meantime, until the second medicament is given, one can soothe the patient's mind and desire for medicine with something inconspicuous such as a few teaspoons a day of raspberry juice or sugar of milk" [18]. In his work on the chronic diseases he advised: "If a homeopathic physician, doubtful without occasion, asks me how, during the many days after giving a dose of medicine that should continue to act undisturbed, to satisfy the patient who demands medicine every day, without harming him I reply in two words: 'give him a daily dose of lactose, about three grains, at the usual time marking it with the continuous number'" [17].

Hahnemann already experienced that the blinding was not always successful. One of his patients, also an eager reader of his



James Lind

writings, had seen through the deception but still remained loyal to Hahnemann: "The powder I took regularly although I am well aware that only number (figure illegible, R.J.) is a medicine as instructed in your worship's books which I looked into" [23]. In Hahnemann's case journals, which are almost fully preserved, he marked placebos with the paragraph symbol (§). After first experimenting with ground oyster shells (*Conchae*) as placebo at the beginning of his homeopathic practice he later on almost exclusively gave lactose in these cases to which the homeopathic *Materia Medica* does not attribute a medicinal effect [39].

On 21 June 1807 the then US president Thomas Jefferson (1743–1826) wrote to a Dr. Caspar Wistar: "One of the most successful physicians I have ever known, has assured me, that he used more bread pills, drops of colored water, powders of hickory ashes, than of all other medicines put together. It was certainly a pious fraud. But the adventurous physician goes on, substitutes presumption for kno[w]le[d]ge" [25]. It cannot be fully ascertained but we can assume that the successful physician in question was Benjamin Rush (1745–1813), a

friend of Jefferson's. The letter proves that, as early as the beginning of the 19th century, physicians consciously used the placebo effect while being aware of the ethical implications ("pious fraud"). During World War I a Jesuit priest employed as a nurse in a battlefield hospital, knowingly administered sodium chloride injections as placebos: "Every evening there was the fight about the morphine that the patients demanded. They begged and pleaded. But we used it sparingly and, if it was at all possible, we did not give them any. [...] If the lamenting did not cease we often had no choice but deceive them with a sodium chloride injection. The moaning and groaning often continued all through the night [...]" [Archives of the German Jesuit Province in Munich, 00/752v1, Kriegslazarett 8, vol. 1-2. P. 126]

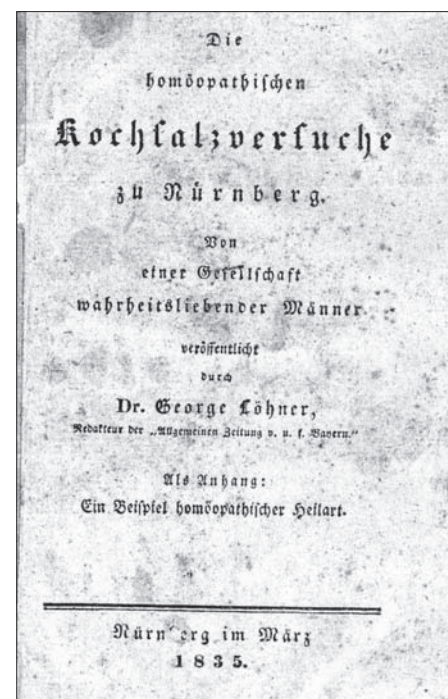
The placebo in clinical research

The beginnings of the controlled trial (with simple, double and triple blinding) date back to the 18th century, though no placebo was used to start with. It began with the Scottish Naval Surgeon James Lind (1716–1794) [43]. In his *Treatise on the Scurvy* (1753) he described how he performed the first clinical drug testing on 20 May 1747 on board a British Navy vessel. Of 12 scurvy patients ("as similar as I could have them") two were given cider, two vitriol, two vinegar, two sea water, two oranges and lemons, two an electuary of garlic, mustard seeds, balsam of Peru and gum myrrh. The patients who were fed citrus fruit recovered within six days. The comparison group remained without treatment apart from "a little lenitive electuary" [32]. We know today that citrus fruits are the treatment of choice because they contain vitamin C the lack of which causes scurvy. As the vitamins had not been discovered yet at the time, lemon juice was seen as a cleansing agent that could rid the body of toxic particles. In 1784, a commission of experts that was appointed by the French king, Louis XVI (1754–1793), and included Benjamin Franklin (1706–1790), carried

out simple blind trials to ascertain whether Franz Anton Mesmer (1734–1815) was right in claiming that the magnetic fluid (animal magnetism) had a healing effect. For the trial, the test candidates were separated from the physician, who was to *mesmerize* them, by a screen. The fluid transfer only worked if the test person knew about the treatment which led the commission to conclude in 1785: "this agent, this fluid has no existence" [27]. This by no means put an end to the debate about the effectiveness and effect of mesmerism. It continued right into the 19th century and there are still magnetisers today who see themselves as continuing Mesmer's legacy [26, 42].

In 1799, the British physician Dr John Haygarth (1740–1827) tested in a simple blinded trial the controversial healing approach of the American doctor Elisha Perkins (1741–1799) who claimed he could deviate harmful energy (electroid fluid) from the sick body by means of a "tractor" made from two metal rods [19]. The test was performed in the following way: there were two groups, one of which was treated with the metal tractors and the other with wooden rods that were made to look exactly like the "genuine" ones. The treatment was similarly successful in both groups.

The first controlled clinical trials with "inert" substances were developed by physicians who either sought to prove the effectiveness of homeopathy or to expose this new healing system as "humbug" [11, 12]. The first was the German-Russian physician Dr J. Hermann who, in 1829, performed a kind of outcome study in a military hospital in Tulchin, now Ukraine. He compared the treatment of malaria patients in a homeopathic and an allopathic ward [20]. In a follow up trial, which he was able to conduct shortly after in a military hospital in St Petersburg under the supervision of a Dr Gigler, a third trial arm was added. The patients allocated to this group basically received only general care (baths, sufficient food and rest):



"During that time the patients were kept in a state of innocent deception. In order to avoid the suspicion that they did not receive any medicine, they were prescribed pills made from white bread crumbs or cocoa, or sugar of milk powder, or salep decoctions as was also the case in the homeopathic ward" [31].

Interestingly, the best results were achieved in the group that was given no treatment apart from loving care.

The first double blind trial with a placebo arm also served the assessment of homeopathy. The initiative by physicians who were sceptical about homeopathy took place in a Nuremberg public house in 1835 [Stolberg, 1996]. The trial was performed as follows: A C30 solution of purified salt and distilled snow water was prepared. 100 vials were meticulously cleaned and numbered, then well shuffled and spread on two tables. Half of them were filled with the homeopathic solution, the other with pure distilled snow water. After a list of the vials and their con-

tent had been made and sealed, the vials were again thoroughly shuffled. Then the principal investigator gave each participant a vial which was also registered with the number and the participant's name. Neither participants nor investigators knew who had been given which vial but this could be discovered with the help of the sealed lists. The outcome was not unambiguous. The homeopaths in particular were critical of the fact that the drug had been tested on healthy subjects. Still, the experiment was ground-breaking in one respect: it constituted the beginning of the modern clinical trial, not yet randomised, but double blind. How progressive the study design was is shown by the forward-thinking comment made by the leading investigator: "Avoid anything that would enable the individual probands to surmise whether they have received distinctly homeopathic or distinctly non-medicinal test substances. Even the producers and distributors of the doses must not know, as was the case in our trial, what this or that person was given" [33].

In the course of the 19th century more placebo controlled studies into homoeopathy were carried out [13], one of them in 1877 at Boston University Medical School in the United States by Conrad J. Wesselhoeft, sr (1834–1904) who tested *Carbo vegetabilis* using simple blinding [45]. Other treatments were also assessed in clinical studies up to the outbreak of World War I, but they did not yet meet modern RCT criteria [27].

Despite a few pioneering efforts, more than a century went by before placebo controlled trials became the standard of clinical research, which was partly due to the lack of a methodology. Only in 1932, the Bonn clinician Paul Martini (1889–1964) submitted his *Methodenlehre der therapeutischen Untersuchung* (Methods of Clinical Investigation) which saw four editions and was the first text book of its kind. Even though the term "placebo" was only introduced in the later editions, Martini was doubtlessly familiar

with the problems surrounding the placebo effect as we can see from his preface: "The best way to exclude suggestive or other subjective factors is to keep the trial set-up unknown. Applied to the main group of our therapeutic armamentarium this means: the medicines must be offered to the patients in a form or disguise that does not reveal their special character or purpose; they must be masked" [36]. The medicine and the non-medicinal substance selected for comparison had to be identical in form, colour and taste. Martini saw greater difficulties in the case of non-medicinal therapies. There it was important, he pointed out, "to compensate as much as possible through strict avoidance of any suggestion, even by using counter-suggestion" [36]. Between 1936 and 1939 Martini evaluated individual homeopathic medicines such as bryony, secale cornutum (ergot), sulphur and sepia (cuttlefish) [34, 35]. From a modern point of view these trials can be criticised because of their ambiguous design with different verum and placebo phases, an insufficient number of probands, heterogeneous dosages, lacking control of carry-over-effects, simple blinding that allows manipulation through the examiner [44]. Compared to the drug research carried out by the Leipzig homeopaths Martini's studies were certainly more progressive in one respect: they were based on intra-individual placebo control.

At almost the same time, the understanding grew in Britain and the USA that the factor "suggestion" had to be neutralised through blinding if at all possible. The work of Harry Gold (1899–1973) at Cornell University Medical School must be mentioned in this context, including his highly regarded study on methylxanthine in the treatment of angina pectoris [16]. One of his colleagues recalled later that the term "blind test" used by the study authors was inspired by a cigarette advertisement from the 1930s [40].

While the placebo controlled double blind trial had been known for some time many scientists did not see the necessity for ran-



domisation. It was a statistician who first advocated it: R. A. Fisher (1890–1962) [47, 8]. In his book *The Design of Experiments* (1935) he emphasised the importance of randomised trials [14]. Most clinicians did not support randomisation at first because they felt it restricted them in their autonomous therapeutic decision-making. Austin Bradford Hill (1897–1991) was an exception. He carried out the first randomised double blind trial in 1948 to assess the effect of streptomycin. In his memories he described to what length he had gone at the time to avoid the word "randomisation" in the study design so that he would not alienate his medical colleagues [22]. When asked in an interview in 1970 which factors had contributed to the introduction of RCTs in medicine, Hill mentioned next to the development of a number of new, promising medicines (sulfonamides, analgesics, antibiotics, cortisone preparations) also the research in military medicine during World War II, when new methods and study designs had been put to the test [40].

In 1955, the *Journal of the American Medical Association* published a paper by Henry Knowles Beecher (1904–1976) titled "The Powerful Placebo" [5] in which he reviewed 15 different placebo studies on the treatment of headaches, nausea or post surgery pain. He arrived at the conclusion that of the 1082 patients who participated, an average of 35% reacted to placebos. For the first time the placebo effect was quantified and scientifically documented on a relatively broad basis [critical: 29]. Today "The Powerful Placebo" is one of the most frequently quoted papers

on the topic of placebos. Its publication in a reputable specialist journal contributed to placebo controlled double blind studies gradually becoming the standard in pharmaceutical research from the 1950s onwards.

In the early 1970s, placebo research took a new direction when the responder concept which claims that some people are more susceptible to placebos than others. A milestone on the way to the epistemic shift was Jerome D. Frank's book *Persuasion and Healing* (1973) which focused on what is called the therapeutic setting [15]. The change in expectations is seen as a crucial mechanism with the placebo effect. According to Frank, it was simply a matter of inducing hope for improvement in a patient who was seeking help.

At the end of the 1970s, placebo research moved a step further after the discovery of endorphins. An American group of scientists showed that it was possible to stimulate the release of endorphins with placebos and thus override pain receptors [30]. They were convinced that they had found the placebo effect's mechanism of action. Almost at the same time Robert Ader and Nicholas Cohen experimented with a strain of mice that spontaneously became sick due to an overreaction of the immune system which is usually treated with immunosuppressives [1]. The two researchers were able to demonstrate that conditioning made it possible to replace the verum with sugared water, thus proving that the placebo effect cannot be reduced to a particular human interaction.

At the beginning of the 1980s there was a new development. In 1983, the American anthropologist Daniel E. Moerman of Michigan University suggested replacing the term "placebo effect" by "meaning response" [37].

1985 saw the first endeavours to bring the various research strands together. The American authors L. White, B. Tursky and G.E. Schwartz advocated an "integrative

synthesis of all relevant views and factors"¹. Despite some initiatives [40, 6] this synthesis remains a desideratum.

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Reduction of the Medical Evacuations

Initiative of eight African western countries.



Kroo Florent

At the invitation of the Commission of the West African Economic and Monetary Union (UEMOA), the administrative and professional medical authorities of eight African countries (seven French-speaking and one Portuguese-speaking) met in Ouagadougou, Burkina Faso in March 2010. The purpose of the meeting was to reflect, analyze and

consider the reduction of the medical evacuations out their regional space through better organization and medical collaboration.

Context and justification

The Member States of the UEMOA have the ambitious objective to develop their systems of health. To this end, the structures of care are organized according to a medical pyramid with three levels. The first level is basic healthcare at the district level, under the responsibility of a general practitioner. The second level is under the responsibility of specialist doctors, who receive patients that are evacuated from the districts. The last level consists of hospitals, which are further equipped and are charged with delivering even more specialized care.

Facing a lack of resources, these West African states are confronted with two difficulties: to ensure the extension of basic care at the first and second levels in order to serve the greatest number, while also developing



Map of West Africa locating the 8 Member States of the UEMOA

specialized care at the third level to ensure the care of the most severe cases.

Progressively, with the consolidation of medical coverage, the need for evacuations to specialized hospitals continues to grow and diversify. Unfortunately none of these states has sufficient equipment to face the growing requirements. These states have thus relied on the hospitals of Europe, the United States, and North Africa (Morocco and Tunisia). These evacuations to facilities beyond the home community constitute significant expenditures (approximately 8 billion francs CFA per annum), without the possibility of improving the local medical system.



Participants of Burkina Faso and Côte d'Ivoire surrounding the Head of the Department of Social and Cultural Development (March 2010)

General objective

The general objective of the recent dialogue was to identify and evaluate the specialized care facilities in each country that could function as regional centers of excellence in order to reduce the medical evacuations out of UEMOA space. These evaluations were made by a competent authority¹ under the supervision of an international expert².

Results

The total number of evacuations made by each country's Council of Health during

the years 2007 and 2008 is 1547 patients for the eight countries of the UEMOA.

The evacuations organized by category are as follows:

- Cardiovascular system: 305 cases (22.6%)
- Musculoskeletal system: 245 cases (16%)
- Urinary tract: 237 cases (15.3%)
- Nervous system: 151 cases (10%)
- Ocular system: 142 cases (9%)
- Gynecological system: 133 cases (8.6%)

Pathologies of these six systems account for 81% of the medical reasons for evacuations.



Participants of the Ouagadougou UEMOA meeting (March 2010)

These 1547 patients are distributed by country as follows:

- Benin: 217 cases
- Burkina Faso: 182 cases
- Côte d'Ivoire: 29 cases
- Guinea Bissau: 747 cases
- Mali: 108 cases
- Niger: 203 cases
- Senegal: 28 cases
- Togo: 3 cases

Among six countries (excluding Togo, whose Council of Health did not sit and consequently did not evacuate any patient during the period, and Guinea Bissau), 767 patients were evacuated by the Councils of Health out of the region in 2007 and 2008. The case of Guinea Bissau is to be taken separately because it evacuated nearly as many patients as all of the other UEMOA countries combined. Its 747 cases were evacuated principally due to urinary pathologies (e.g., urolithiasis, hydronephrosis), which are dealt with successfully in almost all the UEMOA countries.

Among the pathologies listed for the evacuations, most frequent are:

- cardiovascular: congenital cardiopathies, valvular diseases, auriculo-ventricular block
- musculoskeletal system: osteoarthritis of the hip and arthrosis of the knee
- cancerology (radiotherapy): uterine collar and breast cancer
- nervous system: encephalic tumour, meningioma, slipped disc
- ophthalmology: retinopathy repair, lesion of glazed, glaucoma

Reasons given for evacuations are as follows:

- insufficient materials
- insufficient human resources
- political or administrative pressure
- the kindness of the doctors
- insufficient hygiene in local health facilities

The direct cost of these evacuations was evaluated at 13, 445, 421, 453 FCFA, or approximately 7 billion francs per annum.

Recommendations

A list of one to four centers of specialized care, based on facility and not specific pathologies, was proposed and validated. These centers will be the subject of a thorough evaluation, which will make it possible to classify them and to obtain a final list of centers of high-level care eligible to profit from the support necessary to become centers of excellence in the UEMOA region.

The recommendations are as follows:

- To work out a regional medical map of the centers of specialized care
- To educate and inform the decision makers, health personnel, and the population

- To motivate health personnel
- To increase material resources
- To organize regular specialist missions in UEMOA countries for the local assumption of responsibility of certain priority pathologies in Guinea Bissau and in other countries
- To plan the initial and continuing specialized trainings of the health personnel and managers of these centers
- To create training structures for the maintenance of medical material
- To establish the institutional environment (equipment, maintenance, administration, management, control, quality assurance)
- To institute a universal system of addressing disease risk

Conclusion

This regional initiative requires the initiative of local actors and decision-makers in the health field to be coordinated with the integrated efforts of all countries concerned. Realizing this approach to medical collaboration requires overcoming the difficulties inherent in any project in a developing country and making an effort to procure adequate technical material. National medical associations as well as institutional professional organizations must be invested in the initiative in order to successfully address the challenge of integration.

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The Czech Medical Association (CzMA)



Jaroslav Blahoš

The CzMA is a voluntary and independent organization of medical doctors, pharmacists and workers in the healthcare services and related fields. Our membership has been gradually increasing since 1989 when the CzMA became a democratic institution with a democratically elected president and

council members. Similarly, the chairs and councils of individual scientific societies are elected by secret ballot. The members of the CzMA are affiliated on the basis of their specialties in individual scientific societies. In larger cities the doctors organize the local medical clubs. Currently, 107 scientific societies and 40 local clubs are registered within the CzMA.

The history of the CzMA dates from the middle of the 19th century and is closely linked with the propagators of national Czech medical science. Their main representative was Jan Evangelista Purkyně (1787 – 1869), the world-renowned scientist, physician and humanist. In 1862, Purkyně and his colleagues founded the “Club of Czech Doctors,” the predecessor of the CzMA. His name gives prestige to the title of our Association. By associating ourselves with this great personality we express our continuity with the tradition and his human and scientific legacy. The aim of J. E. Purkyně and his col-

leagues was, above all, the development and propagation of knowledge of medical science and related fields and their application in healthcare for the people. These fundamental aims remain unchanged to this day.

The CzMA is the major representative body of scientific medical activities in the Czech Republic. It initiates and supports science and specialist work in a broader sense, not only within its own ranks, but also by offering its experience to other healthcare organizations, e.g., the Ministry of Health, Ministry of Labour and Social Affairs, professional chambers, health insurance companies, and other domestic institutions, including organizations concerned with ethical, pastoral, and ecological issues, the environment, safety and health, and welfare institutions.

The Association is strongly involved in postgraduate and continuing medical education in almost all fields of medicine, and organizes many national and international congresses, symposia, and courses. The CzMA also takes an active part in organizing scien-

tific meetings connected with the most important medical and pharmaceutical exhibitions in the Czech Republic.

The CzMA is editor of 29 medical journals, which are distributed in the country and abroad. The CzMA also has close relations with European and international medical associations. Of these, the most important are the World Medical Association (WMA), the Forum of European Medical Associations, the WHO (in which the

CzMA is represented in the Council), and the Council for the International Organizations of Medical Sciences (CIOMS). We work closely with our friends and colleagues in the Slovak Republic even after the separation in 1993 from the Czechoslovak Medical Association.

Our scientific societies are members of various international organizations. Many of them are representatives in the committees and councils. The CzMA awards honours

and prizes, which are received with great respect. The most prestigious of these is the J. E. Purkyne Prize, which is awarded once a year to one distinguished medical personality, with the ceremony taking place at the castle of Libochovice (near Prague), Purkyne's birthplace.

Professor Jaroslav Blahoš, MD, DSc.

President, Czech Medical Association

Former President, World Medical Association

Brazilian Medical Association (AMB): Objective and Actions

The mission of the Brazilian Medical Association (AMB), founded in 1951, is to advocate for the professional dignity of physicians and for quality health assistance to the Brazilian population. AMB is composed of 27 State Medical Associations and 396 Regional Associations. Moreover, AMB's Scientific Council is composed of 48 Medical Societies, representing the 53 specialties recognized in Brazil. AMB is a member of the World Medical Association and is co-founder of the Portuguese Language Medical Community.

Areas of Action

Professional Qualification

Undergraduate Studies: AMB has been fighting against low quality medical schools since its foundation. Advocating for better medical professionals.

Board Certification: Since 1958, AMB has been pursuing scientific improvement and professional recognition for physicians through board certification after approval in rigorous examinations. AMB also manages the credits required for updating the board

certification through the National Accreditation Committee (CNA).

Continuing Medical Education (CME): Physicians' scientific knowledge is updated through the CME program. Developed in partnership with the Brazilian Council of Medicine, the program is online, free of charge and available for all Brazilian physicians.

Guidelines Program: Since 2000, AMB designs medical guidelines based on scientific evidences in order to standardize practices and support physicians on diagnosis and treatment. More than 300 guidelines have been created since then, all of them available at www.projetodiretrizes.org.br.

Professional Recognition

Regulation of the Medical Profession: AMB is actively involved in the discussions concerning Bill No 7703/06 (Medical Act), a proposal to regulate Medical practice.

Brazilian Classification of Medical Procedures (CBHPM): Developed and continuously updated by AMB, the Brazilian

Council of Medicine (CFM), the Physicians National Federation (Fenam) and the Societies of Medical Specialties, the Brazilian Classification of Medical Procedures (CBHPM) lists all medical procedures scientifically proved and became a reference of health quality for the population.

Position, Career and Wages Plan: AMB is member of the Committee in charge of developing a medical career and wages plan for doctors working at the Brazilian Unified Health System (SUS).

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The Medical Chamber of Serbia

The Medical Chamber of Serbia was revived in 2006, drawing upon the tradition of the Medical Chamber established in 1901 in the Kingdom of Serbia. The original Chamber played a very significant role in the work and life of physicians of that time, however, the functioning of the Chamber was banned after World War II by the new communist authorities, as was the case in all the countries in our neighbourhood.

Within the framework of the reform of the health sector in 2005, the Ministry of Health initiated the establishment of a medical chamber by virtue of the Law on the Chambers of the Medical Profession. Elections were organised to this effect, and MDs from both the public sector and the private sector were appointed to the Assembly of the Medical Chamber of Serbia thus establishing an integrated chamber of doctors of medicine in 2006.

The beginning of the functioning of the Medical Chamber was not simple; we invested a lot of effort in the endeavour, and we did not hesitate to seek and accept advice from chambers with a longstanding experience. Very shortly we drew up our Statute, and then, acting on the basis of the public authority we were vested with on the basis of the Law, we drew up our Code of Professional Ethics, and proceeded with drawing up the full list of MDs and relevant records, and issuing licences and ID cards to eligible MDs, including the drafting of the necessary codes of rules for the functioning of the committees, and organising of our courts of

honour, and all the other aspects necessary for ensuring continuous medical training.

Our Chamber is a self-sustained and politically and economically independent professional organisation, financed from its own sources. All the MDs working in the bodies of the Chamber provide their services without any remuneration, being assisted in that process by the relevant support services involving lawyers, economists, IT experts, and others, who receive appropriate fees.

On the basis of the Law on Health Care issued by the Ministry of Health of the Republic of Serbia, membership in our Chamber is mandatory, and membership fee is proportionate to the member's monthly income. Currently, there are 29 500 doctors of medicine in Serbia, 26 200 of whom are public employees, while 3300 are in the private sector.

Unfortunately, MDs from the private sector are not included in the health care system of our country, as a result of which patients have to pay for the relevant medical services from their own resources.

The Medical Chamber is an institution performing the tasks delegated to it as well as other activities from the purview of the medical profession, and since we dispose of the professional potential of our members – MDs, as well as that of our support services, our objective is to become part of a health care system accessible to all MDs, through which they will be able to influence the resolution of issues relating to the medi-



Nada Radan-Milovančev

cal profession. We have a vision, and we are aspiring for becoming a significant factor in the decision taking process affecting the health care system of our country, as well as aiming to influence the content of all the laws relating to the medical profession.

We take great pride in all that we have achieved over the past four years, particularly stressing the establishment of contacts and friendships with numerous chambers in Europe, the gathering together of the representatives of 15 chambers at the ZEVA Meeting in Belgrade, in September 2009, as well as the fact that we have been keeping abreast of all the developments at the level of CPE and EFMA, and most importantly, the fact that the procedure for the admission of our Medical Chamber to the WMA is in process.

*Dr. Nada Radan-Milovančev
President of subcommittee for international
cooperation of the Medical Chamber of Serbia*

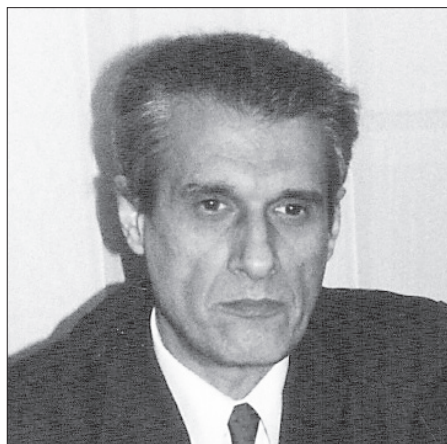
Poor Health System and Active Macedonian Medical Chamber

The Republic of Macedonia is situated in the southern part of the Balkan Peninsula. Won independence after World War II, in

which its citizens took an active part on the side of the antifascist coalition. After the war, Macedonia was part of Yugoslavia, as

one of the six equal federal republics. With the dissolution of the federation, in 1991 the Republic of Macedonia gained its independence and sovereignty.

Macedonia covers an area of 25,713 square kilometres, populated with 2,048,619 inhabitants, according to the data from 31



Josif Dzockov

December 2008. The capital is Skopje, known as a city of solidarity, the name it got after the disastrous earthquake in 1963, when many countries around the world helped to build what was crashed by the natural disaster.

After the liberation of Macedonia in 1945 it was not sufficiently built, without significant industrial facilities and with general poverty. The country was extremely poor, agrarian, with a developed trade production. Evident was the high mortality of the population that reached up to 21 per mille and mortality of infants of 154 per mille. Sixty years later, the overall mortality rate decreased to 9 per mille, and the mortality rate of infants to 12.8 per mille (data from 2005). In 1945 there were in total, 123 physicians and dentists, 92 pharmacists and 120 nurses. There was no significant health infrastructure. In addition to several hospitals, others were mostly small makeshift ambulances and health clinics. During this period the country faced major epidemics of malaria and tuberculosis. This situation changed over the years in former Yugoslavia and a significant improvement was the result of building health facilities supplied with new equipment and education and training of the medical personnel abroad (not only in more developed Yugoslav cities and hospitals, but in foreign countries as well).

The first Medical School (Medical Faculty) was established in November 1947, when the first generation of doctors began their studies. The teachers of the first Medical School were not only Macedonians, but were mostly from Croatia, Serbia, Russia and other countries. On the other hand, in the period between the two world wars many Macedonians studied medicine in several countries in Europe, mainly in France, in Bordeaux and Paris, in Switzerland, in Geneva, and in several universities in Italy.

The state currently has three Medical Faculties that educate medical staff. After the last complete independence of the country (1991), the state found itself in a poor situation, as a result of the need for construction of the new state infrastructure, economic blockades, military conflict in the country in 2001, ongoing privatisation of commercial enterprises that produced many unemployed people and so on.

Under such conditions, in 1995 the Parliament adopted a new Law on health care that was supposed to follow new trends in health care in Europe, setting conditions for a modern health care system. Over the past fifteen years the law has experienced a total of 11 changes that harmonised the system with new experiences and achievements in the country and abroad. However, the low gross social product doesn't allow developing of the system that will fully meet the modern experience.

Today in the Republic of Macedonia there are over 8000 active physicians in all specialties. Most of them are doctors of general practice. Their number is around 2500. The number of unemployed doctors in the country is around 350, so we are not in a shortage of doctors, on the contrary. Many of them are in specialisation training abroad, or they work abroad, and in the state are registered as unemployed. There are also trends in temporary employment abroad. Also, there are doctors that seek permanent employment with the departure to other countries.

What concerns, is the high age of doctors and uneven distribution in the country.

The reform of the health system was started by the process of privatisation in the health care. All the doctors in primary care are privatised, except a small number of them that take care of immunisation of the population. Doctors are paid through the so-called system according to the number and age of the patients attached.

Similar processes are planned for consultative and specialist care. The next stage should be the transformation of hospital care, planned to function as public private partnership.

Currently in Macedonia health care providers are about 8000 doctors, 2500 of whom are primary care physicians, 2000 are specialists in specialist consulting health care, or 2.5 doctors per 1000 inhabitants. The state has about 9500 hospital beds or one bed per 219 residents.

At present time there is an ongoing process of building modern private health care facilities – modern hospitals, organised with private venture capital from the country and abroad. They manage to survive by practising medicine in areas not requiring lengthy and costly procedures for treatment. Thus, they are competitive on the market for health services and can afford to purchase modern equipment and high salaries paid to physicians. That's why there is an ongoing process of migration of physicians from public to private hospitals. In contrast, state hospitals and university clinics as part of the public health, are suffering from insufficient funds with resulting constant problems to maintain the system. Obvious is the poor condition of many facilities equipped with outdated equipment, providing health care in the public health area.

This is a basic situation that served as a background for foundation, organisation and operationalisation of the Macedonian

Medical Chamber. It was restored in 1992, even though, the first association of doctors in a chamber in the region of present-day Macedonia, which before World War II was called Vardarska Banovina – as a part of the Kingdom of Yugoslavia, was formed on 15 December 1929. The Chamber has been active until the beginning of the Second World War.

Today the activities of the Medical Chamber are going in two directions. The first is the scope of work arising from the Statute, Code of Medical Ethics and Deontology and the annual work programme, and the second is the public authority that the Chamber received on the basis of the Law on Health Protection.

Macedonian Medical Chamber, in the place it has in the health system and organisational structure, has adopted the work of the entities that make up the system. Besides the organisational activities arising from the work of the Chamber, through its representatives it actively participates in many bodies where health, health policy and related professional activities are discussed. In this regard, we can say that there is relatively good co-operation with state authorities, the Parliament of the Republic of Macedonia and its Ministry on Health, Health Insurance Fund and other institutions. Although representatives of the Chamber tend to be extremely co-operative, only an insignificant number of proposals are adopted by the competent authorities. In this direction, the Chamber frequently makes remarks to the public that it wants to be a part of the solution of the problem, but only if there is a respect to its proposals.

The Chamber received public authority on the basis of the Law on Health Protection of 2004. Those were the Chamber's suggestions dated back in the past. Unfortunately, the state authorities had no hearing on the proposals from the Chamber, although the proposals were based on international experiences. Although the Macedonian Medical

Chamber was very ahead of the surrounding countries, public authority was won and implemented much later, when these things were operating for many years in those surrounding countries.

Public powers can be divided into three areas. First, the Medical Chamber is leading the process of internship and exam taken by doctors who have completed medical school, after which they have the right to apply for a license to work. Second, the Chamber is authorised for the issue, continuance, renewal and the taking of the licenses for working. In connection with the licenses process, in the second phase, the Minister of Health is authorised to make the final decision. Third, the Chamber maintains a registry of doctors in the Republic of Macedonia, who have a license for working or general license.

Achieved results confirm the correct move by the deviation of the Chamber's authorities to the public powers. The exam is noted to be consistent with the educational process, especially in the area of governance skills. Also the extension of the licenses triggered the process of continuous medical education and permanent professional development.

Doctors' Chamber permanently required being an active partner of the government in making the health policy in the state. Although this definition was introduced in the legislation, after a certain period, with changes in the law, it was withdrawn. Currently the Chamber is on track to restore that right. The Medical Chamber seeks and expects to receive request to be consulted when making decisions in the Health Fund. What in particular will the Medical Chamber contribute if getting the right place in the health care system, is the adoption of a Law for doctors' work, which has been in preparation for almost 15 years. Despite numerous attempts to enter the legal legislation, authorities have not accepted it until now.

Besides these high priorities, Medical Chamber has set many goals to get its valo-

risation. Among other things, that is: providing working conditions, receiving modern equipment in public hospitals, a real appreciation of the work of doctors, etc.

Medical Chamber has its own web page: www.lkm.org.mk and the periodical "Vox Medici", which comes out every three months, printed in 6500 copies, and delivered to all the doctors in the country. The journal publishes information of the Chamber's work, and beyond, about the situation and problems in health care, educational materials and professional papers that are mandatory to review.

There is also the Macedonian Medical Association, as an association of specialist associations in the state.

Macedonia is a small and underdeveloped country. With the gross national income in 2008 of 2980 dollars per capita, Macedonian citizens were annually allocated 7.2 per cent of salaries or 160 Euros per capita. The real situation can be seen considering that the state has about 600,000 employees and the unemployment rate of 37.3 per cent – one of the highest in Europe. Despite this general condition, health care is delivered to all residents of the state. If one had in mind all this information, it would be clear that it is difficult to support a modern and quality health system in Macedonia, but we are doing everything we can.

As a result of our tendency to be integrated in the general European medical processes, this year from 30 September until 2 October we will be the host for a ZEVA meeting – the Symposium of the Central and Eastern European Chambers of Physicians (for the second time).

Sincerely we are hoping to meet as much participants from these countries, and also guests that are not in this group as we can.

*Josif Dzockov,
Medical Chamber of Macedonia*

Health Policy Reform in Albania and Development of the Order of Physicians of Albania



Shaqir Krasta



Din Abazaj

Since 1990, after the changing of the political and social regime, the health system in Albania encounters a lot of difficulties related to:

- very limited technical capacities to establish policies, strategies and national plans;
- the insufficiency in the health care system financing and weak capacities in the field of health management;
- not yet applied institutional and individual professional accreditation;
- the missing decentralisation of competences ranging from government authorities to health institutions and public entities and, as a result, not quite appropriate functioning of the orders and professional organisations;
- the lack of experience in monitoring and controlling the private activity;
- the lack of diagnostic equipment and curative services.

One of the acute problems is the unequal distribution of medical staff. Many communities are left uncovered by the health

service. As a result of free movement and the migration towards big cities or abroad, the physicians have abandoned their working places in remote rural areas.

Taking into consideration the above-mentioned problems, the health reform in Albania was concentrated in an ambitious strategy that introduced many challenges to be faced.

Facing these challenges, Albania has already gained advancements in many sectors, setting up of necessary structures in the sectors of Health Insurance Policies and Management, Quality Control, Accreditation, Licensing, Monitoring, CME, Standardisation and Maintenance of medical equipment and others.

- Actually, the reforming policies concerning the health care system in Albania are directed towards:
- Improvement of the quality of health care.
- Augmentation of access and possibilities to offer health services nearer to the communities.

- Improvement of the budgetary and managerial capacities in the health care system.
- Inclusion in the health insurance scheme of all health services and liberalisation of health insurance trading.
- Improvement of the infrastructure and equipment of health institutions by introducing contemporary technologies.
- Extending information technology to all of the system.
- Institutionalisation of the continuous medical education with accredited programmes and, in relation to this, professional revalidation, recertification and periodic relicensing of health care system professionals.
- Accreditation and licensing of health institutions, management of the risk and improvement of the quality of health institutions, introduction of indicators for performance, efficacy and effective measurement.

Connected to these, the National Centre for Continuous Medical Education and the National Centre for Quality, Assurance, and Accreditation of Health Institutions are established in Albania. Regarding this, special attention has been focused on the collaboration and inclusion of the professional orders and associations.

In this regard, after the changes in the socio-economic and political system, in 1994, by a law of the Albanian Parliament the Order of Physicians of Albania, as a new body without any precedent in the Albanian medical history, was created. This entity began the activity in the circumstances of a very difficult transition in all sectors of the Albanian social life.

Until 2000, the Order for reasons of a handicap to the first law was completely depending on the Ministry of Health; its activity and competence were very restrained. In 2000, the new Law No. 1615 "On the Order of Physicians in the Republic of Albania", which considered the Order an indepen-

dent “public entity”, was promulgated. Just from this time the Order began to develop and enforce the institutional capacities and functioning as an effective, independent, professional body.

The Law assigns the mission of the Order of Physicians, stimulation and preserving of high standards of practising, formation and professional education of the doctors, and protects patients and the public from the misuse and malpractice of health services.

For the implementation of this mission, the National Council of the Order has oriented its work towards these main objectives:

- Raising the institutional capacity and effectiveness of the Order.
- Establishing its independent budget.
- Creating the normative acts based on the Law, Statute, Code of Ethics and Medical Deontology, and the regulations of the Order.
- Establishing the National and Regional Register of doctors, provision of its informatisation and updating.
- Assignment of the medical practise standards and the professional education of doctors.
- Fitness to practice.
- Relations and communication with the public.
- International relations.
- Partnership with the Ministry of Health, Faculty of Medicine and other health system actors.

The progress during these years has been remarkable. The Order has raised the administrative capacity for all its structures. Nowadays the Order is functioning as an independent body and effective partner of the Ministry of Health.

The new Code of Ethics and Medical Deontology, as a data base of professional standards, compulsory to be applied during the medical practice, is available to every doctor and stomatologist.

The establishing of the **National and Regional Register** of the members of the Order and the inauguration of a website (www.urdhrimjekve.org) were the most important accomplishments during these years. This register, compiled as a data base, serves for the periodic professional revalidation of doctors and their relicensing to practise profession.

For the doctors, who are not fit to practice, disciplinary commissions of the first degree at the Regional Councils and the National Commission for Disciplinary Judgment of the second degree (appeal) are established. New regulations for the functioning of these commissions has been approved by the National Council.

The Order of Physicians is a new body without experience, tradition and precedents in the Albanian Medicine. These circumstances dictate widening of the relations with homologous bodies of other countries and international forums. Except bilateral relations, the Order of Physicians of Albania is a member of a number of international organisations, such as: IAMRA (International Association of Medical Regulatory Authorities), WMA (World Medical Association), EFMA (European Forum of Medical Associations), CEOM (Conference des Ordres des Médecins), G.I.P.E.F. (Association of the Medical Orders and Chambers of Mediterranean Countries), ZEVA (Symposium of the Medical Orders and Chambers of the Central and East European Countries), etc.

The extension and improvement of international relations aim at drawing the Albanian medicine nearer to and integrating it with the European medicine. These initiatives have a positive impact and have *“allowed the Order of Physicians of Albania to stand itself as a credible partner towards patients, the Ministry of Health and other factors and actors of the health system”*.

A positive influence on the increasing of credibility and recognition of the Order by the state structures as an independent body of medical self-regulation and on the consolidation of partnership with these structures have visits of many delegations of homologous bodies and international forums and their meetings with the state authorities of our country.

Actually the Order’s activity is aimed at these priorities:

- Perfection of the activity for increasing and consolidating the acknowledgment and credibility of the Order.
- Consolidation and the holding of a firm financial budget.
- Activities vitality and agility for standards of medical educations and everyday medical practices stimulation and improvement
- Maintain the Code of Ethics and Medical Deontology, and upwarding the moral image of doctors toward the society.

The membership and registration to the Order of Physicians of Albania is compulsory and a condition for practising the profession.

The constitutional bodies of the Order are:

- Order’s assemblies (National Assembly and Regional Assemblies).
- Order’s councils (National Council and Regional Councils).

The Order’s councils are elected by the assemblies, respectively the National Council by the National Assembly and the Regional Councils by the Regional Assemblies.

The Regional Councils of the Order are set up and operated according to the administrative division of the country in 12 districts. The assembly meetings and council elections are held every 5 years.

*Dr. Din Abazaj, President of the
Order of Physicians of Albania
Dr. Shaqir Krasta, General Secretary of
the Order of Physicians of Albania*

Bulgarian Medical Association



Stefan Konstantinov

The Bulgarian Medical Association (BuMA) is a legal representative of doctors in Bulgaria. Membership is obligatory for everyone who wants to practice medicine in the country. The organisation was founded in 1901. During the communist regime it was banned.

BuMA is comprised of 28 regional colleges of physicians with large autonomy. Every regional college maintains a registry of doctors with unique identification numbers given by the central office. At the beginning of 2010 the registry comprised about 34 000 doctors, the number of practicing doctors being about 30 000.

Each regional structure appoints delegates who every 3 years elect the Board of BuMA.

Besides the typical tasks of a medical chamber, such as preparation and surveillance of Professional Ethics Code, good medical practice, registry of doctors and continuous medical education, BuMA has specific tasks concerning professional interests of its members. The most important among them are the negotiations with the National

Health Insurance Fund (NHIF) and signing the annual frame agreement. In Bulgaria the National Health Insurance Fund is the major player in health insurance. Private funds hold a very small part of the market although their number is 21. The negotiations with NHIF quite often dominate over other functions of BuMA.

What happened in health care in Bulgaria last year?

There were two landmarks affecting it: the first – the general election held in 2009 and the second – the economic crisis.

The centre-right GERB party, which won the general election last July, was expected to start the health reform. The list of the problems that had not been solved for years was quite long: chronically underfinanced health sector, low level and inefficacy of public expenses, increase of informal payments and decrease of patients' satisfaction, young doctors leaving the country, heavy administration. But instead reforms the major changes which the Parliament made were associated with a substantial reduction of the budget – especially concerning – from 476.192 million Euros (BGN 931.432 million) in 2009 to 362.439 million Euros (BGN 708.932 million) in 2010, i.e. approximately 222 million Euros less. At the same time the state presence in the otherwise independent NHIF was reinforced. And finally and probably the most important – its financial reserve was included in the fiscal reserve of the country in order to keep the budget deficit to an acceptable level.

The financial restrictions led to significant delays of fund disbursements to doctors and hospitals by NHIF and resulted in widespread discontents which found expression in closure of medical offices in the period between 8th and 10th March 2010 and more feeble protests at the hospitals on 7th April.

At the same time attempts to restructure and decrease the number of hospitals in Bulgaria failed. At present we have 331 hospitals in contracts with NHIF. This number is quite high for a country with a population of 7.607 million.

As a whole, the task to implement a health reform under the conditions of an economic crisis and severe financial restrictions is left to the newly appointed minister of health care. Still the major challenges are open. Such as the way of financing hospital care. At present Bulgaria uses the so-called clinical paths. In the course of years the data of morbidity were distorted. Generally low prices and lack of efficient control led to the increase of hospitalisations on national level. There is a considerable disproportion between prices of different clinical paths due to lobbying. Despite the long-running discussion about the introduction of DRGs there still is no such decision.

The problems of outpatient care are also important. Bulgaria has a system of GPs acting as gatekeepers. Access to a specialist is only by a referral from GP. Yet again financial restrictions make maintaining good level of health care difficult. The change of the way of regulation is necessary more than ever, but politicians are reluctant. Fears from unpopular measures like co-payment are stronger than the will for reforms.

The membership of Bulgaria in the EU had no direct impact on health care because the country suffered to take advantage of European funds.

That is the environment in which BuMA works. Besides the internal affairs to deal with BuMA has representation in several international organisations – CPME, FEMS, AEMH – and closely monitors what happens with the common problems of doctors in Europe.

*Dr. Stefan Konstantinov,
Vice Chairman of the Bulgarian
Medical Association*

Medical Women's International Association (MWIA)

MWIA is an association of medical women representing women doctors from 76 countries in all five continents. MWIA is non-political, non-sectarian, non-profit-making. The different cultural backgrounds, medical traditions and problems of its members provide a stimulating forum. There are four types of membership within the association:

- a) affiliated national associations,
- b) individual members,
- c) honorary members,
- d) members of honour.

All medical women, qualified according to the accepted standard of the medical profession in their country, are eligible for membership. It is also a requisite that all qualified medical women of the country (the National Association) must be eligible for membership irrespective of race, religion or political opinion.

The powers of the association are vested in the delegates of the membership, which

elect an Executive Committee to facilitate and expedite the handling of affairs of the association in the intervals between the triennial meetings of the General Assembly.

The legal Head Office of the association is in Geneva, Switzerland. The Administrative Headquarters are at the present time in Vancouver, Canada, where the activities of the member national associations and individual members are coordinated.

The organisation is composed of 8 geographical regions. Each region is represented on the Executive Committee by its vice-president. The president, president-elect, treasurer, secretary-general and vice-presidents are elected by the members.

The present aims of MWIA are: To offer medical women the opportunity to meet so as to confer upon questions concerning the health and well-being of humanity. To promote the general interest of medical women by developing cooperation, friendship and

understanding without regard to race, religion or political views. To overcome gender-related inequalities in the medical profession. To promote health for all throughout the world with particular interest in women, health and development.

International congresses and general assemblies are held every 3 years in various countries of the world, e.g. 1998 in Sao Paulo, 2001 in Sydney, 2004 in Tokyo, 2007 in Ghana. This year the MWIA congress will take place in Muenster/Germany 28–31 July 2010. Topic: Globalisation in Medicine – Challenges and Opportunities.

We as women and particularly women physicians need to continue to make our voices heard, as we fight for the rights of women and women's health care.

In 2001, the Medical Women's International Association wrote a Training Manual on Gender Mainstreaming to educate medical personnel on the importance of considering gender when providing health care. It can be accessed at www.mwia.net and speaks in language understandable by medical personnel and gives case examples.

MWIA was founded in New York, 1919. The various committees within the organisation provide the executive board with ideas and impulses for activities, be it topics for discussion, future projects or active participation with organisations sharing areas of common interest.

The association has consultative status with the Economic and Social Council of the United Nations and is in official relations with the World Health Organisation. The activities of the association are supported by its members through dues and honorary service.

Dr. Waltraud Diekhaus, 9 years Secretary-General of the organisation, since 2007 Vice-President Central Europe



Cruise 2004, Tokyo, Mallorca, Schweden, ExCo, Sri Lanka

Medical Students in Action



Minke van Minde

For almost sixty years, medical students are joining forces to improve health all over the world. They organise projects and run exchange programs coordinated on a local and national level. The national members are united by the International Federation of Medical Students' Associations (IFMSA), one of the largest student organisations in the world. Currently IFMSA represents over 1.2 million medical students, in 2010 97 national organisations are members in 92 countries across the globe, covering all continents.

The IFMSA is an independent, non-political organisation founded in 1951, officially recognised by the United Nations as a non-governmental organisation, by the World Health Organisation (WHO) and the World Medical Association (WMA) itself. The partnership with the WMA is a long-lasting and fruitful one. IFMSA's General Secretariat is based in the WMA's office and many IFMSA alumni are members of the WMA.

After 59 years, IFMSA has now an extremely large network due to its many active members from different backgrounds. The mandate of the IFMSA is to train medical

students at an early age to become advocates for health issues that they will face after as practitioners. This is executed throughout different fields such as Medical Education, Professional and Research Exchange, Human Rights and Peace, Public Health and Reproductive Health. Every year, around 10 000 students participate in the exchange programs of IFMSA abroad – gaining exposure to patients in an international setting, learning about new types of disease processes endemic to a different region, and experiencing first hand the cultural and ethnic diversity of our planet.

IFMSA national member organisations organise numerous projects in the fields mentioned above. 47 of them are IFMSA-recognised projects, which receive IFMSA international support and are often organised in more than one country. Partnerships are established between different organising countries as well as with other NGOs and organisations, which strengthens the project and its cause.

The IFMSA would like to encourage partnerships between its national member organisations and the national members of the WMA, which could have a beneficial outcome for both. Collaboration between doctors and medical students in one country unifies the voice of the medical sector and empowers future doctors and medical professionals to develop themselves in their projects and resources. Medical students are always very eager to get into contact with medical professionals and learn from their experience. The same applies to medical students who would love to benefit from the knowledge of the medical association in their country.

One of the projects that is organised by a majority of the IFMSA members is the Teddy Bear Hospital. Primary school children are invited to come to the hospital

with their dolls or teddy bears who are ill and take them to the medical students who act like the “teddy bear doctors”. Children are introduced to wearing hospital clothes, x-rays, medicine and treatment. The focus of this project is the children dealing with the topic “hospital and illness”. Impressions and ideas, which children have acquired in family and from media, should be critically looked at and corrected in playing if necessary. The topical center lays in the meeting between child and future doctor. Aim of every medical work should not only be the treatment, but also the building of a solid foundation of confidence between the doctor and his little patient. Aim is to show the children that illness and the fight against it is part of everydaylife and does not necessarily have to be experienced as threatening or frightening. The medical students practice in dealing with children in a hospital environment and are trained to develop skills in children's communication.

IFMSA has a range of donation-focused projects concerning organ donation, blood donation and marrow. One of the aims is to teach medical students about the aim of donation, while the other aim is to recruit new donors and educate the public using different methods. Medical students give peer education in high schools, organise street actions or active donations days. All this should meet the ultimate goal: decrease the list of patients waiting for organs, blood or marrow and improve their lives.

In some countries a first aid course or training is not included in the medical curriculum. That motivated many IFMSA members to organise this training to teach medical students the general skills they should be able to acquire as medical students. Workshops include reanimation, basic life support training, taking blood, and physical exams. After the course students have to take an exam to evaluate whether they possess the skills taught. In some faculties they liked the course so much that it is now included in the medical curriculum!

World Medical Journal



Apart from projects IFMSA organises several advocacy events. Major events are held in IFMSA member countries, such as World AIDS Day, Tobacco Campaign and World Tuberculosis Day. During these events medical students actively advocate in the benefit of reducing AIDS, tobacco use and tuberculosis. This is done by organising advocacy events and joint ventures all over the world. For example World AIDS Day is now organised in 40 member countries and more than 10 000 young people are reached.

The IFMSA Exchanges are the biggest project run in the IFMSA. As mentioned over 10 000 participate each year. This needs

a lot of coordination effort on a local, national and international level. Luckily there are many doctors and professors willing to collaborate and invite an exchange student to their department, in order to give the student an amazing experience in a foreign hospital. Because of this collaboration IFMSA can successfully organise its exchanges for years now.

The IFMSA is still working to improve itself and to move forward in this rapidly changing world.

In order to do so and to execute our aims we are more than eager to work together with

medical professionals to teach us skills and to enrich us with their knowledge.

Let's work together for a healthier tomorrow!

For more information about IFMSA, please visit www.ifmsa.org

Minke van Minde, IFMSA Vice President for External Affairs 2009/2010

News from Canada

CMA President warns "If we want to save Medicare we have to change it"

At its annual meeting in August this year the CMA annual meeting will debate a plan for transfiguration of the healthcare system. CMA President Dr. Anne Doig, speaking to the Canadian Club of Ottawa recently gave the above warning, saying that transformation is needed to ease pressure that is increasing in all health sectors. Illustrating this by referring to the fact that Canada has the highest bed occupancy among members of OECD at 91%, she pointed out that 25-30% of those whose acute beds are filled by people who should even not be in hospital "Those patients need 24 hour supervised care, not hospital care".

She said that time had caught up with the five medicare principles outlined in the Canada Health Act (CHA). e.g. The CHA promised universality, but essentially, this applies only to hospital and physician services, at a time when demand for other types of care that are not covered is mushrooming. As a result, the burden of continuing

care is falling on informal, unpaid caregivers whose needs were not foreseen by the CHA. Because people are living longer, roughly one in five Canadians aged 45 and over are now providing such care. Dr. Doig said the CMA act of 1984 may have promised comprehensive care, but in 2010 is unable to deliver it.

When the CHA became law in 1984, physicians and hospital services represented 57% of total health spending, and this had declined to 41% by 2008. "Today, programmes such as seniors' drug coverage and home care that are not subject to CHA criteria consume over 25% of total public spending on health".

She concluded on a more optimistic note, pointing to innovations such as Quebec's plan to introduce a personal annual health account to promote accountability and transparency, and the establishment of health "quality councils" in six provinces. "Innovation is happening across the country not by sacrificing the principles of the CHA, but by building on them. "We

need to capture the momentum for change growing across the country and marshal that energy into a new national vision for health care"

Euthanasia Bill crushed

A private member's bill seeking to legalise euthanasia and assisted suicide by amending Canada's Criminal Code has been defeated in Canada's Parliament. The bill would have allowed doctors to help people aged 18 or older "die with dignity". The changes would have applied to those "experiencing severe physical or mental pain without any prospect of relief" or who were suffering from a terminal illness after they had expressed "free and informed consent to die". The bill was defeated by 228 to 59 in a vote that crossed party lines. In a letter sent to all members of Parliament before the vote, CMA President Anne Doig said "the CMA supports enhancing access to palliative care and suicide prevention programmes and undertaking a study of medical decision making during dying," but it was worried that the bill would create "a slippery slope".

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World Health Professions Alliance, Geneva, May 2010



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