

World Medical Journal



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- Medical Association of Thailand
- Regulation of Health Professions
- Protesting a System. Turkey

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Instead of Editorial

Clinical, Legal and Political Issues in UK Clinical & General Practice; Personal Observations

Retired does not mean tired again, it means experienced. I am retired from the National Health Service but I do locum GP work because I cannot do gardening at home. From the time one is born until the time one dies, everyone has to fill time. I was lucky to be born as a positive thinker and to remain so. I believe that even God only helps those who help themselves. In addition to Locum GP work, I wear many hats including being an Expert Witness in Cultural, Religious & Ethnic Issues in Litigation and also in GP Negligence. Before saying anything, I check three things: Do I have something new to say? (which I always have). Is there anyone willing to listen to me? How much should I say now and say later? Some people listen to me like a Samaritan but, unlike them, take no notice; others find it thought provoking. Criticism is a positive activity to learn in science and politics. I enjoy knowing that I am a British citizen. Britain is a democracy.

I am aware that in a democracy everyone but everyone has a right to be heard before being ignored. The chairman decides. He/she may ask for a vote if the committee agrees, otherwise the item is taken on board. Only a leader is often elected but their appointees are selected. For me, to live and let live is the best policy, as everyone has their own way.

I enjoy whatever I do, including Locum GP work. The perk in GP work is that nothing can happen without my signatures. I have to be skilful, careful, tactful, alert and helpful, without taking any risk to myself. Locum work is a matter of supply and demand. The Principals would try before they buy. It is a good business and there is no reason to cry. I respect idealists, follow realists but listen carefully to both and take balanced steps.

A locum's job is as good as his/her last performance. You can often win but not always. One must remember that eventually we are all answerable about what we do. One of my GP trainers used to say "As a GP, do right and fear no man; do not write and fear no woman". In golden old days, GPs wrote in patient's notes, sometime illegible even to themselves as there were no solicitors or judges to read their notes. Now it is an era of computers, audits and litigation. Everything changes in this world except this principle.

My suggestions to Clinical Consultants and General Practitioners, in Britain, are:

1. Politics, economics and law have as much to do with "Patient care" as medicine.
2. Academics and Politicians, very rarely respect each other. GPs need them both.
3. Never say "never or always" as anything can really happen in general practice.
4. A GP knows and is expected to know "something about everything".
5. A Specialist knows and is expected to know "everything about something".
6. A GP should deal what is possible and must refer to a Specialist what is not.
7. Hospital doctors can only see patients referred by GPs. Let them see, if needed.
8. Patients' confidentiality laws must be followed in Britain. Write notes clearly.
9. Remember, these notes may be read by patients, lawyers, witnesses and judges.
10. No one is immune from law. Idealists get trapped in breeches more than realists.
11. A GP is akin to a bus driver or a pilot, check everything and drive safely.

Please beware;

- A. Do not become totally subjective. There is no such thing as "my patient".
- B. You only need one patient to complain against you and your life would change.

Please remember;

- A. Do every thing objectively and professionally. Write notes wisely and medicolegally.
- B. Listen to Patients and Academics but remain a Realist. Change with changing rules.

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GP Locum & Expert Witness in Clinical GP Negligence.
Author of Transcultural Medicine.
Expert Witness in Cultural, Religious
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Profile of the Medical Association of Thailand (MAT)



Wonchat Subhachaturas

As the host of the WMA GA 2012 and 192nd & 193rd Council Sessions in Bangkok, Thailand, October 10–13, 2012, the Medical Association of Thailand would like to introduce itself for your background information of the organization.

Inception of the Organization

The Medical Association of Thailand under the Royal Patronage symbolizes the collaboration and cooperation of every physician to intertwine their contribution into 'oneness' in order to carry out the constructive activities that surveillance all physicians to practice under the ethical code.

The Medical Association of Thailand under the Royal Patronage has been functioning to promote and develop issues concerning medical studies, researches, including promoting moral and medical ethics among the member physicians. Moreover, this body has also a close collaboration with public sectors and medical organizations nation-

ally and internationally. This is to scale up medical knowledge and practices of the members to international standard at present and in the future.

The Medical Association of Siam was first initiated on 25 October, 1921 by being registered as an association. The temporary office of the organization at that time was located at the Administration Building of Chulalongkorn Hospital Bangkok, Thailand. There were 10 senior physicians involved in the setting up of the Association. Their names were as follows:

1. Naval Colonel M. J. Thavornmongkornwong Chaiyata: Senior Naval Medical Officer, who became a Naval General later on;
2. Colonel Phrayavibul-Ayuravej: Senior Army Medical Officer; his name before royal appointment was Sekh Thamsaroch;
3. Colonel PhraSakda Pholrak: Director of Chulalongkorn Hospital; his name before royal appointment was Chuen Phutiphat, later on, becoming an Army General, he was Phraya Damrong Phatta Phattayakhun by royal appointment;
4. Ammart Tho Luang Ayurapatises: Director of Siriraj Hospital; his name before royal appointment was Sai Khojaseni;
5. Ammart Thri Luang Upphantraphathipisan: his name before royal appointment was Kamchon Bhalangkool, later by royal appointment he was Phra Upphantraphathipisan;
6. Ammart Thri Luang Vaitayesarangkool: his name before royal appointment was Cheuch Israngkool Na Ayuthaya;
7. Dr. M.E. Barns;
8. Ammart Ek Phraya Vechsithipilas: Dean of the Faculty of Medicine, Chulalongkorn University;

9. Colonel M.J. Wallapakorn Worawan;
10. Dr. Leopold Roberte.

The working committee of the Association had asked Field Marshall Prince Nakornsawan Worapinis, Vice President and Director of the Siam Red Cross at that time, for the name of the Association which he named "Medical Association of Siam", and later on it was changed to "Medical Association of Thailand" (MAT). The change affected only the spelling of the name to make it up-to-date.

In 1930 Phrabath Somdej PhraPoramin-taramahaprachathipok Phrapokklaochaoyuhoa, the 7th King, graciously accepted this society under his royal patronage. The words "under Royal Patronage" have ever since been added to the name of the Association.

At the beginning the Association had its temporary office at Chulalongkorn Hospital. The first meeting of the Association was held on 9 January, 1922, with 64 members attending. Field Marshall Prince Nakornsawan Worapinis, Vice President and Director of the Siam Red Cross and Maha Ammarttho Prince Chainatnarenthorn, Director General of the Department of Public Health, also graciously participated at the meeting. The temporary office of the Association at Chulalongkorn Hospital was used until 4 August, 1932, when the office was moved to Bamrung Muang Road, next to the Kasatseuk Bridge; the land belonged to the Red Cross.

In 1923 the Association started using its own emblem, developed by Prince Narisanuwattiwong. The emblem bears a picture of the naga or King of Snake snake and the trident, encompassed by the inscription "Medical Association of Siam" that was changed later on to "Medical Association of Thailand". The trident is a weapon used by God Isuan or Shiva in Hinduism.

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One of the important issues in the work of the Association was the launch of the medical journal, which since then is being used as a network to communicate with the current members, including dissemination of knowledge and information as well as current medical research. At the beginning of the establishment of the Association, there was no official journal produced by the society, however, the Association purchased the Red Cross Bulletins, issued in the early period of the establishment of the Association, to distribute to all its members. On 17 August, 1925 there was a transfer of administration of the journal from the Red Cross to the Association, and the journal was renamed "Medical Bulletin of the Medical Association of Siam".

During 1926–1927 there were no concrete activities provided by the Medical Association of Siam to sensitize the members. The existing journal did not gain much interest from the members. Moreover, only a few copies of the journal were sent out to the members (3 editions annually). The scientific meeting was also rarely held. All members who lived in different areas hardly met one another. Two leading persons – Dr. Luang Chalermcampeeravej and Dr. Luang Chetthawaitayakarn – tried hard to take an initiative in developing the Medical Union Club at Chulalongkorn University.

The Club was legitimately registered on 15 March, 1927 with the temporary office at Siriraj Hospital. The Medical Union Club was dealing with scientific matters, but there was no definite building to house the activities of the members. In the meantime the Department of Public Health, the Ministry of the Interior had built the Bangrak health center for the purpose of treating the venereal diseases. It was a 2-storey building adjacent to Silom Road. Within the compound of this hospital building there was a large wooden high-level house where Dr. Hays had run his clinic and had already closed his business. The Department of

Public Health allowed the Medical Union Club to house there for the purpose of the member meetings.

The objectives were as follows:

1. to foster athletics;
2. to be the place where the new and senior students could mix; and
3. to enrich knowledge and to create contacts between students and schools.

The Medical Union Club organized the first scientific meeting on 1 April, 1928. Thereafter, there was held a regular annual meeting. After each scientific meeting there were published papers a copy of which was distributed to the members every two months. The first scientific paper was issued in November, 1929, under the title "Report of the Meeting of the Medical Union Club".

The other newsletter that was published by the Medical Union Club was named 'Physicians' News' which was issued in 1928 with the aim to educate general public about diseases and illnesses. It was sold for 25 stang per copy and it was issued on a monthly basis. In 1942 this newsletter was closed due to World War II.

The aim of the Medical Association of Siam focused on scientific matters, whereas the purpose of the Medical Union Club concentrated on both scientific and social issues. Thus, it seemed that the work of the Medical Union Club was more interesting than that of the Medical Association of Siam. It was because the membership grew as graduates from medical schools enrolled as new members in the Medical Union Club. Only very few of the new graduates registered as new members of the Medical Association of Siam. This seemed to make the latter more inferior. However, the important point that had never been revealed was that the current members of the Medical Association of Siam at that time had also registered as members of the Medical Union Club when this club came into existence.

They had to pay membership fees to both societies, which meant that those who were members of the two societies had to pay the membership fees twice compared to those who were members of either society. Moreover, the economic situation in the country at that time was weak. There was an idea of combining the two societies together in order to make a stronger body, and at the same time running only one organization would be more economical. However, this idea failed. Until in 1933 Dr. Phrayaborirakvechchakarn was elected President of the Medical Association of Siam as well as President of the Medical Union Club. The merge of the two societies was approved by the members of the societies.

The strategic solution to this combination was that those members who had already paid their membership fees to the Medical Association of Siam were exempted from the fees of the Medical Union Club. The combined activities included finances, the library, medical bulletins and the annual meeting. The offices of both societies were asked to be in the same premises or in a place nearby, if possible. Both societies had a joint agenda for the first time on 2 February, 1933, which was announced as the annual meeting of the Medical Association of Siam and Medical Union Club under the name "Medical Association of Siam and Medical Union Club of Chulalongkorn University". At the beginning each society had a separate working committee.

In 1936 the Medical Union Club moved to the Bangrak Health Center, the same place where the office of the Medical Association of Siam was located, in Bamrung Muang Road. The two working committees were united into one. The office in Bamrung Muang Road was considered a convenient place in terms of public transport, as well as being close to some offices of the Department of Public Health located in Yodse Road. As a consequence, more members frequented the Association. The Association had acquired two billiard tables and



three tennis courts. This had been considered as 'very advanced' facilities provided to the members. Besides physicians there were some visiting civil servants who were not registered as members, but they utilized the facilities at the society and considered it to be a convenient meeting and recreation place.

The Medical Association and the Medical Club continued working successfully until Thailand entered World War II on 8 December 1941, when the Japanese troop occupied several places in Bangkok. Apart

from the effects of the war, in 1982, there was a big flood, the biggest in the Thai history which lasted almost for one month. Most of the roads in Bangkok were under deep water and resembled canals; in some parts of Bangkok cars were not accessible.

During the war and after the flood the Club was on decline due to difficulties to access it, but soon after the war ended and gasoline was available the club started functioning again, but the space was so limited. During 1940–1942, Naval Rear Admiral Sa-nguan Rujirapa, the then President of the Asso-

ciation, tried to find a new bigger place. He was a member of the revolution party, therefore, found it easier to communicate with the country governing people, nevertheless it took a very long time. When Dr. Chalerm Prommas was elected President of the Association the project turned out successful as the Royal Property Estate Office agreed to let the "Baan Saladaeng" which used to be the residence of Chao Phaya Yommarat and was situated opposite to Chulalongkorn Hospital at the intersection of Rama 4 road and Rachadamri and Sirom roads or the location of the Dusit Thani Hotel at present.

The reason why the negotiations took so long was because a residence of high ranking officials and the Old European Students Association were located in the area and, besides, we tried to get the possibly cheapest rent. More than that, when the members learned that we were moving to Saladaeng, there were some disagreement and complaints that it was too far, however, it was not that far when we got acquainted with the location.

"Baan Saladaeng"

The extensive renovation of the new site needed a lot of money, more than tens of thousands of Baht. Those expenses were shared with the Dentist Association and the Pharmacist Association. Therefore, after the renovation was completed the three Associations united and worked together at the same place. The Medical Association moved to "Baan Saladaeng" on 4 May, 1948 during the presidency of Dr. Chalerm Prommas.

In 1949, the Nurses Association asked to join in. Thus, Baan Saladaeng housed four Associations – the Medical, the Dentist, the Pharmacist, and the Nurses and the abbreviation of the building was M.D.P.N. Office.

"Baan Saladaeng" consisted of a big building and possessed an area of more than

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eight rais. The Association set a wooden house near the big building as a club and a section of the Medical Association acquired two billiard tables, several bridge tables and three tennis courts in the rear, a glass court in the front and a residential house. It was bigger and more comfortable than the previous one and more members could be accommodated even though it might seem far away for someone.

The four Associations worked together until 1966 when the Royal Estate Office notified about the termination of the rental permit as it wanted the land to be developed as a modern commercial arcade and was willing to pay 2.5 million Baht to the Association. The negotiations ended in the payment of 5 million Baht. Half of the sum was given to the three Associations and the remaining 2.5 million Baht were spent to purchase a piece of land (3 rais, 2 ngarns and 92 square wahs) from the Kheha Pattana Estate Company at Soi Soonvijai, 300 metres away from New Petchburi Road, and 45 square wahs more for the entrance to the Association. The construction of the new Association building was started in May, 1967 with the budget of 1.3 million Baht.

New Home at Soi Soonvijai, New Petchburi Road

Thus, the Medical Association of Thailand under Royal Patronage acquired a new and permanent Office. But before the processes of land purchasing and the construction finished, it had to be temporarily moved to the Tuberculosis Eradication Association. It moved permanently to Soi Soonvijai on 13 January, 1968.

The Medical Association of Thailand under the Royal Patronage and all the medical professions were greatly honoured when His Majesty the King and Her Majesty the Queen graciously presided over the opening ceremony of the Association building on 1 February, 1968

Today at the Royal Golden Jubilee (Chalermprabarami ๕๐ Anniversary)

Since the number of the Royal Colleges and their activities have been increasing together with the number of college students growing there have been no permanent offices for those colleges due to being non-profit organizations and lacking the government support. The colleges have been providing training for specialists under the supervision of the Medical Council for more than 20 years on voluntary basis as they are not included in the government development plan. Most of the functions, therefore, were absorbed by the institutes where the Chairs or the Secretary General of the College associated. Then the plan of having fixed or permanent offices for each Royal College was initiated.

Professor Dr. Arun PAUSAWASDI, the then Secretary General of the Royal College of Surgeons, sent out invitations to all the Presidents and the Secretary Generals of the Royal Colleges to meet and discuss the issue of permanent offices. Representatives from 9 out of 11 Royal Colleges attended the meeting and decided on finding suitable places for the permanent offices that might be at the Ministry of Health or at the Medical Association or to find their own places.

Several senior members had looked for the site for these permanent offices at the Srirachana hospital, the Department of Medical Services, or even at the construction site of the new Ministry of Public Health, but nothing seemed acceptable. On 23 December, 1993, at the meeting of the Medical Council at the Ambassador Hotel Pattaya, Professor Dr. Arun Pausawasdi, President of the Royal College of Surgeons, called a special meeting to revise the project and at this important meeting Rear Admiral Air Marshal Dr. Kitti Yensudchai, the then President of the Medical Association, proposed that the construction of the specialist consortium should be at the site where the Medical Association was located. The proposal was approved and a committee of

eight members was appointed to continue with the project.

The Consortium of the Medical Specialty Training Institute was afterwards established to strengthen and consolidate the activities of the colleges and invited His Royal Highness, the Crown Prince of Thailand, to be the Chair of the construction project to celebrate the Golden Jubilee of the King's Accession to the throne in 1996. The building was planned to accommodate the Medical Association of Thailand, the Royal Colleges and Medical Societies. At the beginning the Ministry of Public Health had coordinated with the Government Bureau of Lottery and other charity foundations for the seed money to construct a 12-storey building with the working space of 32,000 square metres to accommodate 11 Royal Colleges, 23 Medical Societies and the Medical Council. The construction was budgeted at 440 million Baht and built on the land which belongs to the Medical Association. The budget was administered in the form of foundation that was later named "Vajiravej-vitayalai Chalermprakiert Foundation under the Royal Patronage of His Royal Highness Crown Prince Maha Vajiralongkorn".

The building itself was graciously named by the King as the "Golden Jubilee Building".

On 18 March, 1997, His Royal Highness, the Crown Prince Maha Vajiralongkorn was assigned by the King to preside over the opening of the Golden Jubilee Building on his behalf. The event was of great honour and brought much delight to all the medical professions of the Kingdom of Thailand.

The Medical Association of Thailand

At Present 2012–2014

The Executive Committee of The Medical Association of Thailand under his Majesty

the King's Patronage (according to the constitution and bylaws) composed of 40 members, they are

11 Elective members

- President
- President Elect
- Vice President
- Secretary General
- Treasurer
- House Master
- Publication
- Welfare
- Scientific
- Medical Education
- Ethics

29 Appointed members

- Chair of the Medical Council
- Presidents of the Royal Colleges of Specialty

52 Advisors

18 Representatives from national geographical medical regions

Administration

The Meetings of the Executive Board and Advisors convene every Wednesday of the 4th week of the month.

15 subcommittees are appointed to work on various fields of interest

1. Funding subcommittee
2. Scientific meeting subcommittee
3. Land asset and Welfare Subcommittee
4. Membership Relations subcommittee
5. Medical Journal Editorial Board
6. Subcommittee for Health Professional Security Support Acts
7. Subcommittee on
8. Subcommittee on fund Raising Golf Tournament
9. Subcommittee for WMA General Assembly 2012
10. Subcommittee for Social Medias Activities

11. Subcommittee for
12. Subcommittee to follow the Medical Compensation Acts
13. Subcommittee to provide help to flood Victims (health Professionals)
14. Subcommittee for
15. Subcommittee for the "Royal Kathin Offerings"

What's Done:

1. Promotion and maintaining the standards of Professional Ethics
2. Promotion of the professional solidarity
3. Promotion of medical education, research and medical services
4. Promotion of member welfare
5. Cooperation and collaboration with governmental and private organizations for improving and maintaining medical services at the level of International Standard
6. Advocating medical and health education to public to improve the social determinants of health
7. Collaboration with international organizations to leverage the global health care

What's Next

1. Expanding the network by appointing representatives from 18 National Medical Geographical Regions to the Executive Board
2. Support the professional Security Acts
3. Training of the risk management in medicine twice a year
4. Cooperate Social Responsibility (CSR)

Promotion of Medical Profession and Medical Ethics

1. The Medical Association of Thailand (MAT) has initiated the laws consultation session within MAT to provide consultations to members 24 hours a day

2. Promotion of the member relationships through
 - 2.1. Publication of the monthly medical journal
 - 2.2. Publication of the monthly medical association news letters
3. Professional Risk Management Project. Promotion and support the Health Professional Security Acts.
4. Medical Professions Guidelines Project. Advisory and guidelines lectures to the new graduates from 10–14 institutes every year under the support of Pfizer Foundation since 2004
5. Member Visit Project. MAT pays visits to members working in upcountry from time to time
6. Promotion of Professional Ethics Project. MAT gives lectures on medical ethics to both the public and private hospital staff and institutes

Promotion of Education, Training and Research

The Journal of the Medical Association of Thailand has a long history of publication and it is the only Medical Journal of the country which is included in the Index Medicus. Today it has been developed and improved to meet the needs of the members at monthly distribution.

The Medical Association of Thailand with the collaboration of Takeda Science Foundation has granted funds for its members to continue their education in Japan. The funds are granted in 3 groups: 3 months for three, 6 months for two, and 1–2 years for one grant-holder. Up to now, the funds had been granted to 155 recipients.

Three more separate funds have been granted to members of the Medical Association of Thailand, "Dr. Prasert Prasartthong-osoith Fund" Dr. Prasert Prasartthong-osoith is a member of the association who graciously donated a sum of 1,000,000 (one million) Thai Baht to the association every year to

promote the research for the benefit of the Thai Medicine and to create innovations to serve the health care of the national and international level. Up to now, 37 researchers working on 40 projects had been beneficiaries.

The Medical Association of Thailand itself also provides a grant for the research on development of the primary health care and development of health care provision.

Promotion of the “Best Performance” to Doctors Who Had Dedicated Themselves to the Communities

“Somdej Prawanarat” Award goes to the doctor, selected by the committee, for distinguished performance.

The Awards from the Medical Association go to the doctor for the best performance in the upcountry hospitals.

Scientific Medical Meetings

Two scientific meetings are routinely convened, one in the periphery and one in Bangkok together with the administrative meetings.

International meetings on various subjects have also been called from time to time both in the Medical Associations in the ASEAN countries (MASEAN) and the Confederation of the Medical Associations in Asia and Oceania (CMAAO) communities.

Organization Efficiency Development Plan

Since 2005, under MAT the Thai Health Professional Alliance against Tobacco Network has been established, composed of 21 professional organizations. The Network's activities are supported by the Bureau of Health Promotion. The efficiency of the

Network has been well accepted both in the country and internationally.

The Medical Professional Network for Tobacco Control has also been established consisting of 32 executive members to enhance the research work in controlling tobacco consumption. More than 50 projects had been granted.

International Contacts

The Medical Association of Thailand has been working in collaboration with the international medical and health organizations both in the regions and globally. Representatives from MAT hold several administrative posts in international medical organizations:

Dr. Songkram Supcharoen: President of CMAAO: 1987–1989,

Dr. Kachit Choopanya: the President of MASEAN and CMAAO: 1997–1999

Prof. Somsri Pausawasdi: President of CMAAO: 2007–2009

Dr. Wonchat Subhachaturas: Secretary General of CMAAO: 1997–1999, Chair of CMAAO Council: 2007–2011, Advisor to CMAAO: 2011–Present, 61st President of the World Medical Association: 2010–2011

and many other roles at the conferences and Assemblies.

Service Efficiency Project

Public Relation and Newsletters for members

Health Club Programme on television channel 9 is aired every Monday–Friday at 09.00–09.30 am with a good rating.

Improvement of membership registration
At present the membership has increased up to 24,381 for the life members and 5,330 for the Junior members Development of the modern website 20 new systems

have been developed to meet the needs of the members. The address of the website of the Medical Association of Thailand had been changed from www.medassocthai.org to www.mat.or.th. The content is adjusted twice daily. This website includes the electronic form of the Journal of Medical Association of Thailand that can be traced back and is directly publishable in the PubMed educational column, activities, announcements and etc. with more than 10,000 visitors each month.

Social Welfare to Members

For 12 years the Medical Association of Thailand has been organizing annual trips to observe the Primary Health care abroad, e.g. in such countries as Laos, Cambodia, Malaysia, China, Myanmar, Brunei Darussalam, Japan, Nepal, Jordan, Kazakhstan, Finland a.o.

Association Club

MAT offers 6 furnished accommodation spaces on the 12th floor of the Association building for the members to stay.

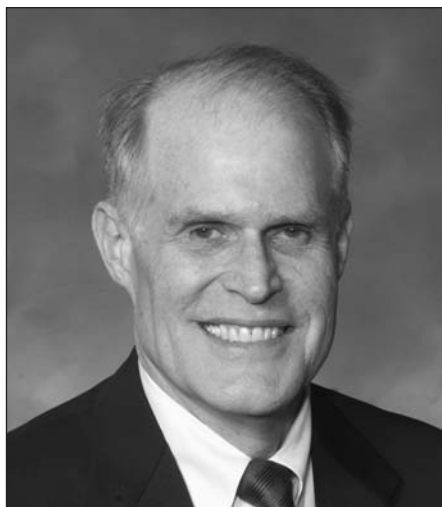
The progress and success of the Medical Association of Thailand are based on the fruitful and sustainable performance of our predecessors who had dedicated themselves to development and facilitation to all members during the past 90 years for the dignity of our Medical Profession and all members, to be accepted and respected by the local and international communities. We will all follow the teaching of the King's Father, Prince Mahidol Adulyadej, the father of the modern Thai Medicine and the solidarity of our Association.

*Dr. Wonchat Subhachaturas
President of The Medical
Association of Thailand*

Regulation of Health Professions: Disparate Worldwide Approaches are a Challenge to Harmonization



Luc Jean René Besançon



Paul Rockey



Marta van Zanten

Regulation of health professions serves numerous purposes and is associated with improved quality of care. Globalization of health care has prompted discussions of harmonization of systems of regulation within various health professions. To inform global discussion of this issue, the authors developed an online survey on regulatory environments.

The survey consisted of queries about respondents' location and profession, followed by specific questions related to regulation. We synthesized the survey responses to produce a final data set consisting of one answer per country and per profession.

The aggregated data includes 197 responses from 78 countries representing 22 systems of regulation for dentists, 38 for doctors of medicine, 45 systems for nurses, 37 for pharmacists, and 36 for physiotherapists. Variations include the type of regulatory bodies, complexity of systems, the entities that set rules, and scope of regulation. Collaboration between governmental bodies and profes-

sional organizations becomes more prevalent as the number of functions ensured through the system of regulation increases.

There is significant international diversity in the systems of regulation for health professionals. Our data describe more differences than similarities for systems of regulation across countries, and illustrate the challenges of a global movement toward harmonization.

"It has been said that arguing against globalization is like arguing against the laws of gravity." Kofi Annan.

Background

Regulation of health professions serves numerous purposes, including defining the scope of competence, ensuring high standards for entry and practice, and promoting and maintaining professionalism and ethics. Regulation has also been associated with better quality of care and improved

patient outcomes in a variety of settings [1–3].

Globalization of health care has prompted discussions of harmonization of standards and systems of regulation within professions. To advance the discussion about these issues, the World Health Professions Alliance (WHPA), which gathers the global associations of dentists (World Dental Federation – FDI), doctors of medicine (World Medical Association – WMA), nurses (International Council of Nurses – ICN), pharmacists (International Pharmaceutical Federation – FIP), and physiotherapists (World Confederation for Physical Therapy – WCPT), organized the Second World Health Professions Conference on Regulation (WHPCR 2010) in Geneva on February 18–19, 2010.

The aim of WHPCR 2010 was to shape the future of health professional regulation within the context of global health systems' redesign and evolving roles, keeping in mind that public protection should be

the primary objective of health professional regulation. Specific objectives of WHPCR 2010 were to:

- Debate future control and direction of health professionals' regulation within the context of changing scopes of practice
- Examine regulatory and professional issues related to international migration of health professionals
- Critically evaluate the relationship between health professional education, regulation and standards of practice

The WHPCR 2010 organizers envisioned that an overview on the current regulation of these five professions would be a good starting point for debating the future of regulation (as mentioned in Objective One). However, we noted that there is a general lack of knowledge about the systems of regulation in which health professions must operate. A few regional or global comparisons of systems of regulation for specific health professions have been conducted over the past decade in the fields of medicine [4–6] and nursing [7], but little published data were found describing or comparing systems of regulation in the fields of dentistry, pharmacy or physiotherapy. In addition, no study was identified that had simultaneously collected such data from multiple countries for these five health professions. Therefore, to provide a global overview of the regulation of healthcare professionals, an online survey was developed in conjunction with the conference to collect data on the regulatory environment of health professions throughout the world. This study was exploratory; we had no prior hypotheses regarding the outcomes of the data.

Methods

The online survey consisted of queries about respondents' location and profession, followed by specific questions related to regulation in five health care professions:

dentistry, medicine, nursing, pharmacy and physiotherapy. When respondents indicated knowledge of regulation of one or more of the five professions for a particular country they were asked a series of detailed questions pertaining to the affiliation (e.g., governmental or professional) of the regulating body, the level of regulation (e.g., supra-national, national, sub-national), and the contact information of the regulator. The survey prompted consideration of at least eight potential regulatory activities: 1) accreditation of initial education, 2) registration (or licensure), 3) investigation, 4) discipline (or sanction), 5) specialization, 6) re-certification, 7) accreditation of continuing education, and 8) practice guidelines. The survey also queried whether a regulatory activity was predominantly the responsibility of the profession (self-regulation), the government, or was shared. If respondents mentioned more than one body involved in regulation, descriptive questions were repeated for each additional organization. We also asked about the entity that sets the rules used by the regulator, the scope and jurisdiction of the regulating body, and any additional activities of the regulator. Finally, free text fields were provided to describe any unique circumstances in a respondent's country or profession.

The survey was available on the WHPCR website from October 15, 2009 to March 1, 2010, and all WHPCR 2010 registrants were prompted to complete the survey. In addition, the five WHPA organizations encouraged their members and other knowledgeable individuals to complete the survey.

We synthesized responses to form a data set consisting of one answer per country and per profession according to the following schema: If more than one individual from a particular country and profession completed the survey, for each question we retained only the answer that was provided by the majority of respondents. If respondents provided an equal number of

disparate answers, we retained the answer given by the respondent employed by the organization with the broadest jurisdiction. Therefore the final aggregated data set consisted of just one set of answers to the survey questions per country and per profession.

Role of the Funding Source

No outside funding was used in this study.

Results

Altogether, there were 292 unique survey respondents from 78 countries providing sufficient data for analysis. The final data set consisted of 197 aggregated responses. When a specific country has at least one regulator in place for one profession, we identified this as a "system of regulation". Existing systems of regulation were reported by 178 (91%) of the aggregated respondents, and nine (5%) indicated that a system of regulation was about to be implemented. No regulation was reported by seven (3%) of the aggregated respondents, and three (1%) did not know. The aggregated data included reports on 22 systems of regulation for dentists, 38 for doctors of medicine, 45 for nurses, 37 for pharmacists, and 36 for physiotherapists.

Income Level

Countries or states represented in the survey¹ were classified by income level according to the World Bank Atlas Method (as described on World Bank website: <http://go.worldbank.org/QEIMY0ALJ0>). The countries were divided according to the 2008 GNI per capita as follows: <\$975 (low income); \$976 – \$3,855 (lower

1 GDP data was not available for Bermuda, Kosovo and (China-) Taiwan. These countries and states were excluded from income-level analyses.

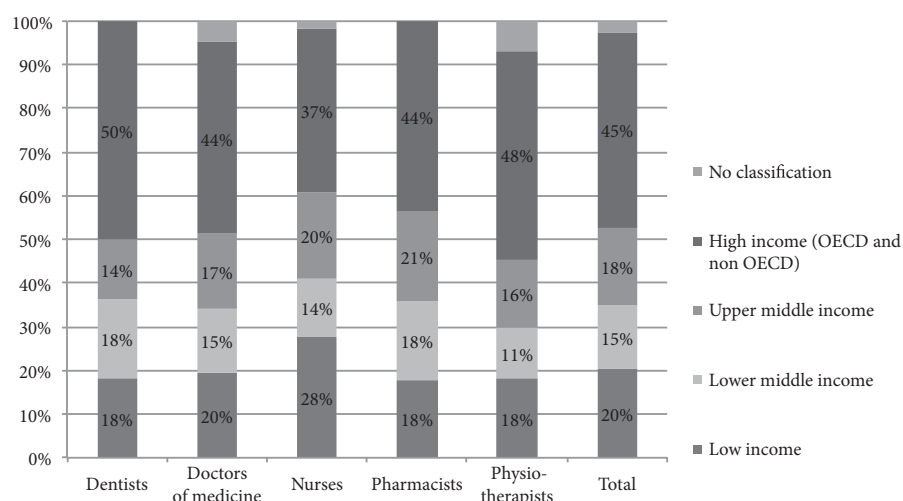


Figure 1. Aggregated respondents by profession and country income level

Table 1. Government vs. professional self regulation within each system of regulation across the five professions

	Dentists	Doctors of Medicine	Nurses	Pharmacists	Physiotherapists	Total
Government-related regulators	59% (n=13)	51% (n=20)	47% (n=21)	50% (n=19)	59% (n=22)	52% (n=95)
A combination	9% (n=2)	21% (n=8)	20% (n=9)	29% (n=11)	19% (n=7)	20% (n=37)
(A) professional body(ies)	27% (n=6)	28% (n=11)	33% (n=15)	21% (n=8)	14% (n=5)	25% (n=45)
Unknown	5% (n=1)	0% (n=0)	0% (n=0)	0% (n=0)	8% (n=3)	2% (n=4)
Number of systems	22	39	45	38	37	181

Table 2. Government vs. professional self regulation by WHO-based geographic region

	AFRO	EMRO	EURO	PAHO	SEAR	WPO	Total
Government- regulators	52% (n=15)	80% (n=12)	56% (n=38)	24% (n=6)	40% (n=4)	59% (n=17)	52% (n=95)
A combination	10% (n=3)	0% (n=0)	20% (n=13)	28% (n=7)	10% (n=1)	38% (n=12)	20% (n=37)
(A) professional body(ies)	34% (n=10)	20% (n=3)	20% (n=14)	48% (n=11)	50% (n=5)	3% (n=1)	25% (n=45)
Unknown	3% (n=1)	0% (n=0)	4% (n=3)	0% (n=0)	0% (n=0)	0% (n=0)	2% (n=4)
Number of systems	29	15	68	24	10	30	181

African region (AFRO); Eastern Mediterranean region (EMRO); European region (EURO); Region of the Americas (PAHO); South-East Asia region (SEAR); Western Pacific region (WPO)

middle income); \$3,856 – \$11,905 (upper middle income); >\$11,906 (high income). Figure 1 displays the regulation systems by profession and income level per capita. The distribution of systems of regulation by country income level was similar among all five professions, and the majority of the systems of regulation included in this study are located in high and upper-middle income countries. The presence of a system of regulation (all professions combined) is similar by income level of the country. For low income, lower middle income, and upper middle income countries, the aggregated responses indicating that a system of regulation exists ranged from 83% to 86%. All of the aggregated responses representing high income countries indicated the existence of a system of regulation.

Characteristics of Systems of Regulation

Models for systems of professional regulation vary around the world. Regulatory schemes can be developed and administered by governmental bodies, such as Ministries of Health or other governmental agencies, professional organizations (whose governance is mainly ensured by elected members of the profession), or a combination of entities. For the five professions combined, 52% (n= 95) of the systems of regulation are government-based, 25% (n= 45) are conducted by non-governmental professional bodies, 20% (n= 37) by a combination of government and professional bodies, and 2% (n=4) unclassified. The types of regulatory bodies present for the five professions are displayed separately in Table 1. Across the professions, there is little variation of the type (government, professional body, combination) of the regulatory bodies. Government-related regulators ranged from 47% of systems for nurses to 59% for dentists and physiotherapists. The frequency of professional bodies administering the regulation system ranged from 14% for physiotherapists to 33% for nurses.

Our preliminary analysis of systems of regulation showed much greater differences among countries than among the five professions within a country. In fact, we observed strong similarities and concordance of system of regulation for any of the five professions within an individual country. Therefore, we made several analyses using countries as the unit of analysis.

To see if there were major regional differences (based on geography and culture) among the administration of systems of regulation, we grouped the countries based on the World Health Organization (WHO) geographic regions. Table 2 demonstrates that there is significant variation worldwide in the control of systems of regulation based on these geographic regions. Government administration of systems of regulation ranges from 25% in the Americas to 80% in the Eastern Mediterranean, and professional organization-affiliation ranges from 3% in the Western Pacific to 50% in the South East Asian region.

In contrast, country income level appears to have only a moderate relationship with the affiliation of the regulatory bodies (Table 3). Governmental regulation ranged from 37% in upper middle income countries to 52% in lower middle income countries. Professional administration of regulation ranged from 15% in lower middle income countries to 37% in upper middle income countries.

Complexity of Systems of Regulation

Worldwide, there is wide variability in how individual countries organize health care professions regulation systems, and differences in the overall complexity of particular systems. In some countries, there is one centralized system that controls and manages a specific profession (or more than one profession); in other countries, numerous regulators have authority within one system. To investigate the relationship between

organization of a country's government and the complexity of systems of regulation, we compared the number of regulators, the number of regulation systems, and the number of regulators per system for federal versus non-federal countries. We defined a federal country as a sovereign country characterized by a union of partially self-governing political entities (regions, states, provinces) united by a central (federal) government. Countries that are considered federal are indicated with an (*) in the Appendix.

Across all five professions and countries, there is an average of 3.92 regulators per regulation system. In federal countries combined, there is an average of 10.83 regulators per regulation system, compared to an

average of 1.13 regulators per system in all non-federal countries.

In addition to the relationship between the number of regulators and the type of political organization of a country, we also investigated the influence of country income level on the complexity of systems of regulation. The numbers of regulators were compared against World Bank country income level (Table 4), demonstrating that complexity increases appreciably in countries with higher income levels.

To further investigate the impact of a country's governmental structure on regulation of health professionals, the survey included a question regarding the level of regulation (e.g., supranational, national,

Table 3. Government vs. professional self regulation across all professions by country income level

Regulator	Low income	Lower middle income	Upper middle income	High income (OECD and non OECD)	No classification	Total
Government-related regulators	50% (n=17)	62% (n=16)	37% (n=11)	56% (n=48)	60% (n=3)	52% (n=95)
A combination	15% (n=5)	23% (n=6)	17% (n=5)	23% (n=20)	20% (n=1)	20% (n=37)
(A) professional body(ies)	35% (n=12)	15% (n=4)	37% (n=11)	20% (n=17)	20% (n=1)	25% (n=45)
Unknown	0% (n=0)	0% (n=0)	10% (n=3)	1% (n=1)	0% (n=0)	2% (n=4)
Number of systems	34	26	30	86	5	181

Table 4. Numbers of regulatory bodies across all professions by country income level

	Number of regulatory bodies	Number of systems of regulation	Number of regulatory bodies per system of regulation
Low income	110	34	3.24
Lower middle income	94	26	3.62
Upper middle income	19	30	0.63
High income (OECD and non OECD)	482	86	5.60
No classification	4	5	0.80
Total	709	181	3.92



or sub-national levels). We compared the levels of the systems of regulation between federal and non-federal countries (Figure 2). Non-federal countries were more likely to have systems of regulation conducted at the national level compared to federal countries. In contrast, a large segment of systems of regulation in federal countries are conducted at the state or provincial

level, or a combination of sub-national and national levels.

Who Sets the Rules?

The survey also included a question on the entities that determine the rules that are subsequently implemented and enforced

by the regulatory bodies. Results of the survey demonstrate that even in settings where systems of regulation are ensured by professional bodies, the entities that set the rules are frequently governmental, such as the Ministries of Health, other government agencies, or the Parliament. In fact, in 41% of these systems the rules or laws are actually solely determined by governmental legislation or Ministry decrees. Only 35% of professional body-affiliated regulators set their own rules, and 24% use a combination of self-determined and governmental rules.

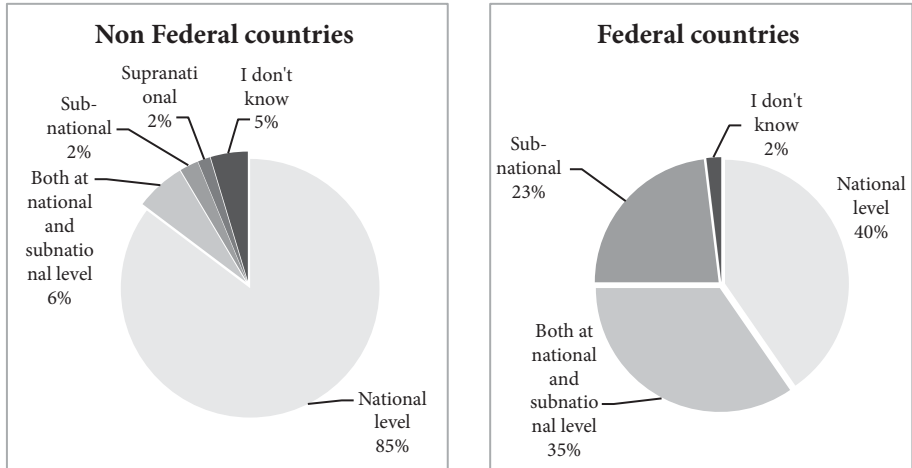


Figure 2. Level of systems of regulation by Non-Federal versus Federal countries

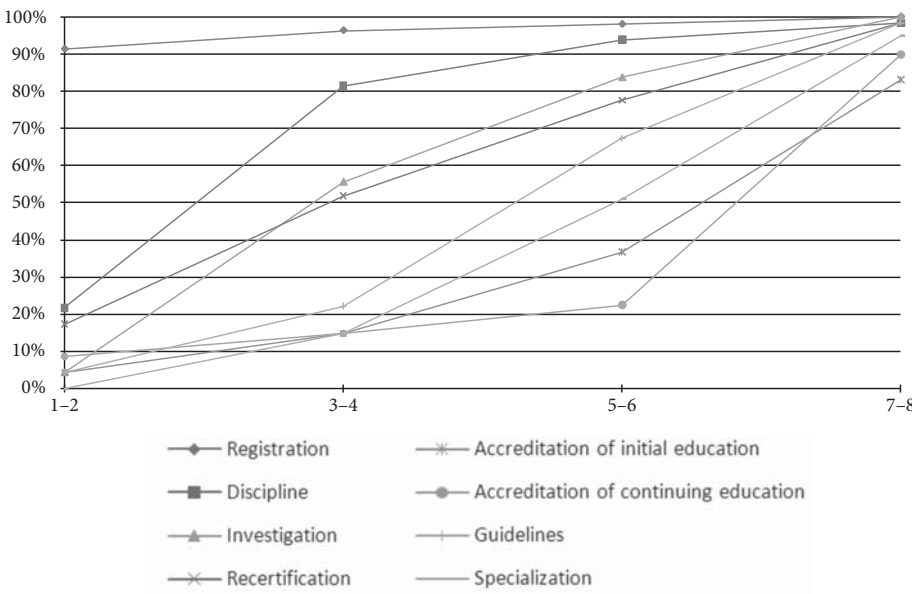


Figure 3. Specific function by number of functions engaged by regulatory bodies

Scope of Regulation and Hierarchy of Regulatory Activities

The final section of the survey included several questions related to the various activities conducted by regulatory bodies. Participants were then given a list of potential functions and requested to indicate which of these activities were conducted by the regulatory body. Across all five professions , 96% of the aggregated respondents indicated that regulators were involved with the activity of registration, 81% indicated discipline, 72% investigation, 70% recertification, 61% practice guidelines, 53% specialization, 45% accreditation of initial education, and 43% accreditation of continuing education.

Figure 3 displays the specific functions carried out by systems or regulation according to the number of functions engaged by each system. This figure shows a hierarchy of functions, indicating that across systems of regulation for all professions, there is a clear pattern of the specific functions engaged in by regulators based on the number of functions in their scope. For example, almost all regulatory bodies, even those that only engage in one or two functions, handle registration. As systems of regulation broaden their scope and undertake additional functions, these responsibilities are generally increased in a hierarchical manner (e.g., discipline is the next most common func-

tion, followed by investigation and recertification). Only those regulatory bodies that engage in seven or eight functions are likely to do accreditation of continuing education and regulation of practice guidelines.

Figure 4 demonstrates that as systems of regulation engage in an increasing number of functions, the system is more likely to involve professional organizations. Specifically, if the system of regulation is performing only one or two functions, professional organizations are involved in the process in only 4% of countries and share responsibility in another 17%. However, if a system includes seven or eight functions, professional bodies are primarily responsible for 36% of the systems of regulation and share responsibility in another 22%.

Based on the survey results, the specific functions carried out by systems of regulation vary depending on the type of regulators. For example, certain functions, such as discipline, investigation, recertification, practice guidelines, and specialization, appear to be more frequently conducted if the regulatory body includes a professional organization. Table 5 displays the functions carried out by various systems of regulation stratified by the type of regulator.

Discussion

Globalization is increasing in all areas of human endeavor, including health care. With international migration, advances in technology, instantaneous communication and improved transportation these trends will accelerate. Within the context of movements towards harmonization of health professions regulation, our survey results support several conclusions regarding regulation worldwide. Systems of regulation are highly variable across countries while being generally similar among the five professions within a given country, and the number and type of regulators in systems of regulation are a reflection of type

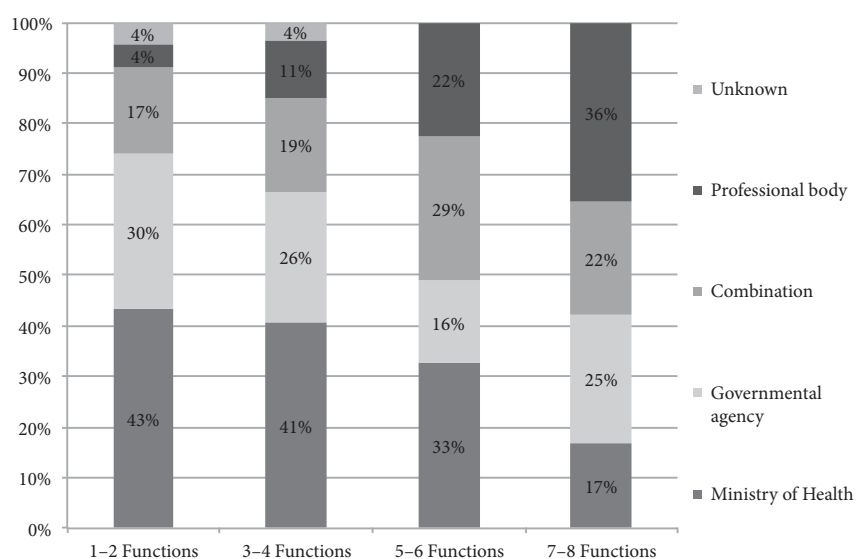


Figure 4. The regulators involved in a system of regulation by the number of regulatory functions

Table 5. The regulators involved in a system of regulation by the number of regulatory functions

	Government based	Combination	Professional body
<i>Functions</i>	%	%	%
Registration	96%	97%	97%
Discipline	80%	78%	95%
Investigation	66%	81%	84%
Recertification	68%	72%	84%
Practice Guidelines	49%	69%	86%
Specialization	46%	61%	68%
Accreditation Initial Education	41%	56%	49%
Accreditation Continuing Education	41%	36%	54%

of government, wealth of nation, and region of the world. Systems of regulation appear to have a hierarchy of functions, with basic systems almost always including registration (licensure) and discipline, and only more complex systems including roles such as accreditation of initial or continuing professional education and regulation of practice guidelines. Also, as systems of regulation become more complex (e.g., administer seven, eight or more functions) the level of collaboration between governmental and professional regulators increases. Also, even

in systems described as self-regulated by the profession, governmental organizations frequently determine the rules that are in turn implemented by the professional body.

Several challenges to potential harmonization efforts are evident based on our results. For example, although elements of regulation may be transportable from one nation to another (e.g., tests used for initial licensure or examinations used to certify knowledge within a professional specialty), regulators should consider how such elements

will be introduced and integrated with the existing system of regulation. Standardized “recognition of qualifications” may make it easier to achieve harmonization for basic functions such as licensure/registration.

Differences among countries between scopes of practice may also complicate competence measures within professions. Variations in levels of access to technology and expensive therapies will affect measures of professional competence, the creation and implementation of clinical guidelines and the content of specialty examinations. For example, treatment of chronic diseases such as those related to obesity (diabetes, hypertension, hyperlipidemia) prevail in affluent countries whereas developing countries face more often widespread infectious and parasitic diseases.

Harmonization of regulation has often focused on the cross-border recognition of professional qualification (diplomas, specialties, etc.) both in Europe and North America, with some systems implemented to ensure such recognition [7, 8]. However, to date little attention has been given to studying the competent authorities (regulators) and their diversity (e.g., in numbers, in tasks, in governance) and the increased importance of investigating the practical feasibility of expanding systems of recognition in regions with different models of regulation. For instance, in the 27 member states of the European Union and for medical doctors, pharmacists, nurses, midwives and dentists, it is estimated that there are at least 900 regulators, while at the same time, there is no common European definition of a regulator nor an official register of these regulators [9]. Such diversity, complexity, and potential redundancy in tasks will likely lead to difficulties when authorities need to work together to ensure validation of the data provided by healthcare professionals.

In addition, variability in the implementation of disciplinary sanctions can complicate

Appendix

Country	Number	Answers for Dentists	Answers for Doctors of Medicine	Answers for Nurses	Answers for Pharmacists	Answers for Physiotherapists
Low income	40	4	8	14	7	8
Afghanistan	2			x		x
Bangladesh	3		x	x		x
Burundi	1			x		
Ethiopia*	5	x	x	x	x	x
Ghana	5	x	x	x	x	x
Malawi	5	x	x	x	x	x
Mali	1			x		
Nepal	3		x	x	x	
Nigeria*	5	x	x	x	x	x
Pakistan*	1			x		
Rwanda	4		x	x	x	x
Senegal	1			x		
Tanzania	2			x		x
Viet Nam	2		x	x		
Zimbabwe	1				x	
Lower middle income	29	4	6	7	7	5
Albania	1				x	
China	1				x	
El Salvador	1			x		
Georgia	1			x		
India*	5	x	x	x	x	x
Iraq*	1				x	
Jordan	1		x			
Macedonia	2	x	x			
Marshall Islands	1			x		
Mongolia	1			x		
Philippines	5	x	x	x	x	x
Samoa	5	x	x	x	x	x
Sudan*	1				x	
Swaziland	1					x
Syria	2		x			x
Upper middle income	35	3	7	10	8	7
Argentina*	2		x	x		
Belarus	1			x		
Botswana	2			x		x
Brazil*	2		x			x
Costa Rica	1				x	
Croatia	5	x	x	x	x	x
Fiji	3		x	x		x
Jamaica	1					x
Libyan Arab Jamahiriya	1				x	
Mexico*	2			x	x	
Russian Federation*	1			x		
Serbia	5	x	x	x	x	x

Country	Number	Answers for Dentists	Answers for Doctors of Medicine	Answers for Nurses	Answers for Pharmacists	Answers for Physiotherapists
South Africa	2			x	x	
Turkey	5	x	x	x	x	x
Uruguay	2		x		x	
High income: non OECD	23	3	5	6	3	6
Bahamas	3		x	x	x	
Bahrain	4	x	x	x		x
Cyprus	1					x
Israel	4	x	x	x		x
Kuwait	1					x
Malta	1		x			
Qatar	1			x		
Saudi Arabia	1					x
Singapore	4	x	x	x	x	
Slovenia	1			x		
Trinidad and Tobago	2				x	x
High income: OECD	65	8	13	13	14	15
Australia*	5	x	x	x	x	x
Belgium*	1					x
Canada*	5	x	x	x	x	x
Denmark	4	x	x	x		x
Finland	5	x	x	x	x	x
France	2				x	x
Germany*	1					x
Ireland	2			x		x
Italy	3		x	x		x
Japan	1				x	
Netherlands	4	x	x	x	x	
New Zealand	4		x	x	x	x
Norway	3		x	x	x	
Portugal	4		x	x	x	x
Spain	1				x	
Sweden	5	x	x	x	x	x
Switzerland*	3		x		x	x
UK*	5	x	x	x	x	x
USA*†	5	x	x	x	x	x
No Classification from World Bank	5	0	2	1	0	3
Bermuda	1					x
(China-)Taiwan	2		x			x
Kosovo	3		x	x		x
Grand Total	197	22	41	51	39	44

* Federal country

† The term 'Doctors of Medicine' for the United States applies to both allopathic and osteopathic physicians, who have equal practice rights.

efforts towards harmonization, as the capability of a regulator to transmit information to a foreign authority is limited by regulator protocols and the national law on privacy. While some countries would expect to receive the complete disciplinary file of a migrating healthcare professional, in many countries only current sanctions can be transmitted. The inclusion as part of the health professionals' official record past sanctions that have been completed varies across regulators. Similarly, regulators are limited in their capability to share cases under current investigation and/or appeal.

While we strived to collect valid information on the regulation of health care professions from a worldwide representative sample across five professions, there are several limitations to these survey data. We did not verify the accuracy of the answers provided by survey respondents. This was mitigated somewhat by our method of data synthesis (e.g., retaining only the answers provided by the majority of multiple respondents), but we did not independently validate the data or adjudicate discrepancies. The survey instructions did not provide definitions of various terms, and therefore the same term could have different meanings across countries. For example, in Northern Europe and the United States, "registration" of pharmacists documents fulfillment of educational and competence requirements and a pharmacist's capability to practice pharmacy legally. In contrast, in Southern Europe, pharmacists can only "register" if, in addition to the educational and competence requirements, they actually practice pharmacy in an authorized pharmaceutical outlet; if they stop practice they are removed from the registry and cannot be re-registered until they resume a professional activity.

We received survey responses from 78 countries and do not know if these results are representative of all countries. It is possible that countries with more effective systems of regulation are over-represented. The survey was provided only in English, per-

haps deterring responses from non-English speaking countries. In addition, based on several instances of incongruity within the survey results, it appears that respondents in several countries and professions do not always have a clear understanding of the composition, affiliations, and roles of the regulatory bodies governing their profession.

Our point of analysis was at the country level, but systems of regulation can vary substantially within countries and across various states/provinces. Collapsing data at the country level may have obscured some differences. Finally, we only reported on the existence of systems of regulation and various functions thought to be implemented by the regulators. The scope of the survey did not include gathering information on the actual execution, efficiency, or success of the various activities associated with the regulatory bodies.

Over time, each of these five health professions has delegated multiple tasks to assistants with lesser training. Such allied health workers are developing systems of regulation as well. This study provides no information about the regulation of such allied health workers or their systems of regulation, a needed area of further research.

Conclusions

Our data describes the significant differences among countries in the systems of regulation for health professionals. Although globalization is rapidly advancing in all spheres of human endeavor, the regulatory systems controlling the health professions are very disparate and may not be amenable to rapid harmonization. These efforts should take into account the diversity of current system of regulations to evaluate the feasibility of harmonization, as similar concepts may be understood differently throughout the world and regulation systems vary in organization and roles.

Competing Interests

The authors declare that they have no competing interests.

Author Contributions

LB led in the development of the questionnaire, ensured the collection of data (via an online tool), collaborated in the analysis and interpretation of data, and assisted in drafting and reviewing the manuscript. PR collaborated in the design of the initial survey, analysis and synthesis of the data, and drafting and reviewing the manuscript. MvZ assisted in data synthesis and drafting and reviewing the manuscript.

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Healthcare Reform in South Africa: a Step in the Direction of Social Justice



Ames Dhai

Over three decades ago, signatories to the Alma-Ata Declaration noted that Health for All would contribute not only to a better quality of life but also to global peace and security. They gave recognition to the fact that promoting and protecting health is essential not only for human welfare but also for sustained economic and social development [1]. In 1996 the Constitution of the Republic of South Africa, in its preamble, established its constitutional imperative to improve the quality of life for all citizens and to free the potential of each person. Section 27 of the Bill of Rights of the Constitution affirms that everyone has the right to have access to health care services, including reproductive health care. Section 27 places an obligation on the state to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of this right [2]. In 2004, the National Health Act [3] was promulgated to provide a framework for a structured and uniform health system that took into account the obligations imposed by the Constitution. The Act identifies in its preamble inter alia the socio-economic injustices, imbalances and inequities of health services of

the past, the need to establish a society based on social justice and fundamental human rights, and the need to improve the quality of life for all in the country as the background context for its enactment. Section 3 of the Act places the responsibility for the provision of health care onto the shoulders of the Minister of Health. One of the objectives of the Act is the provision of the best possible health services that available resources can afford in an equitable manner for the population of South Africa.

In its 2000 Report, the World Health Organization (WHO) stated that the government carried the ultimate responsibility for the overall performance of a country's health system and that all sectors in society should be involved in working towards positive outcomes under the government's stewardship. Managing the well-being of the population carefully and responsibly is the very essence of good government. The best and fairest health systems possible with the available resources need to be established. 'The health of the people is always a national priority: government responsibility for it is continuous and permanent. Ministries of health must therefore take on a large part of the stewardship of health systems [4].'

In August 2011, the Green Paper on the National Health Insurance (NHI) [1] was released for debate and comment by all in the country. The proposed NHI is a step towards health care reform as espoused in the Constitution and the National Health Act and a move towards the Alma-Ata's Health for All. The seven principles of the NHI, i.e. the right to access, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency, could be interpreted as the value assumptions of the proposed reforms. The objectives of the NHI are:

1. To improve access to quality health services for all

2. To pool risks and funds in order to achieve equity and social solidarity
3. To procure services on behalf of the entire population and to efficiently mobilise and control key financial resources, and
4. To strengthen the public health sector so as to improve health systems performance.

Major reform in health financing is required if these objectives are to be realised. In 2005, member States of the WHO committed to develop their health financing systems so that the goals of universal coverage would be achieved in [1]. The WHO identified three fundamental, inter-related problems that restrict countries from moving closer to universal coverage. The first was the availability of resources. Even the richest of countries have not been able to ensure that everyone has immediate access to every technology and intervention that may improve their health. Over-reliance on direct payments at the time that people need care was another barrier to universal coverage. Even where some form of health insurance is available, patients may still need to contribute, e.g. in the form of co-payments or deductibles. Many are prevented from receiving health care because of the need for direct payments. Others are driven into poverty and financial ruin because of this. Inefficient and inequitable use of resources was the third obstacle impeding the passage towards universal coverage. A conservative estimate placed the wastage of health care resources at 20–40% [1]. Corruption could be added to this list as a fourth hurdle, as is the case in South Africa. Corruption erodes 10% of all health expenditure in South Africa, and within the private sector this is estimated to be between R5 and R15 billion yearly [6]. At the recent National Health Insurance Conference: Lessons for South Africa (National Consultative Health Forum), [7] views expressed by members of the World Bank, the WHO and leading health economists in the country were that the financing of universal coverage is not beyond the reach of South Africa, as



currently funds are available within the system. However, what is urgently required is the efficient management and use of the funds coupled with the elimination of corruption. In addition, employment taxation together with other innovative methods of revenue collection will be necessary.

Reforming the healthcare financing system in South Africa dates back as early as 1928 when a Commission on Old Age Pension and National Insurance recommended the establishment of a health insurance scheme to cover medical, maternity and funeral benefits for all low-income formal sector employees in urban areas. In 1935, similar proposals were recommended by the Committee of Enquiry into National Health Insurance. Between 1942 and 1944, the National Health Service Commission (also known as the Gluckman Commission) was set up. It recommended the implementation of a National Health Tax that would allow for the provision of free health services at the point of delivery for all South Africans. Health centres providing primary care services were to be core to the health system. Some of the recommendations were implemented, but gains from these were reversed after the National Party government was elected in 1948. The Health Care Finance Committee of 1994 recommended that all formally employed individuals and their immediate dependants initially form the core membership of social health insurance arrangements, which would be expanded to cover other groups over time. More work on this was done by the Committee of Enquiry on National Health Insurance (1995), the Social Health Insurance Working Group (1997), the Committee of Enquiry into a Comprehensive Social Security for South Africa (2002) and the Ministerial Task Team on Social Health Insurance (2002). In 2009, the Ministerial Advisory Committee on National Health Insurance was established with the objective of providing recommendations on relevant health systems reforms and matters relating to the design and roll-out of a National Health

Insurance as per Resolution 53 passed at the ANC's conference in Polokwane in December 2007.⁵ While several committees, commissions and working groups have been established since 1994 to work towards a way forward for universal coverage, displaying positive political will in this direction, it has only been under the stewardship of the current Minister of Health that positive political commitment towards Health for All has materialised. The two areas to be worked on as a priority, as articulated by the Minister, are improving the quality of care in the public sector and decreasing the cost of private health care [7].

While we embark on the journey towards universal coverage, it is important to remember that there are also other barriers to accessing health services. Proper financing will help poor people obtain care, but will not guarantee it. Lack of transport and transport costs would also pose an impediment to access. In addition, other social determinants are a prerequisite for ensuring the attainment of health, e.g. food and clean water. Because health is so dependent on its social determinants, it cannot be viewed as a silo. It will be imperative for the other ministries to come on board, and perhaps the comprehensive package to be offered by NHI should include some of the social determinants. In addition, while we have so many highly skilled and dedicated people working at all levels to improve the health of our people, we also have the harsh realities of severe shortages of human resources and health care workers with poor attitudes, in part because of the conditions that they find themselves in.

The Green Paper, which outlines broad policy proposals for the implementation of NHI, is currently undergoing a consultation process where public comment and engagement with the broad principles are encouraged. This will be followed by the policy document or the White Paper. Thereafter draft legislation will be developed and published for public engagement before being

finalised and submitted to Parliament for consideration as a Bill. Health reform as proposed by NHI is history in the making, and it is vital that we as citizens of South Africa engage with and interrogate the document and all the subsequent processes that follow. There are a number of positive aspects to the Green Paper. There are also a number of concerns and insufficient clarity on some extremely important issues.

The indicator of success of NHI will be the achievement of universal coverage. Under discussion at the moment is not whether NHI should be implemented, but how this should be done and what method of financing would be the most fair. Trade-offs will be inevitable. This is the experience in countries that have achieved universal coverage and financial security for their people. The trajectory is going to be long and challenging, but worth it for the future of our country and its people.

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Protesting a System which “Evaluates the Price of Everything, but cannot Appreciate the Value of Them”



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Background Information

Physicians are having a hard time all over the world. They lose their job security while their salaries are decreasing, and the social status of the profession is being eroded gradually. Violence against healthcare workers is so common that it is now considered normal to hear about a new incident nearly every day. On the other hand, the conditions are not any better on patients' side. While their rights have been promoted and enforced by legal regulations significantly in the last decades, paradoxically their access to the services they need is decreasing. What is happening? What is being changed in this period, what are the dynamics behind this widespread turmoil? The short answer to the big question is the commercialization of healthcare services, and Turkey is no exception.

The last 30 years passed witnessing the structural crisis of capitalism, and neo-

liberal policies recommended by the International Monetary Fund (IMF), the World Bank (WB) and the World Trade Organization (WTO) were introduced as a global solution. Neo-liberal theory is based on the idea of maximizing the size and the frequency of market mobility and as such it tries to include all human activities in the efficiency area of the market [8]. Through the Washington Consensus between IMF and WB, the structural adaptation programs of IMF, and WTO agreements such as GATS and TRIPS, public services were reorganized according to market economy, while nation-states withdraw from their public responsibilities. Mass privatization of public properties and services is the main characteristic of this period.

Like other services such as education, communication, energy, and transportation, healthcare services were affected tremendously by commercialization policies. A “reform” project of the World Bank was

implemented in Turkey under the name of “Transformation in Health”. The project aims to transform the organization, financing and provision of healthcare from a public to a private model. The coverage of accessible health care provided by the social insurance system became narrower and health is no more considered as a right of citizens. Centers for primary healthcare were transformed into family physicians' private clinics, and public hospitals have become autonomous institutions that are administrated by professional executive boards. The private sector is financially supported by public funds, and public services are increasingly provided according to demand and the ability to pay rather than the need. Competition, performance, productivity, and cost effectiveness have become the leading factors that determine the amount and quality of services provided. Reimbursement policies are also based on cost effectiveness rather than quality. Managers of public healthcare institutions must now learn to buy, sell and compete with the private sector and to prioritize cost effectiveness over their patients' best interests [6].

On the other hand, working conditions of healthcare workers have changed fundamentally. In a very broad spectrum from production relations to modes of employment, they have lost many of their rights. Health workforce was treated as an ordinary commodity in the market; and through flexible working, job insecurity and subcontracting exploitation of the workforce became more evident. The effectiveness, efficiency, profit making criteria are used as a tool of control, and if these criteria are not met the contracts of health workers would not be renewed. Physicians are compelled

to work on the basis of performance-based incentives, which shorten the examining time per patient and increase the number of working hours in a day. Health workers have accepted longer working hours and heavier workload for lower salaries under the threat of losing their job and becoming unemployed. This proves that, in fact, health workers are compelled to act like that. [12]. In the end, the working life in health sector has been transformed from independency to dependency, from qualified and highly prestigious roles to lesser prestigious roles, and from economic prosperity to poverty [12].

Another effect of the commercialization process on physician's working conditions is that their professional autonomy was severely compromised. As the cost-effectiveness became the central measure, reimbursement policies solely based on costs were implemented through treatment protocols, diagnosis related groups, restrictions on prescriptions, global budgeting for healthcare, and narrowing the coverage of insurance packages. This was clearly an assault to the clinical autonomy of physicians, simultaneously violating the right of access to healthcare. The art of medicine which brings together the knowledge and experience of the physician, the possibilities of medicine and the needs of the patient, started to disappear, and the profession has been transformed from a kind of craft into a business entrepreneurship [1]. A few physicians have become capitalists, but many of them are under the control of capital and became proletarian [12]. This internal polarization process differentiated physicians, dissolved them and they fell apart from solidarity. Physicians are squeezed between their personal benefits, social rights and professional values. The team solidarity broken by the performance based payment made physicians rival one another, made them strangers, even enemies to other health workers. It destroyed human relationships in health team. Healthcare workers have been alienated from each

other, from their work, and from patients. In a way, they have been atomized and isolated [1].

TMA and "Many Voices – One Heart Campaign"

The Turkish Medical Association (TMA) is the country-wide professional organization of physicians in Turkey. It was set up by a law dated 1953, which gives it the authority of regulating the profession. At present 90,000 of 120,000 physicians are members, although compulsory membership was lifted except for physicians who work in the private sector, after the military coup in 1980. TMA is interested in all health related problems and carries out its activities with its members working on voluntary basis [2]. The mission of the Association is to ensure that the profession is practiced so as to promote the benefit of public in general as well as each individual, and to protect the rights of physicians.

Particularly after 2003, TMA paid more attention to defending professional rights, as the system which "*evaluates the price of everything, but cannot appreciate the value of them*" was increasingly becoming a major threat to the profession as well as public health. Its struggle against the dominant policies that devalue the labour of physicians was well-accepted by physicians, and marked in the official statements of the Ministry of Health as "TMA's intensive and noisy opposition". In addition to presenting draft laws and opinion on personal rights and benefits of health workforce, TMA also organizes demonstrations and other actions including stopping working temporarily.

In spite of this struggle, the government continued its policy of commercializing healthcare. The government decreased the access to health care by minimum health packages and increasing co-payments, commercialized the public hospitals through financial interventions, manipulated the

modes of working, destroyed peace in working relations by performance based payment and flexible working, seized the university hospitals through financial constraints, increased the numbers of students of the medical schools at the expense of decreasing the quality of medical education.

After all these policies and regulations passed through the National Assembly and became the new legal enforcements for all, TMA decided to carry out a massive campaign called "Many Voices, One Heart". The campaign was basically demanding ceasing privatization policies in order to be able to practice our profession respectfully according to professional values (or "good doctoring"), and to be able to provide good quality healthcare services by respecting the right to healthcare. These demands were not new; TMA has been carrying out its struggle on the basis of defending the right to health and professional rights for decades. So the main themes of the campaign were defined as democratization, peace, the right to health and professional rights [1].

A holistic analysis of actual conditions has been made together with a vision for the future. Today, physicians are fragmented, isolated and turned into strangers to one another. For this reason, the campaign is based on different components and stages in order to understand the subjective needs of physicians and to put them on the agenda. In meetings organized in 44 cities, physicians came together and discussed their problems.

The campaign started on the day when the National Assembly was discussing the health budget. "Budget for health, not for the capital" was TMA's main statement. The campaign brought to the foreground the following: the economic constraint on medical faculties, commercialization of primary care, the problems of specialization training and problems of contractual working in the private sector, violence against health workers, and the policies diminishing access to

the services needed. The conceptual framework of the campaign was based on five demands. These were job security, income assurance, safety of life in terms of protection from violence against health workers, professional autonomy and the right to health. The first four demands were the basic concepts that physicians otherwise fragmented would agree on. The demand “the right to health” was the key word to bring healthcare workers and the people together. TMA made a call to 65 Chambers of Medicine and 97 Specialty Associations with a view to involve them in this struggle. While this struggle was building up in TMA, several meetings have been carried out with other health workers’ unions and associations in order to enhance unity and solidarity. Instead of limiting the demands to physicians’ needs, the campaign invited all healthcare workers, including the cleaning workers, nurses, dentists, pharmacists, laboratory technicians, social workers, to struggle together with the physicians [1].

Organization of the Mass Meeting

After arranging several local meetings in 44 cities, it was decided to organize a mass demonstration in front of the Ministry of Health building in Ankara. The date was chosen March 13, as March 14 has been celebrated as *Medicine Day* all over the country for a hundred years and this is the day that media show interest in the problems of physicians. Seventeen trade unions and professional associations urged their members to participate. Also, different instruments of the media were used to spread the call. In addition to classical methods such as printed materials, e-mail and web announcements, invitation to the mass meeting was made through a collective singing process. A professional agency prepared a project of collective singing, in which a famous song “I can’t take my words back” was chosen as the symbol of the invitation and message to the people. First, individual physicians or

groups of healthcare workers sang the song and recorded it. Then, all over the country thousands of healthcare workers, medical students, and physicians sent their recordings to TMA, and those records were edited to build up a video clip. This video clip has been clicked on tremendously and had a very positive effect on people in the sense that they felt themselves a part of the movement. Collective singing and recording was a way to bring people together (the clip is accessible through: tinyurl.com/canttake-mywordback).

The demonstration on March 13, 2011 was a great success, with the participation of more than 30,000 healthcare workers. Organised by the Turkish Medical Association, the demonstration was the biggest in the Republic’s history on the part of health workers, and the most enthusiastic and participative meeting ever (*for a short video: tinyurl.com/13march*). Healthcare workers protested in the streets of Ankara against the privatisation policies of the Ministry of Health which transform physicians into small entrepreneurs, patients into customers, and healthcare services into a commodity [6].

Over 30,000 healthcare workers declared their demands, and if their demands were not to be met by the authorities, they declared that they would use their power derived from production.

But, unfortunately, the media coverage was lower than expected, creating intense disappointment among physicians. Mainstream media did not cover the protesting at all, or showed it on screen for a few seconds. Also, there was nearly no reaction from the government except the comments of the Minister of Health, stating that only a few participated in the demonstration and they were nothing but “old-fashioned hardliners”. These developments made the campaign pass to another phase. TMA together with ten unions and associations of healthcare workers announced that they

had agreed on a two-day general strike in the country on April 19–20.

During the preparation of the strike, we witnessed the rising movement of research assistants. Their urgent demands focused on the time allocated for training, and the right to have a day-off after their night duties. Their slogan was “research assistants are not slaves”. They were also refusing performance based payment. This rising movement resulted in many local warning strikes before the April strike in several provinces. Some of their demands were met, including a day-off after night duties.

Preparation of the Strike

While preparing the 19–20 April strike, TMA made a declaration to the press in order to explain the conditions and problems lying at the basis of the strike. The rationale of the strike was explained as:

“The worsening working conditions, enforcement of insecure modes of working, disrespectful manner and discourse of the politicians, the new laws and the regulations which propose imperceptible future in the field of health, commodification and commercialization of health care.”

The demands have been defined as follows:

“We have common demands with other people which are to live a decent life. We don’t want to be the “actor” of a commercialized health care; we don’t want to become the “employee” of the low-waged, unsecured, flexible working. As the honorable members of a profession which is dedicated to society, we want to do our job without concerns for the future.

By accepting the right to health, we demand health for all and secure future. We demand job security, income assurance, and safety of life which means protection from violence against health workers, professional autonomy, and the right to health.”

Thus, the urgent demands were formulated as fifteen items given below:

- Performance based payment which creates rivalry instead of solidarity and transform our patients into bonus score should be terminated.
- All co-payments, out-of-pocket payments which commodifies health care should be eliminated.
- Minimum health package which narrows the coverage of social insurance and interferes with the professional autonomy of physicians must be abandoned.
- Medical faculties should maintain their autonomy.
- Day-off after night duties should be given to all physicians and the weekly working time should not exceed 56 hours.
- All healthcare workers should be employed in secure employment modes.
- TMA should be a party in the contracts of private physicians working on contractual basis.
- TMA should have authority in assignment and wage determination of occupational health physicians.
- Income inequality should be ended among primary care physicians and they should be employed securely.
- Necessary arrangements should be made in healthcare institutions in order to establish life security, diminish violence against health care staff and legal regulations should be made urgently.
- The humiliating discourses and attitudes towards healthcare staff before the media should be ceased.
- The salaries of physicians should be reconsidered and they should be sufficient to ensure them decent living and provide assurance regarding the future.
- Physicians should have the right to self-employment.
- There must be a workplace health unit in health care institutions.

Health and social workers, radiologic technologists, subcontracted workers in health care, laboratory technicians, dentists, nurses, pharmacists and their professional organiza-

tions joined in this call along with TMA. A call was made to the public by saying – please, support this justified struggle by not admitting patients to hospitals on April 19–20. At the same time the public was informed about the action that emergencies will be taken care of as usual; health services will be provided as it has been done during the holidays.

The Law Office of TMA prepared an evaluation on the legal issues of the strike. They declared that blaming the participants of a strike is against the legal arrangements of the country as well as the European Convention on Human Rights. TMA as a constitutional organization has the responsibility to share the problems physicians are facing and make society aware of the health care problems. They informed the physicians on possible disciplinary proceedings, secondment, temporary assignments and litigations. The Law Office of TMA declared that they will be defending the rights of the physicians who would face problems because of the strike actions. In addition to the Law Office's statement, TMA declared that "any single investigation about a physician will be the basis of stronger solidarity."

Ethical Dimension

The Minister of Health announced that being on strike endangers patients' health and lives, and therefore it would be "immoral", let alone its illegality. In fact, there is no international consensus whether physicians' strike is compatible with their professional duties. There are different points of view that either support or decline strikes in the health sector due to different reasons (*At this point, we would like to state that there is a real need of WMA Declaration on this issue, as physicians all over the world need guidance urgently in this process of commercialization and violation of rights*). However, TMA takes the position that strikes would be morally justifiable under certain circumstances, as it was stated in its *Declaration on Physicians' Strikes*, adopted in 2008 (see Box). Two

rationales, namely, defending the right to health and protecting professional rights, may allow physicians to go on strike. On these grounds, physicians should first try other ways to make a change, and a strike should be the last option. Moreover, the public should be informed in advance about the reasons of this action and the availability of services. And providing services should not be interrupted to certain groups of patients, i.e. pregnant women, those in need of urgent care, dialysis patients, persons with cancer, intensive care patients and in-patients. When all these preconditions are met, then TMA confirms the strike to be in conformity with professional ethics. And beyond that, under these circumstances defending the right to health and protecting professional rights that are directly linked to the right to health, constitute a professional duty based on social responsibility. That is why TMA is naming the word *strike* as "*g(ö)rev*" (duty), instead of "*grev*" (strike).

The April 19–20 strike was very-well justified in this context. The decision on strike was shared with the public by announcing that "*services will be provided just like on holidays*". Emergency patients, in-patients a.o. were taken care of without any disruption in services, and society mostly supported the action. The only real problem was some out-patients for whom the date of the visit to the clinic had been fixed weeks in advance and not being informed about the strike, they came from a long distance to be examined, but couldn't get the service. This is an issue to be carefully handled in similar situations so as to protect patients as much as possible.

Evaluation of the Strike

The slogan of the mass meeting of 13 March was "I can't take my words back". In accordance with this slogan and in spite of pressures made by the Ministry of Health physicians and health workers kept their promise and this very promising participation encouraged all of us.

Turkish Medical Association Declaration on Physicians' Strikes

Adopted in "Ethics Declarations Workshop" held in Ankara on 4–5 April 2008, with the participation of representatives from 33 medical specialty societies, Society of Turkish Nurses, Istanbul and Ankara Bars, and academicians from Departments of Medical Ethics in universities.

In the "Professional Ethics Rules of Physicians" adopted by the Turkish Medical Association, a holistic approach to health is considered as the responsibility of individual physicians and it is further stated that self-development by human beings is possible only in healthy living conditions:

"Physicians are aware that the profession of medicine cannot be abstracted from social and cultural circumstances surrounding the profession and that the most fundamental precondition for developing and realizing human potential is the state of physical and mental health."

Another fundamental responsibility is stated as protecting human life and health:

"The primary task of the physician is to protect human life and health by preventing diseases and curing patients through fulfilling scientific requirements. It is also among the paramount duties of the physician to respect human dignity while performing his profession."

These responsibilities make it necessary to take into account also social circumstances under which service delivery takes place. Scientific evidence shows that the health status of individuals and societies are determined not only by services provided but also by many other factors including social class, level of education, genetics, nutrition, sheltering, working and environmental conditions.

The Turkish Medical Association declares that, in the context of responsibilities mentioned above, the action of strike is con-

sistent with professional ethics on the basis of following two grounds:

- Policies currently pursued may limit or hinder individuals' access to healthcare services they need. Furthermore, there may also be problems related to the other determinants of health status including social inequalities, human rights violations, environmental health problems, unhealthy sheltering, unfavourable working environments and unemployment. Since all these factors and conditions affect the health status of individuals and society and are in contrast with the requirements of the right to health, it is also among the social responsibilities of physicians to warn policy makers and the executive and to build awareness in public at large. In this context, physicians may talk issues with authorities through their professional organization, make press statements, organize marches, engage in training and extension activities and, when necessary, make strike. An action of strike in this sense is in conformity with professional ethics given that service delivery to pregnant women, those in need of urgent care, dialysis patients, persons with cancer, under intensive care and in-patients is not interrupted and the right to health is properly defended.
- Another fact which justifies the action of strike is the losses that physicians suffer in their professional rights. It runs parallel to the realization of the right to health. It is because health workers themselves can be healthy in conditions of decent life and can provide their services better in case they get a fair return to their efforts and work in safe and secure conditions. Yet, policies geared to establishing rivalry instead of solidarity among health workers, to introducing cheap and insecure employment through privatizations and on-contract recruitment will inevitably undermine the health of health workers and society and further deepen existing inequalities.

When strike decision is taken, the public should have been informed in advance and the reasons for this action should be clearly stated and shared with the public.

The two-day strike took place in most provinces, totally embracing 87.5 % of the physicians (yellow colored provinces). In some provinces where 7.2% of the physicians work, supportive press declarations were made (red colored provinces), and in the remaining provinces (white colored) with 5.3% of the physicians no strike action occurred.

Tents were set up in the hospital gardens. Informative leaflets were distributed to

the people. Meetings and demonstrations were arranged. University hospitals and state hospitals lively participated. In many provinces there were difficulties in participation of employees of private hospitals because of intimidating with dismissals. In each province press declarations were made. Some conflicts occurred between the health personnel and the security staff of the hospitals. The media provided information about the strike by stating that

"on 19–20 of April the hospitals will not provide health care except for emergencies". In the cities which participated in the strike, people supported it by not asking admission to hospitals. Although the Minister of Health made provocative speeches against the strike, not any single confrontation between the patients and the health care staff occurred. TMA appreciates the common sense and tolerance of our people.



The Ministry of Health has conducted disciplinary proceedings, secondment, temporary assignments and litigations. Some presidents of medical chambers, some members of the Board of Directors, even one member of the Central Council of TMA have faced disciplinary proceedings and litigations. The Law Office of TMA has provided a sample of petition to physicians who have been exposed to any kind of pressure. The lawyers of TMA have provided legal assistance. In the end all arbitrary actions of the Ministry of Health were legally halted.

However, on June 6, 2012, 47 students from medical, dental and health sciences schools were detained, and after the prosecution and court inquiries 13 of them were arrested. 11 of these students are from schools of medicine and they are also members of the Student Branch of the Turkish Medical Association. Without being accused of anything, these students were asked by the Prosecutor and the Court about their participation in legal activities organized by the Turkish Medical Association. Due to their prolonged detention the students could not attend to their internship duties, could not take their regular tests; there are even some among them who would have graduated if not detained. Meanwhile, all these events also “criminalize” the Turkish

Medical Association as a constitutional body. The idea is to “criminalize” involvement of medical students in public health issues and health policies in order to deter other students from such activities. This is nothing less than restricting the freedom of expression and association in a state under the rule of law. The process that the Turkish Medical Association has experienced upon the Decree Law No. 663 is clearly articulated in the Editorial by the WMA Secretary General Dr. Otman Kloiber in the first issue of WMJ in 2102; the article by Dr. Eriş Bilaloğlu who was then the President of TMA and the council decision adopted by WMA in April 2012 in relation to TMA. It is considered that the arrest of our students is a part and extension of the same process.

Lessons Learned and a Call From TMA

It was very risky to organize a strike of this scale, as there were serious doubts about physicians’ participation. Most of the physicians were unhappy and hopeless during the meetings organized all over the country before the strike. But in terms of participation, the strike was successful. Physicians massively took part in the action. On the other hand,

in terms of the results or positive gain, it is not possible to claim that it was a success in the short run; the Ministry of Health and policy makers didn’t care about the rightful demands of healthcare workers, instead they focused on decrying the action in the public eye. Nevertheless, it would be unfair to recognize an action of this scale as a failure. On the contrary, TMA and the other organizations have made a very clear signal to the Ministry of Health and to society by this strike. Also healthcare workers have learnt and gathered experience that they have enough power to be heard and to negotiate when they are united under a common platform and acting together. This point is so critical that the World Bank’s expert recommends another approach in the book titled “Getting Health Reform Right” [11]:

“On the negative side, it is important to consider how to divide or undermine coalitions that are opposing you. Suppose that the medical association has decided to oppose a new insurance scheme because it will limit reimbursement for high cost procedures, which would negatively affect the income of some physicians. It may be possible to persuade doctors who provide primary care to switch sides and support the plan, and thereby divide the medical association, if primary-care doctors can be persuaded to see their interests in a different light.”

This book was translated into Turkish under the editorialship of the Minister of Health himself, and this is one of their main guides in policy-making, besides the World Bank project “Transformation of Health” (for a detailed information, please, visit the related project site of WB: tinyurl.com/WB-TransformationinHealth. It is possible to follow the past, current and future policies of the Ministry of Health in a timeline until July 31, 2013). It is crystal clear that national medical associations are direct targets of these commercialization policies, and standing together is vital.

It is also clear that the rights of patients and society in general are not to be sepa-

rated from healthcare workers; they will be either exercised or violated all together. That is why, we, physicians, always need to claim our rights together with those of patients and society. We always need to defend the right to health, emphasize that health care should be financed from general taxes and should be provided by the public sector according to needs. Health care should be equal, accessible, of good quality and free for every one. Otherwise, struggles focused only on professional rights are doomed to fail, as it is not possible to protect professional rights and interests without opposing commercialization policies.

We would like to finish with a call from TMA to all NMAs: It is important to share the experience, as we need to know our shortcomings and gaps, and improve our methods wisely. In this context we would like to propose that WMA would establish a database for physicians struggle all around the world. What were their motives? What were the actions and consequences? What can be improved and how? What was society's reaction? What would they change for the next time? Every NMA might send information about such actions during the last decade. We believe it to be a very precious resource for all of us.

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Our Failed Health Strategy

Today, our country and many others around the world are faced with the epidemics of arthritis, hypertension, obesity, diabetes, heart disease, stroke, and cancer. Obviously, our health prevention strategy of more than half a century has failed in our race and battle against these diseases. While the world has succeeded significantly in the area of infectious diseases, eliminating the killer small pox, and to a great extent, polio, we are still lagging far behind in the race against those seven common illnesses enumerated above.

During the past six decades, medical science and technology have made mind-boggling diagnostic and therapeutic advances. Both pharmaceutical and surgical treatments of diseases have progressed significantly. More effective antibiotics and medications for various illnesses have been developed. Open heart surgery, angioplasty, brain and joint surgeries, conventional and endoscopic (minimally invasive techniques) have come to the forefront, saving and making lives more comfortable. This cutting-edge thera-

pies include new and more effective chemotherapies with lesser side-effects, albeit still far from ideal.

In essence, the world's state-of-the-art knowledge and ability to diagnose diseases and manage many of those illnesses are great strides we have gained during the post World War II period to the present.

But the stark reality today glaringly points to our massive failure as a global society in the vital area of disease prevention. Testament to this are the escalating statistics – the worsening incidence of those major

diseases, their morbidity, complications, and death tolls. We have barely put a dent on them. Evidently, our conventional preventive strategy has not worked and diseases are way ahead of us in the race.

Is medical science to blame? Don't we have enough scientific data in this exploding informational age to help guide us to the right path to health and longevity?

Lifestyle diseases (self-induced or self-inflicted illnesses) are the major killer diseases today. In general, except in impoverished nations who deserve our compassion and help, we abuse ourselves with our abundance and blessings. We eat the wrong food, we overeat and simply loosen our belt, we neglect physical and exercises, we indulge in unhealthy behaviour and vices, like smoking, undisciplined alcohol intake, and even unsafe sex.

Worse than what majority of us are doing to ourselves are the bad examples we are setting for our children, as pointed out in the 800-page coffee-table health guide, entitled *Let's Stop "Killing" Our Children*, which is available at PhilipSchua.com, xlibris.com, amazon.com, and barnesandnoble.com. Anyone not positively contributing to the health and well-being of children under our care, for whatever reason, including love, is literally cutting short the life span of these youngsters and shortchanging them unfairly.

Unfortunately, the negative impact of our bad examples as parents is so subtle and shows up late – when our children are already in their middle-age, where all these infirmities start bothering them, like arthritis, high blood pressure, diabetes, heart disease, stroke, and cancer – that the deadly effects of our unhealthy behaviour on our children before they are born and as they are growing up are not immediately apparent.

Many of us shrug this off and rationalize “When they grow up, they will develop their own habits, behaviour, and preferences.”

But we do not realize, as science has clearly shown, that the first five years in the life of children are the formative years, where “the dye is almost cast,” where their mindset, as influenced by what they learn from us, their parents and guardians, has taken roots, and has become a permanent part of their thinking, behaviour, and choices in life. So, if we waited for them to grow up, it would be a bit too late to iron out the kinks they learned from us, adults.

The proper timing for gifting our children healthy lifestyle starts before they are conceived, when they are in the womb, when they get in the crib, and at least during their first five years and teen years. Doing this will ensure that we maximize the protection of their DNA and immune system, starting healthy lifestyle from the cellular level, or from what I call “Ground Zero” in my new book, to effectively reduce their risk for acquiring arthritis, hypertension, diabetes, heart diseases, stroke and even cancer when they reach their middle age and beyond.

Unfortunately, many seemed to have discounted convincing scientific evidences showing we can chart the course of our own health destiny to a significant extent. As a consequence, they have surrendered to their “fate” (que sera, sera), which they feel is beyond their control. In essence, they have unwittingly programmed their mindset to a casual, careless, self-destruct, slow-suicide mode. They simply accept whatever happens and seek treatment of the diseases when they occur, instead of preventing them in the first place.

The incidence, complications, and death rates from obesity, diabetes, cardiovascular diseases, cancer and other illnesses are escalating to epidemic proportion. And this is unfortunate, because, to a great extent, these diseases are, believe it or not, mostly preventable!

Trite and corny, perhaps, but the adage by Ben Franklin, “an ounce of prevention

is worth a pound of cure,” rings truer and louder when it comes to health, and well-being, and illnesses, especially those that kill. Indeed, no medical treatment is more effective than prevention of diseases.

However, I would like to underscore the fact that the timing of prevention is of utmost importance, which I propose to be at the cellular, DNA level, during infancy in order to be truly effective, and not later.

Our past and current strategy has failed miserably as present day medical statistics show. Common sense tells us we, as a society and as individuals, are doing something wrong in our race against diseases. We are Johnny-come-lately in this battle. We have been joining the race a bit late, when the integrity of our DNAs have already been damaged after years of self-abuse. The race begins at the starting line and not in the middle.

There is a serious need for world society as a whole to re-evaluate our failed strategy and put emphasis on early prevention by being pro-active and pre-emptive in the way we deal with health and longevity, otherwise the future generations are doomed as we are.

While it is never too late for any of us, at any age, to start disease prevention or amelioration through healthier lifestyle, we can save our young children and grandchildren, and theirs, from the ravages of preventable illnesses we ourselves have acquired through negligence and carelessness, by implementing the timely intervention before conception of the child, when in the crib, all through its teenage years, and beyond.

I strongly propose we start at “Ground Zero.”

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Financing Quality in Healthcare – the InterQuality Project Takes on the Challenge



Konstanty Radziwill



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‘Spend not more, but smarter!’ – this idea is the driving force behind the “International Research on Financing Quality in Healthcare (InterQuality)”. Co-financed by the European Commission’s Framework Programme 7, InterQuality is led by the Medical University of Warsaw. Its consortium is composed of the Universities of Hannover (DE), Syddansk (DK), Catania (IT), York (UK), as well as the think tank “The Urban Institute” (US), a Polish research and education-oriented SME specialised in the pharmaceutical sector, Sopharm Sp z.o.o. (PL) and the European Patients’ Forum (EPF) as well as the Standing Committee of European Doctors (CPME). The CPME President Dr. Konstanty Radziwill sees the project’s objective as an attempt to resolve a fundamental challenge: *“The problem of how to pay for medical services probably already arose thousands of years ago. It is said that ancient Sumerian kings paid their doctors until they regained their health. Today the idea of paying for healthcare outcomes rather than for procedures is still vivid.”* While Europe’s healthcare systems vary significantly in structure, economic pressure

on budgets is a unifying reason to review financing systems. *“The problem still exists – how much to pay for efforts and how much for results, how much for procedures performed and how much for availability, presence and care”*, states the CPME President.

Launched in 2010, InterQuality strives to address these questions by concentrating on four models of care and their respective financing systems, i.e. hospital care, outpatient care, pharmaceutical care, and integrated care. In these focal areas, InterQuality works towards establishing a common understanding of the terminology and concepts used to describe different financing system and identify payment systems’ incentives, as well as indicators suitable to assessing quality of care. On this basis, the focal areas will be examined in-depth, with a view to assessing good practices and processing these findings in guidelines for policy-makers. *“There are many solutions in the world; most of them of mixed nature. The question is how to pay in a just and effective way. These questions are addressed by the In-*

terQuality project which is designed to at least get us closer to answering the dilemma: how to fulfil growing patient demand in shrinking economic possibilities?”

Dr. Radziwill explains that *“while this is definitely a task for the economists, the medical profession is also necessary in this research. This is why CPME decided to take part in InterQuality.”* CPME will be contributing to several project deliverables to share the doctor’s perspective on the impact of financing systems on quality of care. As one of the primary stakeholders in the implementation of healthcare financing reforms, CPME shall also be looking at communication strategies which support reform cycles to establish how governments can best ensure that stakeholders’ views are considered and processed. CPME shall be carrying out this work in close collaboration with the European Patients’ Forum (EPF), who is leading the project’s communication activities.

The project is currently entering into its empirical phase in which the four selected models of care will be studied. Results are expected for mid-2013. In the meantime, the consortium will be presenting interim findings at conferences and other events, an up-to-date list of which can be found on the project’s website www.interqualityproject.eu.

The questions InterQuality seeks to answer will increase in relevance as public budgets deal with the mid- and long-term impact of the economic crisis. However, the consortium hopes to show that quality need not be compromised. As the project leader, Prof. Dr. Hab. Tomasz Hermanowski, concludes, *“the good news is that we can realign payment incentives to drive quality improvement and foster better use of our health care resources. To get to better quality, we don’t need to pay more: we need to pay smarter.”*

Dr. Konstanty Radziwill,
CPME President;
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CPME EU Policy Advisor

Alternative Medicine in Oncology



Karsten Münstedt

Problems of Defining Alternative Medicine and Possible Solutions

What is alternative medicine? Unfortunately, there is no clear definition. In general it is grouped with complementary medicine or integrative medicine. In the literature there are basically two definitions:

Alternative medicine is considered to summarize treatments which are outside of conventional medicine

1. which are used instead of conventional medicine to treat a disease or
2. which are used to directly treat a disease.

Accordingly, complementary medicine is considered to cover treatments

1. which are used parallel to conventional treatments in order to improve their efficacy or to decrease side effects or
2. which are used to treat the symptoms of a disease.

From the view point of conventional medicine there may be no need to distinguish between alternative and complementary



Thomas Karl Riepen

medicine. Clearly, both are not generally accepted by conventional medicine, which led to them being grouped together. However, it seems that the distinction is important. In contrast to the protagonists of complementary medicine who accept the conventional medicine's underlying concepts of disease etiology, pathogenesis and treatment, the protagonists of alternative medicine often have developed their own disease concepts, which often are of esoteric nature and conflicting with the concepts of conventional medicine. Thus, protagonists of complementary medicine disclaim the concepts of alternative medicine and do not feel comfortable when grouped with followers of alternative medicine.

In order to write about alternative medicine it seems important to have a clear definition. A possible solution to the problem could be an approach comparable to the use of cross-tabulation with the question of acceptance of conventional medicine's disease concepts on one side and the question of a direct treatment approach versus a focus on the treatment effects on the other. Figure

depicts the result of such a combined definition and gives some examples on where various treatments could be grouped to.

However, such a solution allows defining 3 subsets of alternative medicine:

- A – Approaches directly against the disease which are not consistent with scientific concepts;
- B – Approaches directly against the disease and consistent with scientific concepts but without scientific proof of efficacy;
- C – Supportive approaches directly which are not consistent with scientific concepts.

In the following part, the evidence of various methods will be summarized based on the referred grouping.

Scientific Evidence of Approaches Directly against the Disease, which are not Consistent with Scientific Concepts (Group A – alternative medicine)

Hamer's German New Medicine

In brief, Hamer's German New Medicine considers every cancer or cancer-like disease to originate with a Dirk Hamer Syndrome ('DHS') which is a very difficult, highly acute, dramatic and isolating shock, which affects the psyche, the brain and the organ. Basically, the resolution of the underlying problem is believed to induce the cure of the disease. According to the followers of Dr. Hamer, the method is supposed to work well. Unfortunately, the so-called successes have not been reviewed by independent scientists; however, there are several reports on the internet which show that 149, perhaps another 500 deaths of cancer patients are due to the fact that cancer patients are not allowed to accept any part of conventional medicine, not even pain medication (<http://www.deathsect.com/>; http://www.ariplex.com/ama/ama_ham2.htm; accessed on August 26th, 2012).

Acceptance of conventional medicine's disease concepts			
		No	Yes
Intended therapeutic goal	directly against disease	<div>Hamer's German New Medicine</div> <div>Faith healing</div> <div>Homeopathy</div> <div>Dr. Hulda Clark's Therapy</div> <div>Anthroposophical Medicine</div> <div>A</div>	<div>Galvanotherapy</div> <div>Di Bella Multitherapy</div> <div>High-dose vitamins;</div> <div>Dr. Rath's Vitamines</div> <div>Insulin Potentiated Therapy</div> <div>Galavit</div> <div>Laetrile</div> <div>Enzyme Therapy</div> <div>Dr. Coy's Diet</div> <div>Ukrain</div> <div>B</div>
	supportive only	<div>Homeopathy</div> <div>Anthroposophical Medicine</div> <div>C</div>	<div>Complementary medicine</div>

Faith Healing

Faith healing is healing through spiritual means. It is believed that healing of a person can be brought about by religious faith through prayer and/or rituals, which again would stimulate a divine presence and power toward correcting the disease and disability. A recent analysis shows that it is widely used in pediatrics [1]. Detailed analyses on efficacy are lacking; however, some reports show that cancer cure is out of the scope of faith healing [2]. A meta-summary has confirmed the fundamental importance of spirituality at the end of life and highlighted the shifts in spiritual health that are possible when a terminally ill person is able to do the necessary spiritual work; however, in cancer survivors praying for one's own health was inversely associated with good or better health status [3].

Homeopathy

Homeopathy is based on the idea that the dilution of a substance that causes the symp-

toms of a disease in healthy people will cure that disease in sick people. This dilution is called "potentization". Some protagonists of homeopathy, like Dr. Wurster from Germany, claim that cancer may be cured by homeopathic means. In his book, Wurster describes several cases which he believed to have been cured by this method [4]. There has not been any independent proof for these claims.

Dr. Hulda Clark's Therapy

Dr. Hulda Regehr Clark (1928–2009) claimed that all human diseases were related to parasitic infections, which she claimed to be able to cure by destroying the parasites by "zapping" them with electrical devices which she marketed. So far there are no studies that could provide evidence for these claims.

Anthroposophical Medicine

Anthroposophical medicine mainly seeks to extend, not replace, conventional medicine.

Especially, the use of mistletoe extracts in the treatment of cancer has become quite popular after it was first proposed by Rudolf Steiner and anthroposophical researchers. However, the anthroposophical concepts are not founded on the phytotherapeutic effects of mistletoe extracts, but the merely believed similarity between the mistletoe, which is a hemi-parasitic plant in a tree and a cancer in an organism. There have been several trials which were designed to support the use of mistletoe in oncology. So far, the evidence to support the view that the application of mistletoe extracts has impact on survival is weak [5]. Even protagonists of mistletoe therapy acknowledge that the survival benefit that has been shown is not beyond critique [6]. Positive evidence comes from non-randomized, prospective, controlled cohort studies in matched pair design, or retrolective studies. Prospective, randomized controlled trials failed to show positive effects [7,8].

Approaches Directly against the Disease and Consistent with Scientific Concepts, but without Scientific Proof of Efficacy (Group B – alternative medicine)

Galvanotherapy

Galvanotherapy, also called electrotherapy, uses direct electric current especially to treat superficial tumors. Recently, modern imaging techniques allowed positioning of galvanotherapy wires into tumors in deeper parts of the body (e.g. magnetic resonance imaging-guided galvanotherapy). So far, there has been only one trial on galvanotherapy, which is more or less a feasibility study. It shows that there are some partial remissions, some stable diseases and few progressive diseases in patients with prostate cancer. However, the lack of a control arm and long-term results does not allow any conclusions on whether this method

could be recommended to patients with prostate cancer or other cancer diseases [9].

Di Bella Multitherapy

Di Bella Multitherapy is based on the theory that growth hormones and prolactin are involved in neoplastic growth. The treatment comprised a multidrug, custom-made medical treatment developed by Luigi Di Bella, an Italian physician, who claimed effectiveness in blocking, if not curing altogether, most cancers. Because of his claims the Italian government initiated trials which clearly failed to show that the treatment was effective [10,11]. In spite of these results, relatives of Luigi Di Bella are again promoting this method and claiming higher survival rates for patients with metastatic breast cancer compared to the literature [12].

Dr. Rath's Vitamins, High-dose Vitamins

According to Dr. Rath, all diseases are caused by a lack of lysine and vitamin C (<http://www.quackwatch.org/11Ind/rath.html>; accessed August 26th, 2012). In the past, Dr. Rath claimed to have cured patients from cancer. However, in his publications he presents only evidence from preclinical studies. So far, there have been only few trials which have addressed the effects of high-dose vitamins. Probably the most important study concluded that high-dose vitamin C therapy is not effective against advanced malignant disease regardless of whether the patient has had any prior chemotherapy [13].

Insulin Potentiated Therapy

This is a cancer treatment where insulin is used in order to bring chemotherapeutic drugs selectively into cancer cells. It was developed by Donato Perez Garcia in the 1930s. Due to the combination of insulin and chemotherapy it is believed that only

10-15 % of a standard dose is required [14]. Just recently, a study on this study was reported. However, it does not allow any conclusion on the possible importance of Insulin Potentiated Therapy because all patients with prostate cancer received conventional hormone therapy in conjunction with low-dose chemotherapy and Insulin Potentiated Therapy [15].

Galavit

This is a Russian drug with an immunomodulatory potential. In 1999 and 2000 it was recommended as an anticancer drug. About 170 cancer patients mainly with advanced diseases were treated with galavit. However, almost all patients died from cancer disease, although they were told that cure rates were expected to range around 70% (<http://de.wikipedia.org/wiki/Galavit>).

Laetrile (vitamin B 17)

Laetrile has been promoted as a cancer cure since the early 1950s. In spite of the name, it is not a vitamin in any sense. A recent systematic review found no evidence for beneficial effects for cancer, but a considerable risk of serious adverse effects from cyanide poisoning [16].

Enzyme Therapy

Generally, enzyme therapy is mainly used as a complementary treatment in combination with conventional treatment. However, in the early years it has also been promoted as an anticancer treatment by the Scottish physician John Beard and later by Freund and Kaminer in Vienna. Recently, the results of a randomized, phase III, controlled trial of proteolytic enzyme therapy versus chemotherapy in pancreatic cancer was published, which showed that conventional treatment was clearly superior to enzyme therapy [17].

Ukrain

Ukrain is a combination product of extracts of the plant *Chelidonium* and thio-tepa. A recent systematic review concluded Ukrain to have potential as an anticancer drug, but this positive conclusion cannot clearly be drawn because of the need for independent rigorous studies [18].

Supportive Treatments Inconsistent with Scientific Concepts (Group C – alternative medicine)

Homeopathy

Homeopathy has been investigated in the supportive setting as well. Two independent systematic reviews have shown that there is no convincing evidence for the efficacy of homeopathic medicines for other adverse effects of cancer treatments [19,20]. There is some evidence favoring topical calendula for prophylaxis of acute dermatitis during radiotherapy and Traumeel S mouthwash in the treatment of chemotherapy-induced stomatitis; however, these trials need replicating.

Anthroposophical Medicine

Anthroposophical medicine may possibly improve patients' wellbeing. A recent meta-analysis concludes that the methodological quality of most studies was poor, but that the analyzed studies give some evidence that anthroposophical mistletoe treatment might have beneficial short-time effects on quality-of-life-associated dimensions [21].

Dealing with Alternative Medicine

As demonstrated above there is lacking or insufficient evidence for all type A ap-

proaches. Furthermore, there is no proof for any concept of alternative medicine which is not consistent with scientific concepts. Since analyses have shown that prognosis of patients who give themselves over to alternative medicine of this type is clearly inferior to patients undergoing conventional therapies, these methods cannot be recommended to patients, with no exceptions [22,23].

For type B alternative treatments there is some evidence for some of the named methods. Clearly, they cannot be recommended in general, but there may be certain situations in which some may be considered after conventional treatments have failed. In this group of treatments, some deserve further investigation and may eventually become part of conventional treatment one day.

When alternative medicine is used in a supportive context, it may be used if patients have the desire to try this approach. This conclusion is mainly due to the fact that the methods named here do not interfere with the use of conventional medicine. Since evidence regarding these methods is low, it seems important that new studies are conducted.

In general, it is important to know how to deal with alternative medicine. In 1983, Klimm endeavored to address these issues by devising 10 "golden" rules which should govern CAM use in relation to conventional medicine [24]. Although these rules are almost 30 years old, they still seem appropriate today. These rules state:

1. Conventional medicine is the foundation of a physician's work.
2. Practitioners of conventional medicine must recognize that CAM beliefs and methods exist and are being widely practiced. Ignoring CAM's existence is unwise.
3. Misjudgment of CAM represents ignorance and arrogance – gathering information about CAM represents increasing knowledge.

4. The necessity of educating patients about medical facts is self-evident; educating them about CAM is essential, too.
5. Practitioners of conventional medicine must keep themselves informed about CAM.
6. CAM methods should be clearly rejected where conventional treatments have proven benefits.
7. CAM methods can be allowed where reasonable conventional treatment is not compromised.
8. Harmless CAM methods may be allowed when conventional methods are unlikely to be successful.
9. CAM practitioners and their methods must be critically observed.
10. Physicians who only practice CAM should be censured unless they are able to prove the efficacy of their methods.

If these rules are followed, physicians should be able to cope with dubious practitioners and their offerings. Physicians must be aware that dubious practitioners of alternative medicine are very good at setting up the concept of an enemy, namely conventional medicine. In contrast they present themselves as true advocates of patients' rights and well-being, overemphasizing the side effects of conventional medicine and supporting their conclusions with selective citations. Rhetorically, they are well-educated and very good at alienating patients by various means. For example, they often omit facts which contradict their claims, cite only those which support their ideas and create pseudoscientific technical terms, which suggest competence. One major problem is the fact that critics of alternative medicine are often the subject of personal attacks and discreditation.

What Should Be Done?

Patients must be protected against dubious practitioners of alternative medicine. Since many of them are well organized, it

seems virtually impossible to achieve this goal without support from governmental authorities. It is suggested that it should be ruled that all alternative methods should only be used within clinical studies or under clearly defined circumstances. An institution comparable to the European Medicines Agency (EMA) could be useful in order to define such situations and decide about the mechanisms that could lead to acceptance of the methods. In contrast, methods with clearly proven inefficacy should be forbidden. On the other hand concepts for the scientific investigation of reasonable methods should be developed.

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The Fifth Geneva Conference on Person-centered Medicine

The Fifth Geneva Conference on Person-centered Medicine was held on April 28th May 2nd, 2012, the latest in the series of annual Geneva Conferences on this perspective since May 2008 [1-4]. The gradual building of this conceptual and methodological perspective [5-8] has proceeded through collaboration with major global medical and health organizations, academic institutions, and an expanding community of committed international experts all engaged in an International Network [9], now International College of Person-centered Medicine [10].

As for all previous Geneva Conferences, the main venue of the Fifth one was the Marcel Jenny Auditorium and auxiliary halls of the Geneva University Hospital. Within the framework of growing institutional collaboration (from 27 entities in the previous to 33 in the latest), the Fifth Geneva Conference on Person-centered Medicine was organized by the International College of Person-centered Medicine (ICPCM) in collaboration with the World Medical Association (WMA), the World Health Organization (WHO), the International Alliance of Patients' Organizations (IAPO), the

International Council of Nurses ICN), the International Federation of Social Workers (IFSW), the International Pharmaceutical Federation (FIP), the World Organization of Family Doctors (WONCA), the World Federation for Mental Health (WFMH), the World Federation of Neurology (WFN), the Council for International Organizations of Medical Sciences (CIOMS), the International College of Surgeons (ICS), the International Federation of Gynecology and Obstetrics (FIGO), the Medical Women's International Association (MWIA), the International Federation of Ageing (IFA), the World Association for Sexual Health (WAS), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), the World Federation for Medical Education



Logos of the institutions collaborating on the organization of the Fifth Geneva Conference on Person-centered Medicine.

(WFME), the International Association of Medical Colleges (IAOMC), the Paul Tournier Association, the World Association for Dynamic Psychiatry (WADP), the European Association for Communication in Health Care (EACH), the WHO Collaborating Center for Public Health Education and Training at Imperial College London, the International Federation of Medical Students' Associations (IFMSA), the Zagreb University Medical School, the University of Gothenburg Centre for Person-Centred Care, the George Washington University Institute on Spirituality and Health, the Peruvian University Cayetano Heredia, the Università degli studi di Milano, the Medical University of Plovdiv, and the Buckingham University Press, and with the auspices of the Geneva University Medical School and Hospitals.

With the overall theme of *Chronic Diseases: Person- and People-centered Perspectives*, the Fifth Geneva Conference on Person-centered Medicine encompassed a number of sessions larger than ever before and comprised plenary symposia, workshops, brief oral presentations, and posters, all having an international framework. Additionally, institutional work meetings were held focusing on the guiding principles for person-centered clinical care, person-centered diag-

nosis, an organizational informational base, and special institutional projects.

The Conference Core Organizing Committee was composed of Juan E. Mezzich (President, International College of Person-Centered Medicine), Jon Snaedal (World Medical Association, President 2007-2008), Chris van Weel (World Organization of Family Doctors, President 2007-2010), Michel Botbol (World Psychiatric Association Psychoanalysis in Psychiatry Section), Ihsan Salloum (World Psychiatric Association Classification Section), Tesfamichael Ghebriwet (International Council of Nurses), Shanthi Mendis (WHO Chronic Diseases Department), and Ruben Torres (PAHO/WHO Health Systems Area).

Financial or in-kind support for the Conference was provided by 1) the International College of Person-centered Medicine (core funding), 2) the University of Geneva Medical School (auditorium services and coffee breaks), 3) the Paul Tournier Association (conference dinner), and 4) Participants' registration fees.

Pre-conference Work Meetings

- The first Work Meeting on April 28, 2012 focused on activities and projects

related to the organizational and informational framework of ICPCM.

- The *International Journal of Person Centered Medicine* was launched at the Fourth Geneva Conference on Person Centered Medicine in 2011. As the official journal of the International College of Person Centered Medicine (ICPCM) and created in partnership with the Buckingham University Press, the Journal is advancing the global communication of scholarship and research for personalized healthcare [11]. As it was reported and discussed, the full first volume of quarterly issues has been completed. The first issue of the second volume was presented at the Conference. In this short time, the journal has achieved considerable strength and prestige and is attracting a continuous stream of quality manuscripts from all regions of the world. A productive meeting of the Journal's Editorial Board took place at the end of the first day.
- *Upgrading of College and Journal websites.* The main institutional website for the initiative on person-centered medicine was established early in the course of the Geneva Conferences process and has been upgraded regularly [11]. Advanced videos and interactive capabilities are being planned. The website of the *International Journal of Person Centered Medicine* was launched along with the Journal itself and is serving as an increasingly effective instrument to access the Journal as well as acquiring and managing subscriptions.
- *Use of Social Media in the Promotion of Person-centered Medicine.* Within the framework of the Internet and the World Wide Web (WWW), there is a popular trend to engage in Social Networking Sites. The potential use of these resources to promote person-centered medicine activities was discussed along with concerns and limitations.
- *International Conference and Publication Series.* Dealing primarily with per-

son-centered care for specific clinical conditions, this project is due to start in the second half of 2012. Its general plan was outlined during the initial work meetings and it was the subject of a panel discussion during the course of the core conference.

- *Person Centered Medicine Book Projects.* Monographs have a distinct place in the development of the field, and in person-centered medicine there are early precedents such as Paul Tournier's *Medicine de la Personne* in Switzerland [13], as well as recent contributions appearing in Croatia [14] and France [15]. Future projects were outlined for major textbooks with systematic presentations of the status quo in the field, as well as on broad specialty and discipline areas.

The second ICPCM Work Meeting focused on Person-centered Integrative Diagnosis (PID) and Related Diagnostic Projects. The work is predicated on the understanding that one of the key aspects of clinical care is comprehensive diagnosis as fundamental basis for treatment planning and care. This renders person-centered diagnosis as crucial for the implementation of person-centered medicine. The first session focused on moving forward the PID development process from a theoretical model to practical guide, started in psychiatry and mental health. The conceptual base and structure of the model were published in the Canadian Journal of Psychiatry [16] and more recently a conceptual appraisal was conducted and published [17]. The presentations in this initial session dealt with general development strategies, the heuristic value of ontological analysis, the instrumentation of the various domains and levels of the PID, the utilization of descriptive categories, dimensions and narratives, and the establishment of common ground among clinicians, patients and families towards the formulation of a comprehensive diagnosis and a plan of care.

An ensuing session on Related Diagnostic Projects discussed first the ongoing revision

of the Latin American Guide for Psychiatric Diagnosis (Guía Latinoamericana de Diagnóstico Psiquiátrico) (GLADP) [18-19], an official Priority Program of the Latin American Psychiatric Association, and its next steps leading to the publication of the revised version towards the end of 2012. Other presentations presented updates on the French Diagnostic Project, the World Federation for Mental Health Assessment Project, a pediatric diagnostic plan, and the grounds towards an internal and family medicine diagnostic effort.

The third ICPCM Work Meeting was dedicated to the ongoing development of Person-centered Clinical Care Guiding Principles. Earlier work on this project was summarized and placed in perspective as an orientation to the next steps. It was followed by several brief presentations made by members of the respective workgroup, particularly those representing geriatric, pediatric, family medicine and mental health perspectives.

An extended 3-hour working luncheon took place on the second pre-core-conference day to further discussions in various ICPCM workgroups, each meeting separately. The group participants included those who had made earlier initial presentations as summarized above, and those dealing with person-centered partnership and person-centered young health professionals (the Janus Group). This extended session facilitated the formulation of conclusions and the delineation of next steps. The conclusions were briefly presented in the plenary session.

Complementing the scientific program, two major ICPCM institutional meetings took place during the Fifth Geneva Conference. One was a face-to-face meeting of the Board, which regularly manages the organization through monthly teleconferences. The other was the General Assembly which heard a report from the Board, reviewed prospective activities (the Sixth Ge-

neva Conference and other events, ongoing advancement of the International Journal and other publications, continued work of research groups and projects, and further development of the ICPCM institutional structure and governance), and discussed a draft of the Geneva Declaration on Person-centered Care for Chronic Diseases, an effort for the first time to extend on public policy an impact of the main Conference ideas.

Core Conference

The Core Conference was opened on April 30 by Prof. Panteleimon Giannakopoulos, Vice-Dean of the Geneva University Medical School, and Dr. Manuel Dayrit, Director, World Health Organization. They were joined in the presidium by the members of the Board of the International College of Person Centered Medicine.

The opening address was delivered by the ICPCM president, who presented the progress report, ranking as the most important the consolidation of the International College of Person-centered Medicine which emerged from the International Network and the Geneva Conferences [9, 10]. Among the vital activities is the engagement of a growing number (33 at present) of international medical and health bodies (including WHO for the third time) as co-sponsors of the Fifth Geneva Conference, the strengthening of the *International Journal of Person Centered Medicine* as a joint venture with the University of Buckingham Press [11], activities of the workgroups particularly those on Person-centered Care Guiding Principles and Person-centered Integrative Diagnosis (the latter reflected in several journal publications and books) [16-19], WHO supported path-opening research activities initiated towards the systematic conceptualization and measurement of person-centered care, and collaboration in the anticipated launching of an International Conference and Publication Series



Part of the collaborating organizations' leaders, speakers and participants at the Fifth Geneva Conference 2012

addressing specific clinical conditions. The preparation for the first time of a Geneva Declaration focused on the Conference's main theme (chronic diseases) promises to extend substantially the impact of our flagship event [20].

The first scientific session of the Core Conference was the Symposium on the Effectiveness of Person-centered Care for Chronic Diseases. It started with appraising the contextualized approach to enduring clinical complexity. After affirming the crucial role of relationships and trust in person-centered care, it unfolded the principal aspects of context in terms of family, social network, physical (including left and right brain integration), financial, occupational, spiritual and health literacy concerns. Next, when focusing on well-being and work on personality development it was recognized as highly important, particularly for dealing with people's chronic diseases. Finally, there was addressed the issue of the critical role that the patient can and should play in the cases of chronic diseases, identifying specific approaches for ensuring that the patient's voice is heard in clinical and public health settings.

The Workshop on Person-centered Care for Oncological Diseases started with a review of informational procedures to support the patient's decision making in cancer care. This was followed by a discussion on cancer pain which is currently acquiring a strong

person-centered framework. This involves the need for a comprehensive evaluation of the situation and of the patient's attitudes and preferences, paying considerable attention to good clinical communication, the patient engagement, and participation in decision making. Next, the interface between cancer and sexual health was focused on. Substantial numbers of cancer patients experience long-term sexual dysfunctions, and these need to be addressed emphasizing exchange of information and fluent communication between clinicians and patients. Concluding the session, person-centered care at the end of life was discussed. This encompassed ensuring empathy, family engagement, advance planning, symptom control, fluid management, place of death, and spiritual support.

The Workshop on Person-centered Care for Chronic Psychiatric & Neurological Diseases, addressed the first two of the most common psychiatric disorders, depression and substance abuse, that tend to be chronic and rank among the top human disease burdens. The benefits of employing a holistic theoretical framework, attending to the patient's experience, the range of contributing factors, and the integration of care were emphasized. The personal integrity to be considered when treating the patient with dementia was discussed next. This would include a comprehensive examination of the patient's clinical condition as well as full consideration of his/her needs and prefer-

ences. Concerning child and adolescent chronic psychiatric condition, emphasis was placed on attending to the specific objective and subjective dimensions of the child's illness and health. Finally, a comparative analysis was presented of recovery-oriented and person-centered models of care, noting that the former developed and remains principally in the mental health field, while the latter has broader origins and presence in general medicine and comprehensive health. Both largely coincide in theoretical perspectives, ethical commitment, and clinical procedures.

The Poster Session was held during lunch time on the first day of the Core Conference. The presentations reviewed the relations of person-centered care and, respectively, Eastern Orthodox psychotherapy, reduction of self-report uncertainty in chronic heart failure, care experiences among hospitalized Swedish patients, experiences of "broken heart" syndrome patients, culture-specific patient education in Bulgaria, adherence and self-management in hypertension, and contextualization of functional symptoms in primary health care.

The Workshop on Person-centered Care for Chronic Circulatory and Respiratory Conditions started with a presentation on experiences of patients with acute coronary syndromes. These challenging situations emphasize the importance of individual treatment plans and person-centered

care in order to help patients return to the activities of regular life. Next, the outcome studies on person-centered cardiovascular care were reviewed. Recommendations were offered to design such studies from the patients' perspectives and samples of such designs were presented. It was followed by a presentation on person-centeredness in intensive care medicine. It was noted that physiological circumstances often lead to limit the patients' choices in intensive care units. Therefore clinicians have a high degree of responsibility to ensure that care is individualized and the patients' individuality is respected.

The Workshop on Self-Care and Integrative Approaches to Non-communicable Diseases began with a WHO review on the evidence of self care for non-communicable diseases, and ended with a review of educational efforts needed in this field. It noted that today's chronic and non-communicable diseases (NCDs) are the main cause of morbidity and mortality in almost all countries around the world. It addressed approaches needed within our health and educational systems to increase awareness, knowledge and skills to prevent and manage cardiovascular disease, cancer, diabetes and chronic lung disease. It also pointed out that most NCDs are preventable and that most risks factors (smoking, obesity, lack of physical activity, hypertension, and excessive use of alcohol) can be managed if identified early. It emphasized that all approaches to control NCDs must be person-centered and that continuity of care is crucial for achieving better health outcomes at individual and population levels.

The Symposium on Person-centered Care and Modern Clinical Practice started with a presentation on ethics and social determinants of health. Next it addressed case-based models of practice, arguing that these are more relevant than evidence-based ones for clinical decision-making in person-centered medicine. The casuistic approach seeks warrants from clinical research,

pathophysiologic rationales, personal experience, patient's goals and preferences, and system features, which all must be weighed and negotiated by the clinician and the patient to arrive at reasonable decisions. The following presentation discussed Bayesian statistical procedures for systematically taking into consideration local factors and the results of large multi-center trials leading to more accurate estimations of intervention effects than in case each factor is considered separately, and potentially contributing to the coalescence of evidence-based and person-centered models. Finally, remarks were offered stimulated by the above presentations and an ongoing review of the literature towards an integrated clinical care model.

The Symposium on Transformative Education for Person- and People- centered Care started with a presentation of the WHO Transformative Education Initiative. It pointed out that the World Health Report of 2006 documented the severe shortages of health professionals around the globe and their poor preparation for the needs of health service delivery. Therefore, an adequate transformation of health professional education should put population health needs and expectations at the centre and should be directed by the reality of health service delivery. Next an outline was given on the Health Improvement Card being developed by the World Health Professional Alliance to help prevent chronic diseases. The Card would seek to assess lifestyle and biometric risk factors to enable individuals and their health professionals to take preventive actions. Then professional training to optimize team work for person-centered care was discussed. It noted that in addition to shortage of health professionals there are severe limitations in opportunities for health professional students of different disciplines to learn together and interact adequately during their training. It caused innovative and strategic responses to this challenge. Finally, recommendations from academic

medical centers were formulated for developing person-centered medical education and training. These include group learning with patients and families, shadowing, video-recording, and role plays.

The Symposium on Spirituality and Health started with a presentation on clinical applications towards integrating spirituality into healthcare. It proposed the recognition of spirituality as a component of health and as an important element of compassionate person-centered care, as well as outlined a procedure for a bio-psycho-social-spiritual assessment and plan. Another presentation discussed that healing of the body and the spirit is an integral part of many faith traditions and the lessons learned by chaplains caring for people living with AIDS. It was followed by a presentation examining religious and secular counseling with regard to faith, the need for science, and the variety of available values. Remarks on personal spiritual experiences while facing health challenges and a scholarly summary of the presentations completed the symposium.

The Workshop on Conceptualization and Measurement of Person- and People- centered Care encompassed first the presentation of a literature review on conceptualizing person- and people-centeredness in primary health care. It explored the notions of person and people within primary care as defined in the 1978 Alma Ata Declaration and the 2008 World Health Report, as well as their relevance to the discussion of equity and social justice, causes of ill health, and the integration of primary care and public health. This was followed by a set of short papers on the conceptual refinement and further development of a prototype Person-centered Care Index (PCI) conducted by the International College of Person-centered Medicine. The initial work engaged broad international panels composed of clinicians, public health experts, patients and family representatives, who through Delphi-type consulta-

tions discussed the results of a review of the literature and identified key elements of person-centered care, which led to the design of a prototype PCI. This was subjected to an initial evaluation of its content validity and general applicability to health systems. More recently, the prototype PCI was revised to improve the wording of its items and rating arrangement and was subjected to pilot studies of its internal structure, of its content validity among mental health users in London, and of its inter-rater reliability across various types of health programs in Santa Cruz, California and Lucknow, India.

The Workshop on Swedish Clinical Research on Person-Centered Care encompassed six papers from a specialized and multidisciplinary research center at Gothenburg University, Sweden. It opened with a review of fundamentals in person-centered care. Two ensuing papers dealt with the effects of person-centered care concerning hip fractures and heart failure. Another paper discussed patient reported outcomes. The implementation of person-centered care was the subject of the fifth paper. The last one discussed organization of person-centered care

The Workshop on Person-centered Pain Management started with an examination of the complexity and challenges imposed by pain in chronic conditions such as cancer. Maximizing quality of life must be a guiding principle and a multidisciplinary team approach is usually required. Progress may be achieved by evaluating systematically treatment options towards enhancing health outcomes. When considering invasive procedures for the management of cancer pain, attending to the patient's wishes is crucial. Maximizing quality of life and social integration are important outcomes here. Another presentation posited that pain management largely depends on bio-psycho-social understanding of the situation, as well as on analyzing pain mechanisms, patients' attitudes, and the

role of culture. A presentation on person-centered pain management in the realm of palliative medicine completed this workshop.

The Workshop on Shared Care Plan and Personalized Diagnosis focused on the structure of a treatment plan with particular attention to the development of whole-health objectives. It proposed the integration of general medical, psychological and social interventions to promote wellness outcomes.

The Oral Presentations Session on Conceptual Studies on Person-centered Care began with a presentation of neuroscience perspectives towards person-centered care. It was followed by a presentation on the prospects of personalizing education and mental health through neuroscience and neuroesthetics. Next the Islamic heritage and traditions concerning person-centered medicine were discussed. Person-centered gynecology and obstetrics was the subject of the following paper. Then a review of personality concepts and their impact on the development of Russian psychology and psychiatry was presented. Providing child-centered hospital care to Serbian children was reported in the presentation on a rights-based approach. Another paper dealt with building a person-centered culture in prevention and recovery care service. A role of traditional birth attendants in promoting person-centered care in Asia was reviewed. Finally, a paradigm in pediatrics to deliver family- and child-centered care was discussed.

The other Oral Presentations Session encompassed Experimental Studies on Person-centered Care. The Project PARIS: Parents and Residents in Session is studying the teaching of person- and family-centered care in a pediatrics residency program in New York. An innovative medical school in Madrid reported on the effects of an early clinical experience program in a medical school aimed at raising awareness of the

lational and communicative needs of clinical practice and of the structure and performance of health systems. The UK Program on Type 2 Diabetes presented risk assessment results and their implications for practitioners and patients, as well as a systematic review of barriers and facilitators in the life style modifications for prevention purposes. There was a Swedish presentation on their results when analysing the relationship between organizational culture and the implementation of person-centered care. A study from Cyprus assessed the implementation of person-centered medicine in treating patients with dementia. Victoria, Australia, presented a review on the importance of interdisciplinary support to manage medications in an optimal way when dealing with patients with multiple chronic conditions. A report from Milan focused on reliability and validity evaluation of a person-centered clinical method.

The Workshop on Person-centered Health Systems started with a presentation from WHO on integrated health systems, including conceptual and empirical elements. The other presentation from WHO argued that a person-centered approach is of utmost need to attain the state of reproductive health. It concluded that the adoption of a person-centered approach will often preclude the need for complicated checklists and contribute greatly to improving quality of care and patient satisfaction. A third presentation represented a contribution to the early assessment and prevention of burn-out in the form of a person-centered approach to human resources management in health care. The final presentation dealt with educational factors in health systems. It pointed out that human interactions are the most important aspect of health systems, that learning opportunities are embedded in health system facilities, and that an operational linkage between education and health systems needs a clear definition at the different stages of training and practice paying attention to local, national and global contexts.



LtoR: Manuel Dayrit, Juan E. Mezzich, Carissa Etienne, and Wim Van Lerberghe, at WHO Headquarters following the Fifth Geneva Conference.

The Workshop on Internet and Person-centered Medicine was based on the presenter's experience and perspectives on the use of the internet for health professional purposes. He suggested that the future of scientific professional communication is on the web, promoting useful and dynamic interactions among institutional members, for which videos may be quite helpful, and with webmasters continuously evaluating the offered contents.

A Scientific Panel was organized to launch an International Conference and Publication Series on Person-centered Healthcare. It embraced brief presentations on the aims and scope of the series and on their implications as perceived by officers of public health, clinical, educational and patient organizations.

The Session on Region and Country Experiences on Person- and People- centered Care started with a presentation from Thailand on the measurement of responsiveness as part of person-centered healthcare. It used a set of questionnaires and vignettes to assess the experience at the intersection between person and health system. A presentation from Europe focused on the utilization of health ontologies (terminology, nomenclature, taxonomy) to discuss person-centeredness (as illustrated by the Person-centered Integrative Diagnosis model) and personal factors (as defined in WHO's In-

ternational Classification of Functioning and Health). It posited that limitations in conceptualization and terminology are key barriers to scientific progress and the consolidation of a new scientific field. Another presentation described a collaborative project to promote person-centered care for diabetes and depression in South Africa, Lesotho, Botswana, Swaziland and Uganda. It demonstrated that a holistic person-centered approach may help the recognition, management and outcomes of diabetes and depression. The final presentation discussed African contributions to decision-making in person-centered health practice. It drew on indigenous knowledge, such as the isi-Zulu term "indaba" that refers to a meeting (such as that between a health professional and a service user) that is so substantive that it is an end in itself, and therefore person-centered.

The Workshop on Dance Therapy in Person-centered Medicine reflected interest in the field of experiential creative and artistic opportunities aimed at ameliorating illness and enhancing well-being. Initial introductions referred to the numerous studies documenting the value of dance for health. It may contribute to self-awareness, expression of feelings, improved communication, and personal development. One presentation focused on expressive psychoanalytic dance therapy; the other on integrative dance/movement psychotherapy addressed

to facilitating the fulfillment of a personal life project. Each included an experiential practicum.

The Special Session on Stakeholders' Policies and Contributions for Person- and People-centered Care took place with the participation of major global medical and health institutions co-sponsoring the Fifth Geneva Conference. It started with introductory statements from officers of the World Health Organization and the International College of Person-centered Medicine. They were followed by contributions from the World Medical Association, WONCA, International Alliance for Patients' Organizations, International Council of Nurses, International Federation of Social Workers, International Pharmaceutical Federation, Council for International Organizations of Medical Sciences, World Federation for Mental Health, International Federation of Gynecology & Obstetrics, International Federation of Medical Students' Associations, and European Federation of Associations of Families of People with Mental Illness.

Concluding Remarks

As discussed at the Conference's Closing Session, the Fifth Geneva Conference represented a strong step forward in the process of building person-centered medicine. It was co-sponsored by a record 33 global medical and health organizations, introduced new presentation formats, documented the advancement of our *International Journal* and scientific workgroups, and launched new initiatives. Furthermore, the inaugural *Geneva Declaration on Person-centered Care for Chronic Diseases* was wrapped-up at this session and was then issued in final form by the ICPCM Board on May 19. Also at the Closing Session, and earlier than ever before, an announcement was made for the Sixth Geneva Conference to take place on April 27-May 1, 2013 with the main theme *Person-centered Health Research*.

As a colophon to the Fifth Geneva Conference, the ICPCM president was invited the next day to a meeting at the World Health Organization headquarters with Assistant Director General Dr. Carissa Etienne and Directors Drs. Wim van Lerberghe and Manuel Dayrit. They expressed congratulations for the Conference that had just ended and strong interest for the Sixth Geneva Conference and the prospective development of a WHO Guide on Person-centered Care.

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Tesfa Ghebrehiwet (International Council of Nurses).

All members of the ICPCM Board and of the Fifth Geneva Conference Organizing Committee.

UEMS calls to the Presidents of the European Medical Organisations, National Medical Associations

We are writing to you in order to propose to join forces in co-signing the attached Open Letter on "Standards for medical practice".

We already had the occasion to raise and share our concerns with you all regarding the process that the European Standardisation Committee (CEN – Centre européen

de normalization) has initiated in Aesthetic Medicine. We have had a report on their meeting that was recently organised in Delft and this confirmed our worries.

This invitation to you also provides us with an opportunity to (re)state our position firmly, i.e. that the UEMS was not at the

origin of this initiative, was not actively involved and is strongly opposed to it.

We would be grateful to you for joining this Open Letter as well as circulating it as widely as possible within your networks, the aim being to get as many co-signatories as possible.

Standards for of Medical Practice

Open Letter

Brussels, 14th September 2012

The undersigned European Medical Organisations and National Medical Associations are committed to the achievement of high standards in healthcare because they recognise the importance of these for the safety and quality of care for patients.

These Medical Organisations strongly support the considerable work that has been, and continues to be performed by medical experts in healthcare in developing standards and guidelines for practice based on their clinical experience and research findings.

These Medical Organisations recognise that standards and guidelines are best implemented when the doctors who will be implementing them are engaged in their development and in their application in local healthcare services.

Accordingly, these Medical Organisations have profound concerns about the attempts by the European Committee on Standardisation (CEN - Centre Européen de Normalisation) to introduce standards based on quality management systems that do not have a solid evidence-base within the clinical environment of healthcare systems.

These Medical Organisations further question the rationale for CEN to extend its remit into this area as this would appear to be

in breach of core elements of European legislation as applied to healthcare which is subject to the principle of subsidiarity.

These Medical Organisations consider that the CEN initiative to develop standards derived from the ISO 9000 series and apply them top down in healthcare systems conflicts with:

- The Treaty of Lisbon, Article 168 (update of Treaty of Amsterdam, Article 152)
- The European Directive on the mutual recognition of professional qualifications (2005/36/EC) and in particular the recognition of the right of individual Member States to determine their own training structure while ensuring compliance with criteria set out in the Directive.
- National laws and regulations on healthcare systems and professional practice that are specific to the different healthcare systems in Europe.

These Medical Organisations have attempted to engage in a constructive dialogue with CEN but finds that there is a lack of reciprocity for a meaningful dialogue.

These Medical Organisations have concluded that CEN does not wish to engage in partnership working with representatives of the medical profession.

These Medical Organisations therefore call on the European Commission and Parliament, the EU Member States and other relevant institutions or bodies to challenge the approach being taken by CEN and to question the rationale of its initiative in healthcare.

Forthcoming Events

WMA General Assembly, Bangkok 2012

This year's General Assembly will be held from 10–13 October at the Centara Grand Hotel, Bangkok, Thailand. The scientific session "Megacity – Megahealth?" will be on Thursday, 11 October.

WMA Expert Conference: Revision of the Declaration of Helsinki

The first in a series of expert conferences on this topic will be hosted by the South African Medical Association from 5–7 December, 2012 at the Westin Cape Town, South

Africa. Registration, open to the public on WMA website, closes 5 November 2012

194th WMA Council Session, Bali April 2013

This meeting will be held from 4–6 April 2013 at The Laguna, Nusa Dua, Bali, Indonesia.

WMA General Assembly, Fortaleza October 2013

The General Assembly 2013 will be held from 16–19 October in Fortaleza, Brazil.

WMA TB courses rewarded by CDC

The newly launched MDR-TB online course was rewarded by US Centers of Disease Control (CDC) as the educational highlight of the month. Both TB courses developed by WMA have received this CDC recognition.

TB Courses at The Union World Congress

WMA has been accepted to present the development of the TB refresher course and MDR-TB course at the 43rd Union World Conference on Lung Health in Kuala Lumpur, Malaysia, 12–17 November, 2012.



Violence in the Health Sector conference: "Linking local initiatives with global learning"

24–26 October, 2012 Vancouver, Canada. Dr. Mukesh Haikerwal, Chair of the WMA Council, will open the conference. WMA President-Elect Dr. Cecil Wilson as well as Dr. Dana Hanson, past President, will also participate.

Call for papers: violence and disability

In 2013, the Journal of Interpersonal Violence

will publish a special issue on the topic of violence against people with disabilities. Deadline for submissions: 2 Nov, 2012.

WFME World Conference 2012, Malmö, Sweden, 14–16 November 2012

The World Federation for Medical Education – bringing together the faculties of medical schools worldwide, the global representation of medical students and the World Medical Association – invites participants

to its global conference on quality development in medical education. The conference will discuss the future role of the doctor in health care, standards for medical education and the accreditation of medical education.

Fifth session of the **Conference of Parties to the WHO Framework Convention on Tobacco Control** will take place in Seoul, Korea from 17–20 Nov. 2012.

Speaking Books Recognised as One of 15 Most Innovative African Ideas!

The South African Mail and Guardian has identified 15 ideas they believe can help transform Africa. The Speaking Book is honoured to be recognised as one of the 15 innovative ideas.

A range of easy-to-use audio books designed to get potentially life-saving health messages out to millions of isolated people struggling with depression and mental health problems.

In 2003, Zane Wilson, the founder of the South African Depression & Anxiety Group (Sadag), the country's largest mental health initiative, was horrified at how suicide rates among young South Africans were spiking. Mental health carries a huge social stigma across Africa and information booklets designed to help people with depression or mental health problems simply weren't working, especially in remote communities with high illiteracy rates. People weren't getting the help they needed – a 2009 study showed that only a quarter of the 16.5% of South Africans suffering from mental health problems had received any kind of treatment.

Speaking Books created a range of free books with simple audio buttons talking the

user through each page. The first Speaking Book, voiced by South African actress and celebrity Lillian Dube, was called *Suicide Shouldn't Be a Secret* and focused on how depression is a real and treatable illness, encouraging people to get help when they need it.

Speaking Books have now produced 48 titles in 24 different languages and are now used in 20 African countries across the continent. The books now tackle a number of

critical healthcare issues outside of suicide prevention such as HIV and Aids, malaria, maternal health and clinical trials. Speaking Books has also expanded to China, India and South America. "The situation we face in rural South Africa is the same in any other African country – low literacy compounded by lack of access to services and affordable healthcare," says Wilson. "This means that patients are often not able to get help for many health problems. We believe that this interactive, durable, high-quality, hardcover book engages the user or patient, and allows them to build self-confidence and skills with a simple action plan". AK

<http://www.speakingbooks.com/>



WMA Hails Australian Government Victory on Tobacco

Governments around the world have been encouraged by the World Medical Association to follow the example of the Australian Government in legislating on plain cigarette packaging following this week's High Court victory.

The WMA welcomed the High Court decision in Australia to dismiss the challenge brought against the legislation by tobacco companies. Dr. Mukesh Haikerwal, Chair of the WMA and a family physician in Melbourne, hailed the court's decision as a major step forward in the fight against tobacco.

'The WMA condemned the legal action brought by the tobacco industry and the court's decision shows that governments can withstand and defeat the bullying tactics of the big tobacco companies.

'Governments around the world must now rise to the challenge and follow the example of the Australian Government in banning logos on cigarette packets. We firmly believe that when this legislation is implemented, it will save lives by reducing the terrible health related deaths, long-term illnesses and disability caused by smoking.



'Governments have a duty to do what they can to help smokers give up and choose a healthier way of life.

'When the WMA General Assembly meets in Thailand in October, it will discuss further steps to strengthen its anti-tobacco policy against the aggressive promotion by the tobacco industry to make their products more appealing to young people.'

The 4th World Health Summit 2012 Research for Health and Sustainable Development

World Health Summit aims at a common goal: to shape Healthcare for the 21st century. From October 21st to 24th, 1,400 participants from over 90 countries and all health related fields will gather to discuss the challenges of global health.

Selection of Topics: Diseases of Modern Environments, Translating Research into Policy, Health and Economics, Educating Health Professionals, Information Technology for Health

Selection of Speakers: Peter Agre (Nobel prize in Chemistry 2003), Josef Ackermann (Zurich Financial Services), Daniel Bahr (Min-

ister of Health, Germany), Gerd Binnig (Nobel prize in Physics 1986), Zsuzsanna Jakab (Regional Director, WHO Regional Office for Europe), Gan Kim Yong (Minister of Health, Singapore)

The World Health Summit 2012 offers an excellent forum for informal discussions and new connections, besides a wealth of information, debates and presentations of the newest developments from all fields of research and global health.

www.worldhealthsummit.org

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