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Editor in Chief

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Emergency Resolution
A proposal was put forward by the British Medical Association that

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Future Meetings

e Committee considered the planning and arrangements for future WMA statutory meetings. e Taiwan Medical Association suggested that at the Assembly meeting in Taipei in October 2016 the scienti c session should be on 'Healthcare System Sustainability' with two sessions, the rst on 'Health System Performance' and the second session on 'eHealth'. is was agreed.

e Secretary General reported that as in previous years, a WMA luncheon in Geneva would again be held during the WHO World Health Assembly period. e main theme this year would be public health issues, including health and investments. Dr. Haikerwal reported that a second H20+ Health Summit was also being planned following the success of the Melbourne meeting.

Associate Members

e Committee received an oral report from the Chair of the Associate Members, Dr. Joe Heyman. He informed the Committee of his plans to draw more commitment from individual associate members by promoting membership through introducing life membership. An international conference call was planned for May and he also spoke about holding regional, on-site meetings when statutory meetings were held and linking up with the Junior Doctors Network and the Past Presidents and Chairs of Council Network.

Junior Doctors Network

e Chair of the Junior Doctors Network, Dr. Ahmet Murt, gave an oral report on the JDN's activities. Among the current topics it was

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the World Federation of Medical Education Standards for Post-Graduate Education. e revision was considered thorough and comprehensive.

Dr. Kloiber reported that he has been consulted by the WFME in a personal capacity on the revision of standards for Continuing Professional Development. He thanked those members that had sent comments on the proposed revision and he expected there would also be an open consultation with the opportunity for NMAs to submit further comments.

Statement on Providing Health Support to Street Children

New guidelines for National Medical Associations on providing health support to street children were set out in a revised Statement on Providing Health Support to Street Children.

e reworded Statement was introduced by the Conseil de l'Ordre National des Medecins. Delegates were told that the issue e ected a large number of countries in all continents. It was di cult to quantify this phenomenon but it was a reality in large cities which children sought out after leaving their villages and towns. Many children were dumped in ships and sent across the sea to nd a better future. ey often travelled in groups and many died on the way. So how could doctors help them? A speci c response was required. It was argued that the WMA had a duty to support local organisations working with these children and a duty to sensitise governments. It was urgent to work together with people working in the eld and on the streets.

e Committee agreed that the proposed Statement should go to Council to be approved and forwarded to the General Assembly for approval and adoption.

Proposed revision of WMA Statement on Child Abuse and Neglect

It was decided that this proposed document should be withdrawn.

Statement on Chemical Weapons

e Committee considered the proposed revision of the WMA Statement on Chemical Weapons which deals with the appropriate use of riot control agents. It was proposed that the title of the paper be changed to Statement on Riot Control Agents.

is was approved and it was decided to send the document to Council for forwarding to the General Assembly for approval and adoption.

Proposed Declaration on Alcohol

e Australian Medical Association introduced a draft Declaration on Alcohol which recommends priority legal and regulatory measures as well as social policy interventions to address alcohol-related harm. e document was welcomed by a succession of speakers and after a brief debate it was agreed that with two minor amendments it should be sent to Council for forwarding to the General Assembly for approval and adoption.

Mobile Health

A proposed new Statement on Mobile Health was presented to the Committee by the German Medical Association. Delegates were told that National Medical Associations had commented on the paper and many of their suggestions had been included.

Speakers welcomed the document on what they said was a very important issue. ere was one suggestion that the Statement should include more about secrecy and con dentiality. is led to a debate during which many speakers argued that the guidelines should remain as broad and as general as possible. e meeting decided to reorder the wordopti(It was argu(y the G(al)15.1(W)80(n)appr)(.)70(r)1Tw (-)p)15ooTJ-0. s.n. Delegaswhic ualeto e cM Council to be approved and forwader theia,Td to the General-

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for rea rmation and that the WMA should not attempt to hush up debate. Delegates were reminded that there was already legislation on physician-assisted suicide in several countries. Other speakers, however, said it was not the WMA's role to follow public opinion and argued that discussion on this policy should not be re-opened.

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Preamble

Trade agreements are sequelae of globalization and seek to promote trade liberalization. ey can have a signi cant impact on the social determinants of health and thus on public health and the delivery of health care.

Trade agreements are designed to produce economic bene ts. Negotiations should take account of their potential broad impact especially on health and ensure that health is not damaged by the pursuit of potential economic gain.

Trade agreements may have the ability to promote the health and wellbeing of all people, including by improving economic structures, if they are well constructed and protect the ability of governments to legislate, regulate and plan for health promotion, health care delivery and health equity, without interference.

Background

ere have been many trade agreements negotiated in the past. New agreements under negotiation include the Trans Paci c Partnership (TPP), [1] Trans Atlantic Trade and Investment Partnership (TTIP)[2], the Trade in Services Agreement (TiSA) and the Comprehensive Economic and Trade Agreement (CETA [3].

ese negotiations seek to establish a global governance framework for trade and are unprecedented in their size, scope and secrecy. A lack of transparency and the selective sharing of information with a limited set of stakeholders are anti-democratic. Investor-state dispute settlement (ISDS) provides a mechanism for investors to bring claims against governments and seek compensation, operating outside existing systems of accountability and transparency. ISDS in smaller scale trade agreements has been used to challenge evidence-based public health laws including tobacco plain packaging. Inclusion of a broad ISDS mechanism could threaten public health actions designed to e ect tobacco control, alcohol control, regulation of obesogenic foods and beverages, access to medicines, health care services, environmental protection/climate change and occupational/environmental health improvements. is especially in nations with limited access to resources.

Access to a ordable medicines is critical to controlling the global burdens of communicable and non-communicable diseases. e World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) established a set of common international rules governing the protection of intellectual property including the patenting of pharmaceuticals. TRIPS safeguards and exibilities including compulsory licensing seek to ensure that patent protection does not supersede public health. [4].

TiSA may impact on eHealth provision by changing rules in licensing and telecoms. Its impact on the delivery of eHealth could be substantial and damage the delivery of comprehensive, e ective, cost-e ective e cient health care.

e WMA Statement on Patenting Medical Procedures states that patenting of diagnostic, therapeutic and surgical techniques is unethical and "poses serious risks to the e ective practice of medicine by potentially limiting the availability of new procedures to patients."

e WMA Statement on Medical Workforce states that the WMA has recognized the need for investment in medical education and has called on governments to "… allocate su cient nancial resources for the education, training, development, recruitment and retention of physicians to meet the medical needs of the entire population…"

e WMA Declaration of Delhi on Health and Climate Change states that global climate change has had and will continue to have serious consequences for health and demands comprehensive action.

Recommendations

erefore the WMA calls on national governments and national member associations to: Advocate for trade agreements that protect, promote and prioritize public health over commercial interests and ensure wide exclusions to sece c[(er)-5(nments at 2 5w1(n.)]mtio)resos1.5(WMA)S)f diiods and(a)]Tstment inTw dividuce public-10(als40(al8 Tmw Tshealth-15(ed)]tment inTw)0.6(inc)e.9(y 0(iow m

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Dr. Caline Mattar, Chair of the JDN's Pre-WHA Organizing Committee, provided attendees with an introduction to the WHA and what to expect for the week to come. In addition, JDN members joined the International Federation of Medical Students' Associations' Pre-WHA workshop at the Graduate Institute in Geneva for a successful panel discussion and collaborative issue-based small group sessions on human resources for health, climate change and antimicrobial resistance. ese sessions prepared participants for the Assembly and provided the opportunity to learn more about WHA agenda items.

Representatives from both the JDN and

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in collaboration with the WMA sta and leadership and included interventions on antimicrobial drug resistance, polio, noncommunicable diseases, climate change and Ebola.

On the Global Action Plan on Antimicrobial Drug Resistance the WMA said that antimicrobial resistance was a threat to all countries without regard for geographical boundaries. A commitment was needed from both member states and the WHO to ensure nancial sustainability to implement interventions in LMICs. e WMA's intervention emphasized that the Global Action Plan could not be separated from strengthening healthcare systems, building on lessons learned from the Ebola epidemic. A focus on access to primary care, availability of diagnostic labs including rapid diagnostic methods and surveillance systems was needed to ght the spread of resistant pathogens. e Assembly went on to agree on resolutions to improve access to a ordable vaccines.

On polio eradication, the WMA said, it had condemned in the strongest terms the recent killing of ve health care workers in Pakistan while providing polio immunization to the citizens of Pakistan. is tragedy had underscored the urgent need to ensure the protection of health care workers in con ict areas. It urged the WHO and member states to ensure adequate security for the healthcare workers to enable e ective implementation of immunization protocols, to develop systems sensitive surveillance and immediate noti cation to the WHO of any detected poliovirus transmission and to implement adequate immunization training for health professionals. e WMA also wanted to see an increase in e ective public awareness and education to prevent and dispel myths.

e IFMSA spoke about the need to tackle, prevent and control the global burden of noncommunicable diseases (NCDs), and reduce the worldwide morbidity and mortality related to cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, as well as reduce the four shared risk factors. It strongly recommended that interventions aimed at reducing the burden of NCDs must include addressing risk factors during childhood and adolescence.

e IFMSA also spoke on the issue of health in the post-2015 development agenda asking the WHO to focus its attention on sgsWHO of2 sTc 0.19[(WHO oftTTm(of)]Tagno3(of (of)a Tw ne atC.)70(t[(dis)10(uste9 Tin)-5(a)5.1(oc)-10(ansta)-9.9(10(ar)10uld0(lude)105)]TJ0.04TTm(omn t a mn t topagnoft-1. to0(of)-5(esf(healto enable)a Tw ne a.1(WHO(as

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e 21st Conference of the Parties (COP21) to the UN Framework Convention on Climate Change (UNFCC) will be held in Paris for two weeks from November 30 to December 11, 2015. COP21 is practically the last opportunity to reach an agreement on a plan where all nations would participate to achieve substantive reduction in greenhouse gas emissions to limit global warming within 2 °C. at is why some are even calling it the “historic two weeks.”

Due to the earth's feed-back mechanism, any change, once gaining enough momentum in a certain direction, becomes extremely di cult to reverse. Even if all emission of greenhouse gas is stopped now, it would still be di cult to completely prevent global warming. e goal of limiting global warming to 2 °C is the minimum measure necessary to prevent the worst case scenario.

Health needs to be given the greatest priority in e orts to minimize climate change. Climate change causes change in tempera-

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avoid 'harms' where possible, be truthful and be treated equally with others according to their needs.

e physician also has a duty of care to their patients and should keep their medical records secret within applicable national laws.

ese ethical principles need to become 'internalized' as the individual physician's 'professional' conscience and act as a com-

e Art of the conversation between a physician and their'patien; is at the heart of medical practice [1]. It is a dialogue between a person seeking help and a physician who possesses the relevant medical knowledge and skills is patient/physician relationship is founded both on service and on trust within which two way communication is key. e physician's professional service to their patient must be conducted within a professional code of ethics which has become enshrined within the World Medical Associations International Code of Medical Ethics 1949 et seq.

is statement includes the requirement that "a physician shall be dedicated to providing competent medical service in full professional and moral independence with compassion and respect for human dignity'.

Trust

Trust can only be assured if the patient believes that the physician respects them as individuals, will act only in their best interests,

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One Health is a new term, but an ancient concept that recognizes the inherent links between human, animal, and environmental health. Humans and animals cannot be healthy if the environment in which they live is sick. e One Health concept seeks to increase communication and collaboration between human, animal, and environmental health professionals.

e One Health concept is important for many reasons. Zoonotic disease risks from wildlife, livestock, and pets cannot be adequately addressed without meaningful collaboration and cooperation between veterinarians and physicians. Microbes do not necessarily recognize the di erences between species and could infect across [illegible] given the right conditions. Indeed, approximately 75 percent of emerging infectious diseases and approximately 60 percent of all human pathogens are zoonotic in origin [1].

Some of the greatest discoveries in the history of medicine and public health were made at the intersection between human and animal health. For example, Dr. Edward Jenner, an apprentice surgeon, learned from dairymaids that they were immune from smallpox because they had had cowpox. He applied this concept to the practice of variolation and developed the word "vaccination" from the Latin word "vacca" meaning cow [2]. Approximately two centuries later, Dr. Jenner's vaccine was used to eradicate smallpox from global human populations [3].

Drs. Louis Pasteur and Robert Koch, a French chemist who studied chicken cholera and a German physician who studied anthrax, respectively, independently developed the germ theory of disease. Dr. Pasteur discovh--

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Most antimicrobial use is probably inappropriate. It has been estimated that up to 50% of human antibiotic use and up to 80% of veterinary antibiotic use could be eliminated without serious consequences [1]. e inappropriate use of these drugs increases the risk of selection of resistant bacteria and may contribute to antibiotic resistance [2]. Antibiotic resistance has become a global health problem and is responsible for signi - cant morbidity and mortality and, therefore, restriction of antibiotic use and marketing regulations are among many important strategies to control this problem [3,4].

e sale of antibiotics and other antimicrobial medicines without prescription remains widespread, with many countries lacking standard treatment guidelines; thereby increasing the potential for overuse of antimicrobial medicines by the public and medical professionals [5]. In general, governments support policies on the prudent use of antimicrobials in order to control resistance and recommend control measures to support careful use by encouraging doctors and pharmacists to promote the appropriate use of antimicrobials. However, implementation has generally been weak in many countries, and the prevalence of bacterial resistance continues to increase since antimicrobial resistant bacteria are common in communities where over-the-counter policy is still available.

Prevalence

e prevalence of over-the-counter sale of antibiotics varies across countries, being common outside Northern Europe and North America [5]. e percentage of non-prescription access to antimicrobials is often underestimated, and also depends on the methodology used to estimate it. In 2013, the European Commission published a questionnaire-based study (Eurobarometer), carried out in 28 European countries, including 27,680 respondents, in which 35% admitted having taken at least one dose of antibiotic in the previous 12 months [6]. e large majority of those who had used antibiotics during the time covered by the survey had got them from a healthcare provider, but 3% of users reported to have obtained them without prescription and 2% more stated that they used the leftovers from a previous course. However, when more reliable methods are used the results are much higher. One of the most reliable ways to estimate how frequent the sale of antibiotics is includes simulated-client-method pharmacy studies in which actors simulating certain infectious diseases manage to obtain antibiotics at community pharmacies. Table 1 describes the 30 studies published so far and applying this methodology.

In 2007 in Spain, making use of a mystery shopper who presented at community pharpharmaappl2007 in T*(antibi2007 [(inok3(use)0.5(of)ne dos5(of)0.50.042 6w T*(that 0(esenosei0e)1.9(v)610(estithe20(lientn-10(a)0l staga10(ibeso70(in se) g

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ethics and codes for e-health and telemedicine in order to examine the dimensions of normative con icts involved. From this basis, we propose to develop a speci c WHO mHealth code of ethics along the following lines:

1. Above all, patient interests need to be addressed and questions of autonomy have to be integrated in such a mHealth code as well. is would involve
   - respecting the right to self-determination with respect to active or passive participation where use or application of mHealth are concerned,
   - voluntary participation and the right to withdraw at any time,
   - providing comprehensive and target-group as well as situation speci c information to allow for an informed decision,
   - promotion of health awareness for (self-) con dent decision making in health contexts.
2. Furthermore, the mHealth code of ethics needs to address possible settings where mHealth apps can be bene cial, their inclusive or exclusive character and their accessibility for people potentially bene tting from their use. is would for example mean that
   - the primary bene ts for the a ected persons must be obvious or deducible,
   - objectives of the mHealth app must be achieved based on valid data,
   - decision processes must be transparent and need to include all stakeholders concerned (a ected persons) in order to justify an intervention in a comprehensible manner.
3. Additionally,
   - mHealth interventions must be available to everyone, regardless of social status, income, education, political orientation, religious faith, inclinations and ideals, gender, age, ethnic group but also when it comes to technical a nity, health competence, mental or physical impairments. Neither discrimination nor stigmatization may bntexts. Tw 10(e use or applientqye9(l stakeholders)]TJ0.196 Tw T[(co)1l7t be)]TJ(ust be avail)]TJ0 Tw 0009>BDC ( )TjEMC 0 Tc 0 TjEMC -0.185 06 58.8mHealth in9erventions must be avail
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not only for the patients themselves but often also for the medical sta , their employers, as well as the manufacturers. ere exist many possible sources of risks and the following paragraphs will mention the most obvious ones – the list is by no means exhaustive. Roughly speaking, two areas where problems can arise can be discerned:

1. " e app does not do what is supposed to do!" is sentence and other similar utterances, often voiced by discontented users, for example in user comments that they leave on the stores, is often caused not only by shortfalls in performance that may for example be caused by technical limitations of the devices used to run the app, but also by programming errors, de ciencies of the content or simply bad usability.
2. " e app does more than it should!" is is often caused by non-obvious "features" of an app, for example when data protection and data security or the user's right to self-determination are compromised. is may be caused either with or without intent, e.g. by failing to observe due security measures when dealing with this highly sensitive type of data, lack of providing users with adequate information regarding data handling or even worse, secret and illicit data transmission and evaluation.

e App as a Medical Device

Although many aspects of the app business give the impression of a "wild west" scenario, at least some apps, namely, those where the manufacturers have speci ed that they are a "medical device", have to conform to the of- cial regulatory requirements that apply to such products. However, whether these requirements apply also depends on whether the manufacturer has assigned a medical purpose to his product, in this case the app. Going through the processes is often time-consuming and costly. us, although some apps can be medical products and would therefore have to comply with regulations for such products, manufacturers often avoid or ignore this due to the considerable hurdles raised by the necessary regulatory processes. Currently, compared to the number of available apps, only a relatively small number of apps have so far gained approval by a federal authority (e.g. by the Food and Drug Administration in the USA) or passed an assessment following the federal laws of other states (e.g. conformity assessment for European countries). e impossibility of closer scrutiny of all apps by the authorities, which would be appropriate, can also easily be explained by the sheer number of apps and additionally contributes to the uncertainties in this area, although the intent of regulation is to protect patients as well as users of these products. An exhaustive overview of the subject of "apps and regulations" can be found in [10].

Private Certi cation

For many apps, regulations simply do not apply, while for others, manufacturers ignore the regulatory processes either due to a lack of knowledge about the requirements or intentionally. Unfortunately, this means that in order to obtain some sort of quality seal for their product, the manufacturers have to resort to using the services o ered by a number of private contractors. ese seals can also be used for advertising purposes. Of course, this comes with a price and such services are o ered both nationally as well as on an international level. Still, the reliability of these o ers is highly variable, as was recently underlined by the de ciencies found in the recently halted certi cation processes o ered by Happtique [11].

Appraising the Trustworthiness of Apps

Ultimately, the decision on whether to use an app or to refrain from using it remains with the users. ey carry the prime responsibility and can also be held accountable – at least in a professional context – when using apps [12]. Users of health apps are in a di cult situation: they have to decide for themselves whether they place their trust in an app. is is a di cult and error prone decision making process. e probability for errors can be reduced if users can base their decision on readily available and valid information, but such information is often hard to come by.

Available Information Is not Always Reliable and Reliable Information Is Only Rarely Available

Users often rely on comments made by other users on the distribution platforms. Such comments can be easily created and publicized. e more "stars" and positive comments an app has received, the greater its attractiveness for users as well as for the search algorithms of the stores. However, these comments and ratings are not subject to any review and do not follow any standards. ey can be freely assigned and given pseudonymously. eir quality is often questionable, but still they are generally the main source of information for those interested. Other information can usually only be found via time-consuming searches: blogs, evaluations done by (private) initiatives or databases containing speci c information provided by the manufacturers that are often not widely known. If available, peer reviews of apps or corresponding scienti c studies provide4s]TJ0.3( )45((l the)-5(s149.2488 Tm[(Appr)-5(ailTf(T)90ocesst widel)-12(y kn)5(nl)-12(y be9(v)6(er)60(12 0 g)5(ener)-5(er)10(este)70(e)b)12(y opi2r databa((obabil]TJ-0.0151(sailTf(T71 T

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Q. e half-year of the Latvian Presidency of the Council of the European Union has come to an end. As to healthcare, we have organised a number of European-level conferences on the topics of healthy lifestyles and nutrition for children, tuberculosis, eHealth, popular sports, healthcare nancing as well as addressed a number of other important issues. How do you evaluate Latvia's performance in its half a year of presidency?
I would like to congratulate Latvia for succeeding in delivering results on a set of priority issues during its Presidency of the Council of the EU. Latvia took up the Presidency at a very important moment and contributed to the discussions on the future directions for health policy at EU level. In addition, the European conferences organised under Latvian leadership helped make progress in reducing the risks associated with poor nutrition and lack of exercise. e Latvian Presidency has put the spotlight on tuberculosis – and led discussions towards the adoption of the Riga Declaration which will be guiding action to address this important – and often neglected – disease in the European Union. e Presidency has further explored how eHealth could bene t both citizens and health systems, and contributed to the discussions on how to create e cient, equitable health systems.

Q. Currently there is a tendency all across Europe that patients obtain information about diseases and health from the Internet or magazines. Over 80% of Internet portals and social sites which are dedicated to health topics are nanced by businesses: drugs, dietary supplements or a special method. More often than not, it is di cult for patients to discriminate between the truth about health and surreptitious advertising. As to Latvia, there is even a publication, the magazin

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tion resists to introduce the third sports class per week. Could the European Commission be more active in making the national governments to introduce daily sports classes for children?

I regret to report that the gures are even worse. One out of three children in Europe in 2010 was overweight or obese. is is a major increase compared to 2008 when one out of four children was overweight or obese.

Member States play the key role in providing education for school children in relation to nutrition, physical activity, overweight and obesity – and this is something most are addressing.

I am ready to use all the tools at my disposal to support them in their e orts to promote healthy lifestyles. e Commission is working with Member States in this regard within the High Level Group on Nutrition and Physical Activity. In 2014 this group adopted an Action Plan on Childhood Obesity with the aim to prevent the increase in obesity in children by 2020. A Joint Action on Nutrition and Physical Activity will start after the summer period to further support Member States in the implementation of this Action Plan.

Q. In Latvia, the attitude of the Ministry of Education to children's health is quite an issue. Since 2002, health education is no longer in the school curricula. e situation (i.e., no health education for children) is similar in many countries in Eastern Europe. Could the Commissioner make some pressure on national governments with regard to educating children in the basics of health?

Again, the competence in the eld of education lies with the 28 EU Member States. However, under the EU Strategy on Nutrition, Overweight, and Obesity-related Health Issues for example, the Commission closely cooperates with the national governments to promote healthy lifestyles in children. e High Level Group on Nutrition and Physical Activity brings together governmental experts that promote and exchange best practices in this area. e promotion of healthier environments, especially at schools and pre-schools, is one of the key areas of the 2014 Action Plan on Childhood Obesity.

Q. In the past two years, the Latvian Medical Association managed to introduce two important regulations in legal acts. e rst is that smoking in the presence of minors should be treated as child abuse. is means that in Latvia an adult must not smoke in the presence of a child, be it at home, in the street or at a bus stop.

e other amendment to the law stipulates that a person has the statutory right to clean smoke-free air, and this right has a priority over other persons' right to smoke. ereby, smoking in the presence of another person is impermissible, unless the latter has given permission. Apart from that, in Latvia it is absolutely pro-

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