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

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

I visited various countries as WMA President and participated in many events in the past year.
In the greetings and presentations in the events I have suggested promotion of Universal Health Coverage (UHC). In the inaugural speech, I mentioned that there was a universal health insurance which pushed Japan›s average life expectancy to the world›s top level. I also advocated e orts in

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

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

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

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

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

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

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

Today, at the time I am speaking on this highly-respected podium, more than 10 million physicians all over the world take care of those in need of medical help and nearly half of them have symptoms of burnout de ned as emotional exhaustion, interpersonal disengagement, and a low sense of personal accomplishment. Besides a physician›s well-being, burnout negatively in uences the quality of care and shortens the life-time a physician is able to practice medicine.

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

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

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

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

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

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

While preparing for the future, there is a place to develop recommendations for physicians all over the world to keep this important part of the pledge. Physicians are an indispensable resource of every society; burn out of this resource endangers the society.

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

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

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

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

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

Notwithstanding any future changes, patients and physicians will continue to exist,

tegieinuract.

"Every day, entere given the great privilege of being invited into Td[patients' lives. We are with[patients when they-are born and .]TJ0.0
-
age disease. Od[patients trust us, and .2 Tdenter have always taken Td[advocacy role very seriously. It is part of the essence of Td[pro-

the center of everything enter." (Dr. Chris Simpson, inaugural speech, CMA 2014)

e support of WMA is essential and I am

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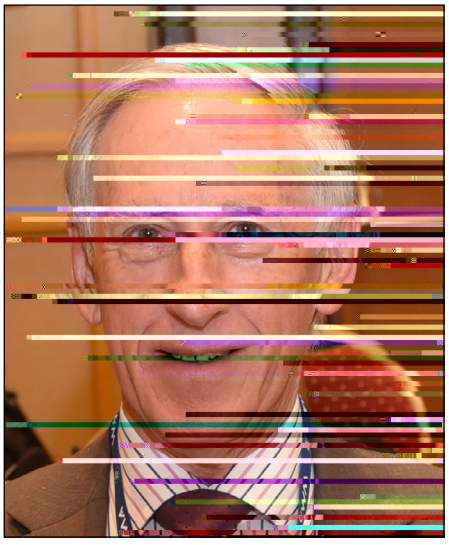
WMA 2018 General Assembly Report

Reykjavik, Iceland October 3–6



Nigel Duncan

Wednesday October 3

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

Council

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

Dr. Otmar Kloiber, the Secretary General, introduced several new Council members – Dr. Tony Bartone from Australia, Dr. Grecco Aguer from Uruguay, Dr. Zion Hagay from Israel, Dr. Hokuto Hoshi from Japan, Dr. Barbara McAneny from America and Dr. Jungyul Park from Korea.

President's Report

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

Secretary General's Report

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

Otmar Kloiber

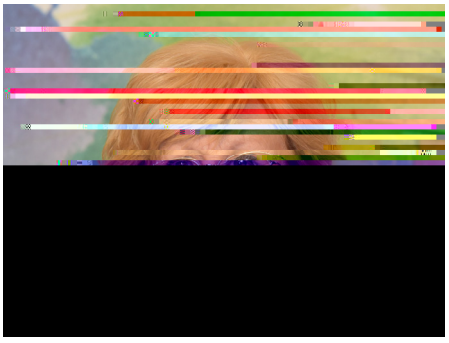
Emergency Resolution

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

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

Chair's Report

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



Ardis Hoven

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

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

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were in most need of support were su ering from this di cult situation.

During a brief debate, speakers argued

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

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

International Code of Medical Ethics (ICoME)

The Committee received an oral report from the workgroup on plans to prepare a comprehensive revision of the ICoME, engaging the entire WMA community as well as external experts through open consultation and public events, if possible. The intention was for the workgroup to submit a concrete workplan and timeline to the Committee at its next session in April 2019. The workgroup had met for the first time the previous day to plan its major revision to the document. Prof. Urban Wiesing, ethics advisor to the Committee, presented a brief overview of the correlations between the Declaration of Geneva and the ICoME and possible options for the revision of the latter. He reminded the committee that the Code, adopted in 1949, had been amended three times, in 1968, 1983 and 2006. It was in three parts – the duties of physicians in general, their duty to patients and their duty to colleagues.

There were many topics contained in the Declaration of Geneva that were not mentioned in the Code, such as the well being of patients and physicians, and human rights. Compared with the Declaration of Geneva and Helsinki, the International Code of Ethics was largely unknown. A revised Code should be a coherent, extended and additional document to the Declaration of Geneva. It could also could become a document on medical professionalism in a globalized world.

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

Assisted Reproductive Technologies

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

The Committee recommended that a workgroup be established.

Capital Punishment

The Committee considered a proposal to

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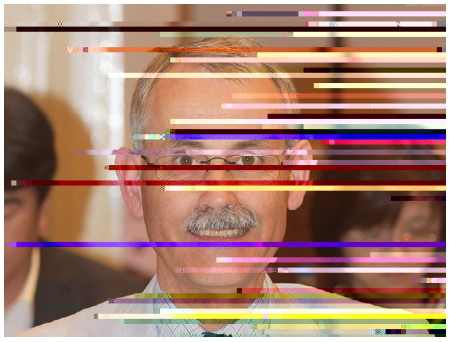
A lengthy debate followed, during which a number of Associate Members from Canada outlined their opposition to changing the WMA's policy.
On a vote it was decided that the document should be circulated to members for comment.

Finance and Planning Committee

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



René Héman

Financial Statement

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

e Committee recommended that the Statement be approved by the Council and

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e Committee considered invitations for future meetings and recommended that:

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

Revision of WMA Articles and Bylaws/Rules

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

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

Regional Structure

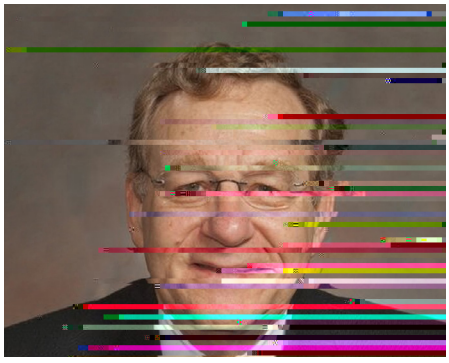
e Committee considered a proposal to set up a sixth region to the WMA's structure, an Eastern Mediterranean region. Dr. Kloiber explained that this would strengthen the WMA's outreach and would give this group of countries a seat on the Council.

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

ursday October 4

Associate Members

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



Joseph Heyman

Junior Doctors Network

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

Report of Past Presidents and Chairs of Council Network

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

Declaration of Geneva (Physicians' Pledge)

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

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

Policy Formulation and Consistency

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

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

Proposed Statement on Medically-Indicated Termination of Pregnancy

An attempt was made to amend the pro-

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Freedom of Conscience

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

Friday October 5

Resumed Council Session

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

- Access of Women and Children to Health Care and the Role of Women in the Medical Profession
- Statement on Antimicrobial Resistance
- Statement on Reducing Dietary Sodium Intake
- Statement on Arti cial or Augmented Intelligence in Medical Care
- Statement on Medical Age Assessment of Unaccompanied Minor Asylum Seekers Minor Asylum Seekers
- Statement on Free Sugar Consumption and Sugar-sweetened Beverages
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Saturday October 6

General Assembly Plenary Session

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

Keynote Speaker

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

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

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

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

Dr. Jorge thanked the Assembly for its support.

Council Report

e Assembly then considered the report of the Council.

Medical Ethics Committee

Medically-Indicated Termination of Pregnancy

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

e Assembly agreed to adopt the Statement on Medically-Indicated Termination of Pregnancy. (*see. p. 28*)

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

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

Socio-Medical A airs Committee

e Assembly adopted the following documents from the Committee:

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

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

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

e Assembly received for information two revised policies:

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

Finance and Planning Committee

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

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

e Assembly approved the following future meetings:

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

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

e Assembly received the following documents for information

- Membership Dues Payments for 2018
- Dues Categories 2019

Associate Members

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

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

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

Dr. Dainius Puras

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

Dr. Poonam Dhavan

Dr. Poonam Dhavan, Se(was5h2bcMig)9.9 ( )]TJ0a.2 Td[(onam Dha)tp (.)Right 0 (h.) of lr the(s duA(P)2dvisme ft Td[Inte (ts)10 ( ).8488 Tm03

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WMA Statement on Avian and Pandemic In uenza

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

Preamble

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

Recommendations

Avian In uenza

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

- Sources of exposure should be avoided when possible as this is the most e ective prevention measure.
- Personal protective equipment should be used and hand hygiene practices emphasized for personnel handling poultry as well as members of the healthcare team.
- All infected/exposed birds should be destroyed with proper disposal of carcasses, and rigorous disinfection or quarantine of farms.
- Stockpiles of vaccines and antivirals should be maintained for use during an outbreak.
- Antiviral medications such as neuraminidase inhibitors may be used for treatment.

Antivatem-34.s disindin of virationd to Aatuenza out

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- Priority for vaccination should be given to the highest risk groups

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

Recommendations

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

WMA Declaration of Seoul on Professional Autonomy and Clinical Independence

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

e WMA rea rms the Declaration of Madrid on professionally-led regulation.

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

1. Professional autonomy and clinical independence are essential elements in providing quality health care to all patients and populations. Professional autonomy and independence are essential for the delivery of high quality health care and therefore bene t patients and society.
2. Professional autonomy and clinical independence describes the processes under which individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue or inappropriate in uence by outside parties or individuals.
3. Medicine is highly complex. rough lengthy training and experience, physicians become medical experts weighing evidence to formulate advice to patients. Whereas patients have the right to self-determination, deciding within certain constraints which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations.
4. Physicians recognize that they must take into account the structure of the health system and available resources when making treatment decisions. Unreasonable restraints on clinical

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

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

WMA Statement on Environmental Degradation and Sound Management of Chemicals

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

Preamble

1. is Statement focuses on one important aspect of environmental degradation, which is environmental contamination by domestic and industrial substances. It emphasizes the harmful chemical contribution to environmental degradation and physicians' role in promoting sound management of chemicals as part of sustainable development, especially in the healthcare environment.
2. Unsafe management of chemicals has potential adverse impacts on human health and human rights, with vulnerable populations being most at risk.
3. Most chemicals to which humans are exposed come from industrial sources and include, toxic gases, food additives, household consumer and cosmetic products, agrochemicals, and substances used for therapeutic purposes, such as drugs and dietary supplements. Recently, attention has been concentrated on the e ects of human engineered (or synthetic) chemicals on the environment, including speci c industrial or agrochemicals and on new patterns of distribution of natural substances due to human activity. As the number of such compounds has multiplied, governments and international organizations have begun to develop a more comprehensive approach to their safe regulation. e increasing amount of plastic waste in our environment is another serious concern, that needs to be addressed.
4. While governments have the primary responsibility for establishing a framework to protect the public's health from chemical hazards, the World Medical Association, on behalf of its members, emphasizes the need to highlight the human health risks and make recommendations for further action.

Background

Chemicals of Concern

5. During the last half-century, the use of chemical pesticides and fertilizers dominated agricultural practice and manufacturing industries rapidly expanded their use of synthetic chemicals in

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

Strategic approach to international chemicals management

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

Plastic waste

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

World Medical Association (WMA) Recommendations

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

Advocacy

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

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

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

Leadership

e WMA:

29. Supports the goals of the Strategic Approach to International Chemicals Management (SAICM), which promotes best practices in the handling of chemicals by utilizing safer substitution, waste reduction, sustainable non-toxic building, recycling, as well as safe and sustainable waste handling in the health care sector.
30. Cautions that these chemical practices must be coordinated with e orts to reduce greenhouse gas emissions from health care and other sources to mitigate its contribution to global warming.
31. Urges physicians, medical associations and countries to work collaboratively to develop systems for event alerts to ensure that health care systems and physicians are aware of high-risk industrial accidents as they occur, and receive timely and accurate information regarding the management of these emergencies.
32. Urges local, national and international organizations to focus on sustainable production, safer substitution, green safe jobs, and consultation with the health care community to ensure that damaging health impacts of development are anticipated and minimized.
33. Emphasizes the importance of the safe disposal of pharmaceuticals as one aspect of health care's responsibility and the need for collaborative work in developing best practice models to reduce this part of the chemical waste problem.
34. Encourages environmental classi cation of pharmaceuticals in order to stimulate prescription of environmentally less harmful pharmaceuticals.
35. Encourages local, national and international e orts to reduce the use of plastic packaging and plastic bags.
36. Encourages ongoing outcomes research on the impact of regulations and monitoring of chemicals on human health and the environment.

e WMA recommends that Physicians:

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

Professional Education & Capacity Building

e WMA recommends that:

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

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

WMA Statement on Gender Equality in Medicine

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

Preamble

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

Recommendations

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

5. National Medical Associations/Medical Schools/Employers are urged to facilitate the establishment of mentoring programs, sponsorship, and active recruitment to provide medical students and physicians with the necessary guidance and encouragement necessary to undertake leadership and management roles.
6.

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are maximized when women and children have access to relevant

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Preamble

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

Recommendations

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

WMA Resolution on Migration

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

Nowadays, we are facing increased migration trends glo05 (oa)5 an snst5 (atio)5ses,Noci[(r)10 d cosvovy tla (uth)]TJ.067 Tw 0 -1.2 Tdme

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WMA Council Resolution on the Prohibition of Nuclear Weapons

Adopted by the 209th Session of the Council, Riga, April 2018

e duties of physicians are to preserve life and safeguard the health of the patient and to dedicate themselves to the service of humanity.

Concerned about current global discussions on nuclear proliferation and given the catastrophic consequences of these weapons on human health and the environment, the World Medical Association (WMA) and its Constituent Members consider that they have a responsibility to work for the elimination of nuclear weapons worldwide.

e WMA is deeply concerned by plans to retain inde nitely and modernize nuclear arsenals; the absence of progress in nuclear disarmament by nuclear-armed states; and the growing threat of nuclear war.

e WMA welcomes the Treaty on the Prohibition of Nuclear Weapons, and joins with others in the international community, including the Red Cross and Red Crescent movement, International Physicians for the Prevention of Nuclear War, the International Campaign to Abolish Nuclear Weapons, and a large majority of UN member states. Consistent with our mission as physicians, the WMA calls on all states to promptly sign, ratify or accede to, and faithfully implement the Treaty on the Prohibition of Nuclear Weapons;

Emphasizing the devastating long-term health consequences, the WMA and its Constituent Members urge governments to work immediately to prohibit and eliminate nuclear weapons.

WMA Statement on Sustainable Development

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

Preamble

1. e WMA believes that health and well-being are dependent upon social determinants of health (SDHs), the conditions in which people are born, grow, live, work and age. ese social determinants will directly in uence the achievement of the United Nations Sustainable Development Goals (SDGs). Many of the SDG goals, targets and indicators that have been developed to measure progress towards them, will also be useful measures of the impact of action is having on improving the SDH and, in particular, on reducing health inequities.
2. is statement builds upon WMA policy on Social Determinants of Health as set out in the Declaration of Oslo, and upon the basic principles of medical ethics set out in the Declaration of Geneva.
3. e WMA recognizes the important e orts undertaken by the United Nations with the adoption on 25 September 2015 of the resolution "*Transforming our world: the 2030 Agenda for Sustainable Development*". e Sustainable Development Agenda is based upon ve key themes: people, planet, prosperity, peace and partnership and the principle of leaving no one behind. e WMA a rms the importance of global e orts on sustainable development and the impact that they can bring to humanity.
4. SDGs are built on the lessons learned from successes and failures in achieving the Millennium Development Goals (MDGs), including inequity in many areas of life. While there is no overarching concept unifying the SDGs, the WMA believes that inequity in health and wellbeing encapsulates much of the 2030 Agenda. e WMA notes that while only SDG 3 is overtly about health, many of the goals have major health components.
5. e WMA recognizes all governments must commit and invest to fully implement the goals by 2030, in alignment with the Addis Ababa Action Agenda. e WMA also recognizes the risk that the SDGs might be considered una ordable due to their estimated potential cost of between US$ 3.3 and US$ 4.5 trillion a year.
6. e WMA emphasises the need for cross and inter-sectoral work to achieve the goals and believes that health must be addressed in all SDGs and not only under health speci c SDG 3.

Policy priorities:

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

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

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

Autonomy and privacy of the Physician

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

Responsibilities of the Physician

10. A physician whose advice is sought through the use of telemedicine should keep a detailed record of the advice he/she delivers as well as the information he/she received and on which the advice was based in order to ensure traceability.
11. If a decision is made to use telemedicine it is necessary to ensure that the users (patients and healthcare professionals) are able to use the necessary telecommunication system.
12. e physician must seek to ensure that the patient has understood the advice and treatment suggestions given and take steps in so far as possible to promote continuity of care.
13. e physician asking for another physician's advice or second opinion remains responsible for treatment and other decisions and recommendations given to the patient.
14. e physician should be aware of and respect the special di culties and uncertainties that may arise when he/she is in contact with the patient through means of tele-communication. A physician must be prepared to recommend direct patient-doctor contact when he/she believes it is in the patient's best interests.
15. Physicians should only practise telemedicine in countries/jurisdictions where they are licenced to practise. Cross-jurisdiction consultations should only be allowed between two physicians.
16. Physicians should ensure that their medical indemnity cover include cover for telemedicine.

Quality of Care

17. Healthcare quality assessment measures must be used regularly to ensure patient security and the best possible diagnostic and treatment practices during telemedicine procedures. e delivery of telemedicine services must follow evidence-based prac-

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

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

e WMA was founded in 1947, in part to work for the highest possible standards of ethical behaviour and care among physicians. is was considered particularly important after the gross ethical violations observed, by physicians themselves during

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"governments and administrators: "Although physicians recognize that they must take into account the structure of the health system and available resources, unreasonable restraints on clinical independence imposed by governments and administrators are not in the best interests of patients, not least because they can damage the trust which is an essential component of the patient-physician relationship." Point 4 aimed at hospital administrators and third-

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als caring for prisoners should strictly and exclusively adhere to their role as caregivers to their inmate patients, acting in complete and undivided loyalty to them, and should rmly refuse to take over any professional obligation that is outside the interest of

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e World Medical Association now offers to its members a free online service, My Green Doctor, which helps health profes---

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Getting Started

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

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

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

Education Steps: Your Biggest Impact

An important purpose of My Green Doctor is to help health professionals to share wise environmental practices and climam l-u5r(e)0.5 (70 (eaan10.1 (e aaw5 (nals n0 (o0

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health professional [3] continuous medical education also known as continuous pro-

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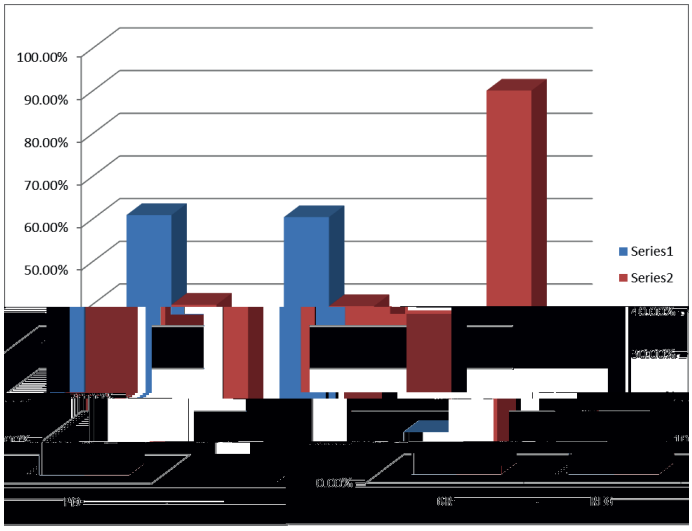

Figure 1. Showing attendance at the clinical meeting

Attended clinical conference Absent from clinical conference

SR: Senior Registrar; **Reg:** Registrar; **PO:** Resident doctor on posting from another department

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

Continuous medical education helps increase the chances of the most positive outcome for patient care. Continuous medical education is aimed at educating practising physicians through the provision of up-to-date clinical information. Grand rounds require much e ort in preparation and prolonged attention by their audience, but their purpose and e ectiveness are rarely investigated or even questioned by physicians [4]. Healthcare leaders and medical educators often rely on Grand rounds to change physician behaviour and improve patient outcomes [3]. Non-medical observers have reached the conclusion that Grand rounds are used in continuous medical education as an instructional method for maintaining and improving clinical skills of practising physicians [10].

Health care is a eld with constant new developments hence continuous medical education prepares health sta for these changes. ere is need to learn the latest in health care technology. Doctors should continually educate themselves to keep up to date otherwise; they would only have the education received before graduation. Doctors have a duty to maintain personal knowledge and skills. In-hospital academic programmes are important to upgrade the knowledge of doctors. ese clinical meetings are bene cial to the residents that is why it is been instituted by the consultants and senior doctors. All residents should be encouraged to attend all academic programmes of their departments and hospitals. Attendance registers should be provided at such meetings instead of using sheets of papers, which can easily be lost. All doctors should be encouraged to put down their names whether it is there hospital or primary department as this may be used for research in future. Topics to be discussed should be discussed should be advertised at conspicuous places to the hospital community so that it can be attended by doctors, nurses and other paramedical medical sta from other departments especially if the topic is related to their discipline. Where resources are available in larger hospitals, a notice board can be dedicated to the advertisements of clinical meetings topics and other in-hospital continuous medical education where that of various departments is kept. A library of all presentations of the various departments can be made for reference purposes to those who cannot attend the meeting. Interesting topics can be submitted as review articles to journals.

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

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

"Commercial revenues" in city hospitals are left to tender winning companies and both "Clinical Support Services" and "Support Services" are also delivered by these companies. roughout the period of contract (25 years) companies are to be paid "Availability payment" as rental and repair/maintenance, and volume based "Service payments" for clinical support services (Laboratory, imaging, sterilization and disinfection, rehabilitation, etc.) and other support services (Linen and laundry, catering, waste management, etc.). Companies that undertake city hospital tenders in Turkey are guaranteed that hospitals will be operated by rate of occupancy of 70% in terms of volume-based care. is rate is 80% for high security forensic psychiatry hospitals.

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

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

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

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

Problems Coming to the Fore in Turkey

e major problem related to city hospitals in Turkey is the high cost of hospital buildings and equipment to the public. Examining the amount of xed investment and annual rentals in tenders arranged by the Ministry of Health we come across signi cantly high costs. According to a report by the Ministry of Development, for 18 city hospitals whose contract price amounts to 10.6 billion USD, an amount of 30.3 billion USD is to be paid in 25 years to companies building and operating these hospitals

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taxes collected from people. For instance, it is gured out that with 2.6 billion TL allocated from the 2018 budget of the Ministry of Health to presently operating hospitals it is possible to build 64 full- edged hospitals each with 150 bed capacity [3]. e extremely high cost burden can be seen

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

In city hospitals in Turkey, the average indoor space per bed is 287 m^2 than can be as high as 350 m^2 in some hospitals. It is observed that this space is generally around 150-200 m^2 in new hospitals built in developed countries. is means that indoor space per bed in city hospitals in Turkey is larger by about 40 per cent than what is recently preferred in modern hospitals. e point is that larger the indoor space per bed is, higher the costs of energy, cleaning, repair and maintenance are.

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

e practice of city hospitals that underwent auditing by the Court of Accounts for the rst time in 2018 since 2005 presents a dire picture. e report by the Court of Accounts observes the following: Hospitals are delivered with yet uncompleted construction and equipment; operations favouring

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- CMAAO Taipei Resolution on Strengthening of Primary Healthcare in Asia and Oceania,
- CMAAO Statement on Task Shifting,
- CMAAO Resolution in Economic Crisis and Health,
- CMAAO Declaration on Tobacco Control in Asia and Oceania,

And this year in this General Assembly, the Malaysia Statement on Pathway to Universal Health Coverage.

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

But let's not forget we are an organisation – united by our values and rich with talent. If each of us puts in what we can, we will become an organisation to be reckoned with and secure a place of recognition in the world.

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