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Editorial

In recent years the documents, declarations and priority setting of the World Medical Association have increasingly focused on the future. The WMA policy is largely determined by its leaders – President, Council members and chairs, Secretary-General. The WMJ also pursues this idea, and the Journal more and more often publishes articles that not only describes the current situation or reflects current realities, but at the same time also seeks to predict the development of global medicine – socio-medical affairs, environmental health, social determinants, public health, universal coverage. The forecast is needed for the WMA to act really as the world medical leader.

Increasingly, we use the concepts of personalized medicine, precision medicine, stratified medicine, individualized medicine. Each of them includes a slightly different set of concepts, but overall, it is the way we see global health care and medicine moving. Personalized medicine is an adaptation of medical care to the individual peculiarities of each patient. In fact, personalized medicine is the reverse thinking for global business that dreams of selling one contraceptive pill every day to every woman in the world, to every elderly person one ibuprofen tablet in the morning and one sleeping pill in the evening. The new thinking advocates that for each person there are only definite drugs in appropriate doses that help to maintain health, ensure quality of life, treat the disease and extend survival.

The adjustment of treatment to patients has already been known at the time of Hippocrates. A holistic approach to a patient is not new either; by the way, various Eastern medical techniques largely have sought to treat a patient holistically. However, in the current understanding of personalized medicine, we can talk about the phenomenon of the 21st century as this approach to a particular patient

as a whole has expanded through the development of diagnostics and information processing, which provides an understanding of the molecular basis of the disease. The new diagnostic and information processing techniques provide a clear evidence base to stratify or group specific patients. Each person has a unique variation of the human genome. The health of an individual is determined by this genetic variation in combination with behaviour and environmental impacts, although most of the differences in the genome do not directly affect the individual's health. Each person's unique genetic profile and unique molecule arrangements make them more sensitive or less sensitive to individual diseases and chemicals (drugs). However, globally, the ZIP Code affects human life expectancy more than the genetic code. Social determinants continue to prove convincingly that a wealthy person with a good education residing in a democratic country lives a considerably longer life than the poor without education, but particularly when living in a country without social guarantees. The World Medical Association today faces two major challenges: universal coverage and the need to provide available doctors assistance to every citizen of the planet, rather than the assistance of poorly educated health professionals. Our goal for the coming years will be focusing on how to combine universal coverage for every citizen of the planet with personalized medicine and the possibility of each individual person be treated for a particular disease and diagnosed by applying genetic mapping. At the same time, we uphold prescribing only appropriate medicines at the appropriate dosage and duration. It will bring to the fore issues relating to medical treatments, patients and relatives, ethics, data security, science ethics, computerization and the big social networks and Internet companies worming their way into medicine.

*Dr. med. h. c. Peteris Apinis,
Editor-in-Chief of the World Medical Journal*

The WMA Medical Ethics Conference

Reykjavik, Iceland, October 2018



Jon Snaedal

The Icelandic Medical Association (IcMA)

Laeknafelag Islands (The Icelandic Medical Association, IcMA) was founded in 1918 by only 39 physicians. A local association in the capital preceded it, but IcMA was the first national association of doctors. The membership slowly increased and the total number of active physicians is currently around 1000 while the population has quadrupled from 90 000 to 360 000. Traditionally, Icelandic physicians seek abroad for specialisation and, therefore, have always been in good contact with international trends of the profession. The leaders of the association followed closely the foundation of WMA after World War II. A representative of IcMA was present at the preparatory meeting in London in 1946 and two representatives attended the first GA of WMA in Paris in September 1947 ensuring that IcMA became one of the 27 founding members. Increasingly, the leaders of the association have had an ambition to participate in the work of the WMA and to attend

its constituent meetings. Small work group meetings of the WMA have been held in Iceland, but four years ago, IcMA sought to organize a General Assembly for the first time, a request well received by the WMA Council.

General Assembly in Reykjavik, October 2018

The Assembly was organized in a traditional manner with the exception of the science day as discussed later. As the venue was in the northernmost capital of the world, there were some concerns regarding the weather. Unsurprisingly, the weather changed more than once a day as is customary in Iceland at this time of the year and the delegates experienced intermittently strong wind with rain, strong and cold wind without rain and calm and cool weather during the four days of the Assembly. All of this was forgotten when the northern lights became visible at the night tour outside the capital. As customary, the local hosts organized the social events apart from the Assembly dinner. A tour was organized to Thingvellir, where the oldest parliament in the world was established in 930, functioning until our times except for 45 years in the first half of the 17th century. The delegates and guests walked through the area in a brisk and cold wind and got hopefully an impression of what this was like in old times. The tour ended by a dinner in a restaurant in a Viking style.

In its ceremonial session, Dr. Gudni Johannesson, President of Iceland, gave an address that was very well received.

However, the Assembly will surely be remembered for the unexpected events leading to the immediate termination of

membership of the Canadian Medical Association and subsequently of the Royal Dutch Medical Association some weeks later. These have been among the most active members of the WMA for years and, hopefully, this will be a time-limited decision.

The Medical Ethics Conference

The traditional science day was extended to a two and a half day conference on medical ethics. The idea was presented early and the WMA Secretariat gave a very valuable support but it was informed of the idea as soon as it came up.

The main purposes of the conference were threefold:

- To allow delegates and WMA guests to discuss more thoroughly the various medical issues central to the association.
- To involve in discussions those physicians not familiar with the work of WMA and thereby increase the visibility of the association.
- To allow for the possibility for WMA workgroups to present their work and to get feedback from those interested but not involved otherwise in the work.

It is fair to say that all of these aims were reached and the presentations and discussions facilitated the work on the various issues. It is worth mentioning examples. The Work Group on the revision on Genetic Medicine had a fruitful open meeting where several ideas were presented. This was very helpful and has a positive effect on the work. It was extremely gratifying for us in the local association that the Medical Ethics Committee subsequently proposed and the Council agreed that even though the

work on this policy was not finalized, it was decided to name it “The Reykjavik Declaration on Genetic Medicine”.

Another example is the session on the central ethical policies for physicians, the pledge of Declaration of Geneva (DoG) and the International Code of Medical Ethics (ICME). The former had been revised thoroughly a year earlier and has since been increasingly visible for physicians, both those active inside the WMA as well as others. It was a moving moment when the pledge was read out in at the Assembly session, first in Icelandic by Guðrún Ása Björnsdóttir, the chair of the Young Doctors Association in Iceland, and subsequently, line by line and simultaneously, in the three official languages of the WMA by all delegates.

It was decided to start a revision process of the ICME with an open consultation method in the same manner as for other major revisions in the last years.

The most heated debate was on end of life issues, primarily on euthanasia, and physician-assisted suicide where the opinion differs vastly. However, it must be kept in mind that active end of life actions are only allowed in very few countries represented in the WMA and hardly any since the CMA and RDMA withdrawal from the Association.

Prominent professionals were invited to give talks on some of the central issues. Dr. Ruth Mcklin, Professor Emeritus in Bioethics at the Albert Einstein College in New York, gave her views on research ethics with special consideration to the Declaration of Helsinki. She argued for some changes of the Declaration and these will surely be considered during the next revision most likely to take place sometimes in the coming decade. Dr. Bartha Knoppers, Professor at McGill University in Toronto, Canada, gave an overview of the ethical challenges in genetic medicine and so did also Kari Stefansson, the CEO

of the Reykjavik based research company DeCode Genetics. Dr. Kristi Boyd from Edinburgh, Scotland, gave a lecture on palliative medicine and Baroness Ilora Finley from the UK on ethical aspects on physician-assisted suicide and euthanasia for which she is a fierce opponent.

Many other issues were discussed in different sessions such as “Hard Choices in Medicine”, “Dual Loyalty of Physicians”, “Future Challenges in Genetic Medicine”, “The Use of Artificial Intelligence in Medical Care”, “Health Care of Undocumented Immigrants”, “Ethical Use of Health Data” and “Person Centered Medicine”. The scientific committee organized all of these symposia but in addition, the Nordic Bioethics Committee organized a symposium on “Prenatal Testing” and the International Federation of Pharmaceutical Physicians another one on “Ethics in Education for Medicines Development”.

Addresses at the opening ceremony were given by Mrs. Svandis Svavarsdóttir, the Minister of Health, and the President of WMA Dr. Yokokura from Japan.

Generally, there is a great competition in getting physicians to attend conferences, at least those that do not have a long tradition. The WMA has, however, a very good name and is well connected to both various National Member Association and many different collaborators and that helped. The attendance to the conference was relatively good with 215 registered participants when WMA meetings were in session and 380 participants on the last day when all the delegates were able to attend.

The local organizers had meetings with representatives from some of the NMAs before the event and that was very helpful. The WMA Secretariat was very instrumental in realizing the event, both before and during the days of the conference and

the local organisers are very grateful for that.

In summary, these are the main take home messages from the conference.

On the positive side:

- The content was generally very well received and ethical issues are very suitable for dialogues.
- Ethical issues central to the WMA were well covered.
- An open session for a WMA work group was well attended and many valuable comments were presented.
- The work of WMA became more visible to physicians that generally are not very well aware of the work of the association

On the negative side

- A part of the conference was parallel with meetings of the WMA and this has been criticised. To avoid this, the organizers had discussed to hold the conference either before the GA or right after but that was found too risky for attendance.
- Most of the time, there were two and even three parallel sessions and many complained of the difficulty of choosing. However, the central issues to physicians are many and thus difficult to choose which to leave out.
- The event faced a financial risk that had to be carried by the local host.

Lessons to learn

- To organize a conference on core issues of the WMA is definitely recommendable, as so many outside the organization will learn about the important work of the WMA.
- As the experience of an open WG meeting was very good, this practice could be used to a greater extent.

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Customer Satisfaction and Medical Scheme Complaints in South Africa



Michael Mncedisi Willie

Introduction

Customer service is viewed as one of the most fundamental concepts that deal with customer loyalty and sustainability in business. It is known that customers who are not happy with the products offered to them are likely to switch to products that meet their needs or their expectations. Prior studies have found that higher levels of dissatisfaction with a company are associated with increased brand switching behaviour and exit intentions [18,7]. Thus, customer service is a necessary component for the success of most businesses across all sectors, particularly in health care. The health sector has typically been slow or reluctant to adopt practices that place a substantial effort into customer satisfaction. There is, however, some empirical evidence that shows a growing interest in focusing on patient and customer satisfaction surveys [1, 14]. Studies [11, 20, 16] show that industry leaders have been focusing their attention on improving patient and customer satisfaction through various initiatives. However, despite their many efforts and successes,

evidence shows that more work in this area is still needed [12, 3, 13, 21].

A few entities assess medical scheme satisfaction surveys in South Africa. These entities conduct surveys on an annual basis and they do attempt to provide some insight. However, various methodologies employed have their own shortcomings. One of the shortcomings is that the survey results are not publicly available other than reported at the aggregate level, thus the true level of customer satisfaction is unknown. The other limitation is that such surveys are mainly conducted for commercial gain. There are also methodological issues such as the sample size, the sample size used in some of the customer satisfaction surveys might not be representative of the medical schemes industry due to small sample size. A GTC (formerly Grant Thornton Capital) study admits that their annual medical scheme survey does not necessarily provide a full picture of medical schemes, as compared with other similar types of surveys [8].

The medical schemes industry in South Africa has been stagnant for the past ten years, hovering at 16% of population covered by medical schemes. Many social economic factors may have contributed to the slow growth of the industry. One of the possible key factors that have not been explored in detail is the effect of customer satisfaction and complaints on the industry growth. The purpose of the current article is the customer satisfaction and complaints analysis pertaining to medical scheme members. The objective of the study is to depict both secondary data sourced from various service providers as well as primary complaints data that are collected by the Council for Medical Schemes (CMS).

A strong correlation exists between customer satisfaction, complaints and the value

the customer derives from the products they purchase. Figure 1 below shows the key components of customer satisfaction and the key factors of perceived quality and customer expectation and complaints [26, 27]. The ACSI model uses survey data as input to the cause-and-effect econometric model which estimates customer satisfaction as the result of the survey-measured inputs of expectations and perceptions of the quality services offered. The ACSI model links satisfaction with the survey-measured outcome of complaints [26, 27]. Thus, if customer satisfaction is not viewed as a function of perceived value, perceived quality and customer expectation as depicted in Figure 1, then there is a high likelihood of these resulting in complaints.

Medical scheme members often complain when a claim for services rendered is not honoured or paid in full as expected. Members often feel that they do not receive the cover and the benefits they expect from their medical scheme. A study [10] showed that customer expectation has a significant positive effect on the customer. Another study revealed that service quality seems to lead to positive word-of-mouth, and therefore the lessening of complaint [22]. There is empirical evidence on the correlation between perceived value, perceived quality and corporate image that have a significant positive influence on customer satisfaction [2].

There are investigations on how the sellers' response to complaints affects complainants' satisfaction, perceptions of fairness, etc. [23]. Furthermore, a study [24] found that patients who register medical aid complaints are four and a half times more likely to voluntarily exit the Health Maintenance Organization.

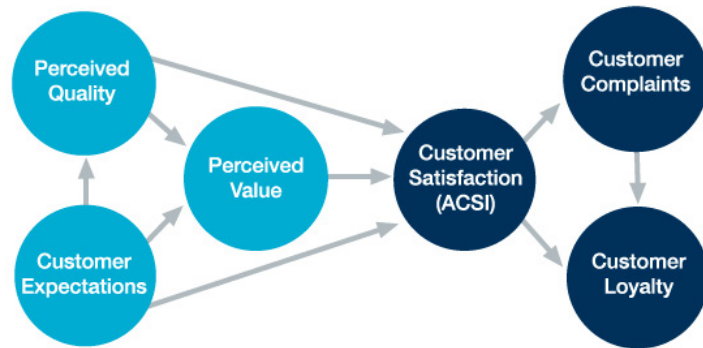
Other studies have also shown that there is a statistically significant impact of the

overall dimensions of complaints handling (service recovery, service quality, switching cost, service failure, service guarantee, and perceived value) on customer satisfaction [25]. Thus, customer satisfaction goes beyond normal service delivery and further taps into meeting the needs of the customer.

In many cases customer complaints arise because their expectations or their needs are not met by the service provider and that is when the perceived value is not realised. A study [17] discussed a framework focused on a firm's pre-emptive value offering (also known as a customer value proposition). Furthermore, [19] proposed a comprehensive customer-value creation framework that identifies four main types of value that can be created by organisations:

- **Functional/instrumental value:** the attributes of the product itself; the extent to which a product is useful and fulfils a customer's desired goals.
- **Experiential/hedonic value:** the extent to which a product creates appropriate experiences, feelings, and emotions in the customer.
- **Symbolic/expressive value:** the extent to which customers attach or associate psychological meaning to a product.
- **Cost/sacrifice value:** the cost or sacrifice that would be associated with the use of the product.

In terms of general business practices, complaints might be a result of basic business practices not being carried out as expected by the member, and thus the product does not meet the customer's desired goals. Typically, a member of a medical aid scheme expects a claim to be paid but, due to administratively related issues, a claim is not paid or a benefit is not paid in full. This is not explained to the member. A rise in the number of complaints is also due to administrative inefficiencies by third parties contracted to the scheme, which ultimately affect the members negatively. This is evident in the two most complained about schemes over the review period.



Customer Satisfaction (ACSI)

Figure 1: ACSI Unique Benchmarking Model [28]

Source: ACSI Unique Benchmarking. The American Customer Satisfaction Index, the nation's only cross-industry measure of customer satisfaction, gives businesses science-based insights across the complete arc of the customer experience.

<p>SPECTRAMED:</p> <ul style="list-style-type: none"> • Administrative inefficiencies due to change in administrator • Delayed payment of members' accounts due to insufficient data. • Incorrect assessment of accounts – valid claims incorrectly rejected. • PMB accounts paid at scheme rate and reprocessed after receipt of CMS complaints. 	<p>RESOLUTION HEALTH:</p> <ul style="list-style-type: none"> • Administrative inefficiencies. • Processing accounts from incorrect benefit category. • Service providers and members informed that PMB procedures will be funded up to monetary limit contrary to Regulation 8(1) of the Medical Schemes Act. • PMB accounts paid at scheme rate and reprocessed after receipt of CMS complaints.
<p>CHANGE IN ADMINISTRATORS</p> <ul style="list-style-type: none"> • Complaints related to delayed payment of accounts and incorrect processing of accounts. • Insufficient data transferred from one administrator to another. • Delayed verification and delayed release of payment of accounts. • Recordings not transferred over to new administrator prior to the take-over. • Section 57 (4)(c): BoI to ensure proper control systems are employed by or on behalf of the medical scheme. • Section 57 (4)(h): BoI to ensure operation and administration of a medical scheme comply with the provisions of the Medical Schemes Act. 	

Figure 2: Spectramed and Resolution Health Medical Schemes complaints related issues

Source: [4,5]

The Resolution Health Medical Scheme and the Spectramed Medical Scheme are open schemes that have reported the highest number of complaints. The schemes have reported 2.6 and 4.4 complaints per 1000 beneficiaries respectively in 2017, and this is considerably higher when compared with other schemes. The trend has continued during the past three years.

The table below shows the number of members and valid complaints about Spectramed and Resolution between 2015 and 2017. The schemes consistently reported more complaints, and this possibly contributed to

a decline in the membership of more than 30% for both schemes.

The other contributing factor to the rise in complaints is the complexity of the product sold. The more complex the product is the higher the risk of it not being fully understood by the purchasers. During 2017 there were 278 registered benefit options operating in 81 medical schemes, thus choosing a benefit option became even more confusing to customers. A study [9] depicts that the number of benefit options available in the medical scheme market creates a complex environment impacting decision making.

Table 1: Membership and valid complaints data for Spectramed and Resolution Health Medical Schemes

Category		Spectramed medical scheme	Resolution health medical scheme
Number of complaints	2017	81	70
	2016	102	100
	2015	167	123
Number of beneficiaries	2017	22,777	28,839
	2016	27,599	37,546
	2015	33,062	45,575

Table 2: Customer satisfaction scores for five selected medical schemes

Scheme Name	Scheme Type	Beneficiaries	Number of Options*	Solvency, %	SA-csi Score, % (2016)
Discovery health medical scheme	Open	2,777,946	17	27.4	73.1 (74.8)
MEDIHELP	Open	200,487	7	29.6	75.1 (72.6)
Momentum health	Open	293,787	6	25.7	72.0 (72.2)
BONITAS	Open	728,943	11	24.5	70.2 (73.1)
GEMS	Restricted	1,807,538	5	15.2	68.8 (64.3)

Source: [15, 4, 5], * Excluded Efficiency Discount Options/Sub-options

It is not an easy task to accurately assess the impact of customer satisfaction in health care, particularly when medical scheme beneficiaries view it with antipathy. Members feel that there is nothing intrinsically satisfying about spending money on medical risk mitigation [15]. They view it as a must have, and there is no denying that in the event of a major medical emergency, medical aid membership is an absolute necessity.

Customer Satisfaction Scores

A number of customer satisfaction surveys have been conducted. The recent data show a declining trend in this regard. The South African Customer Satisfaction Index (the SA-csi) for Medical Schemes survey was done on a sample of schemes, and shows a declining trend in customer satisfaction levels, which dropped from 74.2% in 2017 to 72.7% in 2018. The main factors contrib-

uting to the declining scores are increasing premiums, shrinking benefits and lack of value for money. A survey published by the competition commissioner revealed that for respondents whose family members were not members of a medical scheme the reasons for it were the following:

- no longer able to afford the contributions – 15%;
- no longer a dependant child and could not afford it – 14%.

A survey conducted by one of the largest restricted schemes in 2018 revealed that affordability of the premiums, co-payment, shrinking benefits or benefits exhausting quickly were some of the factors contributing to lower customer satisfaction scores. Table 2 below presents the SA-csi customer satisfaction scores, exposure, and demographic information of the five schemes considered. The list of schemes depicted in the table below accounts for 65% of all schemes, 81% of all

open schemes and 46% overall, in terms of beneficiaries in 2017.

Of the five large medical schemes surveyed, only two had an improved index score. This was an open scheme which had slightly above 200 000 beneficiaries and a higher solvency level, compared with the other five schemes which rose from 72.6% last year to 75.1% this year. GEMS, which is the largest restricted scheme (employer medical scheme), also saw an increase in customer satisfaction level, improving from 64.3% to 68.8% in 2017. The Discovery Health Medical Scheme dropped from 74.8% to 73.1%, while the Bonitas Medical Scheme – from 73.1% to 70.2% over the period.

The Momentum Health remained within the range of 72.0%. Only one of the five schemes is self-administered. Others are administered by third party, which further discloses the impact of the operating model upon the types of services offered. Simplicity of products plays a role. Table 2 shows the number of benefits offered by these schemes that offered a range between 5 and 17 benefit options.

Survey Limitations

While the data give an insight into the customer satisfaction survey, it is of importance to note the following limitations: Only one restricted scheme was considered, which represents less than half of the restricted schemes. There are also considerable differences in the scheme considered in terms of demographics and the number of benefit options offered, which is similar to the operating model.

The other limitation of the survey is that it considers a random sample of 1757 medical aid members. A bigger sample size across other scheme types could certainly improve the findings of the study. The present number accounts for less than a percent (<1% of the overall membership) of the overall population coverage by medical schemes.

Complaints Trend Analysis

Table 4 below reveals the trend data of valid complaints logged between 2015 and 2018, the complaints ratio (valid complaints per 1000 beneficiaries) was slightly higher for open schemes, compared with restricted schemes. There was an increasing trend in restricted schemes between 2015 and 2016; however, a notable trend was noted in 2017 in both sectors.

There were more complaints in medical schemes in 2017 compared with previous years where an increase of more than 10% was noted.

Over the period, the number of complaints and complaint resolution time have consistently increased. Open schemes have reported more complaints than restricted schemes. The data show an increasing trend in the average complaint resolution time within the range of two to six months, in both open and restricted schemes. It is seen that it took longer to resolve complaints in 2017. This might be attributed to the complexity of the complaints received.

Types of Complaints Over the Reviewed Period

The figure below presents a grouping of complaints by the complaint type over the period of three years. Complaints relating to benefit payments accounted for a third of the complaints, short payments – for just under a quarter, pre-authorisations – for 10%, and no-payments – for 9%.

Trends in complaint type

Figure 4 below reveals that the payment of benefits accounted for 1/3 of complaints in 2016 and 2017, and short payments – for under a quarter of the complaints and dropping to 24% of the complaints

Table 3: Demographic Information of SA-csi surveyed schemes

Scheme Name	Name of the administrator	Average Age	Pensioner ratio	No. of dependents per member	No of Trustees
DHMS	Discovery Health (Pty) Ltd	34.6	9.3	1.1	8
MEDIHELP	Self-Administered	37	14.1	1.2	8
Momentum health	MMI Health (Pty) Ltd	32.8	8.1	0.9	8
BONITAS	Medscheme Holdings (Pty) Ltd	33.3	8.3	1.2	11
GEMS	Metropolitan Health Corporate (Pty) Ltd	30.5	6	1.6	11

Source: [4]

Table 4 Complaints ratio – Industry/100 beneficiaries

Year	All	Open	Restricted
2017	0.47	0.50	0.43
2016	0.42	0.46	0.38
2015	0.42	0.47	0.36

Source: Author computations, extrapolated from the CMS reports [4,5,6]

Table 5: Median time to resolve complaints

Category	Number of Valid Complaints	Median Time to resolve complaints	
		Days	Months
Open			
2017	2 500	169	6
2016	2 348	122	4
2015	2 353	91	3
Restricted			
2017	1 690	143	5
2016	1 498	85	3
2015	1 400	63	2

in 2017. Complaints relating to pre-authorisations were within the range of 9 to 10%. Non-payments accounted for 8 to 9% of all complaints. A similar trend was noted for complaints relating to customer service. The data show that in 2015, short-payment complaints had a large share; however, this was improved in subsequent years.

Median time to resolve complaints by complaint type

Figure 5 below shows the median time to resolve complaints within the period 2015-2017 stratified by the complaint category. Other types of complaints such as

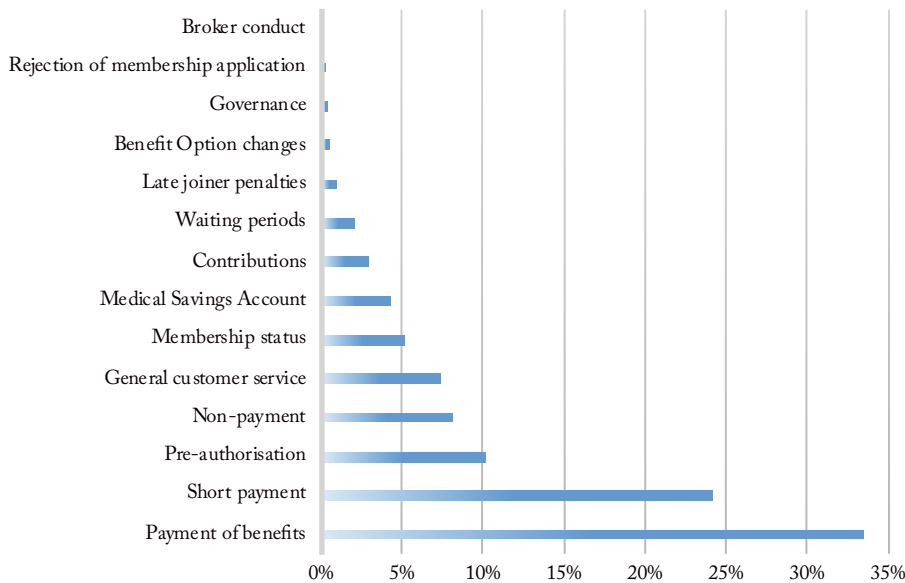


Figure 3: Median time to resolve complaints by nature of the complaint, %

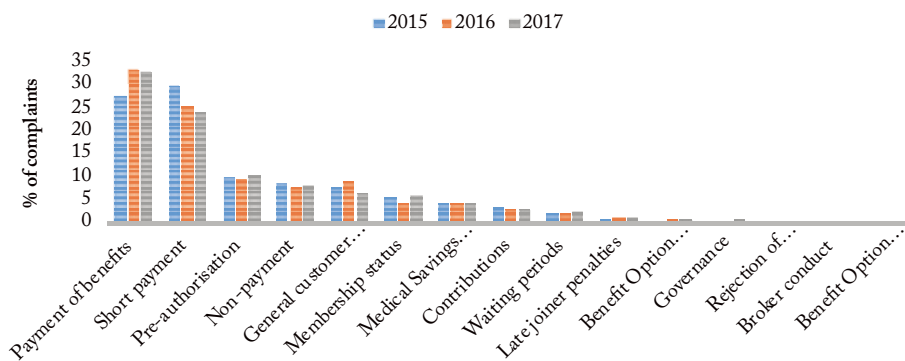


Figure 4: Median time to resolve complaints by nature of complaint, trend data

governance related complaints, late joiner penalties and waiting periods were excluded due to the smaller sample size within the groups. In 2015, the median time to resolve complaints ranged around three months and this increased to six months in 2017. Notable changes affected complaints related to non-payment of claims, membership status, and pre-authorisations that showed a significant shift. Complaints related to payment of benefits, contributions and medical savings accounts increased from two to four months.

Discussion

The current report describes a decrease in customer satisfaction scores, although the sample used to assess these scores has its own limitations. However, the data reveal some valuable facts. One of the key findings the surveys depict is declining of customer satisfaction scores. The medical schemes customer satisfaction score for a select list of schemes surveyed in 2018 was less than 75%. This was substantially lower than that

measured in other financial service industries ranging from 77% to 79% for financial services and life insurance industries, respectively. Due to the complexity that exists in the private health sector, the low customer satisfaction scores might be an indication to members' feeling about the quality of services in medical schemes sector. One of the underlying factors that drives the complexity is information asymmetry, namely, the types of products sold to members. There were over 270 benefit options that are also coupled with complex rules and various treatment protocols. There are, however, studies that do not reflect the complexity of products offered by medical schemes. A recent survey released by the competition commissioner showed that the 1 507 medical schemes surveyed were about their knowledge of cost implications and benefits provided by the various options across medical schemes.

The GTC annual survey conducted in 2017 depicted that consumers were unsure of their own medical scheme details and benefits they were entitled to [8]. Seventy-six percent (76%) of respondents stated that they made sure that they understood the cost implications and the benefits of options provided across a medical scheme before selecting it. At the same time certain participants admitted that they had poor knowledge of the cost and benefit implications of the various medical scheme options. The health market inquiry report published in 2018 made recommendations to standardise benefit packages offered by medical schemes to be able to allow members make better-informed choices based on value-for-money.

In response to such challenges, the CMS is currently working on the benefit options standardisation process, which will ultimately assess the possible simplification of benefit options and meeting members' needs. Another aspect contributing to the declining scores is the affordability of premiums that have consistently risen above the annual inflation rate and, as a result, healthcare is becoming more unaffordable.

Premiums between 2015 and 2017 have increased within the range from 6% to 14%, which is higher than inflation. A study conducted by the GTC also revealed that increase in medical aid premiums continues to outstrip salary increase. Since 2010, the CMS embarked on a process of a stringent review of medical schemes [4].

The data presented in the current report show a correlation between complaints and loss of membership, as revealed by the Resolution Medical Scheme and Spectramed case studies. A noticeable trend was the increase in valid complaints during the period under review, and this trend was evident in both open and restricted schemes. One of the key features revealing the increasing trend was complaints relating to the benefit payment that accounted for more than a third of all valid complaints in the review period. Coupled to this was the median complaint resolution time that increased twice between 2015 and 2017, i.e. from three months to six months. This might be the result of an increase in the complexity of complaint types or the result of increased operational inefficiencies in the industry over the period. Industries, such as the short-term industry, report a lower resolution time with an average resolution time of 131 days, which is equivalent to four months. This shows the unique features and complexity of the medical scheme industry.

Recommendations

The complexity of the medical schemes industry with respect to the number of products offered and the various operating model used needs to be carefully considered when comparing customer satisfaction scores. Considering methodological issues such as smaller sample size and other key features, e.g. the demographics, balance in scheme types used in the survey, corporate governance structures, third-party arrangements, and the financial performance of the scheme over time, could certainly add value

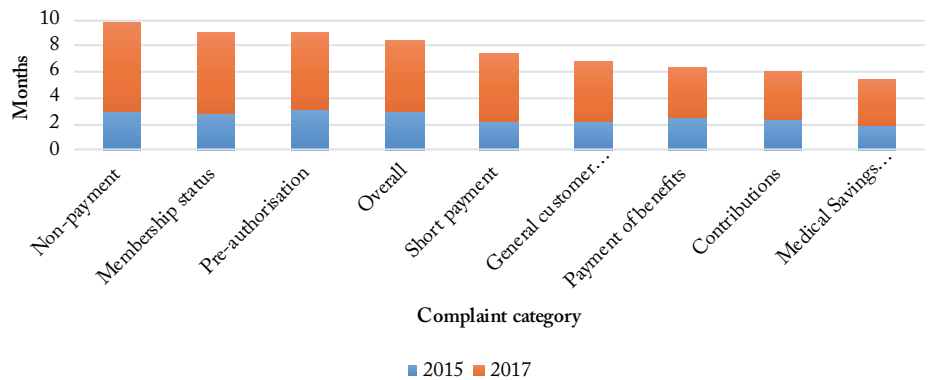


Figure 5: Median time to resolve complaints by nature of complaint, trend data

to annual customer satisfaction surveys. The results presented, indeed, highlight the complexity of the sector and the number of components where a competing interest may have possibly contributed to lower satisfaction scores. One of the main issues consistently evident in most of the complaints relate to the effect of third parties on complaints. There needs to be a clearer separation of duties, responsibilities and accountability between the scheme and contracted parties.

The increase in the number of valid complaints received by the regulator provides an indication that the complaint department needs to be properly resourced to be able to impact positively on the turnaround times. There is also a need to review the overall complaint resolution time and this needs to be consistent with the nature of complaints and should reflect modern challenges that the schemes are facing. The overall complaints process needs to be aligned with the regulatory tools in order to be more effective and such a process should outline proactive measures as opposed to a reactive approach to complaint resolution. One of the key recommendations in this regard is to invest in data analytics as well as in research and development to assist in developing models that will provide insight and ultimately identify systematic issues that need urgent attention from a regulatory perspective.

The current study revealed that more than a half of the valid complaints are related to the payment of benefits. In many cases the scheme does not honour claims and pays only up to a certain threshold. It is recommended that medical schemes need to be proactive, and they must effectively communicate to members what benefits are covered. Furthermore, in instances where a claim is not covered in full, this should be communicated to the members. Schemes are encouraged to provide feedback to the members on benefits paid. Training and member education on the products offered by medical schemes could go a long way towards changing the perception of medical schemes. The latter also applies to third parties who are contracted to a scheme that, in its turn, affects the delivery of service to the members. The operating model of the scheme, particularly where third parties are involved, needs to take accountability for service failures.

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Annexure A1: Complaint Categories – descriptions

Complaint category	Short description
Contributions	Complaints related to contributions/ premiums: These complaints relate to premium increases, incorrect contributions raised to the member.
Payment of benefits	Complaints related to payments of benefits: This is the largest category of complaints and has at least 19 subcategories, the range of complaints transmit to payment on incorrect benefits, claims paid in error, sublimit on options, benefits exhausted, incorrect information on accounts.
Short payment	Complaints where a scheme does not pay in full: This is where the claim in not paid in full due to incorrect diagnosis ICD-10.
Non-payment	Complaints where a scheme does not pay a benefit: This is where the claim in not paid due to incorrect diagnosis ICD-10.
Membership status	Complaints related to the membership status: This category includes suspension and/or termination of membership. This usually occurs when the membership status is terminated by the scheme due premiums not paid, material non-disclosure, fraudulent conduct by the member.
Pre-authorisation	Complaints related to pre-authorisation: These types of complaints are the result of an authorization not granted by the scheme due to benefits that are excluded, protocols, waiting periods, pending outstanding information and non-disclosure.
Late joiner penalties	These types of complaints are the result of late joiner penalties or waiting periods being imposed by a scheme to a member. A “late joiner” refers to an applicant or an adult dependant of an applicant who, at the date of application for membership or admission as a dependant, is 35 years of age or older and who was not a member of one or more medical schemes as from a date preceding 1 April 2001, without a break in coverage exceeding 3 consecutive months since 1 april 2001. A waiting period is a time when a person cannot claim benefits as set out in the Medical Schemes Act. It aims to protect current members of a medical scheme by ensuring that people do not just join a scheme, make a large claim and then cancel their membership.
Waiting periods	
General customer service	Complaints related to customer service: Complaints relating to the service offered, these types of complaints arise where a brochure is not received by a member, schemes failure to provide feedback to the member, where the scheme sends incorrect information to the member,
Medical Savings Account (MSA)	Complaints related to medical savings account and would typically include a clawback of funds, refunds or received by the member and self-payment gap. MSA is usually a percentage of their premiums that get put into a separate account, from which certain benefits are paid, such as doctors’ visits and acute medication, etc.
Benefit Option changes	Complaints related to benefit option changes and typically instances where benefits are excluded or limited when a member moves from one benefit option to another.
Rejection of membership application	Complaints related to membership application where a scheme depict that a dependant is not eligible or due to discrimination.
Broker conduct	Complaints due to the broker’s conduct, this may entail issues related to broker fees or incorrect advice by a broker.

Medical Schemes Act and Medical Schemes
Medical schemes are legal bodies registered in terms of the Medical Schemes Act for defraying medical expenses of its members.
There are two kinds of schemes – open and closed schemes. Any person can join an open scheme, but closed schemes are for specific employer groups.

Annexure A2: Complaint categories and sub categories

Payment of benefits

- o Paid from incorrect benefits -
- o Reversal of a claim - Benefits exhausted
- o Reversal of a claim - Claim paid in error
- o Reversal of a claim - Member terminated
- o Reversal of a claim - Section 59(3)
- o Short payment - Administration error
- o Short payment - Paid at scheme tariff
- o Short payment - Sub-limits in option
- o Unpaid account - 3rd party claim
- o Unpaid account - Account not paid in 30 days
- o Unpaid account - Administration error
- o Unpaid account - Benefits excluded
- o Unpaid account - Benefits exhausted
- o Unpaid account - Incorrect information on account (Reg 6(2) & (3)/Outstanding Information
- o Unpaid account - Legal fees / interest
- o Unpaid account - Member terminated
- o Unpaid account - Refund not received / processed
- o Unpaid account - Section 59(3)
- o Unpaid account - Stale Account

Pre-authorization

- o Authorisation declined - Benefits excluded
- o Authorisation declined - Protocols
- o Authorisation declined - Waiting periods
- o Non-disclosure investigation
- o Pending Outstanding information
- o Pre-authorization not requested

Medical Savings Account
Clawback of funds -
Refund not received / processed -
Self payment gap / ATB -

General customer service
Brochures not received -
Failure to Provide Feedback -
Incorrect information from scheme -
Membership / Tax Certificate not received -

Rejection of membership application
Dependent not eligible -
Discrimination -

Contributions
Annual Increase
Incorrect Contributions
Premium increase due to outstanding documentation

Short payment

NON-PMB - Diagnosis (ICD-10)
PMB-EMERGENCY/CDL/DTP - Diagnosis (ICD-10)
PMB-EMERGENCY/CDL/DTP - Diagnosis (ICD-10)

Rejection of membership application
Dependent not eligible -
Discrimination -

Non-payment

NON-PMB -
PMB-EMERGENCY/CDL/DTP - Diagnosis (ICD-10)

Membership status
Suspension - Contributions not Paid
Suspension - Material Non-Disclosure
Suspension - Unauthorised Deductions of contributions
Termination - Contributions not Paid
Termination - Fraudulent conduct
Termination - Material Non-Disclosure
Termination - Unauthorised Deductions of contributions

Late joiner penalties

Waiting periods
General waiting periods -
Pre-existing conditions -

Benefit Option changes

Benefits excluded -
Limitation of benefits -

Broker conduct
Broker fees -
Incorrect Advice -

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Path to Universal Health Coverage

*“The usual reason given for not attempting to provide universal healthcare in a country is poverty.”
/Amartya Sen, Nobel Prize Laureate for Economics/*



Jose P. Santiago

Since time immemorial regardless of race, regardless of era, health has been a primary concern of human beings throughout history. Life expectancy that has kept on improving in the past centuries serves as a proof to this.

Governments from all over the world started its interventions on health care, first in Germany in 1883, with the Sickness Insurance Law. Employers were required to provide injury and illness insurance for their low-wage workers, and the system was funded and administered by employees and employers through “sick funds”, which were drawn from deductions in workers’ wages and from employers’ contributions. This was later followed by the United Kingdom, the National Insurance Act 1911 provided coverage for primary care (but not specialist or hospital care) for wage earners, covering about one third of the population. The Russian Empire established a similar system in 1912. In New Zealand, a universal health care system was

created in a series of steps, from 1939 to 1941.

Following World War II, universal health care systems began to be set up around the world. On July 5, 1948, the United Kingdom launched its universal National Health Service. Universal health care was next introduced in the Nordic countries of Sweden (1955), Iceland (1956), Norway (1956), Denmark (1961), and Finland (1964). Universal health insurance was then introduced in Asia in Japan (1961), and in Canada in 1962 to 1972.

As a result, life expectancy has kept on improving in the past decades. By 2025, as forecasted by the World Health Organization, it will reach 73 years and it claims that by then no country will have a life expectancy of less than 50 years.

- 1955: 48 years
- 1995: 65 years
- 2025: 73 years

In February 2019, Margaret Chan, WHO Director-General, described universal healthcare as a powerful tool to fight inequality.

According to the WHO, a lack of universal healthcare pushes 100 million people a year below the poverty line because of paying for the services they need, while countries such as the United States and China grapple with how to provide coverage to all their citizens. “Universal health coverage is one of the most powerful social equalizers among all policy options. It is the ultimate expression of fairness,” WHO’s Margaret Chan said.

The path to implementing Universal Health Care in the Philippines, having a high poverty incidence with 25% of Filipinos earning

\$5.21/day, is really tough. The 1987 Philippine Constitution mandates that “Health is a right of every Filipino citizen and the State is duty-bound to ensure that all Filipinos have equitable access to effective health care services”. But with a \$3,580 (2016) per capita income inclusively implementing the UHC makes it more challenging.

On February 20, 2019, President Duterte signed the UHC Act into law. The newly-signed law is groundbreaking as it replaces the previous universal healthcare policies into a definite, coherent government mandate. The Universal Health Care Act expands coverage from just hospitalization to preventive, promotive, curative, and rehabilitative healthcare services. The Act is commendable.

This Act is more inclusive because only 6 out of 10 Filipinos have any form of PhilHealth insurance. Based on the 2017 National Demographic and Health Survey and government data, a little more than half (54.5%) of all healthcare spending was financed by households’ out-of-pocket payments.

There are just some limitations in the implementation of the 2019 UHC Act. The delivery of such healthcare services is also severely constrained by the perennial shortage of health human resources.

Doctors and nurses and caregivers and other healthcare professionals continue to leave the country in droves (especially when vacancies suddenly crop up abroad), and without enough of them, service delivery will surely be compromised. Healthcare in the Philippines suffers from a dire shortage of human medical resources, especially doctors. This makes the system run slower and less efficiently. Only 30% of health professionals employed by the government address the

health needs of the majority. Healthcare in the Philippines suffers because the remaining 70% of health professionals work in the more expensive privately-run sectors.

In 2016, under the Duterte Administration, the Philippines hopes to adopt the Cuban health system but it needs to address the shortage of doctors. The present doctor-population ratio of 1:33,000 is a far cry from the 1:1,000 in Cuba, majority of whom are primary care physicians.

The Philippine Medical Association reported that there are 140,000 licensed physicians in the country, but only 80,000 are active in the profession. A good number have actually turned to nursing and work as nurses overseas. Only 2,300 doctors are produced annu-

ally. Only 30-40% passes the medical board exam every year. It is common to residents in far-flung villages of the Philippines never to have seen a doctor from birth to death.

Another hurdle is the shortfall on its budget. The 2019 General Appropriations Act allocated only P217B (\$4.14B) for the implementation of UHC. The Universal Health Care would require P257 billion this year. It has a deficit of P40B (\$765.40M). This would limit the intended inclusivity of the coverage of the 2019 UHC Act.

For many Filipinos, especially the poor, getting sick is not an option. Each hour spent in bed or in hospital is an hour not spent earning money for one's own family or oneself. Moreover, serious illnesses continue to

push more Filipinos to poverty. This merely affirms what the WHO said about Universal Health Care.

The challenge to implement the laudable Universal Health Care of 2019 is how to address its hurdles systemically. Government, the health care industry and the third sector should put their acts together to do this. This would be a giant stride toward improving the lives of the Filipinos in terms of health and wellbeing. This is also aligned with the vision that the Philippines will be among the healthiest peoples in the South-east Asia by the year 2022.

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The Astana Conference on Primary Health Care. Interview with Otmar Kloiber, Secretary General of the World Medical Association by WMJ Editor Peteris Apinis

Apinis: *Dr Kloiber, I would like to ask you some questions about the Alma-Ata and the Astana conferences on Primary Health Care. The former took place forty years ago in Alma-Ata, which at the time in 1978 was the capital of the Kazakh Soviet Socialist Republic. The latter conference took place last September in Astana, the new capital of the now sovereign country of Kazakhstan. At both conferences, significant declarations on primary health care, named after the cities in which the meetings took place, were adopted.*

At the time the first declaration, the Declaration of Alma-Ata, was adopted I was living in the Soviet Union and you in the Federal Republic of Germany. There was practically no exchange of information between our countries. In the Soviet Union this Declaration was recognised as the most important document on the subject globally.

What was the view of the Declaration in Germany?

Kloiber: To be truthful, I didn't hear about the Alma-Ata Declaration until I was active in organized medicine. The reception of this document in Germany was probably restricted to those who had a very specific interest in primary care or international health. I would not be able to say that the health community in general really took notice of it. In our defence: at that time Germany already had a pretty well-established, high level primary care system with fairly equitable access and high performance. Certainly not perfect, but pretty good on the global scale.

Apinis: *This Declaration largely established the principle that the point of entry into the health care system is the family doctor. In the Soviet Union they were called "precinct thera-*

pists". These specialists saw patients in large outpatient clinics called "polyclinics". These clinics were built in cities throughout the USSR. Other socialist countries and many developing countries followed this example. The reality of the Declaration was that buildings were erected, not that more family physicians were educated.

Kloiber: We as physicians would, of course, argue that each patient in primary care should be seen by a primary care physician, but not everybody interpreted the Alma-Ata Declaration in this way. As you said: some thought you could fulfil the pledge of primary care – and that was the essence of the Declaration – by constructing new buildings. Others thought bare-foot doctors would be enough and, especially at WHO, there was a move, at least by some, to see nurses as "primary care providers". They



Otmar Kloiber

thought that family physicians would be a kind of luxury add-on.

And yes, you are right: in many places the investment in educating and retaining physicians did not take place.

Apinis: *So, the Alma-Ata Declaration did not only bring about positive change, it had negative aspects too. Did the Declaration of Alma-Ata mean some poorer countries stopped educating specialists and sought only doctors with the lowest possible level of general medical education?*

Kloiber: Well there were reports from countries in Europe as well as in Africa that for some time after Alma-Ata the education of specialists was significantly reduced. In some places this was a decision taken by the governments themselves, in other places donors told the countries to focus on primary care physicians. At that time, this meant ending education after the basic medical degree.

Apinis: *The Declaration of Alma-Ata got very special attention from the leaders of socialistic Cuba. They started to train doctors in a very short space of time and export these barely trained people to countries in Africa and Latin America.*

Kloiber: There have been export programmes of Cuban doctors to African and Latin American countries with very questionable methods and success. One new programme started just last year in Kenya. We see these programmes very critically for various reasons. Most importantly: the Cuban doctors are not subjected to the same standards of checking of their qualifications and abilities as everybody else, secondly, they are not paid properly and the money that the host countries pay goes to the Cuban government. Finally, we have seen places where local physicians were pushed out of their jobs, only to be replaced by Cuban doctors.

Apinis: *Could you mention other examples where the Alma-Ata Declaration was translated inappropriately in practice?*

Kloiber: After Alma-Ata, donors discussed how to best fulfil the pledges of primary care. In the end, UNICEF decided to go for a very minimalist approach. The idea was to save as many as possible children with the funds they had. In my opinion, this did not really lead to a sustainable development. In many cases, I would be inclined to judge the development that followed as a deterioration. Primary care is not a minimalist concept. A good primary care structure should be at the core of a comprehensive health care system. There is no room for short cuts.

Apinis: *Did the Alma-Ata Declaration completely ignore the Social Determinants of Health? Although the theory of social determinants was not yet popular, medics already knew that health was affected by social conditions.*

Kloiber: No, I wouldn't say that the Alma-Ata Declaration ignored the Social Determinants of Health. The Declaration itself is not bad, it's only that politicians and donors did not live up to it. Although not expressed verbatim, there is a strong sense of the Social Determinants of Health in the document. What many governments and donors made out of the document was somehow

contrary to the intention: instead of building solid health care systems with quality primary care systems at their core, they took it as an excuse for minimalist approaches.

Apinis: *Did the Alma-Ata conference hinder global medical and health care development in the end? Did the financiers and politicians use the resulting Declaration as an excuse not to allocate enough funds to medicine and health-care?*

Kloiber: It is not a black and white picture. Some countries understood the value of primary care. In the following years, solid evidence was produced showing that proper primary care structures do significantly improve the efficiency of a health care system. Other countries, as I said, went the opposite way.

Apinis: *Did the Alma-Ata conference trigger the global migration of doctors and medical workers? In some poorer countries there are very few health professionals left because most of them have left for rich countries?*

Kloiber: The Alma-Ata conference and Declaration were certainly not the cause of the brain drain from poorer to richer countries. This migration existed before Alma-Ata. The World Medical Association addressed brain-drain in 1971 already, in a resolution which demanded that richer countries educate medical students from poorer countries, but then send them back to their home countries after receiving their degree. Germany, for instance, did this and sent young doctors back to their countries. After Alma-Ata, when donors started to use minimalist approaches, these young doctors wouldn't find any opportunities for post-graduate education in their home countries. Post-graduate education was no longer supported because primary care was enough. These young physicians finally left for other, richer countries, which were happy to hire them.

Not the Alma-Ata Declaration, but rather its misinterpretation aggravated the problem.



Apinis: *You took part in the Astana conference marking the 40th anniversary of the Alma-Ata conference. Was there a sense of celebration? Please describe the atmosphere at the Astana conference in a few words.*

Kloiber: Let me first pay a great compliment to the government of Kazakhstan and all the officials and volunteers who made this a truly celebratory event. But it was not just a big party: I had the impression from our colleagues at the WHO that they took a very serious approach to it. Ten years previously, the WHO carried out a critical analysis of the developments after Alma-Ata in the 2008 World Health Report “Primary Care – now more than ever”.

The fact is that the WHO cannot realize primary care itself, it is the role of the donors to do that: governments, the global financing mechanisms like the Global Fund, GAVI, UNICEF and private relief foundations, to name just a few.

Apinis: *WHO documents state that universal health coverage means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.*

Was the main discussion in Astana not around this – primary care as a step towards universal health coverage?

Kloiber: Yes, definitely. In contrast to the past, the WHO has brought primary care into the global picture of universal health coverage. Primary care is not an end in itself, not a cheap substitute for real health care. Primary care is an important investment in building a real and efficient health care system. Maybe the most important part, alongside action on the Social Determinants of Health. It should certainly be the first step, but it cannot be the last if universal health coverage is the aim.

Apinis: *Please tell me, how do you understand universal health coverage and the difference between how financiers and bankers understand it?*

Kloiber: I cannot tell you how bankers and financiers define universal health coverage (UHC). Personally, I go with the WHO definition. In brief, “UHC means that all individuals and communities receive the health services they need without suffering financial hardship.” If I may take off my physician hat for a moment and argue from an economic perspective, I would define investment in universal health coverage as an important investment into the most productive part of any service-based economy. In other words: in most service-based economies the health care sector is by far the biggest part: highest turn-over, most jobs, great return on investment.

Apinis: *Isn't it true that politicians, financiers and bankers would prefer a low-educated health worker who is able to measure blood pressure, detect blood sugar and cholesterol levels, and dress a wound, over a universal or specialised doctor educated for ten or more years at great expense?*

Kloiber: Do you know of any politician, financier or banker who would prefer to be treated by a community health worker instead of a physician? Those who think ahead, those who care for their people, will accept community health workers in their auxiliary roles, but only in their auxiliary roles. We may all sometimes have to accept second best solutions where physicians are not available, but in the end I hope everyone would agree that all people who need to be seen by a physician should be seen by a physician.

Apinis: *To what extent are global financial custodians and donors nowadays interested in replacing doctors with health workers, especially in poorer countries?*

Kloiber: Unfortunately, we are seeing the same tendencies as after Alma-Ata. Again,

there seems to be a strong appetite for quick fixes. There is not enough focus on sustainable development and long-term planning.

Apinis: *Will the lessons from the Astana conference not become a new incentive for doctors to migrate from poorer countries to wealthier ones?*

Kloiber: Again, like with the Alma-Ata Declaration, the Astana Declaration is not the problem. It is what we make out of it.

Apinis: *Could the Astana conference not become a reason for inequalities among doctors in terms of work and pay, even though it stated the exact opposite?*

Kloiber: There are leaders who believe medicine is a technical service, who believe a control and command approach is all they need. Well, as George Santayana said: “Those who cannot remember the past are condemned to repeat it.” This is such a case. If we don't learn to build good workplaces in health care and decent living conditions in poor countries, the drama will just continue.

Apinis: *What are the main ideas and actions of the World Medical Association for universal health coverage and the global development of primary health care? What new ideas is the WMA preparing for the WMA Conference on Universal Health Coverage in Tokyo this June?*

Kloiber: For us, the biggest insight of the last two decades has been that without taking action on the social and environmental determinants of health, anything else will only produce second rate results. To this extent I think we are in perfect sync with WHO: that universal health coverage is the number one priority in health systems policy. We will do what we can to convince people, politicians, economists and our colleagues to go with us on this.

Apinis: *Dr Kloiber, thank you very much for your time.*

Interview with Leonid Eidelman, President of the World Medical Association by WMJ Editor Peteris Apinis



Leonid Eidelman

Apinis: *Mr. Eidelman! Half of your presidency period has elapsed. Time goes by very fast. You have represented the WMA at various global conferences and events. What do you consider to be the most important part of your global activities?*

Eidelman: As President of the WMA, I stated that I would like to devote my tenure towards evaluating future challenges faced by physicians throughout the world as well as promoting preparedness. During the first half of my presidency, in order to represent the WMA and fulfil my mission, I took an active part in the following conferences and meetings: Global Conference on Primary Health Care (October 25-26, 2018) in Astana, Kazakhstan; Japan Medical Association Ceremony and Medical Congress, (November 1, 2018) in Tokyo, Japan; WHO GCM/NCD General Meeting (November 5, 2018) in Geneva, Switzerland; Unveiling Ceremony of the German Medical Profession Marking the Withdrawal of the Medical Licenses

of Jewish German Doctors (hosted by the National Association of Statutory Health Insurance Physicians) (November 8, 2018) in Berlin, Germany; CPME General Assembly (November 9-10, 2018) in Geneva, Switzerland; Swedish Medical Association Annual Meeting (November 21-22, 2018) in Stockholm, Sweden; UNESCO Chair in Bioethics 13th World Conference (November 27-29, 2018) in Jerusalem, Israel; Universal Health Care International Conference (December 1, 2018) Taipei, Taiwan; International Conclave on Zero Tolerance To Violence Against Doctors and Hospitals (February 8-9, 2019) in Mumbai, India; Meeting at the American Medical Association Headquarters (February 18-20, 2019) in Chicago, Illinois, and 12th Geneva Conference on Person-Centered Medicine, Promoting Wellbeing and Overcoming Burnout (March 25-27, 2019).

Apinis: *You participated at the conference in Astana (now Nursultan) which focused on the issues of primary care and universal coverage in order to provide medical treatment to every citizen of our planet. This WHO conference was dedicated to the 40th anniversary of the AlmaAta Declaration. When it was endorsed you were still in Riga – the WHO meeting was held in Riga in 1986 and was dedicated to the 10th anniversary of the AlmaAta declaration. What are your impressions of the Astana conference?*

Eidelman: The goal of the meeting was to renew a commitment to primary health care to achieve universal health coverage and the Sustainable Development Goals which is part of the UN agenda for 2030. The Conference was co-hosted by the Government of Kazakhstan, WHO and UNICEF. This was the second meeting on Primary Healthcare, the first one was held 40 years

prior in Almaty, Kazakhstan, during which the Declaration of Alma-Ata was endorsed.

Strengthening of primary health care (PHC) is essential for Universal Health Coverage (UHC) which is one the major theme of WMA, particularly promoted by Dr. Yokokura during his presidency the last year. The role of physicians is crucial in PHC from education to prevention and acute and chronic care. High quality, evidence-based PHC provided by a trained team led by a physician is probably the best foundation of future medicine. However during the meeting, it was noticeable that many participants didn't think the PHC model should have the physician at the helm of leadership. The conference focused on other health care providers, traditional (nurses, pharmacists and social workers) and new ones (community health workers and healthcare assistants).

Apinis: *Universal coverage is a global theme nowadays. You have already discussed this in Taiwan and we are looking forward to the Tokyo conference. In June, the World Medical Association (WMA) in Tokyo is hosting the conference HEALTH PROFESSIONAL MEETING (H20) 2019 – THE ROAD TO UNIVERSAL HEALTH COVERAGE. Could you comment on the evolving discussions on universal coverage in Taiwan and Tokyo and on the upcoming Tokyo conference?*

Eidelman: Yes, I attended the conference Universal Health Care International Conference in Taipei. The International Symposium on Universal Health Coverage featured an interesting array of panels including presentations on disease prevention, end-of-life care and quantity and quality of UHC. I had the opportunity to meet Dr. Shih-Chung Chen, Taiwan's

Minister of Health. Dr. David Barbe, Past President of the AMA, and I were on a joint panel moderated by Dr. Otmar Kloiber. Dr. Barbe presented on Ensuring Access to Healthcare in the United States and I presented on Medical Education in a Post-modern Era. We had fruitful discussions with Dr. Tai-Yuan Chiu, President of the Taiwan Medical Association, about how Taiwan achieved UHC in a relatively short period of time. Until approximately 20 years ago, Taiwan had limited health care accessibility.

In addition, I also participated at a very important event in Japan – the Japan Medical Association Ceremony and Medical Congress. The JMA is one of the most active members of the WMA. The meeting marking the JMA's 71st anniversary was attended by many international guests and stressed the involvement of JMA and support to NMAs in Asia and throughout the world. During the meeting UHC was a topic of discussion as well as the role of the JMA in the international healthcare arena.

I'm sure, that the Tokyo Health Professional meeting (H20) results will be ambitious and courageous. I hope that we (WMA) will be heard after the Tokyo meeting by politicians and financiers gathering at the G20 summit.

Apinis: *Aggression and violence against doctors and medical professionals grow in the world. A conference on the issue was held in Mumbai, India. What did you learn at this conference and what did you emphasize on violence against doctors as the WMA President?*

Eidelman: Violence against doctors has increased significantly in India. To this end, the Indian Medical Association and the World Medical Association came together on February 8-9 in Mumbai to discuss the issue of increasing violence against doctors. According to the IMA, nearly 72% of Indian doctors have suffered physical or verbal

abuse in their career. During his remarks, Dr. Otmar Kloiber gave an international perspective. The speakers described causes of violence and ways to withstand it; they urged all doctors to report all forms of violence, big or small.

I presented the statement of the WMA on violence against physicians and stressed that this kind of violence not only has destructive social effect but impairs a quality of healthcare that is provided to innocent patients as well. In addition, I emphasized a role of physician burnout in this intolerable phenomenon.

Apinis: *We know you as a person who has always been interested in the future of medicine, about the direction it will develop. Do you have enough time to work on this?*

Eidelman: On the subject – the future of medicine – I attended an event in Chicago that was very important and instructive – the Meeting at the American Medical Association Headquarters. This two-day meeting organized by Ms. Robin Menes focused on the future of medicine and trends. We discussed augmented intelligence, environmental intelligence, what physicians want to know about technology, healthcare economy and what is on the horizon. There were many discussions about the importance of NMAs learning from one another in order to ensure preparedness for the future.

Apinis: *In Tel Aviv you are currently preparing one of the most interesting conferences ever held by the World Medical Association PHYSICIAN 2030: THE FUTURE IS AROUND THE CORNER – BE PREPARED. Please could you tell me about the ideas and objectives of this conference?*

Eidelman: During the half year period, I allocated a great deal of time preparing the WMA and IMA "Physician 2030" meeting which will be held in Herzliya, Israel, May 13-15. The conference will serve as a plat-

form for discussions in multiple areas and dimensions of physician activity that is expected to be a subject of significant change in the near future and which require special preparations by physicians and the healthcare system.

World-renowned speakers: the Nobel prize winner Yisrael Aumann, Kira Radinsky from eBay, Daniel Kraft from the Singularity University along with representatives of NMAs from Africa, Europe, Asia, North and Latin America will address the issues of the validity of models and predictors in health system, healthcare models and medical workplace in 2030, patient-physician relationship, medical education-how it should be changed and technology- where it can take us.

I call upon NMAs to participate at this unique conference and contribute their knowledge, aspirations and experience in order to understand the future, which is just around the corner, and ultimately improve our preparedness.

Apinis: *One of the topics of modern medicine is the burnout in doctors. You discussed this issue and reported on it at the Geneva conference.*

Eidelman: This year the International College of Person-centered Medicine (ICPCM) convened the 12th Geneva Conference on Person-centered Medicine *Promoting Wellbeing and Overcoming Burnout* dedicated to physician burnout that is one of the most acute challenges of the contemporary medicine and endangers physicians as well as the quality of healthcare. Shortage of physicians that aggravates in most countries of the world will have a negative effect on physician wellbeing and the society at large. Much research has been conducted on the crisis of burnout, its causes and manifestations. Currently, there is a need for studying preventive and treatment solutions. The WMA statement on physician wellbeing was a part of my presentation. The ICPCM has decided to

organize meetings on physician burnout and wellbeing every year.

Apinis: *Each year you organise a global conference on medical ethics, and you are one of the keynote speakers. Please tell me about the conference in Jerusalem?*

Eidelman: Physicians and leading health professionals from around the globe attended the UNESCO Chair at the 13th World Conference on Bioethics in Jerusalem, Israel. I had the privilege of delivering remarks on behalf of the WMA.

There were over 100 parallel sessions with more than 1000 participants from over 70 countries including a sizable contingent of WMA members: Dr. Otmar Kloiber, Secretary General of the World Medical Association, Dr. Yokokura, President of the Japan Medical Association, Yuji Noto, international relations of the JMA, Dr. Selma Güngör, Board member of the Turkish Medical Association, Dr. Jacques de Haller,

outgoing president of the CPME (Standing Committee of European Doctors), Annabel Seebohm, Secretary General of the CPME, Sarada Das, Deputy Secretary General of the CPME, Thomas Hedmark, policy analyst at the Swedish Medical Association, Professor Ravi Wankhedkar, President of the Indian Medical Association, Dr. R.N. Tandon, honorary Secretary General of the Indian Medical Association, Professor Thomas Linden, Board member at the Swedish Medical Association and Jeppe Berggreen Høj from the Danish Medical Association.

Apinis: *Time goes by too fast. The best medical texts and documents become outdated not within decades, but by years. Don't you think about auditing, reviewing and updating any of the WMA declarations of vital role?*

Eidelman: The WMA declarations primarily focus on medical ethics and are revised every decade. Unlike the rapidly changing medical advancements, the issues, outlined

in the declarations, focus on existential rights and our moral obligations as physicians. These are long term and don't change with the same speed. Moreover, NMA's are invited to submit statements to the WMA annually concerning current medical dilemmas, technology and developments.

Apinis: *We are currently going to the WMA Council Session in Santiago, Chile. What are your priorities at this meeting? What documents do you consider to be the priority? What will we achieve with our discussions in Santiago?*

Eidelman: During the meeting there will be elections for new leadership including the Council chair and Treasurer, both key positions. I look forward to joining my colleagues in reviewing the plethora of statements and promoting the WMA mission to serve humanity by endeavouring to achieve the highest international standards in Medical Education, Medical Science, Medical Art and Medical Ethics, and Health Care for all people in the world.

Report of the President on Presidential Activities

October 2018 – April 2019

As president of the WMA, I stated that I would like to devote my tenure towards evaluating future challenges faced by physicians throughout the world as well as promoting preparedness. During the first half of my presidency, in order to represent the WMA and fulfil my mission, I took an active part in the following conferences and meetings.

Global Conference on Primary Health Care, October 25-26, 2018; Astana, Kazakhstan:

The goal of the meeting was to renew a commitment to primary health care to achieve universal health coverage and the

Sustainable Development Goals which is part of the UN's agenda for 2030. The Conference was co-hosted by the Government of Kazakhstan, WHO and UNICEF. This was the second meeting on Primary Healthcare, the first one was held 40 years prior in Almaty, Kazakhstan during which the Declaration of Alma-Ata was endorsed.

Strengthening of primary health care (PHC) is essential for Universal Health Coverage (UHC) which is one the major theme of WMA, particularly promoted by Dr. Yokokura during his presidency the last year. The role of physicians is crucial in PHC from education to prevention and acute and chronic care. High quality, evidence-based PHC provided by a trained team led by

a physician is probably the best foundation of future medicine. However during the meeting, it was noticeable that many participants didn't think the PHC model should have the physician at the helm of leadership. The conference focused on other health care providers, traditional (nurses, pharmacists and social workers) and new ones (community health workers and healthcare assistants).

Japan Medical Association Ceremony and Medical Congress, November 1, 2018; Tokyo, Japan

The JMA is one of the most active members of the WMA. The meeting marking

the JMA's 71st anniversary was attended by many international guests and stressed the involvement of JMA and support to NMAs in Asia and throughout the world. During the meeting UHC was a topic of discussion as well as the role of the JMA in the international healthcare arena.

WHO GCM/NCD General Meeting, November 5, 2018; Geneva, Switzerland

The General Meeting of the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (GCM/NCD) provided an opportunity to increase coordination of activities among participants which were comprised of NGOs, the UN and Governments. The prevalence of NCD is one of the leading challenges physicians currently face and can increase in the future. I had the privilege of participating in a plenary entitled "Collective leadership: Multisectoral engagement and policy coherence as key enablers of action to address NCD and their underlying determinants".

Unveiling Ceremony of the German Medical Profession Marking the Withdrawal of the Medical Licenses of Jewish German Doctors (hosted by the National Association of Statutory Health Insurance Physicians), November 8, 2018; Berlin, Germany

On November 8, 2018, the eve of Kristallnacht, the National Association of Statutory Health Insurance Physicians in Germany organized an unveiling ceremony marking the withdrawal of the medical licenses of Jewish German doctors 80 years ago.

My remarks concentrated on physician's moral responsibility and made mention of the WMA's Declaration of Geneva, recently updated due to the immense contribution

of the German Medical Association, which states that physicians must never use their medical knowledge to violate human rights and civil liberties, even under threat.

CPME General Assembly, November 9-10, 2018; Geneva, Switzerland

The Standing Committee of European Doctors (CPME) General Assembly and Working Groups meetings took place on November 9-10 2018, in Geneva. During the Assembly Prof. Dr Frank Ulrich Montgomery was elected president. There were an array of working groups focusing on diet, nutrition and physical activity, e-health, healthcare for refugees and undocumented migrants, pharmaceuticals and professional practice. One of the central themes of the conference was Healthcare in Danger. I delivered a presentation about Healthcare in Conflict Settings which featured key statements of the WMA and position papers developed by NMAs. I stressed the importance of the physician's professional obligation to the patient and the highest ethical standards.

Swedish Medical Association Annual Meeting, November 21-22, 2018; Stockholm, Sweden

The SMA designed a special program for international guests. One of the day's highlights was a meeting at the Swedish Agency for Health Technology Assessment. There was a fruitful discussion led by Sophie Verkö, the agency's president, on global solutions enabling the implementation of evidence into evidence-informed policies and practices within healthcare. At my stay in Stockholm, it was important to learn about how Swedish physicians tackle with language limitations and cultural differences while taking care of the large number of refugees during the last years. Dr. Heidi Stensmyren was re-elected president of the SMA.

UNESCO Chair in Bioethics 13th World Conference, November 27-29, 2018; Jerusalem, Israel

Physicians and leading health professionals from around the globe attended this conference. I had the privilege of delivering remarks on behalf of the WMA.

There were over 100 parallel sessions with more than 1000 participants from over 70 countries including a sizable contingency of WMA members: Dr. Otmar Kloiber, secretary-general of the World Medical Association, Dr. Yokokura, president of the Japan Medical Association, Yuji Noto, international relations of the JMA, Dr. Selma Güngör, board member of the Turkish Medical Association, Dr. Jacques de Haller, outgoing president of the CPME (The Standing Committee of European Doctors). Annabel Seebohm, secretary-general of the CPME, Sarada Das, deputy secretary-general of the CPME, Thomas Hedmark, policy analyst at the Swedish Medical Association, Professor Ravi Wankhedkar, President of the Indian Medical Association, Dr. R.N. Tandon, honorary secretary-general of the Indian Medical Association, Professor Thomas Linden, a board member at the Swedish Medical Association and Jeppe Berggreen Høj from the Danish Medical Association.

Universal Health Care International Conference, December 1, 2018; Taipei, Taiwan

The International Symposium on Universal Health Coverage featured an interesting array of panels including presentations on disease prevention, end-of-life care and quantity and quality of UHC. I had the opportunity to meet Dr. Shih-Chung Chen, Taiwan's health minister. Dr. David Barbe, the past-president of the AMA, and I were on a joint panel moderated by Dr. Otmar Kloiber. Dr. Barbe presented on Ensuring Access to Healthcare in the United States

and I presented on Medical Education in a Post-modern Era. We had fruitful discussions with Dr. Tai-Yuan Chiu, president of the Taiwan Medical Association, about how Taiwan achieved UHC in a relatively short period of time. Until approximately 20 years ago, Taiwan had limited health care accessibility.

International Conclave on Zero Tolerance To Violence Against Doctors and Hospitals, February 8-9, 2019; Mumbai, India

Violence against doctors has increased significantly in India. To this end, The Indian Medical Association and the World Medical Association came together to discuss the issue of increasing violence against doctors. According to the IMA, nearly 72% of Indian doctors have suffered physical or verbal abuse in their career. During his remarks, Dr. Otmar Kloiber gave an international perspective. The speakers described causes of violence and ways to withstand it, they urged all doctors to report all forms of violence, big or small.

I presented the statement of the WMA on violence against physicians and stressed that this kind of violence not only has destructive social effect but impairs a quality of healthcare that is provided to innocent patients as well. In addition, I emphasized a role of physician burnout in this intolerable phenomenon.

Meeting at the American Medical Association Headquarters, February 18-20, 2019; Chicago, Illinois

This two-day meeting organized by Ms. Robin Menes focused on the future of medicine and trends. We discussed augmented intelligence, environmental intelligence, what physicians want to know about technology, healthcare economy and what is on the horizon. There were many discussions about the importance of NMAs learning from one another in order to ensure preparedness for the future.

12th Geneva Conference on Person-Centred Medicine, Promoting Wellbeing and Overcoming Burnout, March 25-27, 2019

This year conference of The International College of Person-centred Medicine (ICPCM) was dedicated to physician burnout which is one of the most acute challenges of the contemporary medicine and endangers physicians as well as a quality of healthcare. Shortage of physicians that aggravates in most countries of the world will have a negative effect on physician wellbeing and the society at large. Much research has been conducted on the crisis of burnout, its causes and manifestations. Currently, there is a need for studying preventive and treatment solutions. The WMA statement on physician wellbeing was a part of my presentation. The ICPCM has decided to or-

ganize meetings on physician burnout and wellbeing every year.

During the reported half year period, I allocated a great deal of time preparing the WMA and IMA "Physician 2030" meeting which will be held in Herzliya, Israel, May 13-15. The conference will serve as a platform for discussions in multiple areas and dimensions of physicians' activity that is expected to be a subject of significant change in the near future and which require special preparations by physicians and the healthcare system.

World-renowned speakers: Nobel prize winner Israel Aumann, Kira Radinsky from Ebay, Daniel Kraft from the Singularity University along with representatives of NMAs from Africa, Europe, Asia, North and Latin America will address the issues of the validity of models and predictors in health system, healthcare models and medical workplace in 2030, patient-physician relationship, medical education-how it should be changed and technology- where it can take us.

I call upon NMAs to participate in this unique conference and contribute their knowledge, aspirations and experience in order to understand the future, which is just around the corner, and ultimately improve our preparedness.

Leonid Eidelman, President of the World Medical Association

Interview with Miguel Roberto Jorge President-Elect of the World Medical Association by WMJ Editor Peteris Apinis

Apinis: *Presidents of the World Medical Association represent countries of the entire world. ALL of them are highly qualified specialists in different fields. Xavier Deau is a family doctor, Sir Michael Marmot –*

a scientist in social determinants, Ketan Desai – urologist, Yoshitake Yokokura – a surgeon, Leonid Eidelman – an anesthesiologist. You are a psychiatrist. Perhaps it is time for the World Medical Association

to look at health care from a position of a psychiatrist.

Jorge: I am sure that the WMA does not take into consideration the speciality of its

members when electing them as officers of the Association, including for the position of President. But, considering the specialties of our Presidents and other officers in the last few years, it is possible to recognize the diversity represented in the WMA Executive Committee. This adds value to the business conduct by the Association and – in times when mental health problems increase significantly in all regions of the world and are very frequent among patients in primary care services – I believe that being a psychiatrist allows me to emphasize the need of general physicians to attend carefully to their patients' overall needs.

Apinis: *You have worked for global psychiatrist organizations, such as the World Federation of Mental Health, the World Psychiatric Association, you have been a member of the World Health Organization Panel of Experts on Psychiatry, Mental Health and Substance Abuse. You have a great knowledge and experience. What's going on in mental health globally?*

Jorge: There are many different aspects to be considered but, briefly, we can say that the most important problems related to mental health identified in different regions of the world involve a high prevalence of mental disorders (around 30% of people experience a mental disorder during their lives). Mental disorders are a major contributor to people's disability (around 22% of total disabilities are due to mental disorders). There is an important treatment gap (more than 50% of people with mental disorders do not receive treatment). Moreover, child and adolescent mental health problems are not considered enough by health care systems, and the flourishing urbanization (now around 54% of the world population lives in towns) is a risk factor for a considerable part of population to develop mental health problems.

Apinis: *The world's population is ageing. Isn't the main psychiatric problem the increasing*

age related dementia? What is your vision of the role, opportunities and development of psychiatry in a situation where 20% of the world population will be old people with different age-related brain problems?

Jorge: The epidemiological transition in the world population started some time ago and, with the growing increase of the representation of older people, it affects the health sector. Cognitive impairment and even dementia is just one of the problems that physicians face when treating patients. In the mental area, depression in the elderly is also an important issue to be taken into consideration. And, in general, comorbid diseases and over medication are serious problems sometimes neglected in everyday practice.

Apinis: *More than half of the people affected by mental health burden have common mental disorders such as major depression, generalized anxiety disorder, and substance use disorders. These patients are not well cared for in general. Is it possible to treat these patients only by a psychiatrist alone? Primary care professionals are involved in this process, too. Psychiatry is not a priority of big specialized hospitals only. Could you comment on global transformations in psychiatry? How does the integration of Common Mental Disorders treatment take place in primary care?*

Jorge: We do not have enough psychiatrists to treat people with a mental illness. And there are many mental illnesses that can be treated by general practitioners, family doctors and other medical specialists. I believe it is not the nature of the mental illness, but mainly its severity that requires specialized care. The most common mental illnesses are depression and anxiety disorders and usually non-psychiatrists can efficiently manage most of them if they are aware of mental health problems and have received appropriate training. Unfortunately, mental health is not yet given enough attention in medical school curricula and physicians who are specialists in a particular area of



Miguel Roberto Jorge

medicine usually do not pay any or enough attention to other health areas of their patients.

Apinis: *Could you comment on stigmatization in psychiatry? In my opinion, in the whole world stigma is attached not only to sick patients, but also to psychiatry in general. Adverse effects of medical treatment are caused by a low level of knowledge regarding mental illnesses and prejudice and discrimination against people with a mental illness.*

Jorge: Stigma and discrimination against patients with mental illnesses is just "the tip of the iceberg". There are lots of evidence that stigma also reaches patient families, psychiatrists, psychiatric services (particularly hospitals), psychiatric treatments (e.g., use of psychiatric medication, electroconvulsive therapy), some particular mental illnesses (e.g., drug dependence, schizophrenia) and even the occurrence of self stigma. The result is that people suffering from a mental illness are double penalized – by the illness itself and by the stigma against them. Early diagnosis and intervention is of importance to improve response and prognosis, but stigma is an important factor of long delays in seeking for mental health care.

Apinis: *Prevention of mental diseases is a global challenge. Is it important to develop Prevention of Child Mental Health as part of Mental Disorders globally? It seems there is a great stigmatisation in this area. What do you think about the necessity to review WMA documents to draw doctors' attention to the prevention of mental diseases, especially to mental disorders in children?*

Jorge: Prevention of mental disorders and child and adolescent mental health are two priorities of today. Some of the problems identified in the mental health arena for adults are even greater when considering the situation among children and adolescents. Research has shown that experiences build brain architecture and toxic stress derails healthy development. Mental health problems affect 10 to 20% of children and adolescents worldwide and there is a need to propose well developed strategies to take care of our future adults.

Apinis: *As WMA President you agreed to promote solving the needs of each physician and the world's most vulnerable people, to represent a strong voice of physicians from low and middle income countries. Could you describe what's going on in psychiatry and health care in general in the countries of Latin America and the Caribbean Region?*

Jorge: There are many studies showing that the prevalence rates of mental disorders are even higher in low and middle income countries such as those located in Latin America and the Caribbean. Besides facing greater prevalence, access to care is more difficult and there is a scarcity of mental health services and professionals, in addition to their uneven distribution. The work conditions of physicians represent a challenge for provid-

ing sometimes minimal care and, moreover, a good quality medical care. In those countries, there are isles of excellence in terms of the care provided to those who can pay by themselves for good medical services. This situation is not the same found in high income countries but even there it is possible to observe differences in services provided to people in better or worse socio-economic conditions.

Apinis: *You come from São Paulo, a city where eight times more people than in my country live. Is overpopulation, the overcrowding in cities a reason for increasing mental health problems, too? What do you think about mental health problems in the world's megalopolis?*

Jorge: There are data from the United Nations informing that the world had 28 megacities (those with more than 10 million inhabitants) in 2015. Many other studies show that mental health problems are more common in urban than in rural areas, and there are many factors related to urbanism that contribute to the difference. One of the most important ones is trauma experienced particularly through different forms of violence when associated with significant social inequalities and being part of a minority group. Other factors that deserve to be mentioned are a competitive environment and individual loneliness.

Apinis: *There is mass migration in the world. Travelling from one country to another, from one continent to another usually causes overcrowding, stress, depression, ignorance. What is your view on how to take care of mental health issues among refugees and migrants? But is it a problem at all, maybe it is a myth created in social networks?*

There are some aspects related to be a refugee and/or a migrant that can be a risk factor to develop mental illnesses such as to be part of a minority group, to live in a diverse cultural environment, to be deprived of basic human needs (decent housing, food, work, health care access) and to suffer stigma and discrimination among other factors. So, refugees and/or migrants are considered a particularly vulnerable population to develop mental illnesses and unfortunately this is a reality in our world of fake news. No myth concerning this fact.

Apinis: *I promised to ask you not more than ten questions. I know you're not only a psychiatrist, but also a psychotherapist. In which direction does the world go: psychotherapy or medical treatment?*

Jorge: As my training as a medical student and a psychiatrist was mostly between 1975 and 1986 in Brazil, at that time it was not conceivable to separate those approaches. Our patients, with a mental illness or any other illnesses, need to be treated by physicians that take into consideration the biologic nature of their illnesses, their personality characteristics and emotional impact of the illness they present, and also their family and social environment. We know that all those aspects are of importance in planning, discussing different alternatives and adopting treatments. Without an excellent doctor-patient/family relationship no treatment will work well enough. And I do not think that be a medical doctor is just a matter of prescribing a medication even when for some particular illness the medication will be crucial to the desired outcome. That is the way I work in my private practice and what I will emphasize during my presidency term.

Interview with Ardis D. Hoven WMA Chairperson of Council American Medical Association by WMJ Editor Peteris Apinis



Ardis D. Hoven

Apinis: You have chaired the WMA Council since 2015 and were the most influential doctor in our global organization. You were named one of Top 25 Women in Healthcare of the World, in addition to its list of the 100 Most Influential People in Healthcare, and its 50 Most Influential Physician Executives and Leaders. Whatever you do, it is accompanied with smile and optimism. What makes you so positive?

Hoven: I have had the opportunity over many years to work with a variety of organizations and in doing so, I recognized the value of a team and collaborative efforts. As a leader when you recognize that seated around the table are your partners and colleagues, it makes being positive and supportive so much easier. Building trust and sharing values are equally important.

Apinis: In your time, the Council meetings and the General Assembly have been held in Oslo (Norway), Moscow (Russia), Buenos

Aires (Argentina), Taipei (Taiwan), Livingstone (Zambia), Chicago (USA), Riga (Latvia), Reykjavik (Iceland). Very different cities, different countries, different continents. Are the WMA statements, settings and policies affected by the continent and country we come together?

Hoven: Perhaps by a small amount, but overall I would say that they represent all who attend and are seated at the table. It is the job of leadership to make sure that all voices are heard, and that the minority opinion is recognized and valued.

Apinis: Under your leadership, the Council meetings and the General Assemblies became shorter and more specific. The discussions were more geared to working groups and commissions. Consequently, at major events, people worked quickly and constructively. Is that at the basis of your leadership?

Hoven: I have tried throughout my years in leadership to learn from mentors and understanding “best practices”. Small groups are definitely better than large ones when attempting to come to consensus and determining a policy or statement for debate.

Apinis: The leaders of the national medical associations are leaders because they are ambitious, charismatic and energetic. At the WMA Council meetings, the global leaders sit friendly and in good humor at the table. How did you make a team out of these brilliant leaders? Isn't it the way the conductor runs an all-star orchestra?

Hoven: Doing our work well at the Council meetings and those of the General Assembly, requires all at the table to know that what they say is important and respected. No one's voice should be diminished. I think because of this, individuals feel more com-

fortable. By the way, a bit of humour goes a long way in easing any tensions that might develop around the table.

Apinis: Is it true that the chairperson of the WMA Council has a key job on the phone or at Internet conferences because all Board members need to reconcile the nuances in documents and strategies? How many hours a day did you have to talk to world medical leaders?

Hoven: Yes, the role of Chair of Council requires making important phone calls and communicating on a regular basis with the members of the Executive Committee and any other groups as needed. I honestly have not kept track of the time spent.

Apinis: The main issues of the Council are nevertheless dealt with by the Committees. Could you describe the leaders and performance of the Medical Ethics Committee, Finance and Planning Committee, Socio-Medical Affairs Committee?

Hoven: (I am not quite sure about this question). During my tenure as Chair, I have been very fortunate to have had elected chairs of the committees who are committed to high quality work, strong leadership skills, and the willingness to work on behalf of WMA. As we have seen during recent sessions, when the work of the Committee is done well, it makes the work of the Council so much easier and efficient.

Apinis: What are the main WMA documents adopted under your leadership, and of which are you proud to have adopted?

Hoven: I am going to have to go back and review a lot of materials on this one. Several Declarations in particular come to mind. I will need to get back to you on this.

Apinis: *During these four years you had to work with six WMA presidents: Xavier Deau (France), Sir Michael Marmot (UK), Ketan Desai (India), Yoshitake Yokokura (Japan), Leonid Eidelman (Israel), Miguel R. Jorge (Brasil). They all are great doctors. Could you describe each of them and their contribution to the world community of doctors?*

Hoven: All of these gentlemen, during their years of service have represented the WMA well. Although they may have different styles of leadership, each one was able to project their ideas and concerns graciously and knowledgeably to those listening to them. I learned that they each have a special side to them be it a sense of humour, gentleness, charisma, or a passion in life and health care that brought them to the WMA.

Apinis: *Opportunities to familiarise themselves with culture, medicine and nature of different countries of the world, tours and parties play an important role in all General Assemblies, Council meetings and conferences. What do you remember most about our events?*

Hoven: The opportunity to travel around the world, and see amazing sites along with having the opportunity to experience new cultures, environments, and food has been extraordinary. Perhaps what I have learned the most, is that no matter where I have travelled, the people of that country have been wonderful and kind. Each country has demonstrated great pride and we all have been the recipients of graciousness and kindness. I particularly am fond of learning more about the culture and art of a country

and in my travels, I have learned a great deal. It has been an extraordinary experience.

Apinis: *The achievements and success of WMA are also based on the precise and qualitative work of the Secretary General and the Secretariat. Could you comment on the role of the Secretariat and your cooperation with the Secretariat?*

Hoven: Words cannot adequately express my appreciation to Dr. Kloiber and the Secretariat for all that they have accomplished over the past four years. Guidance, encouragement and education have always been plentiful and so valued. The WMA is very fortunate to have individuals so committed to the work of the WMA and working diligently to make all of us look good!

Interview with Frank Ulrich Montgomery Vice-Chairperson of Council of WMA by WMJ Editor Peteris Apinis



Frank Ulrich Montgomery

Apinis: *Elections to the European Parliament are approaching. The new Parliament will face serious challenges in different areas, and we are interested in issues related to public health, a*

healthy environment, social determinants and medicine, particularly in universal coverage and access to medicine. How will CPME try to ensure that these issues are always on the agenda of the European Union?

Montgomery: Health in all policies is a fundamental demand of CPME in the work of the European Commission, the EU Parliament and the Council of Member States. We hope that the next Commission will be more interested in the wellbeing of citizens and good health than in industry and commerce and we will constantly remind the three large players of European politics of their obligations and responsibilities in these subjects.

Apinis: *There is a lack of clarity in Europe on the relationship between the United Kingdom and the European Union after Brexit. Could you comment on what the European Union expects with restricting doctor mobility and, to*

a large extent, narrowing of cooperation? Are there opportunities to minimise Brexit's negative impact on the health of European patients and the work of medical professionals? Will CPME make concrete proposals to the European Parliament on post-Brexit medical development, including receiving of cross-border medical services on the island of Ireland?

Montgomery: "British medicine is European medicine" – This is the core message of CPME on Brexit. At present nobody knows what the exact results of Brexit will be but it certainly demands changes in legislation on both sides of the Channel. It is obvious that we are fighting for maintaining free mobility of health care professionals. But there is more to Brexit: Shortages of drugs both in mainland Europe and the UK can be foreseen, liability questions arise when licenses from the UK are no longer valid in Europe. All this has to be dealt with and CPME is prepared to take over responsibilities.

Apinis: *How could CPME at European level influence vaccination attitudes, increase vaccine coverage, strengthen immunisation programmes while reducing unnecessary antibiotic use in Europe and active action against antimicrobial resistance?*

Montgomery: Vaccination needs information and awareness. It is sad that not only the public but even European legislators are badly informed on the values of vaccinations. And AMR is another subject where information is pivotal. Not only do we talk to the other health care professions but we also accompany campaigns by the G7-States and the EU.

Apinis: *How can we increase the safety of European patient data while allowing these data to be used for medical science and pharmaceutical development? What perspective do you see in introducing personalized medicine that relies heavily on patient genome data and large amounts of data processing?*

Montgomery: Though difficult to handle on an individual level, the General Data Protection Regulation (GDPR) guarantees a high level of data-security. In the context of co-creation of health, personalized medicine relies on the information and consent of patients and data processing must not end up in “data mining”. CPME and its Executive Council closely cover the development in the European arena and keep close watch not only on legislators but also on member states – in the best interest of patients and physicians.

Apinis: *Globally, the main issue of the planet's future existence is climate control. The European Parliament has done much to make Europe*

significantly reduce greenhouse gas emissions. We hope and believe that the next European Parliament will be even more active in this area. However, the turnout of Parliament is influenced by stakeholders and in the field of controlling and reducing climate change doctors' opinion has a very large role to play. What will the CPME policy be, in cooperation with the new EU leadership and Commissions, specifically in the field of climate control?

Montgomery: Climate control is an obligation of all citizens – not of physicians and their organizations alone. Within this range CPME takes part in international activities to reduce greenhouse gases and enhance climate control.

Apinis: *What are the main CPME priorities concerning prevention? Can we achieve that the provision that is already in force in some European countries is incorporated in EU legislation, namely that use of tobacco products in the presence of children is violence against children? And the fact that non-smokers have a right to clean air and that right is always a priority over a smoker's right to smoke close to others?*

Montgomery: CPME stands for a strong anti-smoking policy. We need a strict ban on tobacco advertisements and we fight for protection of children. It is absurd that in some countries the taxes levied on tobacco and alcohol by far exceed the investments in prevention.

Apinis: *How can we affect the European Union to promote healthy living across Europe, reduce alcohol consumption, take care of healthy diets and increase sporting activities for every European citizen?*

Montgomery: Alcohol and food labelling are important aspects of providing information to citizens. But the “health in all policies” strategy entails more than that. Healthy living has to become part of all industrial relations, of city planning and the development of industry.

Apinis: *Education of future physicians is an important topic for Europe. The Professional Qualifications Directive (PQR) was a milestone on the implementation of a common training regime in Europe. What is the CPME position on the PQR?*

Montgomery: CPME has always been heavily involved in all issues of basic professional training and specialization of physicians. We are deeply concerned about the introduction of new training schemes by private institutions that have a clear financial interest. Medical training courses on an IT basis are an important tool to achieve basic knowledge but a medical training course has to contain large quantities of practical training. It has to be on a scientific basis delivered by a university and it has to contain at least 5500 training hours in five years to comply with the PQR.

Apinis: *Everyone talks of digitization. What is the CPME position?*

Montgomery: Digitization of medicine is one of the most important topics of the future. But it must be seen as a tool to assist physicians and patients in the co-creation process of health. We not only have to defend the rights of patients but also of physicians to data security and we have to fight data corruption. But we must also be open to new technologies that are designed to help us!

European Doctors Towards the European Elections 2019



Miriam Beatrice Vita D'Ambrosio

The Standing Committee of European Doctors (CPME) has launched its *Health Check 2019* ahead of the upcoming European elections. The European doctors call on EU decision-makers to: put health high on the EU agenda, support skilled doctors and safe conditions, enable healthy living, invest in health security, foster trust in the sharing of health data and guarantee access to medicines.

Future of Health

The *CPME Health Check 2019* puts emphasis on the future of health. Although the need to respect budgetary restraints is recognised, it is equally important to as-

sess the impact that any budgetary plan may have upon health policy. Health is an essential element of the European social model and contributes to social cohesion, inclusive growth and nurtures a sound economic environment which is a prerequisite for investment.

The future newly-elected European Parliament and European Commission will have the power to make concrete contributions to the creation of a healthier European Union and to keep health policy on the EU agenda. Therefore, CPME considers it essential that the political groups within the European Parliament, national representatives in EU Member States and the new Commission commit to health priority on their working agenda.

Skilled doctors, safe conditions

Ensuring the best possible conditions for doctors' education and professional practice remains a priority of CPME. Therefore, the European medical community asks that safe and attractive working conditions for doctors be ensured across Europe, even more so with Brexit changing the paradigm of medical migration and education and training. Brexit will bring many changes within the EU membership and within EU institutions. For the European medical profession, the impact of Brexit on mobility is a great concern. Doctor mobility in fact takes many forms: students cross borders

to attend medical schools in other Member States, junior doctors seek specialist training in another country, and professionals take the chance to develop their capacities by accepting posts abroad, be it temporary or long-term. European doctors will therefore continue to advocate for a solution that safeguards quality of care and a continued knowledge transfer in the profession throughout Europe.

Invest in health security

The health status of the population faces challenges which cannot be contained without coordinated and systematic action, often within a very short timeframe. This is the case for the spread of antimicrobial resistance (AMR) and vaccine hesitancy. Therefore, European doctors ask for constant efforts to tackle AMR and to increase vaccination coverage. Resistance to antibiotics is progressing at a rapid pace and old, vaccine-preventable diseases are reappearing. Since these threats may cross national borders, collaboration between Member States and allocation of resources at European level to raise awareness are crucial. Policies must strengthen doctors and other health professionals in playing an active role in the fight against AMR and vaccine hesitancy.

CPME thanks you for your support of the *Health Check 2019* and the work of CPME towards a safer and better Europe for all its citizens.

Miriam Beatrice Vita D'Ambrosio
Communication and Project Officer
Standing Committee of European Doctors

10 Questions for SEEMF's President, prof. Andrey Kehayov, MD



Andrey Kehayov

Apinis: In 2019 the Southeast European Medical Forum (SEEMF) organizes its Tenth Anniversary International Medical Congress. SEEMF's congresses take place in different Eastern European countries every year. This year, the Congress will take place in Sofia, Bulgaria. What are the main goals of the events? What are the main topics of this year's Congress?

Kehayov: The main objectives of SEEMF are to promote partnership between the medical associations of the member countries; to discuss common problems in the healthcare systems in the southeastern part of the European continent; to exchange experience in and develop common approaches towards all fields and activities of the medical organizations; to promote continuous medical education; to assist its members in improving their medical and managerial qualifications and skills; to establish contacts and partnership with other international medical organizations. The scientific program of the Tenth Anniversary Medical Congress of SEEMF is

comprised of variety of topics and will host the attendance of leading lecturers, prominent representatives of medical academia with recognized academic and practical competence.

- Aging of the population;
- Cardiovascular diseases and cardiovascular surgery. Transplantations;
- Gastroenterology. Transplantations;
- Neurology, neurosurgery and psychiatry;
- Nephrology and urology. Transplantations;
- Sexual medicine and reproductive health;
- Orthopedics and traumatology. Calamity medicine;
- Pharmacotherapy;
- VARLA.

We hope that during the round table discussion on the topic "Challenges in the Healthcare Systems- 21st Century. Values and Principles" participants will have the chance to share their views on and aspires towards the present and the future of the global healthcare. The Congress has already received the support of the Bulgarian authorities and the World Medical Association. The President of WMA- Dr. Leonid Eidelman has already confirmed his participation. As usual, the Congress will apply for European Accreditation Council for Continuous Medical Education (EACCME) accreditation. The social program of the event will be comprised of several tours- one around Sofia- the capital of Bulgaria; to the Rila Monastery- a historic Christian monument and a visit to the Cultural Capital of Europe for 2019 – Plovdiv, the city with a thousand year old history. I would like to use the opportunity to appeal to all the members of the WMA and the readers of the World Medicine Journal and cordially invite all of you to attend the 10th Anniversary Inter-

national Medical Congress of the SEEMF. All information about the event – registration and hotel accommodation is available on the website of the organization: www.seemfcongress.com.

Apinis: At present, 18 countries (20 medical organizations) are members of SEEMF's society – Albania, Azerbaijan, Belarus, Bosnia and Herzegovina, the Medical Associations of Bosnia and Herzegovina and Republika Srpska, Bulgaria, the Czech Republic, Georgia, Greece, Kazakhstan, Russia, Northern Macedonia and Montenegro, Slovenia, Ukraine, Uzbekistan, Serbia, Moldova, Croatia, the European Medical Student Organization. Does SEEMF continue to extend? Do you think that doctors from other countries will join your organization?

Kehayov: Southeast European Medical Forum (SEEMF) was found in 2005 by the medical organizations of 4 Balkan countries – Albania, Bulgaria, Greece and the Republic of Northern Macedonia as an association of doctors' organizations from Southeastern Europe- neighbouring countries with similar problems. Today, SEEMF is one of the rapidly developing organizations that unites 20 medical associations. Last year, during the Board Meeting held amidst the Ninth International Medical Congress of SEEMF, we approved the applications for membership from Russia, Croatia and Montenegro- our newest member countries. As you can see every year, the membership base of the organization is enriched with new medical experience in the face of its new members. From 4 founders of the organization, we became 20. SEEMF is expanding naturally as a result of its mission and causes, which are also part of the causes and missions of the world medical organizations.

Apinis: Throughout the years, SEEMF's Congresses have been held in countries with politically unstable situations, an example of which is the Congress in Odessa, Ukraine, at a time when the military conflict in East Ukraine



took place. Does SEEMF thus show a political standing?

Kehayov: SEEMF is an independent organization of physicians and is not under any political ward. Our congresses are interdisciplinary events. We are not only interested in scientific and practical achievements in medicine, but also in the organizational structures of the healthcare systems of our members. We outline the real labour market; the problems of financial and human resources and aim to provide guidance for rational solutions. Before the institutions that are involved in shaping the health policies and before the society, we form our unequivocal and prominent physicians' position in order to find the adequate balance to change the system. These are the real challenges of the time we live in. Through brainstorming together, we raise our experts' and specialists' platforms and display them before the various national and international institutions.

Apinis: *The Board meetings of SEEMF are often held on The Island of Kos, Greece, where Hippocrates was born. Does this historical reference serve the philosophy of your organization?*

Kehayov: In accordance with SEEMF's Statute, SEEMF organizes at least two board meetings annually. The board consists of 30 individuals, most of whom are heads of the medical associations of the member states and prominent representatives of the medical and academic society. The Board meetings are held in different countries, and this year for a second time we have decided to hold our meeting in Kos, Greece – The homeland of the "Father" of modern medicine – Hippocrates. The mission of SEEMF, as an organization of physicians from different countries, is to transform moral-ethical behaviour and norms that distinguish the medical profession from all other professions as a leading one. Parallel to the Board meeting, we have organized an event with the title "International Confer-

ence on Medical Ethics and Moral. Oath of Hippocrates – Symbol of Medicine". Well-known lecturers will present various moral and ethical models, practices and standards in medicine.

Apinis: *Most of the countries, represented in SEEMF, are former post-soviet or post-socialist states. Is it not the debate in your Congress on the transition from socialistic medicine to European medicine?*

Kehayov: The discussions that participants in SEEMF's congresses hold are mainly related to the socially significant diseases and their prevention. However, the primary mission of the doctors and the medical specialists is to take care of the health of their patients and it has nothing in common with the country we come from or live in. SEEMF's congresses are multidisciplinary universities and one of our main goals is to improve participants' knowledge and professional qualifications with the latest theoretical and practical achievements of the global medicine. Implementing the established European and global medical standards and practices with a focus on what quality medical care really is, we endeavour towards the improvement of the healthcare systems in the countries of the region.

Apinis: *A regular topic during SEEMF's Congresses is the one about the migration of doctors and medical professionals. Doctors tend to go work in richer European countries and for better wages.*

Kehayov: The Migration of the medical professionals in the European region has been observed since the 1940s. After the accession of Bulgaria to the EU, the most active amongst the "migrants" became the medical specialists with qualifications and diplomas that are recognised by member states of the EU. We witness a trend of general migration – Bulgarian doctors migrate, but specialists from other countries come to Bulgaria. This process is two-sided.

Apinis: *Medical tourism plays an increasingly important role in Eastern Europe. To what extent are Bulgaria and the Balkan countries updating medical tourism?*

Kehayov: Due to its enormous natural resources Bulgaria has posed a serious request to become one of the biggest health centers in Europe. Using its endowments and intellectual resources, as well as the hundreds of mineral water springs, healing climate, organic farming and services promoting a healthy lifestyle; cultural, wine, seaside and mountain tourism Bulgaria is turning into a competitive destination for a quality tourism. Bulgaria ranks first in Europe according to the availability and diversity of mineral water and spa resorts. The Ministry of Tourism in Bulgaria encourages development of medical and health tourism and provides legislative changes to adapt it in accordance with the European standards and European market requirements through implementation of innovative practices and quality improving strategies.

Apinis: *SEEMF is a WMA associate member. How would you describe the collaboration with WMA?*

Kehayov: The World Medical Association is a constant supporter of the activities and the missions of SEEMF. SEEMF shares strongly WMA's goals, values and standards. As President of SEEMF, I have the honour and pleasure to participate in the annual meetings of WMA- the General Assemblies and Council Sessions. Many of the declarations and suggestions proposed by our organization on different issues, an example of which are the ones on climate change and reduction of emissions in the Mediterranean Sea, were accepted by the WMA and noted by the World Medical Journal. What greater recognition than the participation of several WMA's Presidents in the Congresses of SEEMF? I would like to use the opportunity to thank Dr. Otmar Kloiber – WMA

Secretary General for his incredible moral support and acknowledgment of SEEMF throughout all the years.

Apinis: *The next WMA General Assembly will take place in one of SEEMF's member countries—Georgia. You organised one of SEEMF's congresses in Georgia with the aim of investigating the extent to which Georgia is prepared for very large medical congresses and events. What is your impression of the Georgian hospitality?*

Kehayov: In 2016, in cooperation with the Georgian Medical Association we conducted the Seventh International Medical Congress of SEEMF in Batumi, Georgia. Georgia acquitted our expectations! The President of the Georgian Medical Association – Prof. Gia Lobzhanidze, professor in surgery at the University of Tbilisi – is also one of the Vice President of SEEMF. Thanks to his exceptional personal and organizational potential and with the active support of the members of the Georgian Medical Association, SEEMF's Congress in Georgia was a significant event with participants from 20 countries. Georgia proved to Europe and the World its scientific, medical

potential and incredible skills in conducting large-scale international events. The generous Georgian hospitality combined with the mixture of ancient cultural monuments and wonderful nature turned the Congress days into an impressive collection of shared practices, thoughts and friendship.

Apinis: *One of the subjects you teach as a professor in a medical university in Bulgaria is ethics. What are the challenges of medical ethics in Bulgaria?*

Kehayov: I am an Associated Professor in the Medical University of Sofia, faculty of Public health, "Health policy and management Department". As a former President of the Bulgarian Medical Association (2009-2012), and as a member of the ethical Commission and university professor, I worked and continue to work in the field of medical ethics and moral. If we look at the vision of ethics in public health, in our country we witness the same problems that effect the ethical values in most countries, namely: with reference to availability, fairness, timeliness and quality of healthcare. If we take a look in particular at the challenges facing medical and clinical ethics,

I believe that the informed consent is essential. The form, which the patients sign expresses their "consent" only. In practice, the process of communication that leads to an informed consent, is missing, or is too limited. The Autonomous model predicts that the patient receives full and accessible information about his disease, diagnostic and therapeutic activities, as well as the prognosis of his illness. This is not necessarily the case in every situation, but is possible. However, patients are increasingly informed and empowered, seeking their rights, and the physicians' responsibility is to recognize the necessity of the informed consent, which is a legitimate mode to protect not only the patient, but the physician as well. Otherwise, we witness tension and growing distrust towards the profession. The problems of patients with disabilities who need additional care and more attention have also become widely known. Of course, the issues of confidentiality are also relevant; assisted reproduction- especially against the background of the demographic crisis in which our country currently is; donation and transplantation; clinical trials and medical tourism; ethical issues related to death, including assisted suicide.

Georgian Medical Association Turns 30 years old

The General Assembly (GA) will be held in Tbilisi, Georgia, in October 2019. This is one of the most strikingly original cities in the world, founded in the 5th century by King Vakhtang I Gorgasali.

A legend tells us that once the King hunted in the forests near Mtskheta, the first capital of Georgia. After some time, he saw a pheasant, shot and killed the bird. The King sent his falcon to find the prey. The falcon flew away, and after a while, the king lost sight of him. In search of the birds, Vakhtang Gor-

gasali with his hunters came upon a spring and saw that both the falcon and the pheasant had got into its waters which turned out to be hot. Amazed by this find Vakhtang I decided to found there a city realizing the great advantages of the location. In addition to the hot spring, the location had many important other factors for building a city: a protected position between the mountains, location on a trade route, strategically favorable factors. Thus, according to the legend, the city of Tbilisi was founded. The word "tbili" translated from Georgian means "warm".



Gia Lobzhanidze



Historically, Tbilisi has been home to people of multiple cultural, ethnic, and religious backgrounds, though currently it is overwhelmingly an Eastern Orthodox Christian country. Georgia is the educational and transportation hub for the Caucasus region. It has a unique cultural national heritage: songs, dances, foods and wine. Wine has been produced in the country over 8000 years. Georgia's traditional winemaking method of fermenting grapes in earthenware, egg-shaped vessels "Qvevri" has been added to the UNESCO World Heritage list.

For Georgians "the guest is a gift from god".

Georgia is an enjoyable and spectacular country. It is a country where many hospitable and generous people live. The word for Georgian meal is *supra*, which is best translated as "feast".

The Georgian language and alphabet are included in the UNESCO's Intangible Cultural Heritage List and UNESCO acknowledged Georgian polyphonic music as "a masterpiece of the world's cultural heritage".

Autumn is the velvet season in Georgia when weather is still pleasant. Temperature

range is between 18-23°C (64-73°F).

The hotel *Sheraton Grand Tbilisi Metechi Palace* will host the GA. There will be a city tour for the accompanying persons on 24 October to old Tbilisi and the classical half-day tour for all the participants is scheduled on 25 October to Mtskheta, one of the oldest cities of Georgia, located approximately 20 kilometers (12 miles) north of Tbilisi.

After the tour, dinner will be served in Mtskheta. The guests will be able to taste Georgian traditional cuisine.

Organizational Committee of Georgian Medical Association from 1988 worked with Rustaveli Association of Georgia. From November of 1988, the mentioned organizational committee separated from Rustaveli Association and began independent functioning. Committee unified as deserved doctors, so pedagogues, scientists- so, young apolitical generation.

Georgian Medical Association (GMA) was officially founded on May 05, 1989 on the first meeting, it is the first non-governmental professional organization in Georgia which was registered in the Ministry of Justice of Georgia. GMA:

- From 1995 is the member of European Forum of Medical Associations and World Health Organization (EFMA/WHO);
- From October 2002 is member of World Medical Association (WMA)
- From 2011 is the member of South-East European Medical Forum (SEEMF).
- From 2015 is the observer of European Permanent Committee (CPME).

GMA unifies more than 90 professional associations acting in Georgia and cooperates with multiple organizations and funds as inside the country, so abroad.

Georgian Medical Association (GMA) is an independent, professional union of doctors founded for supporting professional and personal needs of doctors working in Georgia; it unifies doctors of all spheres of medicine within the whole country; it is voice of doctors-professionals and medical students before official health structures and administrations of the country, it is interested in active participation of its members in formation of issues of strategic development and health policy of the country; it aims to active involvement of doctors in protection of their civil, professional and social – economical interests; supports improvement of quality of medical aid of population and improvement of health system of the country.

Tasks of GMA are: supporting decentralization of health system, protection of doctors' rights, support of professional improvement of doctors, popularization of scientific achievements, illustration of ecological and demographic problems, bio-medical ethics, supporting young doctors, organization and management of educational, scientific and practical actions, licensing-accreditation of doctors and medical institutions, constant medical education and constant professional development (CME & CPD); close

relationships with legislative authorities and lobbying of doctors interests.

GMA helps doctors and patients and in order to achieve it supports union of doctors to work in direction of social health and most important professional issues.

What has been done in recent period

Cooperation with Georgian Parliament:

Working on legislative changes (2001–2008), working in scientific consultation board of field professional associations at the Parliament (2008–2012), working in scientific – consultation board for prevention and support of health (2017–2019), preparation of some initiatives (2008; 2010; 2012);

Cooperation with the Ministry of Refugees from the Occupied Territories of Georgia, Labor, Health and Social Affairs of Georgia

- Working in professional boards of the Ministry of Labor, Health and Social Affairs of Georgia (1999–2009);
- Health regulation sphere – preparation of list of specialties (1999–2008); participa-



tion in doctors' and postgraduates qualification exams (commission, members, translators, operators) (2002–2013);

- Expertise of medical documentation (2007–2010)

Other activities:

- Involvement of Tbilisi State Medical University in international libraries network (2000–2008);

Internal and international grants

- Together with organization OPM there were arranged several workshops for optimisation of calculation of human resources in health sphere. 21 field association was actively participating in the workshop (2000–2001);
- Assisting Georgian citizens in foreign and Georgian clinics (Germany, Austria, Switzerland) (from 1989 to present);

Sending members of Medical Associations abroad for improvement of qualification (from 1989 to present).

- By initiative of World Medical Association joining of Georgian Medical Association to the project of rehabilitation of torture victims "Istanbul Protocol" (2002) and realization and implementation of this project in Transcaucasia together with Rehabilitation Center of Torture Victims "Empathia" (from 2003 up to present);
- In November 2008 in Georgian Parliament there was conducted a meeting which was devoted to medical aspects of August events;
- On October, 2008 there was created a Fund for helping families of medical personnel damaged by war;

Exclusive contract with Georgian Airways (from 2010 to present) (with discount on flight tickets for GMA members).

- Together with foreign partners there was concluded a contract with insurance company "Ardi Group" and in 2011 there was created "Georgian Insured Medic's Agency", the basic functions of which are: support of development of culture and practice of professional liability insurance in medical sphere, supporting protection as of medics, so patients' rights; mediation in disputes between medics and patients; development of strategy and recommendations of professional liability insurance on the basis of got experience;
- Together with Ivane Javakhishvili Tbilisi State University and Faculty of Medicine, on July 09, 2014 there was executed Cooperation Memorandum between Ivane Javakhishvili Tbilisi State University and Georgian Medical Association (GMA);
- In 1999, membership of students of Medical Faculty of TSMU, and in 2010 membership of students of Medical Faculty of TSU in EMSA (European Medical Students Association);
- Celebrating annually with participation of EMSA-TSU official days regulated by World Health Organization (WHO);
- Organization of annual scientific workshops (autumn, spring) and school-seminars (winter, summer) of students;
- Preparation of official Georgian translation of Geneva declaration of World Medics Association and its update for gradutors of higher schools (oath text) – Medical Faculty of Ivane Javakhishvili Tbilisi State University, from 2010;

Editing activities

Translation and edition of "Medical Ethics Manual" of World Medical Association; together with 3 field professional associations preparation and edition of "Rules of Professional Activity of Doctor"; together with Medical Faculty of Tbilisi State Uni-

versity there was founded electronic scientific magazine "Translational and Clinical Medicine – Georgian Medical Journal);

International forums in Georgia:

- April, 2015 Tbilisi – EFMA/WHO;
- September 2016 Batumi – SEEMF;
- September 2017 Tbilisi – First Meeting of Georgian Surgeons;
- August 2018 Mestia – Congress of Georgian Surgeons

Future plans:

- 2019–2021 – working on the project of university clinic together with administration of TSU and Dean's Office of Medical Faculty;
- 2020–2021 – Conduction of workshops of GMA Regional Organizations and renewal registration of GMA members;
- 18–20 September, 2019, Batumi – "New Approaches of Diagnostics and Treatment";
- 23–26 October 2019, Tbilisi – 70th General Assembly of World Medics Association (WMA).

Working on legislative initiatives

- Question of certification – recertification (among them restoration of certificate);
- Postgraduate and continued medical education;
- Protection of legal and social rights of medical personnel.

*Prof. Gia Lobzhanidze – Chairman
of Directors' Board of GMA*

*MD/PhD Tinatin Supatashvili –
Deputy General Secretary of GMA*

*David Lobzhanidze – Deputy
General Secretary of GMA*

*Gvantsa Modebadze – Head
of Legal Office of GMA*

Activities of the Belarusian Medical Association in the Modern Period



Dmitry Shevtsov

The Belarusian Medical Association was founded in 1992. As of January 2019, its aggregate membership is about 25.0% of the total number of medical practitioners.

The mission of the Belarusian Medical Association is to promote collaboration, cooperation and mutual understanding on the basis of professional competence, professional ethics and deontology.

The Belarusian Medical Association is the founder of the peer-reviewed research journal *Medicine*; it has its own website [www:wmdoc.by](http://wmdoc.by), where colleagues can find interesting and useful information, learn about the activities of the association, ask questions and get knowledgeable assistance. The Belarusian Medical Association established the Ethics Commission chaired by Professor V. P. Krylov. It considers ethical issues in the relationship between the colleagues and administration of health care institutions.

Chairperson of the Belarusian Medical Association is a member of the Supreme Attestation Commission of the Ministry of

Health of the Republic of Belarus for awarding qualification grades to health officials.

The Belarusian Medical Association has its own regional and sectoral organizational structures. Our activity is aimed at a broad representation of the Belarusian medical community, including its representation at an international level. We have concluded partnership and cooperation agreements with international associations: the Lithuanian Medical Association, Latvian Medical Association, Slovak Medical Chamber, and the National Medical Chamber of Russia. The Belarusian Medical Association is admitted as a Member of the Southeast European Medical Forum (SEEMF), EFMA, and WMA.

The Belarusian Medical Association is currently implementing a skills enhancement and professional development program for Belarusian medical specialists by organizing and financing their participation in international academic programs and events. In close cooperation with sponsors, we send more than 250 medical specialists a year to international symposia and conferences. This makes it possible for our health professionals to adopt the best practices and introduce them into the domestic public health as well as to promote the achievements of the Belarusian medical school on the global stage.

Every year the Belarusian Medical Association organizes and sponsors conferences and forums held in the Republic of Belarus for medical specialists on diverse subject matters, involving representatives of the leading world schools.

The Belarusian Medical Association coordinates the activities of public associations operating in the health sector and holds joint meetings with the heads of these associations to discuss issues related to coop-

eration with the Ministry of Health of the Republic of Belarus.

In June 2018, a working meeting of the top management of the Ministry of Health with the chairpersons of medical public associations was held, during which they discussed issues concerning the development of legal protection of medical practitioners, improvement of furnishing information about risks and particular complications in the process of providing medical treatment to patients. The Ministry of Health welcomed a broad participation of the medical community in revisions of the clinical protocols for the diagnosis and treatment as well as participation of members of public associations in the activities of the Higher Attestation Commissions of the Ministry of Health for awarding qualification grades to health officials. Subsequent to the results of the meeting, a decision on joint coordination of activities was made.

In 2018, the Belarusian Medical Association established the award *For Devotion to Profession*. The prize is awarded to the health professionals who have made a significant contribution to the development of Belarusian medicine, the public health system of the Republic of Belarus as well as to the development of medical science. At its core, this is recognition of the long-standing selfless service and contribution made by the awardees to preserve and promote life and health in the Republic of Belarus.

The Belarusian Medical Association does its best to strengthen the corporate solidarity, to protect the honor and dignity of colleagues, to provide legal protection and assistance in professional and occupational training of specialists, to enhance the prestige of people in white coats.

*Dmitry Shevtsov, Chairperson of the
Belarusian Medical Association*

A Medical Voice Is Needed at the Human Rights Council in Geneva



Susannah Sirkin

The past few months of violence and bloodshed in Sudan alone make a compelling argument that the international medical community should be more present in Geneva, where the United Nations human rights machinery is centered.

Since December 2018, more than 100 doctors in Sudan have been arrested, and some tortured, for their peaceful advocacy for the independence of their profession and the proper functioning of Sudan's health system. More than seven hospitals have been invaded by security forces firing tear gas into the buildings. Doctors have been prevented from treating the sick and the wounded, and at least one was shot dead as he tried to treat an injured demonstrator. The Sudan doctors' union, along with other professional groups, has been leading a civil society movement to end one of the most brutal military dictatorships in the world, one in which the president and others in his cabinet are wanted by the International Criminal Court for genocide. Physicians for Human Rights (PHR)'s April 2019 report "[Intimidation and Persecution: Sudan's At-](#)

[tacks on Peaceful Protesters and Physicians](#)," detailed these violations.

And yet, the medical voice is rarely seen or heard in the corridors of the Human Rights Council in Geneva, where delegates from a rotating roster of 47 governments elected from each region of the world regularly sit to review human rights reports, evaluate information, and make public pronouncements on violations, pressing for prevention, protection, and promotion of human rights globally.

Non-governmental organizations (NGOs) like PHR that have consultative status with the UN are able to address the Council at its sessions. The messages are live-streamed through UN media, so the reach can be significant and preserved for the international record.

Since the establishment of the Human Rights Council in 2006, PHR has submitted its reports to this body, spoken at the open sessions of the Council, distributed information to governmental delegates, and participated in "side events" to provide medical evidence of torture and sexual violence and to highlight the devastating erosion of protection of health facilities and personnel guaranteed in the Geneva Conventions of 1949.

Following the Myanmar government's 2017 campaign of extreme violence and persecution against the Rohingya Muslim minority, PHR went to Geneva in September 2018 to present its medical evidence of atrocities against the Rohingya collected during a series of population-based surveys and clinical evaluation of survivors.

PHR and other NGOs also advocated for the Council to launch an independent investigative body led by prominent experts to

investigate crimes against the Rohingya; the mechanism was established in 2018. PHR continues to press for the body's operational effectiveness as well as to advocate against the ongoing crisis of displacement of Myanmar's Rohingya and failures in accountability for atrocities committed against them.

At the Human Rights Council's March 2019 session, PHR was once more at the table, delivering oral statements on the relentless attacks on medical personnel and facilities in the eight-year Syrian conflict and also on the trauma faced by many asylum seekers crossing the US-Mexico border. "This is a human rights crisis that is being treated as a security crisis," PHR Senior Researcher Tamaryn Nelson told the Council, citing PHR's documentation of trauma among asylum seekers and calling upon member states to press for an end to U.S. policies that restrict the right to seek asylum.

Dr. Craig Torres-Ness, an emergency medicine physician at the USC Keck School of Medicine and a member of PHR's Asylum Network, joined the PHR team in Geneva to share his experiences of clinically evaluating asylum seekers who bear the physical and psychological scars of gang-related and domestic violence. It was an extraordinary platform for a medical professional who is using his skills to advocate for human rights.

Another unique opportunity for human rights organizations and civil society to be heard at the Council is the Universal Periodic Review process. Every year, the Council reviews the human rights record of 42 countries. Governments, UN bodies, and NGOs are able to submit information to the UN Office of the High Commissioner for Human Rights for the Council's country reviews. Issues relevant to medical organizations include: independence of the medical

and scientific communities and the right to information about epidemics or outbreaks of disease; persecution of health professionals for their independent medical or human rights activities; attacks on health facilities and personnel; medical evidence of torture and sexual violence and their severe physical and psychological impacts; reproductive rights and health; collusion of health professionals in human rights violations, including torture and executions; overt ob-

struction of the right to health; discrimination within health systems; and much more. PHR has submitted documentation to this process on human rights violations in Bahrain, Myanmar, the United States and Zimbabwe, among other countries.

Dozens of organizations worldwide regularly send representatives to speak at Human Rights Council meetings on a range of issues. But the credible and influential voice

of the medical community in these halls of power is singularly underrepresented. PHR has been opening a door to these opportunities and welcomes company to develop a more robust presence in Geneva as threats against the independence of medical professionals and the silencing of civil society become ever more pervasive across the globe.

Susannah Sirkin, Director of Policy, Physicians for Human Rights

Euthanasia and Physician-Assisted Suicide are Unethical Acts



Ewan C Goligher



Maria Cigolini



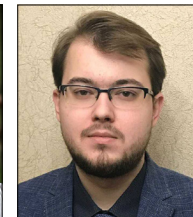
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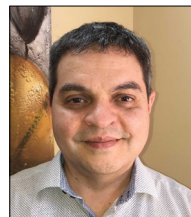
Mark Komrad



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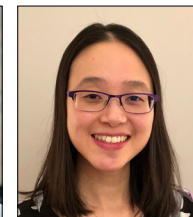
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Sephora Tang



John Quinlan

The World Medical Association (WMA), the voice of the international community of physicians, has always firmly opposed euthanasia and physician-assisted suicide (E&PAS) and considered them unethical practices and contrary to the goals of health care and the role of the physician [1]. In response to suggested changes to WMA policy on this issue, an extensive discussion took place among WMA Associate Members. We, representing a voice of many of those involved in this

discussion, contend that the WMA was right to hold this position in the past and must continue to maintain that E&PAS are unethical.

The Central Issue Under Debate is the Ethics of E&PAS

The question is whether it is ethical for a doctor to intentionally cause a patient's death, even at his or her considered re-

quest. The fact that E&PAS has been legalized in some jurisdictions and that some member societies support these practices has no bearing on the ethical question. What is legal is not necessarily ethical. The WMA already recognizes this distinction, for example, by condemning the participation of physicians in capital punishment even in jurisdictions where it is legal. The WMA should be consistent in this principle also with respect to E&PAS.

E&PAS Fundamentally Devalues the Patient

This devaluation is built into the very logic of E&PAS. To claim that E&PAS is compassionate is to suggest that a patient's life is not worth living, that her existence is no longer of any value. Since the physician's most basic tasks and considerations are to 'always bear in mind the obligation to respect human life' and 'the health and well-being of the patient' [2, 3], E&PAS must be opposed. E&PAS distorts the notion of respect for the patient. On the one hand it claims to help suffering persons, while on the other hand it eliminates them. This is a profound internal contradiction; the ethical priority is to respect the fundamental intrinsic worth of the person as a whole.

E&PAS Puts Patients at Risk

Patients are autonomous agents but are not invulnerable to their need for affirmation from others, including their physician. Amidst the overwhelming fears of those who suffer (4, 5), a free autonomous decision to die is an illusion. Particular concern exists for those who may feel their life has become a burden due to changing perceptions of the dignity and value of human life in all its different stages and conditions, and an explicit or implicit offer of E&PAS by a physician profoundly influences the patient's own thinking. The troubles of human relationships within families, the presence of depression, and problems of abuse and physician error in an already stressed medical system, make muddy waters even more turbulent [6]. Evidence shows that societies cannot always defend the most vulnerable from abuse if physicians become life-takers instead of healers [1, 6]. The power of the therapeutic relationship cannot be underestimated in the creation of patient perceptions and choices.

E&PAS Totally Lacks Evidence as 'Medical Treatment'

The consequences of E&PAS are unknown as both physicians and patients have no knowledge of what it is like to be dead. Advocates of E&PAS place blind faith in their own assumptions about the nature of death and whether or not there is an afterlife when arguing that euthanasia is beneficial. E&PAS is therefore a philosophical and quasi-religious intervention, not a medical intervention informed by science. Doctors should not offer therapy when they have no idea of its effects—to offer E&PAS is to offer an experimental therapy without any plans for follow-up assessment. Therefore, key elements in any medical intervention such as informed consent are simply not possible without knowing what stands on the other side of death. Rather than a standard medical discussion of alternatives based on scientific data or clinical experience, the discussion must leave the clinical domain and enter the domain of speculation. This is not an exercise in informed-consent. This is not the accepted medical ethics of medical practice. All this is, in part, why E&PAS cannot be a medical procedure.

These Weighty Moral Considerations are Supported by the Ethical Intuition of the Global Medical Community

Only a small minority of physicians support E&PAS. The vast majority of doctors around the world wish only to foster the will to live and to cope with illness and suffering, not to facilitate acts of suicide or to create ambiguity around what constitutes a medical treatment. We must remember that the four regional WMA symposia demonstrated that most doctors would never be willing to participate in euthanasia. Even the insistence of E&PAS proponents on (a)

using ambiguous language such as 'Medical Assistance in Dying' to describe their practice and (b) avoiding mention of E&PAS on death certificates suggests that they share to some degree this fundamental ethical intuition about killing patients.

Acceptance of E&PAS Undermines Boundaries Between End-Of-Life Care Practices That do not Intend Death (palliative care, withholding/withdrawing life-sustaining therapy) and Those that do Intend Death (E&PAS)

Confusion is created at a societal level about what constitutes "medical treatment," especially when language such as "medical assistance in dying" or "voluntary assisted dying" is used. This renders the reality of such acts and their application unclear. As many patients share our conviction that deliberately causing death is wrong, a misunderstanding of the distinction between E&PAS and palliative care may lead to rejection of palliative care or insistence on futile life-sustaining therapies. The availability of E&PAS also distracts from the priority of providing social services and palliative care to those who are sick and dying [7].

The WMA's Code of Ethics Strongly Influences Standards for the Practice of Medicine Around the World and Neutrality on E&PAS by the WMA Would be Interpreted Globally as Tacit Approval

A change in the WMA statement would imply a tacit endorsement of E&PAS and render the WMA complicit with such practices [8, 9]. Neutrality by professional medi-

cal organisations on E&PAS is perceived by society, governments and the international pro-euthanasia lobby as that organisation's acceptance of them as medical practice, rather than as a response to a societal/political agenda. Those who seek international approval to justify these practices will create a silencing of the majority of the community, which has real medical, societal and ethical concerns around E&PAS and their effects on society internationally.

WMA policy on E&PAS reflects that which is in place in hundreds of jurisdictions with widely divergent legal and political traditions. While it may be tempting to placate some member societies so as to avoid dissension, we must not destabilize medical ethics around the world. We must continue to characterize E&PAS as unethical even if it conflicts with the demands of the state or influential groups backed by the law. We must not let imperfect law trump good medical ethics. Undoubtedly many doctors who perform E&PAS believe themselves to be acting nobly; but it does not follow that they should expect others to affirm their views or not to oppose them; nor are they wronged by existing WMA policy. Any society that insists on transforming suicide from a freedom to a right, should stand up a different profession with the duty to fulfil that new right, as killing does not belong in the House of Medicine.

Neutrality on E&PAS has Serious Consequences for Physicians who Refuse to Participate

In jurisdictions where E&PAS is legalized, physicians who adhere to the long-standing Hippocratic ethical tradition are suddenly regarded as outliers, as conscientious objectors to be tolerated and ultimately excluded from the profession [10]. A neutral stance by the WMA would compromise the position of the many medical practitioners

around the world who believe these practices to be unethical and not part of health care. In some jurisdictions it is illegal **not** to refer for these practices, creating a dystopic situation where the doctor who practises quality end-of-life care needs to conscientiously object in order to do so, and may be coerced to refer for E&PAS. Neutrality from the WMA would promote the contravention of the rights and ethical practice of these doctors, undermining their ethical medical position at the behest of a societal demand that can fluctuate with time.

In sum, the changes currently being debated, arising from political, social, and economic factors, have been rejected time and again and most recently by the overwhelming consensus of WMA regions. The present debate represents a crucially important moment for the WMA that must not be squandered. Given the influence of the WMA and the profound moral issues at stake, neutrality should not be an option. The WMA policy must continue to stand as a beacon of clarity to the world, bringing comfort to patients and support to physicians around the globe. The WMA should not be coerced into promoting euthanasia and assisted suicide by making its stance neutral.

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The Defensive Medicine isn't the Best Way to Avoid Mistakes

Defensive medical practice represents an increasing concern in all over the world. The practice of defensive medicine is mainly associated to the rising number of medical malpractice lawsuits. It negatively affect the quality of care and waste the limited resources in health sector. The economic burden of defensive medicine on health care systems should provide an essential stimulus for a prompt review of this situation. Defensive medicine in simple words is departing from normal medical practice as a safeguard from litigation. The most

frequent daily practice of defensive medicine is performing more unnecessary tests and referring more patients to consultants and hospitalization. Such behavior is an ethically wrong and disagrees with deontological duties of the doctor. Investigating the prevalence of defensive medicine in a number of international healthcare settings, defensive medicine has been found to be highly prevalent in many countries. Majority of physicians across various specialties tends to adopt a defensive professional culture.



Daiva Brogiene



The survey of 2440 physicians manifested broad spread of the defensive medicine in Lithuania. Results show that 86.3% of doctors admitted that they refer their patients to other specialists without any true need and solely to protect themselves from potential legal challenges. Moreover, 60.7% of the consulted physicians admitted to having performed unnecessary additional test for the same reason. Also, 66.6% of the physicians avoid 'risky' patients, which are defined as those with a complicated or dangerous disease, or those who are prepared to challenge doctors' decisions. In addition, 59.9% of the physicians consulted avoid using necessary, but risky procedures. Lastly, 40.3% of the physicians indicate that they have prescribed or used unnecessary medicines (Prevalence of defense medicine in Lithuania. Liutauras Labanauskas, Viktoras Justickis, Aistė Sivakovaitė. Health policy and management, 2013).

We have to speak up about defensive medicine, because it is a low-value care, which has no benefit neither to the patient and nor to the doctor. Defensive medicine brings enormous prolongation of waiting time for all patients. This causes great harm to patients who should receive the medical care in a proper time, especially to the patients who have the most serious diseases. But a physician instead of doing his best to help his patient is concentrated on defending himself from any legal prosecution in the case on unsuccessful treatment.

Doctors who prescribe unnecessary tests and procedures out of fear of being sued waste a lot of money each year. Defensive medicine practice is difficult to precisely quantify. Low value care – is a faulty and dangerous phenomenon in the healthcare. International projects analyze opportunities to eliminate waste and lower value care. But the efforts to rid the nation's healthcare system of waste and inefficiency faces a defensive medicine.

Clinical medicine has always been based on patient – physician trust. Unfortunately,

this fundamental trust has been progressively eroded by lack of patient face-time. This is not a picture limited to one country, for example Lithuania. If this relationship is lost or diminished to unacceptable levels, then defensive medicine is the logical consequence. Time directly spent with patients has been overtaken by time devoted to electronic health records and other documentation. It is necessary to reestablish the trust between doctor and patient. Lithuanian Medical Association demands the government to normalize the workloads of physicians and allow them to spend the time they need with their patients. A doctor who sees patient's distrust as an expression of his hostility has no other option than to defend and to use defensive medicine methods.

In keeping with the growing trend towards considering healthcare as a consumer product and patients as consumers, patients and their families not infrequently demand access to medical services that, in the considered opinion of physicians, are not appropriate. This problem is especially serious in situations where resources are limited and providing 'futile' or 'nonbeneficial' treatments to some patients means that other patients are left untreated. As a general rule a patient should be involved in determining futurity in his or her case. Overtreatment with antibiotics is one example of defensive medicine that endangers everyone. Continuing efforts must be made to educate the public that information acquired from online sources outside of an appropriate clinical context is generally inappropriate.

There is no secret that a patient can sue the doctor, betting on a chance to win a big award. Such culture of litigation impact both the medical and legal systems. The laws and legal systems in each country, as well as the social traditions and economic conditions are different, but the fundamental principles of litigation culture are similar for every country. So the adoption of no-fault systems or other extra-judicial mediation are shown to be the most effective

strategies to reduce the number of litigations in courts, with consequent economic savings. In countries where a no-fault system or a system of conflict mediation is in force, most of the litigations are disputed out of the court of law. Lithuanian government is also trying to solve this problem and intend currently to enter the no-fault compensation system without requiring a proof of negligence. Lithuanian Medical Association speaks up against the increasing criminalization or penal liability.

The physician who has personally been named in a lawsuit becomes so called 'second victim'. He/she committed an error, and are consequently severely affected in both their private life and subsequent practice. They suffer physically and psycho-socially and try to overcome the post-event emotional stress by obtaining emotional support. Psychological support obtained by these physicians in health care institutions today is poor and inefficient. There is a need for effective support to 'second victims', because despite that they will continue their defensive medicine in the future. 'Second victims' may feel anxiety, fear, guilt or anger and experience social withdrawal, which may lead to depression. Over the years, this situation may lead to deterioration in his/her work and personal life and, in rare circumstances, may lead to pharmaceutical and even alcohol consumption. It is no secret, there were the cases when the physician have committed suicide. But this support is not meant to disrupt any correct medical investigation or to stand for a doctor in any way, but rather to allow him/her to focus on handling stress, accepting the consequences of the mistake, and finding out solutions to avoid similar situations in the future, it means training and learning from mistakes. Lithuanian Medical Association openly and truly provides the help to the colleagues which need it. We hope that maintenance of high standards in daily practice with continuous training, clear communication and a signed Patient's Informed Consent Form

along with the appropriate documentation of any procedure carried out may provide professional safety.

So we are sure, the better care is the best defense. The defensive medicine isn't the best way to avoid mistakes.

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Lithuanian Medical Association*

CPME Position Paper on Defensive Medicine

The Standing Committee of European Doctors (CPME) represents national medical associations across Europe. We are committed to contributing the medical profession's point of view to EU and European policy-making through pro-active cooperation on a wide range of health and healthcare related issues [1].

Definition/ Background [2]

Defensive medicine has seen an increase in both prevalence and impact over the past years.

The concept of 'defensive medicine' is subject to varying definitions which broadly describe the practice of ordering medical tests, procedures, or consultations which are not medically indicated or refusing the treatment of certain patients in order to protect the responsible physician from malpractice challenges.

Defensive medicine consists of two general behaviours. As Studert et al. set out, "[o]ne is assurance behaviour (sometimes called "positive" defensive medicine), which involves supplying additional services of marginal or no medical value with the aim of reducing adverse outcomes, deterring patients from filing malpractice claims, or persuading the legal system that the standard of care is met. The other is avoidance behaviour (sometimes called "negative" defensive medicine), which refers to physicians' efforts to distance themselves from sources of legal risk" [3].

THE Prevalence of Defensive Medicine in Europe

A review of international scientific literature confirms that defensive medicine is widespread and occurs in all diagnostic-therapeutic areas, although some medical specialties are affected more often than others. Various studies have looked at the situation at national level, both within the EU and internationally [4–13].

Impact of Defensive Medicine

The adverse effects of defensive medicine affect healthcare systems worldwide.

It is complicated to calculate or quantify the economic impact of defensive medicine due to the many conflicting and overlapping factors [14–17]. Nevertheless it is expected that the cost of defensive medicine is significant.

A culture of litigation impacts both the medical and legal systems with damaging consequences to the patient-physician relationship and the quality of healthcare services even though the national legal frameworks for litigation differ.

Recommendations to Prevent and Reduce the Practice of Defensive Medicine

There is no universal solution for all countries of how to reduce this phenomenon due to cultural, economic and social differences in the countries which create the different expectations of the patients, different legal systems and legal procedures. However the common essential directions may be put forward.

Recommendations for professionals

1. To ensure that healthcare responds appropriately to each individual patient's health needs.
2. To maintain high standards and evidence-based clinical guidelines in daily practice. Clinical guidelines require regular revision to ensure they reflect the best available evidence, while allowing for clinical independence to adequately respond to individual patients' needs and choices.
3. To practice more valuable care for every patient through informed choices and good conversation. With a patient engagement and clear communication promote awareness about appropriate care, unnecessary tests, treatments and procedures.
4. To support Continuous professional development (CPD) with the objective of ensuring that professional practice is up-to-date.

This will contribute to better patient outcomes, quality of care as well as increasing the public's confidence in the medical profession.

5. To maintain clear, well-documented and detailed medical records. Appropriate documentation of all treatments and procedures contributes to quality of care and patient safety.

Recommendations for policy-makers

6. To build a patient safety culture aimed at transparency, and preventing and learning from errors. Appropriate open disclosure policies can support both patients and doctors and should be appropriately resourced. It has furthermore been established that the disclosure of adverse events, which may include an apology to the patient affected and their family, lowers the probability of litigation against the doctor involved.

7. To engage in a debate with the public to contribute to improving media literacy on health information in particular in relation to online sources. To inform the public about the consequences of defensive medicine: reluctance to treat high risk patients, costs and dangers if professionals continue to practice defensive medicine.

8. The medical community and administration of health institutions need to be aware of the 'second victim' phenomenon (or the clinical-judicial syndrome) and ensure adequate psychosocial support to both patients and doctors in the disclosure process.

9. To reduce fears of liability proceedings by reforming compensation mechanisms for medical malpractice. Mediation and administrative compensation systems all hold promise.

10. Further development of the liability system is necessary to enable a reform of tort law focused on balancing the 'no blame principle' with the 'accountability principle'. The use of extra-judicial mediation and the adoption of no-fault systems have proven to be effective approaches in reducing both defensive medicine and the waste of resources it incurs.

11. Under-resourcing and under-staffing contribute to clinical error and defensive medicine. Employers and funders have a duty of care to ensure that clinical services are adequately resourced and staffed to deal with appropriate workloads.

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1. CPME is registered in the Transparency Register with the ID number 9276943405-41. More information about CPME's activities can be found on www.cpme.eu.

2. In 2016, CPME carried out a survey mapping the situation of defensive medicine across Europe (CPME 2016/008 FINAL). Responses to the CPME survey showed that a majority of National Medical Associations support further CPME action concerning defensive medicine, in particular to raise awareness about this problem. The impact of defensive medicine is discussed in relation to several policy areas. There are CPME policies relating to the liability of doctors which also address the concept of defensive medicine, in particular the CPME policy on the liability of service providers adopted in 1991 (FR only) and the CPME Proposal for a directive on health care liability adopted in 2000. Although discussions on doctors' liability were raised both in the context of the Services Directive 2006/123/EC, the Cross-Border Healthcare Directive 2011/24/EU and the Professional Qualifications Directive 2005/36/EC, there is currently no EU legislation on this issue. Awareness of an increasingly defensive medical practice culture and its negative implications has paved the way for a much-needed political focus, like the 'Choosing Wisely®' campaign in the UK launched by the Academy of Medical Royal Colleges. International projects analyse opportunities to eliminate waste and lower value care (Netherlands, Alliance of University Hospitals and Training centres - NFU programme), the European Collaboration for Healthcare Optimization (ECHO).
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