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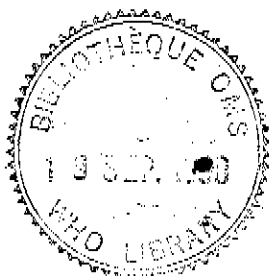
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FOURTH JOINT MEETING BETWEEN
WHO AND NATIONAL MEDICAL ASSOCIATIONS
ON
HEALTH FOR ALL IN EUROPE

Rome
1-2 February 1990



1990

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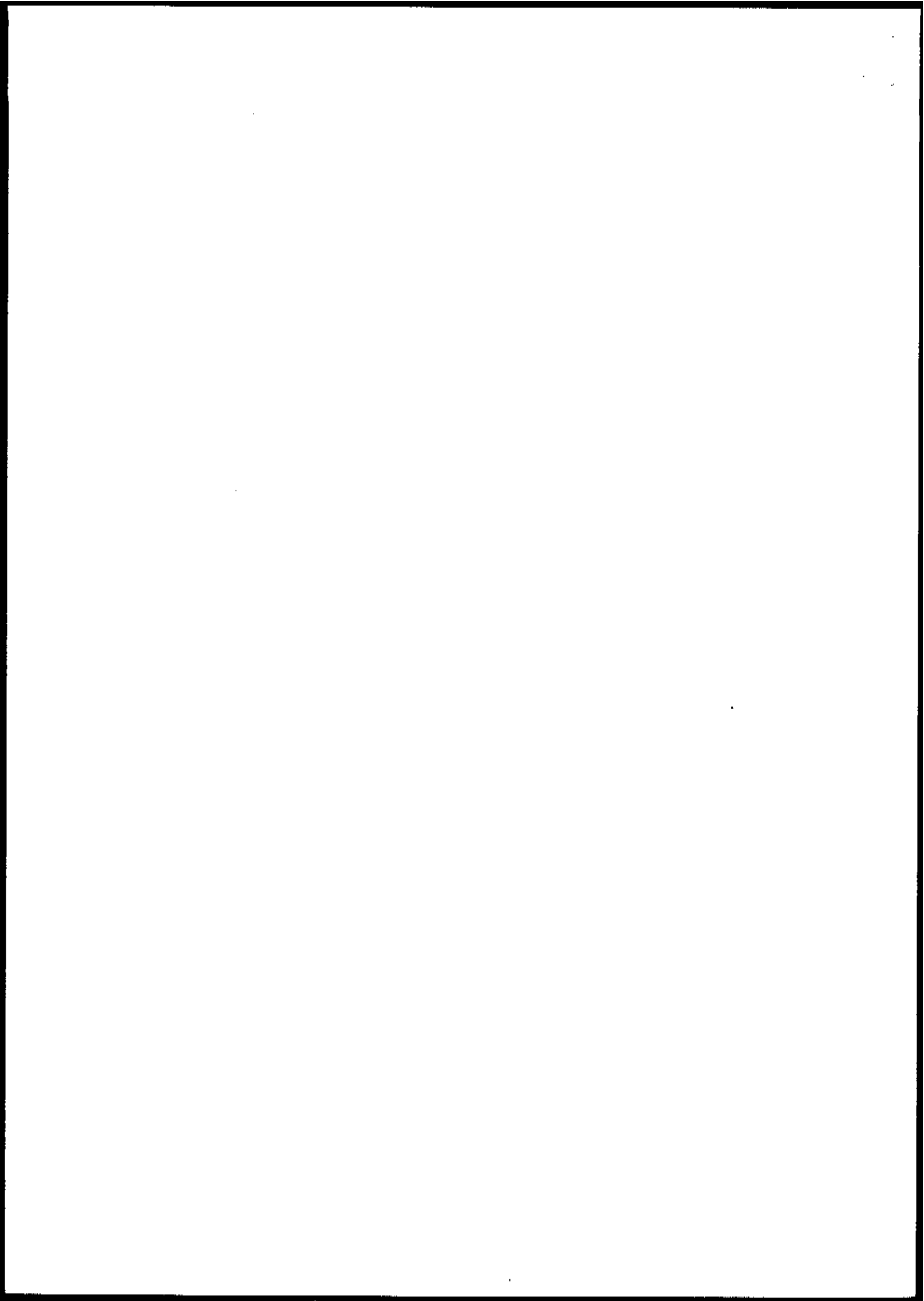
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HEALTH FOR ALL
HFA STRATEGY COORDINATION
ORGANIZATIONS
QUALITY ASSURANCE, HEALTH CARE
EDUCATION, MEDICAL, CONTINUING
ACQUIRED IMMUNODEFICIENCY SYNDROME
PATIENT ADVOCACY
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EUR

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Summary

Representatives from medical associations in 28 of the 32 Member States of the WHO European Region participated in the Fourth Joint Meeting between WHO and National Medical Associations on Health for All in Europe. Observers included representatives of the medical associations of Andorra and Morocco, and of the European Working Group of Practitioners and Specialists in Free Practice, and of the Standing Committee of the European Common Market. A list of participants is given in Annex 4.

A major agenda item was a discussion on the nature of the meetings of national medical associations and the WHO Regional Office for Europe. This being the fourth such meeting, it was generally accepted that a European forum for medical associations now existed, and the meeting adopted the statement on the European Forum of Medical Associations (Annex 1). Representatives from medical associations of Hungary, the Netherlands, Norway, Portugal and Switzerland were appointed to the advisory committee mentioned in the above statement.

As regards other agenda items, continuing medical education and quality assurance in Europe was discussed. It was generally agreed that these interrelated but not identical aspects of medical activity were of the greatest importance.

Trends in the rights of patients, a draft declaration of these rights and the implications for the work of physicians were discussed. A general trend to ensure patients' rights by legislation was noted; medical codes of ethics are no longer accepted as sufficient. In the Netherlands, the medical association and the patients' organization have made a reciprocal agreement.

A draft paper on the humanization of medicine was presented. Most representatives agreed that the increasing use of technology in medicine, if not properly handled, posed a potential threat to the humane treatment of patients, and that some common principles for action was needed to counteract this.

An overall review of the medical associations' work for health for all since the last meeting was presented and supplemented by several speakers.

Introduction

The Fourth Joint Meeting between WHO and National Medical Associations on Health for All in Europe must be seen against the background of the changes in medicine and in European politics.

For example, nearly all Member States of the Region have increased the emphasis on prevention and rehabilitation in medicine. Rapid and improved communications and a free flow of information between western and eastern Europe are making medicine more international than previously, and the medical authorities in all countries are becoming aware of the dangers of an excessive reliance on technology.

The political changes in eastern Europe have led to a change in the representation of medical personnel. In the last few months, countries in which physicians were previously organized in state-sponsored health workers' unions have allowed the establishment of nongovernmental, free medical associations, corresponding to those found in western Europe.

Most medical associations have also become increasingly aware of the need to take part in the organization and administration of health care in their countries. More and more, they want to become medical advisers to society.

The strength of interest in these topics was shown by the fact that medical associations from all but four (Israel, Luxembourg, Monaco, San Marino) of the Member States of the WHO European Region were represented.

The meeting was opened by Dr F. de Lorenzo, Minister of Health of Italy, who welcomed the participants, and presented his views on medicine, medical organization and the main problems facing the health services for the next 10 years. The President of the Medical Association of Italy, Professor E. Parodi, added his welcome and best wishes for the meeting and stressed that the medical profession faced challenges different from those of the past. Both suggested that physicians might be the leaders in the adoption of healthier lifestyles.

Dr J.E. Asvall, WHO Regional Director for Europe, thanked the organizers of the meeting, and mentioned some of the most important work of the Regional Office in the previous year:

- progress in national health for all policies;
- efforts against diabetes;
- work on the environment and health, basic medical education, and the Healthy Cities project;
- the European campaign against tobacco.

He challenged each medical association to attempt to set clear targets for reducing smoking among its members, for example by 20% within the next year. Dr Asvall also commented on the political situation in eastern Europe and the need for medical books and journals in and professional contact with these countries.

A European forum of medical associations

It was suggested that the national medical associations start the new decade by strengthening the European forum of medical associations. The aims and objectives of this forum should correspond to those of the regional strategy for health for all in Europe. This suggestion was strengthened in a paper later presented by Dr J. Rochon, Director, Programme Management, in the Regional Office.

It was proposed that the forum have the following objectives:

(a) to promote the exchange of information between national medical associations and WHO, and the dissemination of information to physicians, to achieve better integration of health promotion activities and disease prevention services with the clinical practice of medicine, particularly in:

- the reduction of tobacco consumption;
- the prevention of drug misuse;
- the prevention of HIV infection;
- the improvement of nutrition;
- the prevention of stress and mental illness;
- the prevention of chronic diseases;
- the highlighting of the importance of sex education and family planning and the care of the elderly;

(b) to develop models of good practice in fields including:

- health promotion and health education;
- the prevention of disease and disability;
- quality assurance and the evaluation of the outcome of medical services;
- collaboration with other health professionals;

(c) to develop programmes of health education and health promotion and to integrate the principles of health for all into basic, postgraduate and continuing medical education;

(d) to assess the effects of the declaration of patients' rights on the doctor-patient relationship and the quality of health care;

(e) to formulate policy statements on health issues, particularly:

- healthy lifestyles and behaviour;
- the effects on health of the physical, biological and social environments;
- health care services;
- balancing the costs and benefits to health care of increasing the use of medical technology;
- the equitable distribution of medical personnel.

The future of the European forum of national medical associations was discussed in two sessions. As the meeting was the fourth in a series it was generally accepted that a European forum already existed. Most participants seemed willing to accept that a more formal structure would improve future work in the forum. However, the discussion of these objectives also revealed that some participants were not willing to accept all the points set out in the policy of health for all. The main objection appeared to be related to a perceived fear that this could entail limitations of the free practice of medicine. Because progress must be based on consensus, the aims, organization, structure, participation and voting rules of the forum would be further discussed at the next meeting.

After some discussion, the meeting agreed that an advisory committee should be established to assist the Regional Office for Europe in preparing the next meeting, which is to be held in Finland from 31 January to 1 February 1991. The advisory committee is to comprise one representative from each of the following countries: Hungary, the Netherlands, Norway, Portugal and Switzerland.

The text accepted by the participants as the basis for follow-up work on the organization and structure of the forum comprises Annex 1.

Continuing medical education

It was important to relate continuing medical education to participants' practical experience and problems, to disseminate information regularly, to find engaged leaders, to make use of the advantages of new technology (especially videotapes and computers), and to carry out further research in this area. Videotapes had been used in continuing education in Yugoslavia. The project, carried out in collaboration with Japan, had been a great success. Two thirds of the 200 multiprofessional unions that had tried the system had continued working with it. It had helped to build professional competence and confidence, particularly as personal factors had been taken into consideration in the selection of educational material.

Perspectives and proposals for the future were also discussed. The explosion of knowledge can turn into an explosion of ignorance. Continuing medical education is needed, as health professionals would need to deal with increases in both centralization and autonomy. A discussion of incentives, funding, management, rewards, scientific value, pedagogic value, independence and impact of continuing medical education focused on the point that an integrated system for continuing medical education (after the completion of medical professional training) was needed in all countries in the Region.

In the ensuing discussion reports were made on various systems for continuing medical education, and suggestions were made on how physicians could be encouraged to participate. The question of recertification was raised, as well as economic remuneration. It was pointed out that continuing education had been discussed at many European meetings and a multinational academy for continuing education had been established near Frankfurt.

In summation, emphasis was placed on the needs for continuing medical education, for adequate financing, and for a joint statement from the European medical associations to stress once again the importance of this topic.

Quality assurance

Quality assurance activities in blood transfusion in the Netherlands were described. A consensus development conference on blood transfusion policy held in 1982, had made 11 explicit recommendations. A survey carried out in 1986 showed that 19 out of 20 blood bank directors had attended the conference, and that 16 had established formal guidelines for transfusion policy consistent with the consensus text. Only 2 of 57 heads of haematological laboratories were unaware of the consensus statement, which had led to changes in transfusion policy in 36 of the hospitals. The conference had led to general improvement of services, although less than one third of transfusions were given in a way consistent with the recommendations.

It was important to identify problem areas, formulate guidelines, and carry out activities to bring practice into agreement with them. This was an appropriate and essential activity for medical associations.

Technology assessment was discussed as a tool for the development of quality of care. A study on diabetes management had given astonishingly good results; the quality of treatment had improved significantly in several participating centres. The results of the study in the centres had been compared and evaluated according to a standard of outcome developed by the participants on the basis of the results of their care. The centre with the best results had been selected, and the others were invited to send observers to study and copy its methods. Similar studies are under way on the management of tonsillitis and surgical intervention.

The role of the patient was a crucial factor in quality achievement. In conclusion, multinational, multidisciplinary technology assessment studies could have measurable impact on the development of quality in health care.

National medical associations had a role in quality assurance. After a brief discussion of the nature of and partners in quality (the users of the services and their families, health professionals, administrators and the general public) several points were stressed that medical associations should help to realize:

- all practitioners and institutions should know the outcome and quality of their care;
- the education of health care personnel in quality assurance should be improved;
- political, financial and legislative support should be given to quality assurance;
- medical associations should provide incentives for quality assurance;
- separate bodies of experts should be set up to help implement quality assurance activities in their fields.
- international cooperation in quality assurance should be strengthened.

A table summarizing the quality assurance activities in European countries was provided, and a request made for additional information.

In the ensuing discussion examples were given of quality assurance activities in many countries. It was pointed out that technical quality currently seemed easier to assess than the social and human aspects of the services provided. Further, it was agreed that all specialties should accept general criteria for quality assurance, but each should develop its own specific criteria on the basis of its technical and objective measures.

The rights of patients

The trends in patients' rights in Europe were described. These rights are based on legislation, declarations from the Council of Europe, and international declarations such as those made by the World Medical Association.

An important recent development was the establishment of patients' associations. Information was increasingly important - both the safeguarding of information and the patient's right to full information to allow self-determination. Further, increases in the possibilities and costs of care had increased the importance of the right to treatment.

A WHO study and draft declaration of rights of patients was described and comments solicited with specific reference to possible alterations.

The implications for physicians were discussed. National medical associations should not only protect professional interests but also consider the interest of the public. Important needs included: openness in medical matters; the giving of necessary and clear information; the partnership between patient and physician; and an awareness of the tendency of the increased use of technology to dehumanize medicine. The human aspect of medicine was especially important in treating chronic diseases, cancer and addictions.

The right to refuse treatment gives the patient more responsibility for the outcome of investigation and treatment. Adequate information, especially on therapeutic options, however, was essential to informed consent. Openness and clarity are necessary, but information should not be forced on anyone.

The legal rights of patients in Finland were described. An act has been prepared to regulate patients' rights to professional care and respectful treatment. The proposed act covers complaint procedures, an ombudsman system and a framework for ethical committees. Patients' rights in Finland had previously been based partly on legislation, but to a greater extent on guidelines and regulations issued by the National Board of Health, ethical guidelines for physicians and rules set by hospitals and other health care institutions.

In the discussion of the draft European declaration on the rights of patients, some speakers pointed out that such a document might be unnecessary, in view of the multitude of ethical codes and the legislation covering various aspects of patients' rights in many countries. On the whole, however, the draft was well received.

Participants pointed out that it would be desirable to combine the declaration of the rights of patients with a similar declaration of the rights of physicians. In the Netherlands, for example, the Royal Dutch Medical Association and the Dutch National Patients' Consumers Platform have made a reciprocal agreement to secure the rights of both groups.

The inclusion of specific statements on the rights of minors and incompetent adults and on legal representation was also suggested.

Specific comments were also made on details in the text, signalling the need for a broad discussion of the draft before it can be accepted by all Member States.

Humanization of medicine

A paper was presented that was intended to be the background to future discussions at a planned meeting of representatives of the public, churches and medical practitioners, health officials and WHO staff. The meeting is intended to produce a document affirming the place of spiritual and human values in health. This document may be a starting point for planning programmes of collaboration between health personnel and religions and other humanitarian voluntary bodies.

A panel discussion followed the presentation. There was broad agreement on the need for stressing the human and spiritual values of medicine. The comments of the panel and the views presented by the other participants would be included in a revised edition of the manuscript.

The activities of the national medical associations in 1989

The activities of the national medical associations since the Third Joint Meeting in 1988 were reported. The participants were requested to provide additional reports in writing and this information and the comments made at the Fourth Joint Meeting have been incorporated into two documents comprising Annexes 2 and 3.

Several countries reported on their progress in reducing smoking, and a participant urged physicians to work together in lobbying both parliaments in their countries and the European Parliament on this topic. Smoking is a major health problem, and it was suggested that all medical students sign a declaration on nonsmoking. As reported in Annexes 2 and 3, medical associations are now becoming much more active in anti-tobacco campaigns, a very positive development.

Little success had been achieved in reducing alcohol consumption. A general belief was that the reduction of consumption must be based on a better knowledge of the health hazards of drinking; restrictions alone are of limited use.

A few reports were also made on progress in fighting AIDS. HIV infection seems to have spread less rapidly in the Region than had been feared, but continued effort in this area was necessary. Especially important was the work to remind people of the risk of heterosexual transmission.

Conclusion

The existence of a forum for discussion between WHO and national medical associations in Europe is a major step forward, providing a framework where representatives of all European countries can exchange information and plan common activities. Recent developments in the eastern and central parts of the Region further enhance the value of this Pan-European dimension of such cooperation. The nomination by the forum of an advisory committee from among its members to prepare for the next meeting (in Finland), provides for a more structured link from one meeting of the forum to the next.

Annex 1

STATEMENT ADOPTED BY THE FOURTH JOINT MEETING BETWEEN WHO AND
NATIONAL MEDICAL ASSOCIATIONS ON HEALTH FOR ALL IN EUROPE
Rome, 1-2 February 1990

European Forum of Medical Associations

At the Fourth Joint Meeting between WHO and National Medical Associations on Health for All in Europe, held in Rome on 1-2 February 1990, satisfaction was expressed at the substantial progress that has been made in developing the dialogue that is taking place between medical associations and WHO towards the maintenance and improvement of health in Europe.

It is apparent that the relationship that has been built can be highly effective and a forum of national medical associations^a and WHO has come into existence.

It was agreed that any relevant issues relating to health in Europe should be included for discussion in the forum which should be developed and strengthened by further cooperative programmes intended to achieve the WHO regional targets for health for all by the year 2000, in addition to those already carried out by the forum, such as that to reduce smoking.

Particular importance was attached to the plea, made by participants from the newly emerging free and independent (nongovernmental) medical associations in eastern Europe, for an urgent exchange of information and cooperation between eastern and western European countries.

The WHO Regional Director for Europe undertook to provide secretarial and other support services for the work of the forum, and five participants were appointed to advise the Regional Director until the next joint meeting of WHO and medical associations, at which the best ways of developing the forum should be further studied and discussed.

^a These are defined as free, independent (nongovernmental) professional associations of physicians.

Annex 2

REPORTS OF NATIONAL MEDICAL ASSOCIATIONS ON ACTIVITIES
SINCE THE THIRD JOINT MEETING, SOFIA, OCTOBER 1988

This report includes information derived from the written reports of the national medical associations and information provided during the meeting in Rome. It is necessarily an overview of the most important items reported, but indicates substantial activities by national medical associations related to a number of regional targets in the HFA programme.

1. AIDS

A number of national medical associations have reported activities related to AIDS, particularly educational ones directed towards the profession, but some also involving education directed towards the public. A noteworthy initiative has been undertaken by the Swiss Medical Association providing training for doctors to provide the public with consistent information on AIDS. This Association was preparing to make a statement on HIV testing, but the text is not, so far, available.

Hungary, which belongs to the "low HIV-endemic" countries, continues to incorporate training in AIDS, at both undergraduate and postgraduate level, as well as carrying out public educational campaigns. Screening appears to be limited to donated blood and other screening carried out on volunteers.

Reports show that in the German Democratic Republic, the incidence of HIV infection and AIDS cases remains low, possibly due to previously limited travel and low drug dependency incidence. In 1984 the first case occurred and there are now 18 cases and 86 HIV-positive cases. There is concern about the problem of haemophiliacs who have acquired AIDS. This appears to have occurred solely due to the use of materials bought from abroad. Concern was expressed about the methods of contacting "at risk" groups as the people in these categories tended not to read informative literature.

The Standing Committee of Doctors of the EC has issued recommendations on the duties of hospitals with regards to AIDS. These deal with such headings as the duty of doctors to provide care for AIDS patients and the duties of hospital staff to care for them, information for staff and the provision of training for staff, informed consent to testing, confidentiality and counselling of patients and other obligations of hospitals to their staff in connection with AIDS.

The British Medical Association (BMA) has produced a book on AIDS and Human Rights which has been widely distributed and used as a basis for discussion by experts at the WHO global programme and UN Centre of Human Rights meetings. As a result of pressure the Government in the United Kingdom has accepted anonymous screening of blood residues to provide more epidemiological information. The BMA has produced various educational videos

which have been used in other countries. The BMA Foundation for AIDS has expressed very grave concern at what appears to be a change of attitude towards AIDS. Initially, government, doctors and all relevant agencies cooperated in information campaigns and efforts to combat the spread of the disease. Statements have appeared in the press recently stating that HIV infection was not transmissible through heterosexual intercourse, a Cabinet committee on AIDS has been disbanded and the Government refused to fund a survey on sexual behaviour. It was felt that complacency must be avoided, misinformation not based upon scientific fact must be combatted, and every care must be taken to avoid discrimination against AIDS patients.

Poland pointed out that AIDS was classified as an infectious disease which was subject to obligatory treatment. Training for physicians, both at basic and postgraduate level, has continued; there is compulsory reporting of HIV positivity and AIDS cases, screening of blood donors and of those who had lived in a high-risk area abroad returning to the country, including seamen and aircrew.

The French report educational activity in schools concerning AIDS and the Federal Republic of Germany feels that there is a very great need to inform the public and the executive as to why there is special attention being paid to AIDS patients. It feels that what is happening in the United States will arrive in Europe in five years' time and serious attention should be paid to the way in which things are developing in the United States, in particular in relation to the incidence of the disease in cities and high-risk groups. The Italian Association reports 5500-6000 AIDS cases in Italy and special training is being given to general practitioners in relation to this disease. The Swiss Association has produced a booklet on AIDS and the bulletin of the Ordre des Médecins Français has had a special article on the subject. The Icelandic Medical Association reports that the profession has made a direct approach to the homosexual community to collaborate in reducing the incidence of AIDS.

The Danish Medical Association is concerned that the subject of AIDS should retain a high profile and to this end has arranged to repeat a national AIDS conference later this year similar to the successful conference held 18 months ago.

2. Education

All responding associations have shown activity in the field of continuing medical education. In Hungary, where CME is compulsory for physicians, dentists and pharmacists every five years, there is a national agreement between the Federation of Hungarian Medical Societies and the Postgraduate Medical University on accreditation of courses, conferences and individual learning programmes organized by the national medical societies of the Federation. Such courses constitute one third of the courses undertaken by 6000-8000 doctors a year.

The Norwegians and the Swiss report continuing activity in this field. The Swiss are working on regulations for continuous assessment in postgraduate training and possibly also for further continuing medical education.

The Federation of Swiss Physicians has financed a study group of physicians and university lecturers to visit a number of universities in

Canada and the USA. This was followed by a seminar in Berne in June 1989 to discuss the results of this educational study and to make recommendations. The Federation endorsed the decisions of Edinburgh and of Lisbon and agrees that training should be geared to the needs of society and feels that medical schools should look again at the undergraduate curriculum in relation to these policies.

The Finnish Medical Association has drawn the attention of medical schools to the importance of teaching about alcohol and the problems of alcoholism. It is extremely concerned that there should be a reduction of the number of doctors being trained. The number of new medical students has gone up by approximately 20% and there is a shortage of teaching personnel in specialist training. Whilst it calls for an increased number of properly trained doctors for general practice, it comments that at the moment the number of training posts for those entering general practice is insufficient.

The Polish Medical Association, in expressing its view that one of the major tasks of the Association is to organize conferences and symposia, provide information on the most recent advances in medicine and assist young doctors developing their professional qualification, reports that in 1988, 2029 scientific sessions were organized. The Association has, in particular, developed several specialist sections on chemotherapy, clinical genetics, intensive therapy, etc. Conferences and symposia were organized at both national and local level and during 1988, 169 doctors carried out training abroad and 167 doctors visited the country during the same period. The Association opened a library, together with reading rooms.

3. Care of the elderly

Some special activities have taken place in relation to the care of the elderly. Hungary reports an increase in the number of "social homes" for the elderly; new care centres and 52 clubs for the elderly were developed in areas where there was a noted lack in the elderly care system. It is further reported that between 1987 and 1988 there was approximately a 20% increase in the number of people cared for at home, and the provision of meals, including "meals on wheels", increased by 57%.

In Switzerland a model system of ambulatory care for old people is being discussed in the cantons. The European working group of practitioners and specialists in free practice (EANA) has endorsed the recommendations of the Council of Europe on classification of the elderly into "independent, semi-independent and fully dependent" and has issued a policy statement on the principles of how to provide services to the elderly, in order that they can be maintained in home care as long as possible. One of the German member associations of EANA has been pressing the extension of social services in the domiciliary care of the elderly since 1970.

4. Other activities

In 1988 the Hungarian Medical Association was engaged in a national initiative concerning the prevention of hypertension. This was backed up with television and radio programmes of information, re-training programmes for

general practitioners, continuing discussions in the scientific programmes of monospecialist and general practice academic societies and the availability of machines for self-monitoring of blood pressures. During this period it was noted that the prescription of medicines for treating hypertension had increased by 30%. The Hungarian Federation has also been involved in many other aspects of health for all, including recommendations on diet, teaching health care in schools and universities, accidents at work and general health promotive activities. They were also involved at national level in anti-drug actions.

The Polish Medical Association has initiated the idea of reactivating the the Chamber of Physicians which has now been reconstituted for the first time since its suppression in 1951. In this connection it has actively supported the concept of appointment to managerial posts by open competition instead of administrative decision as in the past. The Association has organized a large number of activities to coordinate medical society in its country. In order to benefit from the experience of other associations and discuss the problems which it shares with other countries, it has established a section of international relations. The Polish Federation has organized conferences on the protection of humans from environmental pollution and has been involved in the problems of health care technology, patients' rights, the responsibility of the physician and the legal problems of new developments in human reproduction.

The Finnish Association has encouraged teaching about alcohol problems in medical schools and established a network to assist doctors with alcohol problems. It has also produced an educational video on drug dependency, promoted the involvement of physicians in environmental health problems, developed a new system of primary health care organization for general practitioners and is actively considering the legal problems of patients' rights.

In the Federal Republic of Germany, the pilot project of the NAV in Munich since 1986 on health education in schools has continued and has been dealing with such lifestyle subjects as tobacco and nutrition.

The British Medical Association has carried out the biggest and most comprehensive campaign in its history against the draft legislation proposed by the Government reforming the health care delivery system in the United Kingdom. This has involved the production of videos, leaflets, advertisements in the press, and a series of public meetings throughout the country. While certain features of the proposals, such as medical audit, have been welcomed, the major concern relates to the intention to introduce into the health care system radical organizational changes, which have been untried anywhere in the world, without any pilot trials. The French Medical Association has been concentrating particularly on regional targets numbers 10 and 16 in collaboration with the National Cancer Coordinating Committee activities to inform people about cancer. A national fund for preventive activities has been established and funded by the social security system, but doctors have not been asked to give their advice on the implementation of these preventive programmes. The Swedish Scientific Society has engaged in a programme to reduce alcoholism by 25% by the year 2000. Experiments in assessing the effects of a rationing system of alcohol are being set up as a combined effort between social and medical disciplines; but there is a need to develop sensitive markers including biochemical markers which will indicate over-use of alcohol.

The German Democratic Republic reports that a programme on reducing cardiovascular disease has been established by the medical societies and the academic societies.

The Icelandic Medical Association is very concerned about the working conditions of doctors and in particular the "burn out" of young doctors following the long hours of work. There is great concern about the increasing problems of female doctors due to the shortage of baby-sitters and the high cost of baby-sitters. To ease this problem the Medical Association itself has purchased a day-care centre. Legislation has been passed concerning confidentiality and disclosure of records and it was reported that medical information can only be accessed by the patient for the first time in the presence of a doctor. After that the patient has the automatic right of access to the information. There is an initiative to encourage an input from doctors into savings which could be effected in health care without reducing services. The Association is very concerned about differences it is experiencing with the Ministry of Health concerning the health for all policies on prevention. In particular it is concerned at a perceived trend in highly developed countries to divert resources from high technology to primary health care. The Association feels that resources should be given to primary health care without reducing the resources available in specialist care. The Pan-Hellenic Medical Association referred to a major campaign against alcoholism in which it had been engaged, together with a programme to reduce cancers of the skin due to excessive exposure to sunlight. The latter was directed not only to the indigenous population, but also to the visiting population.

5. Smoking

Ever since the Second Joint Meeting between WHO and National Medical Associations on HFA in Europe there has been an increasing activity by national medical associations (NMAs) on smoking. At the Third Joint Meeting NMAs undertook to attempt to carry out enquiries into the smoking habits of doctors. The reports this year showed a very positive activity by national medical associations in relation to smoking and there appears to be every indication that this activity will continue. This is a very gratifying indication of the value of the meetings of NMAs and WHO and it is therefore dealt with in a separate document.

Annex 3

REPORTS OF NATIONAL MEDICAL ASSOCIATIONS CONCERNING ACTIVITIES
RELATED TO TOBACCO SINCE THE THIRD JOINT MEETING, SOFIA, OCTOBER 1988

It is gratifying to note that all the reports referred to positive activity relating to smoking.

A report on surveys on smoking habits among doctors and nonsmoking promotion activities of the medical associations

Introduction

The Third Joint Meeting between WHO and National Medical Associations in 1988 recommended that national medical associations should start systematic, periodic surveys of physicians' smoking patterns and encourage physicians who smoke to stop. The associations should help to educate the public on the risks of smoking and put pressure on legislative powers for appropriate legislation on no-smoking areas, the advertising and taxation of tobacco products and the level of tar permitted in cigarettes.

This report is based upon the results of surveys of smoking habits among doctors carried out by some NMAs and other information presented prior to, and during, the Fourth Joint Meeting, together with material available in the Regional Office. It is not intended to be a comprehensive review, but highlights the information available.

Several national medical associations have made commitments to support nonsmoking promotion and smoke-free environments. In general, the medical profession has been in a central position in implementing anti-smoking measures and legislation. Professor Michael Kunze, the University of Vienna, has shown that in many countries the medical profession is the leading group in giving up smoking. This is also reflected in the activities of medical associations. As the country information shows, many European medical associations have made all-out commitment to stop-smoking campaigns to push for a smoke-free society.

Smoking prevalence among physicians

The data was not provided in a comparable format and therefore this report describes smoking prevalence data from two other sources. A recent study carried out in EEC countries showed that in several countries general practitioners are smoking considerably less than the population; however, the reverse is true in some countries.

Hans Adriaanse and his co-workers have summarized in 1986 data from several available surveys looking at the smoking rates among physicians and the general population. In Table 2, data from recent surveys relevant to the European Region are described. These tables illustrate the wide variations between countries. Comparison of data in Table 1 (1988) and Table 2 (the

Table 1. Smokers among general practitioners and the whole population in 1988 in EEC countries.

Country	GPs	Population	Difference
United Kingdom	10%	35%	-25%
Ireland	20%	37%	-17%
Netherlands	29%	45%	-16%
Belgium	29%	39%	-10%
Denmark	38%	45%	-7%
Germany, Fed. Rep.	25%	32%	-7%
France	31%	35%	-4%
Greece	39%	42%	-3%
Luxembourg	36%	33%	3%
Spain	45%	41%	4%
Italy	41%	33%	8%
Portugal	39%	27%	12%
Total	36%	35%	

Source: Commission of the European Communities, 1989

Table 2. Smoking habits among physicians and the general population in Europe in the 1980's.

Country	Year	Physicians		Population	
		Males	Females	Males	Females
Belgium	1983	34%	16%	47%	28%
Denmark	1980	39%	27%		
Finland	1984	19%	12%	37%	22%
France	1985		57%		43%
Hungary	1981	52%	39%		
Netherlands	1981-83		52%		44%
Norway	1984	19%	11%	46%	41%
Portugal	1980	67%	64%	41%	9%
USSR	1982	42%	15%		
Spain	1985	51%	52%	59%	20%
Sweden	1982	22%	14%	30%	30%
United Kingdom	1985	13%	7%	36%	32%

Source: Adriaanse H et al. 1986.

beginning of the 1980's) suggests, while keeping in mind the methodological difficulties, that there might be rapid decreases in smoking among physicians in some countries. This has been earlier demonstrated in some other countries, including Finland, Norway, Sweden, and the United Kingdom.

Information by country

Belgium

A study of doctors' smoking habits and attitudes has been carried out within the Edith Cavell Institute. It comprised a sample of 290 doctors working in the Institute of whom 73.6% were males and 26.4% females.

Among respondents, there were 74% nonsmokers, 7% occasional smokers and 19% daily smokers. Most ex-smokers (91%) had already quit over two years ago. Even the daily smokers were pretty sure that they will not be smoking after five years (60%). Nobody was sure that he or she will be a smoker after five years. The great majority (80%) of current daily smokers said that they never smoke in the presence of a patient. The most important reasons to be a nonsmoker were protection of one's health, unpleasantness for those around and avoidance of symptoms. Pressure from colleagues was not important.

Patients were counselled in the vast majority cases (around 90%) of smoking-related illnesses. However, 47% of respondents often raised the question of smoking with their patients with non-tobacco-related diseases. Smoking was allowed in 21% of the waiting rooms, but 92% thought that smoking should be banned or restricted in hospitals. Most doctors considered their skills adequate (77%) in advising a patient to stop. Very few (around 5%) thought that medical training in cessation support and smoking prevention is not needed.

Czechoslovakia

In Czechoslovakia, the medical association made a survey among doctors by publishing a questionnaire in eight medical journals. The association got 1403 answers. The respondents were predominantly nonsmokers or ex-smokers. Only 7.4% were smokers. More data was gained by assessing the smoking prevalence in the workplace of the respondents. This showed that 27% of doctors are smokers, although it varied widely according to the type of workplace: ambulance 54%, health centres 35% and scientific institutions 11%. The respondents felt their knowledge on cessation support insufficient in 52% of cases. However, an overwhelming majority of respondents recommended their patients not to smoke.

Denmark

The Danish Medical Association made a survey among members of the Representative Body of the Danish Medical Association. Of 183 members, 143 (78%) replied. Results: nonsmokers 58%, daily or occasional smokers 42%. The counselling practices didn't differ remarkably between nonsmokers and smokers, although there was a difference between counselling pregnant women to stop smoking (73% and 58%). Smoking was not usually permitted in waiting rooms.

Federal Republic of Germany

In the Federal Republic of Germany the National Medical Association (Bundesärztekammer) carried out a pilot survey among the participants in "Deutsche Artztetage" (120 respondents, 45% of the sample). Most of the respondents were men (89%), and they were older (55 years) than the average doctor (42 years) in the German Federal Republic. In the sample, there were only 11% daily smokers and 11% occasional smokers. Most of them smoked less than a pack a day. As much as 62% had quit smoking. Only one doctor said that he smoked in front of a patient. The respondents were active in counselling the patient: even when the patient had no smoking-related complaints and did not mention smoking, 39% often advised quitting. The vast majority (94%) supported the idea of smoke-free hospitals, either total ban or limitations of smoking.

A study about smoking habits was carried out among the practitioners and specialists in free practice in the national association (NAV) and in the European Working Group of Practitioners and Specialists in Free Practice (EANA). Of those surveyed, 54% were general practitioners and 46% were specialists. They were predominantly male (92%). There were 46% nonsmokers, 23% occasional smokers and 31% daily smokers. Most of the nonsmokers were ex-smokers. The average daily consumption among smokers was 10 cigarettes, 4 pipefuls of tobacco and 6 cigars. Serious quitting attempts were common (46% of smokers) and only 15% of smokers thought that in five years' time they will probably still be smoking. Protecting one's health was an important reason for not smoking, as was setting a good example. None of the respondents smoked in front of a patient. Smoking was not permitted in the waiting rooms. All patients were usually advised to stop smoking if they had smoking-related diseases. Smoking in hospitals should be restricted or eliminated according to the vast majority of the respondents (92%).

German Democratic Republic

In the German Democratic Republic the HFA objectives relating to tobacco are agreed both by the Government and by the medical profession. Doctors have a duty to talk to patients about smoking and to counsel their families concerning smoking and lifestyles. Emphasis has been placed upon the role of tobacco in reducing cardiovascular disease. Referring to the observed reduction in life expectancy in smokers, the first report on cardiovascular disease and smoking 25 years ago had a substantial impact in the German Democratic Republic. Currently, smoking promotion has been banned for some time. Smoking has also been banned in schools, restaurants, health buildings and in public places. There is an observed reduction in smoking among the middle-aged, but a marked increase in young women smoking. The incidence of lung cancer in men ceased to rise about ten years ago, but its incidence in women has doubled in the period 1960-1985. All medical societies have formed a common committee in order to coordinate antismoking activities. It is estimated that 10-20% of physicians smoke.

Finland

The Finnish Medical Association has been active for several years in the field of smoking control. The latest representative study (N=3249, response rate 84%), supported by the Association, on smoking prevalence among

doctors was made in 1984. Compared with the study in 1974, the prevalence of daily smoking had decreased among men from 22% to 14% and slightly among females (from 10% to 9%). However, occasional smoking had increased slightly. There were interesting differences between different specialties (men in 1984): surgeons 19%, psychiatrists 17%, paediatricians 9%, others 12-15%.

The Association has had a working group on tobacco control policy for several years. In 1985, it carried out a campaign among doctors and patients. The campaign materials consisted of an appeal to intensify smoking cessation support to patients and a series of articles published in the Finnish Medical Journal, posters and no-smoking recipes intended for patients. In 1988, a seminar was held with the representatives of labour unions and of employers' organizations on involuntary smoking in the workplace. A recommendation on protection from passive exposure was approved. In 1989, an article on nonsmoking policy in the Mayo Clinics, USA, originally published in JAMA, was translated into Finnish and distributed to all physicians in leading positions.

A survey was made about the smoke-free policies in hospitals and health centres as well as availability of quitting support for willing smokers. Out of 400 head physicians, some 349 responded to the survey. The results indicate that the smoke-free policies are overwhelming in Finnish health centres and hospitals. Rooms are smoke-free even in cafeterias and the like. Only 7 out of 192 (4%) health centres and 22 out of 157 (14%) hospitals permit any smoking, usually limited, in their cafeterias. The problem is now that many smokers are smoking in front of the main door, which makes an unpleasant impression on a coming patient or visitor. The sale of tobacco products is limited (usually totally banned) in one quarter of the health centres and in one fifth of hospitals. Patients are usually not allowed to smoke in the patient rooms. Usually they have smoking rooms or areas. Over one half of the health centres said that they had organized some cessation activities, but only 15% of the hospitals. Surprisingly, all medical meetings are not yet smoke-free: smoking was allowed or partly allowed in about one tenth of the institutions.

France

In France, l'Ordre National des Médecins, is conducting an extensive study among physicians according to the WHO guidelines. The 1635 replies to the questionnaire have yet to be analysed. The Confédération des Syndicats médicaux Français has very actively engaged in the French national campaign against smoking.

Greece

The Greek Medical Association was able to report substantial positive progress as a result of its campaign to reduce smoking among pregnant women. It is felt that the success in smoking cessation among mothers will have a beneficial effect on smoking in the family as a whole.

Hungary

In Hungary a sample of 50 doctors, 12 of them pneumonologists, filled in a questionnaire. There were only 20% of nonsmokers, 4% of occasional

smokers and as much as 76% of daily smokers. They had very little intention to stop, but they didn't smoke in front of a patient. Smoking in waiting rooms was usually not permitted. The conference of pneumologists issued a declaration emphasizing the responsibility of all physicians in influencing smoking habits. Smoke-free Europe booklets 1-9, originally published by the Regional Office, were translated into Hungarian. The booklets "Help your patient stop" and "How to quit smoking" were translated and adapted. Also a leaflet persuading smokers to respect the rights of nonsmokers was printed. Fifty-five doctors were recruited to conduct cessation clinics and a manual "Doctors to doctors on smoking" was prepared. A law to protect nonsmokers was proposed to, but rejected by the Parliament. Most of these activities were carried out with the National Council for Health Promotion.

Iceland

Iceland was able to report that smoking among doctors and patients has diminished.

Italy

It was reported that the Ministry of Health has drafted a recommendation for discussion with the profession concerning smoking which it hopes the physicians will support. There is a bill before Parliament at the present time concerning smoking in public places.

Morocco

The Moroccan Medical Association made a survey among 76 male and 22 female doctors, most of them specialists in various fields of medicine. Very few of the respondents said that they smoke in the presence of a patient. Smoking was allowed in one quarter of waiting rooms, but most respondents (82%) favour restrictions in hospitals.

Norway

The Norwegian Medical Association reported on a recent study carried out among representative samples of physicians. The study compared surveys from 1952, 1974 and 1984. In 1984 the response rate was 91% and the respondents included 435 female and 969 male physicians. The proportion of smokers was 19% among males and 11% among females. The respective figures in 1952 were 75% and 45%. Based on the study, it was concluded that some 2400 Norwegian doctors have quit smoking. The smoking respondents in 1984 were very much in favour of quitting and only 11% of male and 4% of female doctors were sure that they will still be smoking after five years. The authors concluded that based on the trend of decrease among smokers, the Norwegian doctors would be smoke-free by 1996. The study showed that nonsmoking doctors were more likely to discuss smoking with the patient. They were also more interested in helping patients to quit. Younger doctors, general practitioners and graduates from Norwegian medical schools were most likely to support patients in quitting.

Poland

Although it was reported that there have been activities in education concerning the risk of tobacco and smoking, it was reported that the results

of the campaign had not been good. Prior to 1939 it was reported that Poland produced 7.5 billion cigarettes a year; it now produces 100 billion cigarettes. There were 13 000 lung cancer cases last year, with an average of 100 deaths per day from smoking-related diseases. Nevertheless, it was hoped to achieve no-smoking by the year 2000. It was felt that smoking in medical schools should be prohibited.

Sweden

The Swedish Medical Association has made a survey amongst 1100 doctors, the results of which are not yet fully available. As part of a very active campaign to reduce smoking, much publicity was given at the National Convention, no-smoking areas were being encouraged, and patients have been asked to contact their doctors who have been supplied with no-smoking packs to give to patients. These packs include an audio-tape, as well as instructions on to how to stop smoking. These have been produced by the other medical organization in Sweden, Läkarsällskapet, and the Swedish Medical Association has appointed a special working group on tobacco which is preparing a booklet containing facts about tobacco-related diseases, as well as guidelines for prevention of smoking and other forms of tobacco use.

Switzerland

The Swiss National Medical Association has reported enhanced activities in 1989/1990, with considerable funding, against smoking, especially among youth. It is of interest, that the professional association of Swiss doctors is actively supporting a petition for a referendum promoting the abolition of tobacco and alcohol advertising for the benefit of the young. Similarly, efforts are being made to encourage physicians to carry out preventive medicine activities in their day-to-day practice.

United Kingdom

The British Medical Association continues to chair two tobacco groups, one based in London and the other in Edinburgh, which meet regularly to coordinate the activities of campaigners and cancer charities active in tobacco control in the United Kingdom. Collaboration includes press, Parliamentary and scientific activities and the BMA's panel of 500 doctors active in tobacco control.

The British Medical Association contributed to the World Health Organization First European Conference on Tobacco Policy, held in Madrid in 1988, handling the translation and production of nine of the conference booklets published as a "Smoke-free Europe" series. These include the booklet "The physician's role". The BMA produced with WHO, ICF and UICC a booklet for general practitioners "Help your patient stop". This has already been translated into Spanish and French. A new booklet "Clearing the air: a guide for action on tobacco" will be published in collaboration with WHO. A further book is to be produced on the experience of smoking cessation in eastern Europe.

The British Medical Association has, in addition, been very active in counteracting tobacco in the fields of smoking and children, smoking at work, tobacco taxation, and the need for tobacco legislation.

Annex 4

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