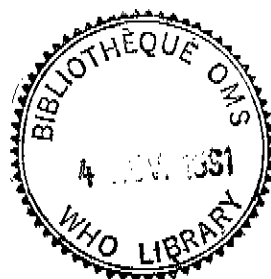




WHO

REGIONAL OFFICE FOR EUROPE

*FIFTH JOINT MEETING
BETWEEN WHO AND
NATIONAL MEDICAL
ASSOCIATIONS
IN EUROPE*



Helsinki
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Index terms

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HFA STRATEGY COORDINATION	CZECHOSLOVAKIA
ORGANIZATIONS	DENMARK
ENVIRONMENTAL HEALTH	FINLAND
POLIOMYELITIS - prevent/control	FRANCE
PHYSICIAN'S ROLE	GERMANY, FEDERAL REPUBLIC OF
QUALITY ASSURANCE, HEALTH CARE	GREECE
URBAN HEALTH	ICELAND
HOUSING	NETHERLANDS
LIFE STYLE	NORWAY
PATIENT ADVOCACY	POLAND
EDUCATION, MEDICAL	SWEDEN
	TURKEY
	USSR

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SUMMARY

There are three noteworthy achievements of this Fifth Meeting.

First, the activities of medical associations throughout Europe are now well documented - their organization and functions, their involvement in continuing medical education, their journals and their year-to-year activities.

Second, the European Forum of Medical Associations with WHO (EFMA) has emerged as an effective vehicle for integrating new and emerging nongovernmental professional associations in central and eastern Europe within a Europe-wide network.

Third, continuing dialogue with the medical profession throughout Europe, east to west and north to south, is now assured through the European Forum of Medical Associations. The Forum is established as a loosely-structured organization in which member associations are bound together with minimal formality through a Statement of Guiding Principles.

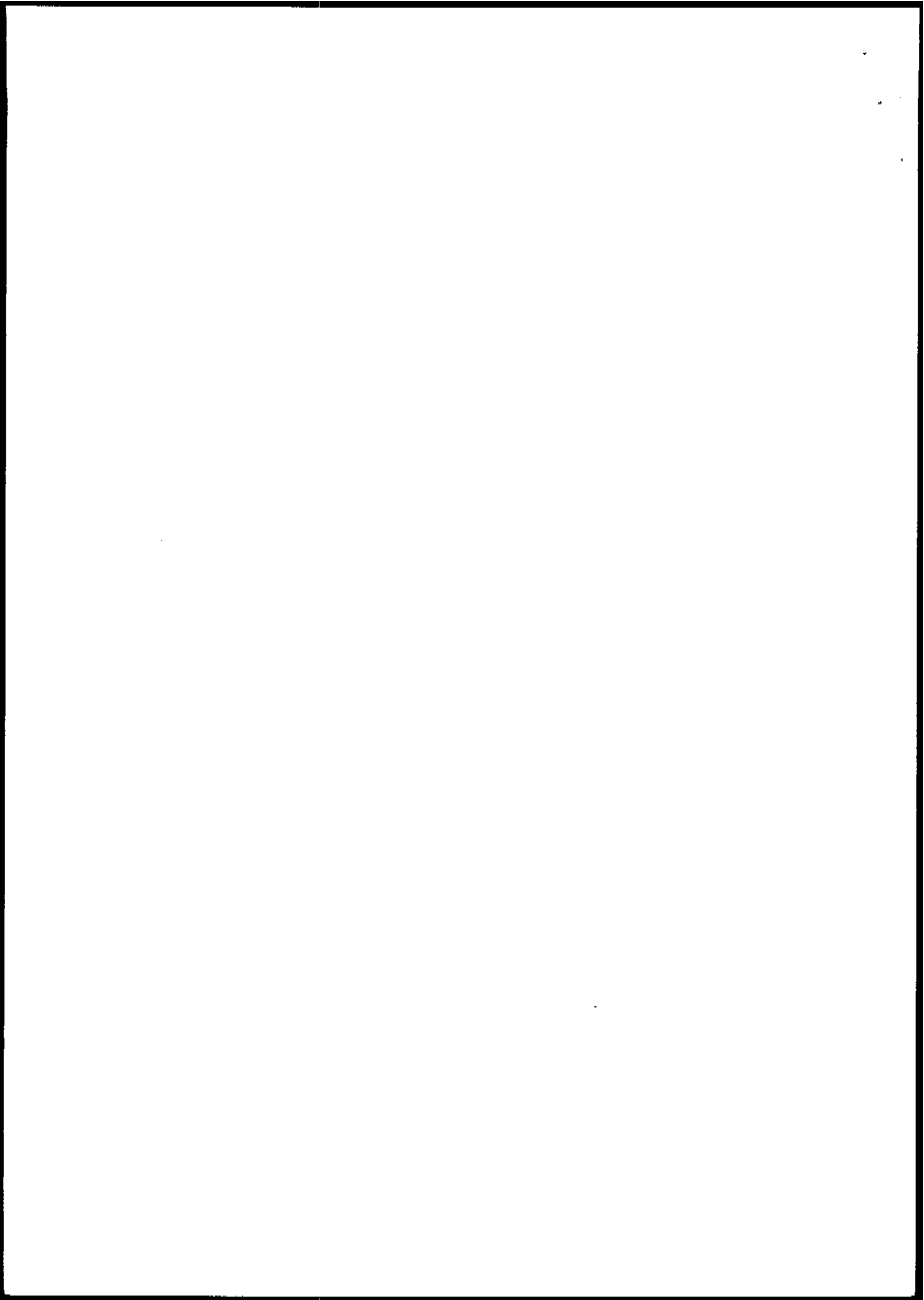
The report provides a collective guide from the medical associations to anyone involved in continuing medical education. This is one area in which the profession and the WHO Regional Office for Europe have a common purpose in raising the level of health care for all Europeans.

An area that is no longer neglected by the medical profession is the reduction of the risks to health from poor environmental conditions. The report describes how several national medical associations have recognized the importance of the physician's role in environmental health.

National medical associations were active in 1990-91 in areas of health policy, since many countries - not only those of central and eastern Europe - are reforming their health care systems.

Innovations are reported in the use of informatic services for continuing medical education. Public health action against smoking continues to be a dominant activity. Several associations report a shift of concern, in assuring quality of care, towards evaluating the outcome of hospital care and primary health care.

Future collaboration between European medical associations and WHO will go beyond the annual meetings (the next will be hosted by the Swiss Medical Association and will take place in Basel on 30-31 January 1992). Collaboration will now extend to undertaking joint activities in the inter-conference period.



Opening remarks

Post-1992 Europe

The meeting was opened by Mr Mauri Miettinen, the Minister of Social Affairs and Health of Finland, who referred to the integration of European countries through the European Economic Area, comprising the countries of the European Communities plus those of the European Free Trade Association. The mobility of the medical profession will be affected by the freedom of movement of labour, goods, services and capital in post-1992 Europe.

Finnish health for all (HFA) strategy

Finland adopted a national health for all (HFA) strategy in 1986, based on the WHO European health policy and strategic targets. Intersectoral cooperation is considered by Finland to be the key to achieving a healthy society. The country had just completed a review of the national HFA strategy by a process of quality review of policy implementation.

Effects of environmental deterioration on health

The Minister complimented the organizers for including as an agenda item the theme "The Physician and the Environment". Physicians are giving more and more emphasis to the effects of environmental deterioration on health. Finland had participated with other ministers of health and ministers of the environment in 1989 in the meeting in Frankfurt that generated the European Charter on Environment and Health. He was pleased to announce that Finland had offered to host the follow-up ministerial conference in 1994.

The role of health professions in times of conflict

Dr K. Juva, President of the Finnish Medical Association, referred to the need for European physicians' associations to support individual physicians when they encountered violent action. In these times of armed conflict, the ethics of medical practice need to be applied in the same way as in times of peace. The health professions in these areas of conflict need to be protected in order to be able to carry out their humanitarian activities.

Are we conducting our professional activities in the most effective way?

The two main purposes of the profession are to restore and to promote health. All association members therefore have a responsibility to the individual patient and to society. Physicians have to ask themselves the question "Are we conducting our professional activities in the most effective way?". If we do not, others will seek to answer the question. Medical associations are finding that members have increasing interest in the outcome of health care and are seeking to increase their competence in assessing this. In addition, there is an increased desire for managerial and economic skills among association members.

The need for bye-laws for conducting the annual dialogues

Dr Juva referred to the need for bye-laws for conducting the annual dialogues between medical associations and WHO, especially if cooperation between associations is to be further strengthened. This strengthening is desirable because European physicians face common European problems and share a common cultural heritage.

Welcome to member associations

The WHO Regional Director for Europe, Dr Jo E. Asvall, welcomed the 23 member associations and 70 participants and observers to the Meeting (Annex 2). Despite the international situation this was the largest attendance ever. However, what impressed him was not the numbers but the weight of representation. Gathered in this beautiful conference centre was the medical leadership of Europe.

Facing exploding social problems throughout Europe

In Rome, there had been optimism about a new beginning in Europe. Since then, social problems had exploded in the faces of decision-makers. Dr Asvall depicted a stark picture of deprivation, falls in living standards and unemployment in countries in central and eastern Europe. These were compromising the health of their citizens, which is already lower than that of citizens in the rest of Europe. Since 1983, all countries have been reporting the health of their populations to WHO through a set of regional HFA indicators. These indicate that countries of central and eastern Europe are some five to six years below the rest of Europe in life expectancy at birth. Rates of infant mortality and cardiovascular disease mortality greatly exceed those in the rest of Europe.

Progress in central and eastern European countries

However, progress is being made. In Romania, a strong WHO team launched an action programme even as the revolution was proceeding. The nosocomial AIDS epidemic was curtailed. Maternal mortality has fallen by two thirds as family planning services have been restored. Comprehensive child health services are being developed with the assistance of funds donated to the Regional Office for Europe by the United Kingdom Government. Training in health management has been introduced. To support Romania on its long road to health improvement, new efforts have been made to mobilize resources for the country's health services.

The year has seen the emergence of democratically elected governments, and the health sector has been influenced by this process of democratization and economic reform. The new democracies have formulated health reforms that encompass forward-looking policies and that have been generated by new processes of policy-making. To support these, a new WHO health programme for central and eastern European countries was launched in September 1990 by a Resolution passed by the WHO Regional Committee. This gives to the Regional Office for Europe the role of serving as honest broker between those with problems and those with resources.

The emergence of independent medical associations in central and eastern Europe

In the course of the year, new independent, nongovernmental medical associations have emerged in central and eastern Europe. Within the framework of these annual meetings, the Regional Director hoped that means would be found to support the new associations, for example through fellowships.

Crisis in the Gulf

The Regional Director referred also to the assistance in disaster preparedness given by WHO to Turkey in the face of the crisis in the Gulf.

Regular WHO programmes: polio eradication in Europe

These new and unforeseen problems had not deflected WHO from its regular programmes. For example, the Regional Office was still pursuing polio eradication, despite new outbreaks in the Asian republics of the Soviet Union and in Turkey.

Organizational aspects of the European Forum of Medical Associations and WHO

Dr Asvall referred finally to the organizational aspects of the European Forum of Medical Associations and WHO. Participants at the Rome meeting had appointed a committee of five to advise him and the present Meeting on the aims, organizational structure, participation and voting rules of the Forum. The advisory committee had completed its task and a draft constitution had been distributed to all participants last November. No comments had been received in the Regional Office. Nevertheless, a considerable part of the discussion at this Meeting would be devoted to the constitution drafted by the committee and he hoped that a broad consensus could be achieved. The aim was to ensure that, through the Forum, all physicians in Europe can enter into dialogue with WHO and vice versa. With this issue settled, the Forum could then proceed to a new phase of going beyond annual meetings and develop concrete projects for cooperation.

Officers of the Meeting

Dr Asvall proposed that the officers of the Meeting should be: Chairperson, Dr K. Juva, President of the Finnish Medical Association; Vice-Chairpersons, Professor M.E. Machado Macedo, President of Ordem dos Medicos, Portugal, Dr J. Haffner, President of the Norwegian Medical Association and Professor F. Varnai, Secretary-General of the Federation of Hungarian Medical Societies.

Medical associations and continuing medical education (CME)The lack of information as to which CME approaches are effective

Professor M. E. Machado Macedo, who chaired the CME session, had recently participated in the Fifth World Conference on Medical Education at Rancho Mirage, 22-28 October 1990, which had also dealt with CME practices in various countries. There is considerable variety in the organization of CME but little information as to which approaches are effective.

The goal of CME is to ensure that optimal medical care is delivered to the patient and to the community

Dr René Salzberg, President of the Committee for Continuing and Further Education, Verbindung der Schweizer Ärzte, introduced his discussion paper on the role of national medical associations in the continuing education of physicians.^a

The goal of CME is to maintain and improve the competence of physicians. This is attained through a learning process that begins with entry to medical school, extends through the long period of postgraduate specialty training,

^a The role of national medical associations in the continuing education of physicians (ICP/HSC 017/7).

and continues for the rest of professional life. The components of that competence include not only knowledge and technical skills but those ethical and moral values that are called behaviour. These are expressed through educational objectives for CME that meet both the needs of individual physicians and those of society, so that medical care is delivered effectively.

Adult learning is effective when it is patient- and problem-oriented

Unfortunately, CME often consists of poor pedagogy with formal lectures or half-day seminars. Discussions of patients and problems in peer groups, consultations with experts, use of literature and databases are all practical measures that the individual can take to improve individual performance.

Funding and independence

Funding can be from the professions individually or collectively, from private sponsors, such as pharmaceutical companies, or from governmental bodies. Funding by physicians themselves allows CME to be independent.

Should CME be voluntary or compulsory?

There is a long standing polemic as to whether CME should be voluntary or compulsory. Arguments against the latter point out that changes in physicians' behaviour are not guaranteed by merely participating in a CME activity. Advocates of voluntary systems draw attention to the invisible character of many types of CME, such as the study of literature, work in small groups, interactive audiovisual methods and learning through computer-assisted instruction. Voluntary systems are more likely to guarantee quality, since participation will rise in relation to its relevance and usefulness. However, voluntary systems require that physicians learn early in their education to become lifelong learners.

Rewards, careful preparation, pedagogic training and introducing quality control

In summary, medical associations are encouraged to:

- reward efforts by physicians to improve their competence;
- plan carefully CME content based on the needs of practising physicians;
- give teacher-training in modern pedagogic techniques of adult learning; and
- introduce quality control of CME through chart review or peer review models for evaluating physician' skills.

Proposed working group on inducing physicians to participate in CME

Dr Salzberg concluded with the proposal emerging from a survey of medical associations conducted by the Norwegian Medical Association. The concluding recommendation invited interested associations to join a self-financed working group to prepare working papers for the next meeting of the Forum on how physicians working in different health care systems can be induced to participate in CME.

Adequate health care: the goal of WHO's education policy

Dr Mila Garcia-Barbero, Medical Officer for Health Manpower Development, WHO Regional Office for Europe, emphasized that the main point of all basic and further education is to provide adequate health care. Motivation to be a lifelong self-learner has to be acquired in medical school. Medical education must be changed to meet the health needs of the community. Continuing education needs to be planned more effectively. Many efforts have been devoted lately to this task: the World Conference on Medical Education in August 1988; the Ministerial Consultation on Medical Education in Europe held in Lisbon the same year, and the 1990 Council of Europe Conference of European Health Ministers held in Nicosia. Based on two European health policy targets,^a a WHO education policy document is being prepared for presentation to the WHO Regional Committee - the health parliament of Europe. She invited medical associations to discuss this policy document and to promote changes in continuing education in their publications and professional meetings.

What changes are needed?

The following changes that affect professional work are needed:

- the focus of care needs to shift from curing illness to promoting positive health;
- continuous and comprehensive care should replace episodic care;
- the health care system should be organized on a base of well-coordinated teams that include general practitioners and other personnel; and
- health should be promoted through intersectoral collaboration, community participation and personal responsibility.

Changes in pedagogic strategies are needed, since adults learn better if the subject is closely related to their everyday work and if:

- disciplines are joined in interdisciplinary groups;
- lectures are replaced by problem-solving and teaching by learning; and
- education is multiprofessional to promote teamwork.

Conclusions of the 1988 Lisbon Conference

At the end of the Meeting, the national delegations at the 1988 Lisbon Conference stated how much needs to be done to change medical education in Europe. Their final conclusions were that:

^a Target 36. Before 1990, in all Member States, the planning, training and use of health personnel should be in accordance with health for all policies, with emphasis on the primary health care approach.

Target 37. Before 1990, in all Member States, education should provide personnel in sectors related to health with adequate information on the country's health for all policies and programmes and their practical application to their own sectors.

1. A country's medical education policy should reflect a clearly defined health policy stemming from the European health for all strategy.
2. Mechanisms should be established to foster close cooperation between the health and education sectors in defining policies and programmes for health professional education.

Response of associations to the Finnish Medical Association's questionnaire on CME

Dr K. Winell, Vice-President of the Finnish Medical Association, reviewed responses to a questionnaire on CME that the Association had received from 20 other associations. The responses were categorized under motivation and incentives, funding, management, rewards, relevance, scientific value, pedagogic value, international CME and impact.

Should CME be a condition for recertification?

Answers from Belgium implied it would be good if CME were a condition for recertification and the Spanish Consejo General de los Colegios Oficiales de Medicos also replied that CME-related legal norms should be defined for all doctors and that recertification is needed.

Diversifying funding sources

Diversification of financing sources was favoured by Czechoslovakia, the Netherlands, Poland and Switzerland. Countries with primarily government-financed CME hope that other sources would participate in the financing of CME to a larger extent than has been the case so far.

How much CME do physicians receive in a year?

For physicians in primary health care, the quantity of education is somewhere between 5 and 15 days annually, and for hospital physicians between 10 and 20 days.

Who is the ideal provider of CME?

Ten out of twenty respondents consider medical associations the most important providers of CME. The ideal provider of CME seems to be a professional organization.

What is the preferred form of reward?

Repayment of CME expenses was given as the preferred form of reward (15 out of 20). Linking CME to an increase in salary is also favoured by many respondents (12 out of 20).

Defining CME needs through surveys

Surveys seem to be the least often used systematic method for defining the need for CME.

Contents of CME

The most important contents of CME include clinical diagnosis, clinical therapy and drug therapy. Prevention of disease is also valued highly in the order of priority: Iceland and Portugal named it as the most important

issue. Other issues in descending order of importance include medical ethics (6) and social medicine (6), international health (4) and administration and management (3).

Experience of evaluating the impact of CME

There is little experience of evaluating the impact of CME. This would require peer review and medical audit. The conclusions drawn from the survey are that there is a need for closer control and evaluation of CME. More information is required on the legal basis of CME in Europe, and the content in the future will need to include bioethics and health promotion.

Financing mechanisms for CME; examples from Ireland and Norway

In the discussion, the practices of the national associations of Ireland and Norway were cited. In the former, there is reported to be a state budget for further medical training and a body for managing that training. In Norway, CME is financed from the increase in fees negotiated for all doctors. From these increases, lump sums are transferred each year to CME funds, thereby reducing the increases for doctors in general, unless they have participated in CME. Two other financial mechanisms proposed were that 1% of physicians' fees go to fund continuing medical education and that a percentage of medical association membership fees be allocated to CME. These mechanisms have the advantage of making the physician independent of governments and of any commercial sponsorship.

Views of the Belgian, Czechoslovak, German, Italian and Polish Associations

Dr A. Wynen of the Association belge des syndicats médicaux stated that his association favoured compulsory training or sanctions for physicians who failed to participate. This would, however, have to be accompanied by the monitoring of any compulsory training and evaluation by peer review. Professor Chrusciel of the National Physicians' Chamber, Poland, welcomed the recommendations in Dr Salzberg's paper, but pointed out the difficulties of coming to a consensus on models for evaluating physicians' skills.

Professor J. Blahos, President of the Czechoslovak Medical Society, drew attention to the existence in Prague and in Bratislava of institutes for postgraduate and continuing medical education. The nature of these institutes is changing and closer cooperation is now established with scientific medical societies and academic institutions. It was pointed out that similar institutes exist in other central and eastern European countries, and all were undergoing similar changes to those described in the Czech and Slovak Federal Republic as new models of CME develop in central and eastern Europe. In Poland, for example, the institute was part of the Ministry of Health but training is now cosponsored by the National Physicians' Chamber.

Professor P. Paci of the Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri, Italy, felt that the primary responsibility for CME and quality assurance should lie with the medical association, with the hospitals and universities acting as collaborators. Associations should not accept funding for CME by reducing the funds available for health care.

Dr K. Vilmar, President of the Bundesärztekammer, felt that it would be wrong to exact penalties from physicians who do not participate in CME. Rather, it would be more reasonable to investigate why participation is low. Physicians could have good reasons for not participating.

Differing roles of medical associations and scientific societies

In conclusion, Dr Salzberg emphasized the different roles of medical associations and scientific societies. The latter, as the consumer group, should determine the content and aims. The medical associations should look for funds and provide the opportunity for CME to its members.

Quality assurance

Quality assurance has been on the agenda of previous meetings. Although it was not very well received initially, the situation has improved remarkably. The report of the 1990 meeting reflects that the national medical associations have an important role to play in quality assurance, and emphasizes that the profession should be able to provide information on the clinical outcome of their patients. Secondly, it states that the medical associations should play a role in training in quality assurance at both pre- and postgraduate level. These positive statements in the 1990 report have been followed-up by concrete action, and numerous quality assurance initiatives are described in the annual reports of most western national medical associations.

Defining state of the art in quality assurance within each speciality

If one defines quality assurance as a methodology for getting the highest quality of health care, grounded in solid scientific evidence for minimal cost, it becomes obvious that the medical associations and their affiliated specialized societies must be the key actors in providing information on the state of the art within each speciality.

Refocusing on clinical outcomes

The emphasis during the last 10 years has been on the structure and process of care but the time has now come to focus on outcomes. If quality assurance is to be a continuous development for attaining better outcomes, national medical associations must be actively involved in defining the outcome indicators to be measured within each speciality. Associations should also participate in the development of information systems that provide feedback to physicians on the outcome of care.

Quality control: diabetes prevention and control of hospital infection

Two WHO activities in the field of diabetes prevention and control of hospital infection were presented by Dr Anne-Marie Worning, Medical Officer, Quality of Care and Technologies. Both projects rely on the constant surveillance, monitoring and feedback to the medical professionals on rates of selected clinical outcomes. Promises were obtained from several countries stating that the national medical associations wished to participate in these programmes.

Who should pay for CME? - the key question

In summing up, the Vice-Chairperson, Professor M. E. Machado Macedo, urged participants to follow up the practical suggestions made by Dr Worning. A crucial issue is who should pay. The existing system often wastes resources through offering an abundance of courses. The other key issue is motivation. It is the role of the medical associations to give prominence to the idea that medical education begins on the first day of entry to medical school and continues to the day the physician dies.

The physician's role in environmental health

Quantifying the impact of the environment on health

The working paper presented by Dr Savolainen (ICP/HSC 017/8) states that priorities must be established for the physician's involvement in environmental problems because there are many more environmental risks than can ever be prevented. Thus, it is vital for the physician to identify key issues. Understanding causal links and concepts of dose-response relationships are prerequisites for quantifying the impact of the environment on health.

The most important environmental factors endangering human health

Combustion of fossil fuel is one of the major hazards to nature. Furthermore, emissions from fossil fuel combustion are probably the most important environmental factors endangering human health. This shows how policies, starting from choices for energy production, have an impact on both the quality of the environment and on health.

Environmental health issues in meetings and publications of medical associations

A prerequisite for medical involvement in environmental problems is the education of all physicians about health hazards of the environment. National medical associations should therefore be active in promoting environmental health by giving time and space to environmental health issues in national meetings and publications.

Role of medical associations

In summary, the particular role of medical associations should be to:

- work for strengthening the influence of the medical profession in public debate and policy-making on environmental health issues;
- promote implementation of the European Charter on Environmental Health in order to give prominence to health and the environment in policy considerations for social and economic development; and
- promote training and research in environmental health amongst medical professionals.

European Charter on the Environment and Health: a tool for medical associations

Dr S. Tarkowski, Director, Environmental Health, WHO Regional Office for Europe, informed Associations that the European Charter on the Environment and Health has been translated into 17 national languages. At the opening session, Minister Mauri Miettinen had announced that a ministerial conference would take place in 1994 in Finland to follow up the implementation of the Charter. Practical examples were cited of the physician acting as a "sentinel" in monitoring adverse effects of the environment. It was a paediatrician, for instance, who first recognized that the neurological syndrome which occurred in Spain, in epidemic proportions, was due to toxic oil.

This sentinel role is important, for example, in detecting manifestations of respiratory disease due to environmental causes. In work-related health disorders, there is the example of the relationship of angiosarcoma of the liver to vinylchloride exposure. The physician has an important contribution to make to the epidemiology of environmental health problems by acting as an observer and indeed as a hypothesis-generator.

In addition to his individual role, the physician has an environmental health role at the community level. There is also the important role of the further education of the medical profession in environmental health issues. The Finnish Medical Association has been promoting the training of physicians in environmental health. Physicians and their associations can widen their knowledge of environmental health, can influence decision-makers, support professional training and promote research in environmental health. The Charter on the Environment and Health is an excellent tool for stimulating discussions in national medical associations and for promoting discussion in society in general. Finally, participants were reminded that the Regional Director had offered prospects for joint projects between WHO and the medical associations.

Presentation from the Association of Physicians of Kazakhstan

Dr Z. Alimkhanov from the Association of Physicians of Kazakhstan then reviewed the relationship between various mental and neurological disorders and exposure to radiation from the detonation of nuclear devices in this Asian republic of the Soviet Union.

The Kazakhstan Association of Doctors and Pharmacists, which was founded in 1990, has been taking an active part in solving the problems of ecology in Kazakhstan and in eliminating environmental conditions that have harmful effects on people's health.

The Association has started research on the possible harmful influence of nuclear tests on the mental health of people living close to the site of nuclear testing. Half of all registered cases of mental diseases are people suffering from oligophrenia (49.5%), the second place belonging to schizophrenia (29%). The greatest frequency of oligophrenia is seen in the age group 10-30 years (61.2%). Some 42% of patients with schizophrenia are older than 40 years - these are people born before the first nuclear explosion of 1949. Oligophrenia rates are high among persons born during the last 30 years. The region close to the experimental site is characterized by an epilepsy rate which is twice as high as that in the other parts of the Republic. A direct correlation has been determined between suicide rates and distance from the experimental site. This investigation was reported at the First International Congress on "International Citizens for a Nuclear Test Ban" at Alma-Ata in May 1990.

Environmental "observer" practices of physicians in Germany

Professor G. Osterwald of the Bundesärztekammer described the activities of physicians in Germany, in collaboration with WHO, in the project of "observer" practices: 150 physicians spread throughout Lower Saxony collect information on environmentally-caused damage to health and report this to an office of the Federal Republic.

Healthy Cities

The Healthy Cities project was described by Dr A. Tsouros, who supplied the associations with a contact address list of the Healthy Cities projects in their countries. The Healthy Cities Project is a process which can truly make a difference to the health and wellbeing of those who live and work in cities.

The project offers opportunities for collaborative work with medical associations and medical practitioners in the areas of environmental health, quality assurance, prevention, training and information exchange.

The problems in our cities are many: much mortality, morbidity and disability is preventable; air, water and noise pollution problems are often acute; services are often not planned to be sensitive to the special needs and wishes of the most vulnerable groups; there are growing contrasts between wealthy suburban localities and deprived inner city localities with run-down housing, unacceptable environmental conditions, and lack of appropriate structures and support.

The WHO Healthy Cities Project involves a network of European cities which have endorsed the principles and policy directives of the Health For All strategy and are committed to a five-year plan of action for health (1988-92).

The project, which was initiated in 1987, has grown to include 30 project cities in Europe and 17 national networks. Many cities from central and eastern Europe have expressed interest to work with the project. Establishing national networks in these countries is a major priority for WHO in 1991.

The project has well-established mechanisms to promote information exchange and the sharing of experience. Activities of the project which have a direct relevance to the work of medical associations at national, regional and local level are:

- addressing the support and care needs of vulnerable groups such as the elderly, children, migrants, the homeless and people with disabilities and chronic conditions; and
- reorienting health services with special emphasis on community-based care programmes, prevention and health promotion in primary and secondary care settings, methods for measuring patient satisfaction, and building professional alliances for continuing care.

Groups of cities have started addressing common concerns by jointly developing and implementing action programmes in areas such as tobacco, AIDS care, elderly people, youth (including the Healthy Schools project), the health promoting hospital, nutrition and mental health.

WHO is at present setting up databases and systems which will facilitate the flow and exchange of information on the numerous projects that are going on in cities and the skills and expertise that can be shared in Healthy Cities networks.

A good starting point for collaboration with the Healthy Cities networks would be for medical associations to join as partners, at national and local levels, the steering committees of the respective Healthy Cities projects. Medical associations and individual practitioners, whether clinicians, generalists, managers, public health specialists or epidemiologists, could

play a crucial role in improving urban health especially by performing a public health advocacy role. Associations can also facilitate information exchange and support to cities of central and eastern Europe.

The major strength of the project is its attractiveness to different groups and professions and the political and community leadership in cities.

Cities should be first and foremost for people. Economic and technical issues must no longer be our overriding concern - human development, health and wellbeing must be the focus.

The Regional Director amplified this by pointing out that WHO had different constituencies. The opportunity was being taken at this Meeting to try to interlock the Healthy Cities project with the national medical associations network.

Two of the German delegates, Dr E. Hirschmann and Dr K. Vilmar, said that the Chamber of Physicians was not involved with the Healthy Cities project in Bremen. Dr I. Field, of the British Medical Association, also raised similar concerns about the collaboration with Healthy City projects in Bloomsbury where the BMA headquarters is sited and where there is no relationship with the project.

Subspecialty of environmental health

Dr K. Winell pointed out that in Finland the Medical Association had been powerful in persuading the Government to agree to establishing a subspecialty of environmental health. Professor Varnai closed the session recommending to the Meeting points extracted from Dr Savolainen's presentation which are described above.

Action by national medical associations

Questionnaire, written reports and updating of activities reported to WHO

This item was introduced by Dr David M. Macfadyen, Coordination with other Organizations, WHO Regional Office for Europe, who presented a brief analysis of responses by national medical associations to a questionnaire survey conducted by the WHO Regional Office for Europe. Included in the analysis were written reports from medical associations, updating the action taken by associations in 1990.

Support to health reforms in central and eastern Europe

Many medical associations have been participating, as has the WHO Regional Office for Europe, in the health reforms that are taking place simultaneously in the countries of central and eastern Europe. During 1990, all the German associations had been helping medical doctors in the eastern part of Germany to rebuild their health care system and to retrain physicians from Germany's five new länder. The Royal Dutch Medical Association has been involved in recent missions to Poland and Hungary, and the European Working Group of Practitioners and Specialists in Free Practice (EANA) has been helping Hungarian physicians in their health transformations, through a meeting in Budapest to exchange experience of different health systems. The Danish Medical Association will report at the next meeting of the Forum on a meeting among representatives of the five Nordic medical associations to

exchange information and views as to how relationships can be developed and improved between the Nordic associations and the profession in central and eastern Europe.

Selected activities of individual associations

A selection of activities that individual associations are pursuing are described below.

Health policy

It is not only medical associations of central Europe that are facing health care financing and organizational changes. Finnish and British associations are too.

New proposals for health care financing have also been a concern of German and French associations during 1990. The participation of physicians in management decisions is extending in Belgium and other countries. The Finnish Association, like many others, is mobilizing technical and political support for the national AIDS programmes. An important report on the elderly in Europe has been prepared by the Standing Committee of Doctors of the European Community. The creation of comprehensive geriatric care, social care and rehabilitation is a common concern expressed by the members of EANA. The establishment of the four freedoms of post-1992 Europe will have consequences that medical associations are beginning to analyse; for example, Sweden is studying the effect of alcohol taxation policies, and the reform of medical education is being proposed in Germany. All of these are health policy issues for each and every national medical association. They are, moreover, issues which increasingly appear European and not merely national.

Informatic services

The provision of information services to physicians is another aspect of national medical associations' activities with the potential for having a Europe-wide scope. The questionnaire sent from the WHO Regional Office posed the question "Does your association have access to telecommunications, including electronic mail networks?" The Confédération des syndicats médicaux français provides electronic mail, professional services, address lists and a calendar of activities to members through France's Minitel network, and BMA members are linked through a corresponding British Telecom network. The use of Minitel is being studied in France for its effectiveness in individual and group continuing medical education. Associations developing these innovative approaches might arrange to share these services with other EFMA members. Already the British Medical Association is sharing its library services with Poland, through a telecommunications link.

Continuing medical education

Even before such technology is in place on a Europe-wide basis, there are exchanges in the field of continuing education that could be implemented immediately. A number one priority in central and eastern Europe is continuing medical education for physicians in health care administration. Programmes in this area have been developed by the Finnish Association and training in health policy and practice management has been introduced recently in Germany. Turkey is seeking support for general practitioner training.

Lifestyles

Last year, Dr Asvall put a challenge to associations to reduce the prevalence of smoking by physicians by 20%. In the interim, the Regional Office has published the following six points for action and practical modules^a for national medical associations:

- using the WHO model questionnaire, conduct regular surveys of members' smoking habits and publicize the results;
- develop and implement smoking cessation programmes for use by doctors with their patients;
- inform elected representatives in national and local government of the importance of a fresh air environment and the consequences for health of tobacco use;
- inform the public of the medical consequences of tobacco use;
- provide information to the media about the advantages of good health and the wellbeing that people demand from living and working in smoke-free, fresh air environments;
- cooperate with other health professionals to ensure the effective communication of a single message about the consequences for health of tobacco use.

A national seminar has been held by the Hungarian Federation on "Doctors and Smoking" and follow-up letters were sent encouraging affiliate societies to formulate anti-smoking policies. The Federation has also issued a booklet, "Doctors to Doctors About Smoking". Poster campaigns against passive smoking have been mounted in Finland. The Federation of Swiss Doctors reported a smoking prevention campaign as has the Consejo General de los Colegios Oficiales de Medicos of Spain.

Another Hungarian initiative for risk factor reduction is general practitioner-led blood pressure clubs.

In Germany, the Association of Doctors in Free Practice in Germany (NAV) has a programme on the Physician and the Schoolteacher for Prevention, an approach that seems applicable to other European schools.

Quality assurance

Quality assurance, in the view of the Danish Medical Association, should be outcome-oriented. It should not be aimed at regulating or directing the behaviour of medical personnel. Rather, it should aim at identifying examples of effective care with a view to disseminating that effectiveness widely for the benefit of patients.

^a "It can be done: a smoke-free Europe". World Health Organization, Copenhagen, 1990.

"L'Europe sans tabac : le rôle du médecin". World Health Organization/Commission of European Communities, Copenhagen, 1990.

Outcome evaluation of primary and hospital care is already underway in Finland and several other associations are involved in developing quality assurance or medical audit procedures. Associations have expressed interest in the possibility of establishing collaborative links in this field between interested associations.

Environment

The environment is the area which is most clearly of Europe-wide health impact. From the updates of the activities of national associations sent to the Regional Office for Europe, it appears that contacts have been established in this field between the Swedish Society of Medicine and the Baltic and Polish medical societies or chambers of physicians. The Swedish Society is collaborating with the Danish and German Medical Associations on a project on epidemiology around the Baltic. The British Medical Association has recently produced a report entitled "Pesticides, Chemicals and Health".

Activities reported by national medical associations

Conseil de l'Ordre des médecins, Andorra (written report)

The Andorra Association has completed the first year of a programme on continuing medical education, established at the request of the Council of Leisure and Wellbeing. The programme includes quality assurance, clinical sessions, short refresher courses and training on single topics, such as diabetes. The programme is supported by a health library. Initial evaluation of the programme is positive, although there have been problems for the physicians in finding time to participate and in getting recognition for attendance.

Association belge des syndicats médicaux

Dr A Wynen described the recent court decision on the use of social security funds to support political parties, which upheld the Association's objections. He referred to the relationship of the medical profession to hospital management, and the increasing involvement of hospital physicians in hospital management. Like other associations, the Belgian Association is also involved in quality assessment, particularly by peer review. He also referred to the powerful obstacles to effective action by medical associations on tobacco sales. With the single European market, more tobacco would be crossing frontiers.

The Regional Director reminded the associations that he had asked them at previous meetings to take up the issue of smoking among physicians and had encouraged the associations to survey the prevalence of smoking among their members. He was pleased to note the progress that had been made, but again enlisted the cooperation of associations in trying to bring about smoke-free air in Europe. This would involve persuading national carrier airlines to be smoke-free.

Dr Salzberg referred to the difficulties of applying quality assurance in private practice settings.

Czechoslovak Medical Societies

Professor J. Blahos, President of the Czechoslovak Medical Society, described the changes in this 40-year-old organization since the revolution of

1989. It was now a new medical association and had been participating in the reform of health services with enthusiasm and optimism. It is now apparent that centrally-oriented health care systems cannot be transformed in a short period. Transition will take many years. The Society had been involved in WHO programmes such as the European health strategy, the prevention of drug and alcohol abuse and the antituberculosis programmes. However, there are now new priorities, namely the development of the health service in the community and quality assurance activities. The community health project is introducing the process of democratization through health committees in small towns. These committees are helping the population of the towns to improve the ecological situation. A collaborative effort on diabetes complications is under way, and diabetic centres have been established in large factories and communities. Czechoslovakia is having to make priorities and his Association would like to see more attention paid to the health care of elderly people and to health staffing issues. The Society has positive attitudes towards the Forum, which it considers offers an additional way of strengthening links with the health services of other countries and exchanging experience by talking to associations directly.

Danish Medical Association (written report)

The Association participates actively in the work of the EC Commission within the field of advanced informatics in medicine. The final report of this work, which covered a period of approximately one year, was published on 7 May 1990 under the title, "Operation 1992: Investigation of Requirements and Options in the Field of Advanced Informatics in Medicine - Consolidation of Results." The background report provided by the Association, with an emphasis on ethics, was well represented in the final report.

The Association in cooperation with the EC Commission and the Organization of General Practitioners will hold a meeting in June 1991 to define the content of training in oncology for general practitioners. This conference will include participation from the 12 EC Member States and a report on this will be made at the next meeting of the Forum.

During the year, the Danish Medical Association has continued activities in the field of combating the involvement of the medical profession in torture. In cooperation with the International Centre for Rehabilitation of Torture Victims in Copenhagen, the Association organized a meeting attended by doctors and lawyers from countries of eastern and western Europe, Argentina, Egypt, Pakistan, South Africa and Uruguay. A report of the meeting was published in the journal of the Danish Medical Association.^a

The Association is active in a number of international organizations, including the Standing Committee of Doctors of the EC (CP), the European Union of General Practitioners (UEMO), the European Union of Medical Specialists (UEMS), the Permanent Working Group of European Junior Hospital Doctors (PWG), the European Association of Senior Hospital Doctors (AEMH) and the International Conference of Orders (CIO).

A highlight of these cooperative activities is the Statement of Madrid - a European declaration against doctors' participation, actively or passively in torture.

^a [Revolt against the crime of silence]. Ugeskrift for Læger, 152(29).

In cooperating with the EC Commission's research programme on the human genome, the Association put forth the view that it is essential that the medical profession be involved in the group being established by the Commission to consider the ethical aspects of this research. Names of distinguished colleagues have been submitted to the EC Commission for membership in that body.

The Association took an historic decision at its last annual meeting to resume its membership of the WMA. Along with the other Nordic medical associations, it had withdrawn from the WMA in 1978 because of dissatisfaction with statutory changes regarding the balance of power and other matters. Since then, the five Nordic medical associations and other associations which had withdrawn from the WMA held regular meetings aiming at a possible renegotiation of relations. The Danish Medical Association continued to hold the view that the work of the WMA, particularly in the field of medical ethics, was of vital importance, so it was with pleasure that the DMA could announce that this year the negotiations with the WMA had borne fruit and it intended to resume its membership of the WMA.

The DMA considers this a very important development in its activities in the international field of medicine at this important moment in world history.

Finnish Medical Association (written submission)

The Finnish Medical Association emphasizes health care administration and data processing in organizing CME. The number of courses on data processing and informatic systems will be significantly increased during 1991.

In the area of quality assurance the Association has a project to establish a company, together with municipal and state health care officials, to evaluate the standard of health care systems. A similar company exists in laboratory quality assurance. In 1992, state funding for health care, social affairs, cultural life and education will be paid according to the number of inhabitants in a municipality. This may relatively reduce the amount of money used for health care in the future.

The Regional Office has been making an evaluation of the European Health for All Strategy in Finland. The Association, in its own evaluation, criticizes the effort the Ministry has been making to achieve its own goals. The number of doctors in primary health care has developed more slowly than planned. It was also planned that resources would be used for developing specialist education, not for increasing the number of doctors, whereas the opposite has happened.

The Ministry needs to be stronger in persuading other ministries in looking at the health aspects of social planning. Traffic accidents have been growing and smoking has not diminished, as planned. The Association asks for new political attitudes to develop health care. Private specialist clinics at care units should be more actively included in health care systems.

Ordre national des médecins (written submission)

The Ordre continues to be involved in various statutory duties. Within the framework of France's reform of medical education, it is involved in recognizing qualification for general practice. Preparations are being made for an international Conference on Medical Ethics to be held in Paris on 9-10 March 1991, covering various topics such as pre-natal diagnosis, epidemiology,

confidentiality, health economics and health education. Current concerns are the reforms in medical education and in continuing medical education.

Confédération des syndicats médicaux français (written submission)

The aim of the Confédération continues to be to develop the means for attaining a state of complete physical, mental and social wellbeing for the population. The protection of the health of the population requires that the profession has at its disposal the best scientific techniques. This presupposes the increasing intervention of social institutions, including sickness funds. The Confédération seeks to meet the needs of all French citizens in all social groups.

Apart from the Minitel project described above, the Confédération continues to communicate with its members through its journal Médecine de France, which includes important issues such as that of elderly people.

Bundesärztekammer, Germany

The Association had submitted the report in writing and Dr K. Vilmar wished only to highlight one particular item, namely the unification between the western and eastern parts of Germany over the past year. The life expectancy differentials reported by Dr Asvall between eastern and western Europe are also seen in eastern and western parts of Germany, where there is a 20% difference in life expectancy. Other statistics reported from the eastern part of the country had clearly been wrong, for example the infant mortality rate. Vast sums of money would be required to bring the five new länder up to the health levels of the west. Another important east/west difference is in terms of physicians' productivity. In the five länder, there are eight support staff for every doctor, compared to only five in the west.

A preoccupation with the integration of the health profession does not deflect Germany from being supportive of countries of central and eastern Europe. These countries have common and serious problems, and it is in everyone's interest to help them to solve their problems.

Professor G. Osterwald complemented Dr K. Vilmar's intervention by presenting an account of the effect of the new social security laws on the associations in Germany. The Association has been active in promoting quality control and had published a policy paper on quality control in pathology. Other quality control studies are continuing and a project has been introduced to introduce quality control in all Länder. A more exhaustive report on quality control was submitted to the annual meeting of the association in Hamburg.

Association of Doctors in Free Practice in Germany (NAV)

Dr E. Hirschmann of the Association of Doctors in Free Practice in Germany also highlighted some points from his paper, particularly on the relationship of schools and health. Doctors and teachers are working together in schools in an NAV four-year pilot project which is now being extended more broadly with the purpose of motivating the least healthy groups. The main focus has been on involving parents and parents/teachers associations. The project applies to 10 to 15-year-old children in schools in Cologne, Munich and other cities. The topics dealt with include nutrition and sex education, which are worked into the general school curriculum.

Hartmannbund, Germany

Mr K. Nöldner, Secretary-General of the Hartmannbund, also described his Association's work on health education in schools. They had been working in association with secondary school teachers, holding meetings in 50 areas and covering subjects such as AIDS. They have also been involved with the European Community in its broad programme for the prevention of cancer. The association of teachers and physicians is expanding to cover areas such as the environment.

Hellenic Medical Association (written submission)

Priority activities of the Association include overseeing that ethical rules are observed, giving opinions on laws relating to the medical profession, giving opinions on medical education and publishing periodicals.

Federation of Hungarian Medical Societies

Apart from the campaign against tobacco, described above, member societies of the Federation have been active in many fields. The Association of Gerontology, for example, organized 15 meetings in various aspects of health care of the elderly. The most important activities of the Hungarian Scientific Society for General Practice were in healthy nutrition, preventing substance abuse and mental disorder. The Hungarian Respiratory Society has been active in measures to combat asthma through control of house dust and pollen counts.

Icelandic Medical Association (written submission)

The Icelandic Medical Association continued its consultations on the Action Plan of the Ministry of Health regarding Health for All by the Year 2000.

Plans on quality assurance were issued for the health services, both inside and outside hospitals. The Association will initiate the various aspects of quality assurance.

Owing to increasing numbers of female doctors, the Association has prepared proposals on adaptation of the traditional work arrangement of doctors inside and outside hospitals.

The Association has provided opinions on parliamentary bills, regarding health legislation and the Medical Doctors Act, on tissue and organ transplants and on criteria for death.

In cooperation between the Medical Faculty of the University of Iceland and the Association, a Council of Continuing and Speciality Education has been established.

The Association has appointed a committee to propose a system of assistance for doctors and other health workers having problems with alcohol and habit-forming drugs. An opinion has been given on how supervision of doctors' work can be carried out without risking a breach of confidence between the patient and the doctor.

The Association has been engaged in solving the problem of long working hours of doctors and has proposed reforms on several fronts.

In cooperation with the Chief Medical Officer, the Association drafted regulations on writing and issuing medical certificates and on keeping medical documents and records and delivering them free to patients.

The Association has taken steps, in cooperation with other health workers' associations, to improve the relationships between the various groups of health personnel.

Disputes regarding the terms of employment of one-doctor health centres in rural areas and regarding private specialists have been brought to an end. Still unsolved (in January 1991) was a long standing dispute on wages and other terms of employment of hospital doctors.

The Royal Dutch Medical Association

Dr M. Van Leeuwen spoke about the quality of professional care. In the Netherlands, this is viewed as primarily the responsibility of the medical association. Other roles are fulfilled by the patients themselves and by the providers. Physicians, consumers and providers or insurers have participated in recent conferences on the quality of medical care: this is referred to as the trilateral model. A phrase used and promoted is "good providership", namely the close relationship of the provider to the funder of care.

Attitudes are also changing on the organizational aspects of medical practice. The issue of the rights of patients, as reported in Rome, has been pursued further. A recent report on the rights of the consumer has been translated into English and is available to interested medical associations. Studies of the scientific organization of diagnosis and treatment in general practice have been undertaken. Standards of good medical practice are in the process of being developed.

The Association is also active in medical education and is reviewing the three-year clinical phase of basic training, an activity that is planned to redefine this phase. The Association is also looking at the interface between the output of medical schools and the input to advanced training. It is playing a role in defining educational goals at the outset of advanced training and continues to play an important role in defining internship programmes. During the clinical phase, greater exposure is being given to ethical problems occurring in practice. The main issue in quality is to obtain outcome data in order to provide meaningful feedback to practitioners.

Dr W. H. Cense, from the Dutch Medical Association, described how in the last year the Dutch Government had invited the medical society to join in missions to Czechoslovakia, Hungary and Poland in close collaboration with the Regional Office's programme on central and eastern Europe. The missions are intended to be bilateral and multilateral efforts in collaboration with WHO, aimed at providing direct support (but not necessarily money) to the target countries through expertise in health care management, technology assessment, the evaluation and organization of health care, primary health care, financing and insurance problems. Several countries want to strengthen general practice, but they have practical problems in organizing and funding it, educating for it and preparing a curriculum. In the countries visited so far (Hungary and Poland) the physicians were well motivated, but they must be educated about the liberal and free environment in which they are now practising. In accommodating to economic changes, they are looking at issues such as financing health care and negotiating with governments which are less familiar in the east than the west. A report on this is to be published next year.

Many questions followed the Dutch Association's report, particularly on the various dimensions of quality assurance including measures of patient satisfaction. Dr Cense, also from the Dutch Medical Association, pointed out that there were three aspects of quality, namely medical/technical aspects, organizational aspects and relational aspects. This was amplified by the Regional Director who drew attention to the five dimensions of quality as defined by WHO, comprising safety, medical efficacy, impact of outcome, patient acceptance and cost benefits. He cited the example of a feedback mechanism in which hospitals informed of their infection rates achieved a 30% reduction in hospital infections by this measure alone.

Norwegian Medical Association

Dr H.A. Holm amplified his paper by describing what the Norwegian Medical Association is not doing. Foremost was the need to do more for colleagues in the rest of Europe. The Association is increasingly concerned about how to organize effective engagement with their colleagues in the rest of Europe: there needs to be better coordination and concerted action in support of the free medical associations that are emerging in central and eastern Europe. This Forum had a great role to play in improving medical practice and health care all over Europe by supporting these associations. His Association had recently been approached by physicians in Kosova, Yugoslavia. The problem in a meeting such as this was to discuss such a role in depth. A Forum of free medical associations, because of its nongovernmental nature, has the freedom to take an interest in solving such problems. He would strongly support establishing a powerful mechanism to support colleagues in all parts of Europe.

Federation of Polish Medical Societies

Professor B. Gornicki, President of the Federation of Polish Medical Societies, said that it had just completed its 25th anniversary. It had been involved in AIDS and tobacco campaigns. The Society is independent of the Ministry of Health. It has only a consultative role and has no executive role on behalf of the Health Ministry.

Polish Medical Association

Professor J. Woy-Woyciechowski of the Polish Medical Association described how it had been established in 1820. Thirty-nine percent of the physicians in Poland were now members of the Association. Activities last year included an international symposium on smoking, and the Association had been working very closely with the regional chambers of physicians. It was organizing the First World Conference of Physicians of Polonia in June 1991. The Association was interested in collaboration in Warsaw with the WHO Healthy Cities project. Scholarships had been received from Germany. The Association had produced a video cassette entitled Prescription for life which had been distributed to schools and homes and become a popular medical film. The Association has international contacts with the World Medical Association and local links to the Ukrainian and Lithuanian Associations.

National Physicians' Chamber, Poland

Professor T.L. Chrusciel described how the Chamber had been recreated after 40 years of inactivity. There are 23 chapters representing all the physicians in Poland. The main activities in the last year had been the creation of a structure for the organization, and helping to draft the 1990 health law, on the basis of which new legal instruments had been adopted. The

Chamber has now taken over responsibility for licensing and regulating physicians. It is concerned with all aspects of the profession and has been involved in discussions on remuneration, with positive results. It has also been involved in parliamentary committee discussions, and has been discussing changes in general practice in the new health system. It has been collaborating with WHO, for instance, with regard to the St. Vincent Declaration, and with the British Medical Association on a medical library project designed to supply bibliographic references. It has also established bilateral relationships with the Royal Dutch, the German, French and British Associations.

The Chamber believes that the exchange of people is important and has set up a system for physicians to exchange flats for recreational purposes. It has been receiving children of foreign physicians and visits by young people.

The Chamber produces a journal and official bulletin and is interested in exchanging publications with other associations. It has been involved in environmental health, particularly in Silesia where the environment is very poor. In this area, it has been collaborating with the Czech and German associations to develop a common environmental approach. He suggested that future discussions might be on the theme "Physicians facing a changing world", focusing on the development of modern medical technologies, access to and training in the use of appropriate technology. Learning from the experience of neighbouring countries and the harmonization of laws relating to health in the European Community are additional topics suggested for future meetings.

There is a need to exchange practical experience of health care delivery, particularly with general practitioners in their new role, and on the training of general practitioners. The Chamber is facing a great number of problems, particularly with changes in the structure of health services. Medical associations in the Nordic countries, Germany and the countries of central and eastern Europe could perhaps form a working group to discuss aspects of modern medicine. These would cover the transition of health care systems to a public/private mix, quality assurance for professional services, health reforms, the financing of health care and providing for the rights of patients. This could be a subregional meeting of associations, together with WHO, which could cover other problems such as environmental health. Ethical issues could be taken up, particularly with regard to the social image of the physician, his status in society and professional behaviour.

On being asked if the tasks of the medical associations have now been taken over by the Chamber, Professor T.L. Chrusciel replied that by law all physicians have to belong to the Chamber. The Polish Medical Society has its own statutes, but collaborates closely with the Chamber, and some activities of the Polish Medical Society are financed by the Chamber. The Regional Director said the organization of a subregional meeting would be no problem and he would take this up separately.

Swedish Medical Association

Dr A. Milton of the Swedish Medical Association described relationships with colleagues in Latvia and Estonia, to whom his Association has been transferring know-how and equipment. Two month-long visits have been arranged to Swedish hospitals. There is popular support in Sweden for helping the independent associations in the Baltic.

The Swedish Medical Association and the Swedish Society of Medicine work closely together on quality assurance. They are seeking to develop quality of care indicators for the most frequent diagnoses in different health care fields. Quality assessment is achieved through inspection and systems of peer review, so that it is introduced as an integral part of the physician's work. Specialty training has been revised in Sweden: the specialist degree is given after the same timespan, but is based on meeting predetermined goals rather than just fulfilling a certain quantity of time. Internal medicine, surgery, psychiatry and radiology are the specialties undergoing review from the point of view of training. The Association would be pleased to receive and exchange concrete information on quality assurance indicators with interested associations. The Swedish Medical Association has approved a new system to strengthen primary health care.

The Regional Director said that indicators of quality are of great interest to WHO and may be one area of cooperation both for the future meetings of the Forum and as separate projects for collaboration with WHO. The associations could perhaps agree on a number of indicators as a developmental project. Dr A. Milton said the Swedish Society of Nursing had also been involved in quality assurance; they were trying to achieve down-to-earth tools for use in everyday professional life. It would be useful to report on these in one year's time.

The Swedish Society of Medicine

The Society has an environmental project on the Baltic Sea and announced that an international conference on epidemiology in the Baltic will take place in 1992, with the aim of obtaining available data from around the Baltic. This is part of the profession's efforts to improve the environment. The Society had also been looking at the effect of the Internal Market in Europe on alcohol consumption.

Turkish Medical Association

The Turkish Medical Association was established in 1953; 60% of the 42 000 Turkish physicians are members. The aims of the society cover ethics and public health, public health issues and members', professional, patients' and human rights, especially the rights of prisoners. Continuing medical education of general practitioners is not well organized at the national level. Specialist training is much better than that for general practice.

The Turkish Medical Association is evaluating continuing medical education for its relevance to primary health care, and is looking for ways to reward people who undertake their own training. Some core courses are being organized in new areas, such as health management. However, the main need is to stimulate general practice and the Association would like to have assistance in this respect, perhaps from Denmark or the Netherlands. They would like to get more experience in distance learning for physicians. There are several obstacles which the Association faces, particularly in the recent circumstances in which 400 medical staff have had to move to the border with Iraq, and it is not clear how long they will have to be there. Health personnel are not equipped for possible warfare. The hope was expressed that the medical associations present at the Forum would be able to help the Turkish Medical Association with these and many other problems.

In the general discussion, the United Kingdom raised the issue of public health, particularly on banning smoking on airlines. The experience in the United Kingdom is that a national carrier will be reluctant to suppress

smoking if other national carriers do not follow suit, since this puts them at a competitive disadvantage. The United Kingdom also described its library support with Poland, which had been part of the expansion of its own library. Polish physicians requesting literature searches receive a quick turn-round not only of the bibliographic search, but also with timely receipt of the full document requested. This service is provided through a satellite communication system via Warsaw. A model which might be useful in central and eastern Europe is provided by the Commonwealth Medical Association which organizes workshops to assist officers of national medical associations.

Scientific Medical Federation of the USSR

The Soviet Association reported that the deplorable situation described in the former German Democratic Republic was even worse in the Soviet Union. In a recent press conference it had been revealed that in one republic 40% of maternity hospitals have no water and no sewerage. Such are the exceptionally difficult conditions in which the new independent association has to work.

Since 1917, all scientific societies have been monopolies of the state with little influence on government policy. The Federation represents all the national republics. Some 600 000 physicians and scientists of the 1.2 million physicians in the Soviet Union are members. The Federation wished to maintain ties with WHO directly, not through the Ministry of Health. He hoped that it would be possible for subnational associations, such as that from Kazakhstan, to be represented with his Association at future meetings of the Forum. The Federation has also had contacts with the World Medical Association.

European Union of General Practitioners (UEMO) (written report)

The Danish Medical Association assumed the Presidency of the UEMO for the period 1991-1994 under Dr Ole Asbjorn Jensen. Among the main objectives of the Danish Presidency during its term of office in the UEMO will be:

- the improvement of the specific training for general practice in Europe by attempting to increase the minimum duration in the relevant EC Directive to three years;
- increasing cooperation between the various groupings of the medical profession in Europe to help achieve a more firmly united attitude towards the most important issues for health and medical care, in the interest of the European patient;
- assuring that advice is given to European politicians on matters relevant to primary health care in Europe by UEMO representatives who are themselves general practitioners with direct personal knowledge of patients' needs within the primary health care system, rather than by technocrats with a purely theoretical knowledge of the field.

Draft constitution of the European Forum of Medical Associations and WHO

Decision of the Rome Meeting

Dr J. Haffner, President of the Norwegian Medical Association (and Chairman of this session), reminded participants of the decision at the Rome Meeting that the aims, organization, structure, participation and voting rules would be further discussed at this Meeting. An advisory committee had been established to prepare for today's discussion. Annex 1 of the report of the

Fourth Meeting included a statement adopted in Rome which proposed that the best ways of developing the Forum be further studied and discussed. The advisory committee's proposals are contained in the working paper on the draft constitution (ICP/HSC 017/6).

Proposals of the Advisory Committee to the Fifth Joint Meeting

The contents of the working paper were described in detail by Dr Alan Rowe, Secretary to the Advisory Committee.

Title

The title, The European Forum of Medical Associations, is the what was adopted in Rome. The Meeting was, however, invited to propose alternative titles.

Statement of aims

A statement of aims was necessary to know what subjects future meetings should discuss. The document therefore included five aims, ranging from improving the quality of health care in Europe to formulating policy statements on health issues.

Membership

The Advisory Committee had given considerable thought to the issue of membership, particularly by defining criteria which might be used in inviting associations to enter into dialogue with other associations and with WHO. A medical association is defined as "a free, independent, nongovernmental association of physicians whose activities cover all aspects of professional practice."

Several views had been expressed in the Committee as to who should be considered founder members, and the Committee's proposal was that all those medical associations invited to the Helsinki Meeting and conforming with the criteria should be founder members. For future membership, a separate admission procedure was proposed. Observer status was proposed for groups of associations rather than individual associations, as well as for individual medical associations from outside the European Region of WHO.

Rules of procedure

Rules of procedure were defined as to how business should be conducted during the annual meetings, including provision for a democratic voting process. Voting would, however, be exceptional and most decisions would be arrived at by consensus. The main exception was for the election of officers, and procedures were specified for this.

Secretariat

A secretariat was proposed to provide liaison between the Forum and the WHO Regional Office for Europe.

Funding

Finally, the working paper described a process for funding.

Invitation to amend the document

Dr Rowe concluded by emphasizing that the draft document was presented for discussion and for amendment. He pointed out that some rules were necessary to establish the Forum as a formal body. These were framed in such a way that most decisions would be arrived at by consensus. He expressed the hope that by the end of the Meeting participants would arrive at a set of rules that would formally recognize the existence of the Forum as a body, and would specify mechanisms so that there could be future meetings of the Forum as an independent institution, with a meaningful dialogue between WHO and representative medical associations covering all physicians in Europe.

Relationship to the Standing Committee of Doctors of the European Communities

Professor M. E. Machado Macedo, speaking as a member of the Advisory Committee, emphasized that the intention had never been to establish an organization that was supranational. The Forum's purpose was to establish dialogue; the European Communities' institutions propose and adopt supranational legislation and include a Standing Committee of Doctors with functions that are quite different from the Forum.

The Advisory Committee had framed rules that would establish a working relationship between the medical associations collectively and WHO. He described how the Committee had met in Copenhagen and Zürich. The document that the Committee submitted was one which, with modification, could be accepted by consensus by the whole Meeting. He noted however that the document in its formal appearance as a constitution had given rise to strong reactions. He suggested therefore that some title such as guidelines for operation might be more appropriate. He reminded the medical associations that they attended the Meeting as guests at the invitation of WHO, and that the aim was to establish rules of conduct so that the next meeting could be organized more as a real dialogue between medical associations and WHO. Again, he repeated the mandate given to the Committee in Rome, which had been restated by Dr J. Haffner when he took up the chairmanship of the session.

Procedure for discussing the Advisory Committee's draft document

Dr J. Haffner explained that the procedure proposed for this session was that anyone who had views should be free to express them now. Written comments on the working paper had been received by the Committee and the Advisory Committee had reviewed them.

Controversy over the proposed procedure

Dr K. Vilmar, on behalf of the Bundesärztekammer, opposed this procedure. He felt that these meetings were constituted to exchange information and this had been successfully achieved over the previous four meetings. Now the participants were faced with a more formal procedure which went beyond the mandate given to the subcommittee in Rome, particularly since there were implied financial implications. Dr A Wynen, of the Association belge des syndicats médicaux, said that participants in Rome had pointed to the danger of going beyond the informal structure that allows associations to meet on a regular basis. These dialogues allow WHO to present its broad objectives to the medical profession, to hear the medical profession and to defend jointly the interests of patients. He said the aim was that WHO and the medical associations should work together. The regular meetings address

themselves to all physicians in Europe. Many associations come to these meetings to report the progress they have made in the fight against tobacco or AIDS, but to go beyond this with office bearers and so on, would establish a European medical establishment in which WHO had no identity. He felt there was no need for a constitution.

Dr J. Haffner pointed out that there would indeed be no decision that day but the session gave participants an opportunity to express their views on the draft Constitution. Any decision could then be considered the following day.

Dr E. Hirschmann pointed out that there had been a majority in Rome in favour of establishing the Forum and that a mandate had been given to the Committee to draw up rules and voting procedures, etc. It was very important for the medical profession to have a forum for dialogue. Discussions should therefore continue on the draft constitution since, in his view, it could be improved.

Dr K. Winell said that rules were needed for holding meetings. Meetings cost money, which has to be gathered in advance. There has therefore to be a structure for planning the yearly meetings. These will not take place unless there is a mechanism whereby they can be carefully prepared and worked out. The choice was to let WHO build them up or to involve the medical associations more in their planning and running. Such involvement was the aim of the Advisory Committee. He proposed that a liaison body was needed to work with WHO and to prepare the programme and budget for future meetings.

Mr K. Nöldner thought that the Meeting should have the courage to set up the Forum. It might not require statutes, but guidelines for a dialogue-oriented Forum were necessary.

Dr J. Beaupère explained the position of his syndicate. To date, the Forum had been exceptionally useful and he was anxious that this should continue as a two-way dialogue. However, he felt that the draft constitution went beyond what was agreed in Rome and that an organization with statutes, constitution and fees could be dangerous. The problems with regard to membership were complicated and difficult to settle. It was, however, possible to have definite rules for meetings without having a legal personality. It was certainly necessary to establish the Forum as a body. That he agreed to. But there was no need to establish a European Forum as a legal organization, and there was a risk, with the two bodies formally established, that there might be confusion between the European Forum of Medical Associations and the Standing Committee of Doctors of the European Communities. These two should not be mixed.

These views were reiterated by Dr K. Vilmar, who again asked if an institution with proper statutes and fees was really needed.

Dr Salzberg said that so far as non-EC countries were concerned, there was clearly a difference of opinion with participants from the European Communities' Standing Committee of Doctors. Many new associations represented at this Meeting did not have long-standing democratic traditions, and there needed to be an organizational structure to welcome them into the European medical fraternity. The draft proposal suggested that there should be a committee of member associations to liaise with WHO.

Dr K. Vilmar pointed out that the amendments submitted from his association consisted of two parts. If part I of the German proposal was accepted, there would be no statutes and the question of a committee,

contributions and voting would become redundant. Part II proposed methods for establishing an organizing committee, if the consensus was that rules were indeed needed. Dr E. Hirschmann felt that the need for rules of cooperation and membership had to be settled one way or another. Rules were necessary to permit new members to participate in future meetings.

Professor P. Paci agreed with Dr Wynen. It was simple to call the meeting a Forum, that is to say a body for the free expression of views. He felt that there was no need to institutionalize the organization. However, the Forum would be a living body and could grow in importance over the years. We could simply agree on the name and not change anything from the present arrangements.

Dr M. Aarimaa, Secretary-General of the Finnish Medical Association, said that there appeared to be a conflict of ideologies at the Meeting, namely between the members of the Standing Committee of Doctors of the European Communities and others. In the objections expressed to the draft constitution the key word is "institutionalization". There clearly was over-emphasis on institutionalizing the Forum. It certainly did not mean that a registered legal body would be established. There was nothing legally binding in the constitution that was being considered. He suggested that the "executive committee" be changed to "liaison committee". This would still allow it to be a body to prepare the work of the Forum. And financing must be organized somehow.

Various associations, for example the British Medical Association and the Polish National Physicians' Chamber, asked for clarification, particularly with regard to the issues of aims and membership.

The WHO Regional Director intervened to point out that, as seven of the 33 associations present could not go along with the proposals for the constitution submitted by the Advisory Committee, it was necessary to find some compromise. From the discussions it was clear that everyone wished to see closer cooperation between physicians and the Regional Office through their medical associations. This required an identity and the Advisory Committee, which was appointed in Rome by the Associations, was seeking to achieve this. There seemed to be no disagreement on the existence of the Forum. The issue was the degree of formality. He could understand therefore why a formal constitution was not acceptable to the Meeting. However, some mechanism was necessary to prepare for future meetings. Therefore, some guiding principles could perhaps be established by common agreement. This would be a type of document that required no signature. It would include aims as already proposed by the Advisory Committee, and the type of issues to be taken up at future meetings. Some reference would have to be made to membership and he felt it would be possible to arrive at this without disagreement and without going to a formal vote. We already had an important agreement from Rome and if we could get agreement on the kind of organization we wished to establish, this would help in future work.

Dr S.S. Yarmonenco, representing the Scientific Medical Association of the USSR, said that since this was a nongovernmental body there was less need for rules. What was unique about the present Forum was the active role played by WHO. It was important that the national associations should have their independence and that the Regional Office should continue to participate in the life of the Forum. However, for this it was unnecessary to legalize the Forum, since in principle it exists. A declaration might be adopted, together with a set of rules for a liaison committee with the Regional Office.

Dr A Wynen said that we were living through an important period: for the first time, nongovernmental organizations were participating from the Soviet Union and central Europe. Clearly there were a number of questions as to how we should proceed, and we could perhaps reach certain rules. If we proceeded properly, we should be able to do this without having to have a constitution. He therefore proposed that rules or principles be established for the further development of the Forum, dealing in particular with how the meetings should be organized. He felt that the Regional Director could reflect on this and be prepared to consider some informal procedures which could be adopted by consensus. We could therefore think things through and come back to the issue next year. The Regional Director welcomed Dr Wynen's proposals and said that he would be willing to accept any form of cooperation, provided this could be arrived at by consensus.

Adoption of Statement of Guiding Principles

After overnight consideration an amended document, The European Forum of National Medical Associations with WHO: Statement of Guiding Principles, was distributed to participants, who were invited to submit comments in writing by mid-day. Written amendments were received from Czechoslovakia, Denmark, France, Germany, Poland and Sweden. These were read to the Meeting and the Advisory Committee's recommendation given on each. The majority of amendments were accepted. The document, dated 1 February 1991, was accepted by consensus at the closing session of the Meeting (Annex 1).

Clarifications requested by certain participants

Certain participants asked that clarifications be made in the report of the Meeting. It was suggested by the Conseil national de l'Ordre des médecins (France) that the associations present and those who participated in earlier meetings be reaffirmed as members. It was requested therefore that the report should state that those who were interested but not present would nevertheless be founder members. Dr Yarmonenco felt that there was no need to spell this out, not even in the report of the Meeting. He pointed out that the Scientific Medical Association of the USSR was independent of the government now, and requested that future invitations be directed to the association and not to the government. The observer from the Conseil de l'Ordre des médecins (Andorra) asked for clarification on the issue of observers, particularly the procedure for determining observer status and how long people remained with observer status. He suggested that the establishment of founder members be less formal, and that the liaison committee should put it to the Forum that eligible observers be invited as full members.

The British Medical Association representative, Dr I. Field, suggested that associations wishing to participate in future meetings should declare their interest in doing so. Those who so declare their interest could therefore be reviewed by the Liaison Committee who could propose a list of members to the next meeting. This suggestion might be included in the report of the Meeting, reaffirming that the Forum has existed since the Rome Meeting. Invitations to participate in the sixth meeting should be reviewed by the Liaison Committee, before being sent by the Regional Office.

In the final session, the Liaison Committee was requested by the Conseil national de l'Ordre des médecins (France) to look again at item 5 of the Guiding Principles, particularly from the point of view of its implication for voting: should this be one country voting or one association voting? The

Liaison Committee was also asked to consider the wording of paragraph 4a and 4b. Any comments received should be reviewed by the Liaison Committee and the Committee's comments submitted for consideration next year.

Report of the Advisory Committee

Database built up since the last meeting

This item was presented by Dr Alan Rowe, Secretary to the Advisory Committee. He drew attention to the fact that the intention of the Forum was to achieve a dialogue with the medical profession as a whole throughout Europe. A considerable database had been built up since the last meeting, namely:

- the journals published by national medical associations;
- the questionnaire on national medical associations undertaken by WHO;
- the reported activities of national medical associations and the update on 1990 activities;
- the questionnaire on continuing medical education undertaken by the Finnish Medical Association; and
- the questionnaire on future meetings undertaken by the Norwegian Medical Association (proposed guidelines for the organization of future meetings are to be submitted by the Association for discussion at the next meeting of the Forum).

Medical associations were invited to share in keeping the databases up to date. In the meantime, it was proposed that the Regional Office should ensure their maintenance.

Medical associations in central and eastern Europe

Item 3 of the Committee's report dealt with medical associations in central and eastern Europe. The Helsinki Meeting had contributed greatly to establishing a real dialogue with the new medical associations and to building up mutual support activities.

Declaration on patients' rights

Item 4 of the report of the Committee referred to the declaration on patients' rights. This had been redrafted but was not yet in a state suitable for the extensive consultations necessary. Great interest had been expressed in it, and it was helpful that the Dutch Medical Association had agreed (at this Meeting) to distribute the English language version of their own document on patients' rights.

Linking the Forum's work to the work of other associations of physicians in Europe

Item 5 described how the Committee has been concerned about linking the work of the Forum to the work of other associations of physicians in Europe.

Interim committee

Item 6 contained the proposal that the Committee should continue for the ensuing year as an interim committee.

Dr K. Vilmar proposed, and the Meeting accepted, that the Committee continue to work for the next year as a liaison committee.

1992 Meeting

Dr H. Sahli, President of the Verbindung der Schweizer Ärzte, was happy to invite the associations to meet in Switzerland in 1992. The place and date were later given as Basel, 29-30 January 1992. As far as the programme was concerned, this would be left to the liaison committee.

Future collaboration

The Chairperson, Dr K. Juva, hoped that the new explicit guiding principles would facilitate the working together of national medical associations and WHO. A number of cooperative areas had been clearly identified, particularly quality assurance. Steps had been taken to achieve a more effective way of working. There were promising indicators for future collaboration, both bilaterally and multilaterally, through WHO. Most importantly, the Guiding Principles had been approved at the Meeting by consensus.

In his closing remarks, the Regional Director expressed appreciation for the several technical papers presented and for the wide participation in the technical issues discussed, especially the reports from the new medical associations. Future meetings will certainly take up the issue of quality assurance, and the other topics proposed would be considered by the Liaison Committee. It had been a good Meeting for the Regional Office staff participating who had been helped very effectively by their dialogue with the medical associations. At the outset, the hope had been expressed that the Forum would go beyond annual meetings and begin to develop concrete projects for cooperation. Helsinki had witnessed the transition of the Forum to this new phase of cooperation.

Annex 1

EUROPEAN FORUM OF MEDICAL ASSOCIATIONS WITH WHO

Statement of Guiding Principles

Preamble

The European Forum of Medical Associations with WHO has developed from the need for dialogue between the national medical associations representing members of the medical profession and WHO in order to discuss relevant issues concerning health and health care in Europe.

The medical associations which have participated in the first meetings of national medical associations with WHO recognize the success of these meetings and wish to continue such annual meetings.

To facilitate the work of the Forum, the basic principles and statements relating to the form and working methods of the Forum are set out below.

Name and purpose

1. The organization shall be called "The European Forum of Medical Associations with WHO", hereafter referred to as the Forum.
2. The aims of the Forum shall be, by establishing a dialogue and cooperation between national medical associations and WHO in the European Region, to:
 - (a) improve the quality of health and health care in Europe;
 - (b) promote the exchange of information and ideas between national medical associations and between the associations and WHO;
 - (c) integrate appropriate aspects of policies for health for all into basic, postgraduate and continuing medical education; and
 - (d) formulate consensus policy statements on health issues.

Participants

3. Any national medical association in the European Region shall be eligible to participate in the Forum and its programme of work. For the purpose of the Forum, a national medical association shall be defined as "a free independent nongovernmental association of physicians constituted in an organization which elects its own officers, appoints its own staff and determines its own constitution, except for any statutory duties that it undertakes, and whose activities cover all the various aspects of professional practice".
4. (a) Applications from national medical associations not invited to the Meeting in Helsinki will be evaluated by the Liaison Committee in accordance with the criteria set out in paragraph 3 above, who will make a recommendation to the next meeting of the Forum.

(b) European groups or associations of national medical associations invited as observers at the Helsinki Meeting shall have observer status in the Forum. Such groups who meet the criteria set out in paragraph 3 above, but who were not represented at the Helsinki Meeting, may be proposed by the Liaison Committee to the Forum for observer status.

(c) National medical associations and groups of such associations from outside the European Region may, at the invitation of the Liaison Committee, attend meetings of the Forum as observers.

Procedure

5. Decisions, recommendations and policy statements shall be made by consensus between participating national medical associations' countries.

6. The Forum shall normally meet once a year.

7. At its annual meeting, the Forum shall:

(a) determine the national medical association which shall host the following year's meeting of the Forum; and

(b) determine the members of the Liaison Committee, which shall comprise five representatives of the national medical associations who shall be geographically representative of the Region.

8. The Liaison Committee shall advise the WHO Regional Director for Europe and the host medical association on the programme and arrangements for the next meeting of the Forum and, where appropriate, on any actions arising from the previous meetings.

Secretariat services

9. Secretariat services for the Forum shall be provided by the WHO Regional Office for Europe.

Languages

10. Depending on the availability of funds, the working languages of the Forum will be English, French, German and Russian.

Financing

11. A financial statement shall be presented to the Forum, on the basis of which the Forum will decide on the level of contribution towards the cost of each meeting, if any, to be made by national medical associations.

Annex 2

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