Contents

WMA OFFICERS

OF NATIONAL MEMBER MEDICAL ASSOCIATIONS AND OFFICERS

President-elect
Dr. J. D. Coble
American Medical Association
515 North State St.
Chicago, Illinois 60610, USA

President
Dr. J. Appleyard
British Medical Association
BMA House,Tavistock Square
London WC1H 9JP, UK

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Finnish Medical Association
P.O. Box 49
00501 Helsinki, Finland

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Dr. K. Vilmar
German Medical Association
Herbert-Lewin Strasse 1
50931 Köln

Chairman of Council
Dr. Y Blachar
Israel Medical Association
2 Twin Towers, 35 Jabotisky St.
P.O. Box 3566, Ramat-Gan 52136

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Dr. T.J. Moon
Korean Medical Association
302-75 Ichon1-dong,Yongsan-gu,
Seoul 140-721

Secretary General
Dr. D. Human
World Medical Association
BP63, 01212 Ferney-Voltaire Cedex
France
Tel (33) 4 50 40 75 75
E-mail: delon@wma.net
Fax (33) 4 50 40 59 37

Website: http://www.wma.net

WMA Directory of National Member Medical Associations Officers, Council

Association and address/Officers

ANDORRA
Col'legi Oficial de Metges
Edifici Plaza esc. B
Verge del Pilar 5,
4art. Despatx 11, Andorra La Vella
Tel: (376) 823 525 Fax: (376) 860 793
E-mail: coma@andorra.ad
Website: www.col-legidemetges.ad

ARGENTINA
Confederación Médica Argentina
Av. Belgrano 1235
Buenos Aires 1093
Tel/Fax: (54-114) 383-8414/5511
E-mail: comra@sinectis.com.ar
Website: www.comra.health.org.ar

AUSTRALIA
Australian Medical Association
P.O. Box 6090
Kingston, ACT 2604
Tel: (61-2) 6270-5460/Fax: -5499
Website: www.ama.com.au
E-mail: ama@ama.com.au

AUSTRIA
Österreichische Ärztekammer
(Austrian Medical Chamber)
Weihburggasse 10-12 - P.O. Box 213
1010 Wien
Tel: (43-1) 51406-931
Fax: (43-1) 51406-933
E-mail: international@aek.or.at

REPUBLIC OF ARMENIA
Armenian Medical Association
Yerevan 375 010
Tel: (3741) 53 48-63
E-mail: armainter@hotmail.com

AZERBAIJAN
Azerbaijan Medical Association
AZE 370001, Baku
Tel: (994 50) 328 1888
Fax: (994 12) 315 136
E-mail: Mahirs@lycos.com /
azerma@hotmail.com

BAHAMAS
Medical Association of the Bahamas
Javon Medical Center
P.O. Box N999
Nassau
Tel: (1-242) 328 6802
Fax: (1-242) 323 2980
E-mail: mabnassau@yahoo.com

BANGLADESH
Bangladesh Medical Association
B.M.A House (Bangladesh Medical
Association House)
15/2 Topkhana Road, Dhaka
Bangladesh
Tel: (880) 2-9566060
Fax: (880) 2-9568714
E-mail: bma@aitlbd.net.com

BELGIUM
Association Belge des Syndicats
Médicaux
Chaussée de Boondael 6, bte 4
1050 Bruxelles
Tel: (32-2) 644-12 88/Fax: -1527

BOLIVIA
Colegio Médico de Bolivia
Casilla 1088
Cochabamba
Tel/Fax: (591-04) 523658
E-mail: colmedbo@supernet.com.bo
Website: www.colmedbo.org

BRAZIL
Associaçao Médica Brasileira
R. Sao Carlos do Pinhal 324 – Bela Vista
Sao Paulo SP – CEP 01333-903
Tel: (55-11) 3266 9391
Fax: (55-11) 3266 6631
E-mail: presidente@amb.org.br
Website: www.amb.org.br

BULGARIA
Bulgarian Medical Association
15, Acad. Ivan Geshov
1431 Sofia
Tel: (359-2) 954 -11 69/Fax:-1186
E-mail: usbls@inagency.com
Website: www.blsbg.com

CANADA
Canadian Medical Association
P.O. Box 8650
1867 Alta Vista Drive
Ottawa, Ontario K1G 3Y6
Tel: (1-613) 731 9331/Fax: -1779
E-mail: monique.laframboise@cma.ca
Website: www.cma.ca

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Editorial

OFFICIAL JOURNAL OF THE WORLD MEDICAL ASSOCIATION

Hon. Editor in Chief
Dr. Alan J Rowe
Haughley Grange, Stowmarket
Suffolk IP14 3QT
UK

Executive Editor
Dr. Ivan M. Gillibrand
19 Wimblehurst Court
Ashleigh Road
Horsham
West Sussex RH12 2AQ
UK

Co-Editor
Prof. Dr. med. Elmar Doppelfeld
Ottostr. 12
D-50859 Köln
Germany

Business Managers
J. Führer, D. Weber
50859 Köln
Dieselstraße 2
Germany

Publisher
THE WORLD MEDICAL ASSOCIATION, INC.
BP 63
01212 Ferney-Voltaire Cedex, France

Publishing House

Our current efforts include providing treatment, care and prevention services to control AIDS, TB and malaria; large-scale immunization campaigns to eradicate polio; and promoting healthy lifestyles. These and our other programme areas give some idea of objectives we are working for and they provide the necessary framework for our efforts. Their attainment, however, depends to a very large extent on the work you do with the users of the health system.

In addition, we have to respond to emergencies. SARS and Avian Influenza continue to be a major concern particularly in our Western Pacific Region. Their control has depended to a very significant extent on the efforts of people in your three professions.

Armed conflict and natural disasters also continue to impose extreme and unforeseeable demands, particularly on doctors and nurses. They can occur in any part of the world but are particularly severe at present in parts of our Eastern Mediterranean and African regions. Courage and tenacity will continue to be key requirements for health leadership in the future, not only in disaster areas but in the many places where health work is under-funded, under-equipped and under-staffed.

Just as health authorities depend on your professions to put policy into practice, health workers need good policies to work with. The current shortages of human resources, especially in developing countries, reflect the need for an enormous effort at rethinking and rebuilding health services. This is a unifying theme in all our acitivities at present.

One of our most important current initiatives is to scale up access to antiretroviral therapy for people living with HIV/AIDS. In December last year, on World AIDS Day, WHO launched the strategy to accelerate access to antiretroviral treatment. The initial objective is to get three million people in developing countries on to treatment by the end of 2005. We are working with the health services in countries to achieve this, following a double imperative: universal access to treatment by the earliest possible date, and

At a historic meeting in Geneva on 15-16 May, the World Health Professions Alliance held its first global conference under the title "Teaming up for health" The meeting brought together for the first time at global level leaders representing member organisations of the International Council of Nurses (ICN), the International Pharmaceutical Federation (FIP) and the World Medical Association (WMA). Sixty-five countries were represented by more than 250 people, including observers from a number of other health professions and non-governmental agencies.

From the enthusiasm in the hall it was clear that the organisers had gone a long way towards the objective of motivating health professionals and their organisations to work together at local, national and international levels to respond to the huge health challenges facing the world today.

Speakers were drawn from the health professions, policy makers, patients' disease group organisations and supranational bodies, both intergovernmental and non-governmental.

From the opening remarks of the three professions, it was clear that few doubted that a united voice from the professionals delivering health care could be more effective when dealing with the huge health problems facing the world today, which require governments to engage in positive actions for humanity at large, not only for their own communities.

Those present demonstrated this in a positive way, responding to the clear statement of reality in which Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa, underlined the immediacy of the crisis in Africa, and the grave risk of this extending in a short time to the Indian sub-continent and to China. The certain death of six million people in Africa from HIV/AIDS in the next few years, and the increasing number of orphans, were illustrations which could not be ignored. The Conference adopted unanimously the following resolution:

"Recognising that

- *the current HIV/AIDS pandemic presents an extraordinary human, human rights and humanitarian crisis;*
- *especially women and children are affected;*
- *focused prevention programmes can significantly reduce new infections;*
- *treatment options allow HIV positive persons to lead a quality life;*
- *without the appropriate prevention and treatment this crisis will worsen to a level where some countries' populations may be decimated and their futures destroyed; and*

that countries at the heart of the HIV/AIDS pandemic, provided that they are supported with the necessary financial and human resources, can rise to the challenge.

Therefore we, as leaders of the medical, nursing and pharmacy professions, call on all governments, intergovernmental agencies and health professionals to recognise the scale of the tragedy, to stop procrastinating and to commit immediately, the necessary funds and resources against HIV/AIDS.

As health professional leaders we give our full commitment to this cause and call on all physicians, nurses and pharmacists to act as strong advocates and social leaders in the war against HIV/AIDS."

In a final address to the meeting, the Director-General of the World Health Organizahose in the
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There is general acceptance that the relationship between physicians and industry is complex, and one that has been subject to

The Medical Council of India, in its Code of Ethics released March 2002, does not relate to doctors accepting gifts or cash from drug companies. [13]

Israel – Israel has historically had selected guidelines written by the pharmaceutical industry, the government, the health funds and the medical profession. Over the past year, several events occurred that portend changes in the current status. The Israeli Parliament has begun deliberations on a proposed law that seeks to codify the relationship between physicians and the pharmaceutical industry. The Israel Medical

although most physicians do not view themselves as subject to bias, they do admit that conflicts of interest might influence other physicians' decisions [24, 25].

In particular, gifts of nominal value such as pens, notepads or mugs are viewed as not affecting a physician's behaviour. In addition, certain "gifts" such as drug samples are not really viewed as gifts at all, since they are medically related and intended in essence for the patient rather than the physician. One might even suggest that drug samples serve to promote equitable access in health care, since they allow patients to try out products before committing themselves to an expensive product. [6] However, such products are really intended to induce the physician to prescribe the new product, and research shows that when patients run out of a free sample, physicians are more likely to prescribe that same product rather than a less expensive one such as a generic product. [26] In essence, all industry-supplied medical information or products are promotional. In addition, as previously stated, all personal gifts establish an implied social contract of obligation and expected reciprocation. [4]

One position paper, put out by the American College of Physicians in conjunction with the American Society of Internal Medicine, lists the following questions as helpful in gauging whether a gift relationship is ethically appropriate: "What would my patients think about it, what is the purpose of the industry offer, and what would my colleagues think about the arrangement?"

Studies have shown, in fact, that patients' attitudes and physicians' attitudes towards accepting gifts are not always the same. Overall, patients tended to find gifts less appropriate than did physicians – this was true even for gifts that existing guidelines deem acceptable, such as pens, medical books, and conference meals. [12] About half the patients in one study were aware that physicians receive gifts from the pharmaceutical industry. Among those who were not aware, 24% felt that this knowledge changed their perception of the profession. However, more than 90% of physicians accepting a gift were willing to have it generally known, indicating that perhaps physicians overestimate patients' feelings regarding the appropriateness of gifts. [12]

If one accepts that modest gifts that enhance medical practice or knowledge are acceptable, can one set a limit or specific parameters as to what is acceptable? It is difficult to set an exact amount or description, although several countries do so, as mentioned above. However, it is generally accepted that inexpensive gifts for office use such as pens, notepads or calendars meant for educational purposes or patient care such as medical books are more acceptable.

In one USA study, researchers questioned over 100 residents in internal medicine concerning their attitudes towards nine promotions or gifts offered by pharmaceutical companies. Most residents considered 7 of the 9 items as appropriate (the exceptions being luggage and funding for travel to CME conferences). In 1ding f one stbn foro set ac8d.0187 Tc0.6263 Tw(c8rning ensiv0 i-)Tj

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Reference was then made to a suggested note of clarification from Dr. William Steiger (US Dept. of Health and Human Services). Bearing in mind the problems associated with an insertion into the preamble, it was then proposed that this be a note of clarification of paragraph 30, analogous with the note concerning paragraph 29.

After an extensive debate and some modification of the wording, the following form of wording for the note of clarification to paragraph 30 was adopted as a recommendation.

Clinical trials in Populations with Insufficient access to Health Care

The Committee considered a Proposed WMA Statement on "Clinical Trials in Populations with Insufficient Access to Health Care" and agreed that the Finnish Medical Association would review this in the light of the recommendations on paragraph 30 of the Declaration of Helsinki.

Relationship between Physicians and Commercial Enterprises (also see article p. 33)

This subject will be further discussed at the October WMA meeting.

Socio-Medical Affairs

Dr. Henry Haddad was elected Chair of the Socio-Medical Affairs Committee.

Water and Health Care
Council approved a proposed Statement on Water and Health Care, to be forwarded to the General Assembly.

Armed Conflict
Council approved amendments to the Regulations in Time of Armed Conflict, to be forwarded to the General Assembly.

Quality Improvement in Medical Education
Council approved a proposed WMA Resolution on Global Standards for Quality Improvement of Medical Education, to be forwarded to the General Assembly

Health Emergencies Communication and Coordination
The Recommendations of a proposed WMA Statement were approved as a Council Resolution (box, p. 44)

Council also approved circulation of the proposed Statement and set up a Work Group to develop a plan for the establishment of a global physician network to improve preparedness for health emergencies.

Finance and Planning

Dr. J. C. Nelson was elected Chair of the Planning and Finance Committee.

Finance
Subject to an unqualified audit opinion, the Financial Statements for 2003 **were approved.**

Santiago 2005
Council approved the themes for the Scientific Session and the arrangements for the 2005 General Assembly in Santiago. The themes will be "Health Care Systems Reform" and "Access in Medicines".

Policy review
Council endorsed the recommendation that the Secretariat should develop a simplified process for review of existing WMA policies.

Membership
Recommendations that the applications for **constituent membership** of the **Medical Associations of Estonia and Vietnam** be forwarded to the General Assembly, **were approved.**

An application for **cooperative relations** with WMA from **Project HOPE, was approved.**

Official Languages
Council approved the establishment of a work group of officers to review the problems of official languages of the WMA.

Obligatory notification of AIDS as an infectious disease
Council also referred an emergency proposed Council resolution that AIDS be classified as a notifiable disease, to the Socio-Medical Affair Committee.

Zimbabwe
The Council discussed its serious concerns about reports of the collapse of the health care system in Zimbabwe and **mandated the WMA leadership** to investigate the situation in Zimbabwe and take appropriate actions.

Strategic Plan
The Council concluded with a further debate on a Strategic Plan in which many issues were aired and discussed. It was decided that a survey should be commissioned, to be overseen by a working group; a full report of discussions would be sent to

for international collaboration between non-governmental organizations (NGOs) and intergovernmental organizations (IGOs) such as WHO and the European Union. The outstanding example of international collaboration is the MONICA study, "the world's largest study of heart disease, stroke, risk factors and population trends" which WHO was instrumental in establishing and supporting. The compilation of the resultant monographs, edited by Professor Hugh Tunstall-Pedoe of Dundee, is now available from WHO in hard copy and in CD-ROM, the MONICA Monograph and Multimedia Sourcebook (WHO 2004) (www.ktl.fi(monica). This presents unique data on CVD factors, mortality and morbidity and medical care from 21 countries over four continents involving 38 research groups from 1979 to 2002. It offers challenging hypotheses about the relationship between risk factors and changes in the pattern of CVD, and is a unique and invaluable resource for clinicians, public health practitioners, researchers, policy-makers and students. It is particularly to be praised for acknowledging the difficulties involved in such a complex exercise.

In this context, it is timely that WHO has developed its STEPWISE (STEPS) approach to surveillance of risk factors (2003) relating to NCDs. This aims to provide standardized materials and methods to

The fight against malaria over the past twenty-five years or so has been a story of success and disappointments. The discovery of various drugs has advanced and

telomeres at the ends. There are 22.8 million bases (Mb) of DNA, of which complete sequences are available for chromosomes 1-5, 12 and 14. The other chromosomes still have some gaps remaining that are being “closed up”.

Within the genome, 5279 genes have been identified. Only 40% of the proteins expressed by the genes resemble others in databases, where a similarity often suggests what their function might be. So around 60% of the proteins may well be unique to this organism, which is a very high percentage in comparison with other sequenced eukaryotes. This reflects both a massive evolutionary distance and a highly specialised ecological niche occupied by this organism. The subtelomeric regions are of particular interest because they contain highly variable gene families, a variation due largely to the deletion or insertion of DNA sequences, that help the parasite evade the human immune system. They are also highly diverged between species of Plasmodium and undergo high levels of recombination, which generates further diversity.

Insights into metabolism

Only 733 of the 5277 genes have been identified as enzymes, proteins that make the parasite tick, driving the metabolic pathways that build up or break down the organism’s tissues for parasite use. Not only is this a lower percentage than in all other

This is not an exhaustive list and serves

Quality control

Action Against Substandard and Counterfeit Medicines

Asian and African Countries Move to Improve the Quality of their Medicines

Geneva – The World Health Organization has launched an action plan against substandard and counterfeit medicines with six countries from the Greater Mekong subregion. The plan follows similar initiatives in Africa and will continue to expand in response to countries' increasing call for assistance to improve the quality of their medicines.

Counterfeit and substandard medicines are frequently detected in Cambodia, China, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam and the problem seems to be increasing. Products most commonly counterfeited in this region include antibiotics and those used in the treatment of tuberculosis, malaria and HIV/AIDS. The use of poor-quality or counterfeit medicines has little or no therapeutic effect and in poor settings often leads to death.

"Combating low quality or illegal medicines is now more important than ever. Expanding access to safe, effective treatment for AIDS and other illnesses is no longer an option, it is an imperative," says Dr LEE Jong-wook, WHO Director-General.

At a meeting from 11-13 November 2003 in Hanoi, Viet Nam, WHO and the six countries kick-started joint activities directed at key decision-makers, health professionals and the general public to strengthen inspection and post-marketing surveillance.

Substandard medicines are thought to account for 8.5% of medicines on the market in Thailand. Eight per cent of randomly collected samples in Viet Nam and 16% in Myanmar failed laboratory testing for quality assessment. From these batches, Rifampicin (used to treat tuberculosis) showed the highest failure rate at 26% followed by Cotrimoxazole (an antibiotic used mostly for children) at 24%.

In 2001 it was estimated there were 2,800 illegal medicine sellers in Cambodia and 1000 unregistered medicines on the market. In the Lao People's Democratic Republic 2,100 illegal drug sellers are said to exist.

With more complex combination medicines now being recommended for drug-resistant malaria, there is a strong possibility that more substandard and counterfeit medicines will enter the market in malaria-endemic countries. Even in terms of older, more traditional antimalarials, the quality of the medicines is often poor.

A recent WHO survey of the quality of antimalarials in seven African countries (samples from Gabon, Ghana, Kenya, Mali, Mozambique, Sudan, and Zimbabwe) revealed that between 20% and 90% of the products failed quality testing. The antimalarials in question were chloroquine-based syrup and tablets, whose failure rate ranged from 23% to 38%; and sulphadoxine/pyrimethamine tablets, up to 90 % of which were found to be below standard. The medicines were a mixture of locally produced and imported products.

The reason why many of the antimaterials tested were substandard seems to stem from pervasive poverty. Poorly equipped laboratories, under-funded regulatory authorities, and poor handling and manufacturing practices mostly contributed to the results of the tests.

"Many tools exist to improve medicines' quality control and supply systems," explains Dr Vladimir Lepakhin, Head of Health Technology and Pharmaceuticals at WHO. "The problem is one of resources. Most of the countries with the lowest quality pharmaceuticals are also the ones with the highest disease burden and the poorest economies."

The findings of the report have provided a basis from which to address potential problems in the transition to the combination artesimin-based medicines for drug-resistant malaria and have given impetus to the fight against poor quality and counterfeit medicines in Africa.WHO is now running a series of training workshops in several African countries assisting manufacturers to upgrade their standards, and regulatory authorities (the national bodies meant to assure the quality and safety of medicines) to improve their practices in the screening and testing of local and imported products.

WMA Secretary General

From the Secretary General's Desk, May 2004

In political circles, the term **VISIBILITY** means a great deal. If a politician or organization has visibility, it has a better chance of convincing the electorate or general public of new directions or policies which should be followed, or the importance of maintaining a current position. Translated into our world of health care, the World Medical Association (WMA) can only act effectively as a strong advocate for the profession and the patients it serves, if it is **VISIBLE** on the global stage of leadership in health care. The question is therefore how visible the WMA is today, particularly in relation to its collaboration with the World Health Organization (WHO) and its impact on the members of WHO (the governments of the world).

Currently, the global leadership in health care is represented by a curious mix of players, including governmental, intergovernmental, non-governmental, and private groups, as well as some public-private partnerships. Because these groups have to get their message communicated and heard in a globalizing and highly information-driven world, there is tremendous competition to be the one to actually set or influence the

UN, World Bank and Global Fund call on European Ministers to scale up HIV prevention and treatment programmes

Dublin – AIDS is rapidly spreading in Eastern Europe and is on the rise again in Western Europe because integrated prevention and treatment programmes have not been sustained or do not exist. Countries in Eastern Europe, home to the fastest-growing epidemic in the world, will be in Europe's borders following the European Union's enlargement on 1 May 2004. The Baltic States, which will be part ot the EU, are also experiencing a rapid rise in HIV infections.

Leading UN agencies, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank are calling on European Ministers to urgently take decisive action to prevent the further spread of AIDS across Europe and to treat those in need. They warn that young people and other groups, such as sex workers, men who have sex with men and injecting drug users, are particularly at risk of HIV infection. The agencies participated in a Ministerial Conference hosted by the Irish EU Presidency, "Breaking the barriers – Partnership to fight HIV/AIDS in Europe and Central Asia", in Dublin.

"Europe and Central Asia are the centre of the fastest-growing HIV epidemic in the world. There is no time to waste – European Ministers must urgently scale up and roll out effective HIV prevention and treatment programmes," said Dr Peter Piot, UNAIDS Executive Director. "Given that the EU will form the biggest trading bloc in the world, covering more than 500 million people, it is

Roy Porter and David Wright,Eds.,
Cambridge University Press 2003,
£59, pp 371, ISBN 0521802067, Hardback

Samuel Johnson defined ‘to enlighten’ as ‘to illuminate, to supply with light, to instruct, to furnish with increase of knowledge, to cheer, to exhilarate, to gladden, to supply with sight, to quicken the faculty of vision’. So we are informed in Roy Porter’s brilliant book ‘Enlightenment’ (2000). In all senses of the word, Roy Porter himself enlightened the history of medicine, including psychiatry, in his own writings and in his exhilarating teaching of a host of gladdened and quickened students at the Wellcome Institute for the History of Medicine. Many of these have contributed to this volume, which is dedicated to him. He died – much too early – in March 2002, but not before contributing a characteristically lively and generous Introduction, summarising all the contributions and reviewing some of the conflicting interpretations of the chequered history of psychiatry. He relished the clash of views, and the opportunies to challenge all of them in turn, through careful research.

The sub-title ‘International Perspectives’ is fully justified, as every continent gets attention – Switzerland, Germany, France, England and Ireland in Europe; Nigeria and the Cape (Robben Island) in Africa; Victoria in Australia; Canada, USA, Mexico and Argentina in America; India and Japan in Asia. All the contributions make interesting reading.

The dates are not so precise as suggested, a few accounts beginning before 1800 and several going up to the end of the last century. The print is clear, but some of the figures, a murky patchwork of grey stippling, are rather difficult to make out.

A simplistic narrative of British psychiatry begins in the late 18th century, when some leading local benefactors decided to build

sary criterion for admisssion, as it was for the ‘official’ patients, so people could be admitted before they had frightened their families irrevocably. Nearly 40% were admitted by their spouses, husbands and wives in equal proportions. Compared with the ‘official’ patients, they were more likely to be released – too early, the psychiatrists complained – but they were transferred to other asylums less frequently, and after much longer stays, often more than two years, at St Anne. In general, the relatives were not waiting for a complete recovery but for a tolerable level of behaviour, with a capacity to provide support either at work or at household tasks. The prolonged absence of a wife could result in children being sent away to relatives and the husband left to fend for himself. Although in hospital, the patient retained the important support of remaining involved in his or her rôle in the family.

The scenario in Paris in the late 19th century may seem fairly familiar to most readers of the World Medical Journal. But Akihito Suzuki’s contribution on ’The state, the family and the insane in Japan 1900 - 1945’ takes them to a different society, where home care meant confinement in a cage, in or near the family house, and where lunatics, beggars (and also Koreans, socialists and those suffering from infectious diseases) were ‘swept’ off the streets into some sort of confinement on the days preceding

practice which also occurred in the Soviet Union on certain public holidays.

The responsibility for confining lunatics, generally regarded as dangerous, rested with the family. In T9regcdll, iring a R

CHILE
Colegio Médico de Chile
Esmeralda 678 - Casilla 639
Santiago
Tel: (56-2) 4277800
Fax: (56-2) 6330940 / 6336732
E-mail: sectecni@colegiomedico.cl
Website: www.colegiomedico.cl
Vicepresidente

CHINA
Chinese Medical Association
42 Dongsi Xidajie
Beijing 100710
Tel: (86-10) 6513 4885
Fax: (86-10) 6512 3754
E-mail: cmafrd@public3.bta.net.cn

COLOMBIA
Federación Médica Colombiana
Calle 72 - N° 6-44, Piso 11
Santafé de Bogotá, D.E.
Tel: (57-1) 211 0208
Tel/Fax: (57-1) 212 6082
E-mail: federacionmedicacol@
hotmail.com

DEMOCRATIC REP. OF CONGO
Ordre des Médecins du Zaire
B.P. 4922
Kinshasa – Gombe
Tel: (242-12) 24589/
Fax (secr.Gen): (242) 8846574

COSTA RICA
Unión Médica Nacional
Apartado 5920-1000
San José
Tel: (506) 290-5490
Fax: (506) 231 7373
E-mail: unmedica@sol.racsa.co.cr

CROATIA
Croatian Medical Association
Subiceva 9
10000 Zagreb
Tel: (385-1) 46 93 300
Fax: (385-1) 46 55 066
E-mail: orlic@mamef.mef.hr

CZECH REPUBLIC
Czech Medical Association .
J.E. Purkyne
Sokolská 31 - P.O. Box 88
120 26 Prague 2
Tel: (420-2) 242 66 201/202/203/204
Fax: (420-2) 242 66 212 / 96 18 18 69
E-mail: czma@cls.cz
Website: www.cls.cz

UNITED STATES
Colegio Médico Cubano Libre
P.O. Box 141016
Coral Gables, FL 33114-1016
Tel: (1-305) 446 9902/445 1429
Fax: (1-305) 4459310

DENMARK
Danish Medical Association
9 Trondhjemsgade
2100 Copenhagen 0
Tel: (45) 35 44 -82 29/Fax:-8505
E-mail: dadl@dadl.dk
Website: www.laegeforeningen.dk

DOMINICAN REPUBLIC
Asociación Médica Dominicana
Calle Paseo de los Medicos
Esquina Modesto Diaz Zona
Universitaria
Santo Domingo
Tel: (1809) 533-4602/533-4686
/533-8700
Fax: (1809) 535 7337
E-mail: asoc.medica@codetel.net.do

ECUADOR
Federación Médica Ecuatoriana
V.M. Rendón 923 – 2 do.Piso Of. 201
P.O. Box 09-01-9848
Guayaquil
Tel/Fax: (593) 4 562569
E-mail: fedmedec@andinanet.net

EGYPT
Egyptian Medical Association
„Dar El Hekmah“
42, Kasr El-Eini Street
Cairo
Tel: (20-2) 3543406

EL SALVADOR, C.A
Colegio Médico de El Salvador
Final Pasaje N° 10
Colonia Miramonte
San Salvador
Tel: (503) 260-1111, 260-1112/
Fax: -0324
E-mail: comcolmed@telesal.net

ETHIOPIA
Ethiopian Medical Association
P.O. Box 2179
Addis Ababa
Tel: (251-1) 158174
Fax: (251-1) 533742
E-mail: ema.emj@telecom.net.et /
ema@eth.healthnet.org

FIJI ISLANDS
Fiji Medical Association
2nd Fl. Narsey's Bldg, Renwick Road
G.P.O. Box 1116
Suva
Tel: (679) –315388
Fax: (679) 387671
E-mail: fijimedassoc@connect.com.fi

FINLAND
Finnish Medical Association
P.O. Box 49
00501 Helsinki
Tel: (358-9) 3930 826/Fax-794
Telex: 125336 sll sf
E-mail: fma@fimnet.fi
Website: www.medassoc.fi

FRANCE
Association Médicale Française
180, Blvd. Haussmann
75389 Paris Cedex 08
Tel: (33) 1 53 89 32 41
Fax: (33) 1 53 89 33 44
E-mail: cnom-international@
cn.medecin.fr

GEORGIA
Georgian Medical Association
7 Asatiani Street
380077 Tbilisi
Tel: (995 32) 39868 / Fax: -398083
E-mail: Gma@posta.ge

GERMANY
Bundesärztekammer
(German Medical Association)
Herbert-Lewin-Strasse 1
50931 Köln
Tel: (49-221) 400-4360/Fax: -4384
Teletex: 2211315 - BAK
E-mail:auslandsdienst@baek.de
Website: www.bundesaerztekammer.de

GHANA
Ghana Medical Association