World Medical Assembly

The 46th Assembly of the World Medical Association, held on Sept 1–5 in Stockholm, was different from previous ones for two reasons. First, it elected its first woman president, Prof Priscilla Kincaid-Smith. Second, its new secretary-general Dr Ian Field, formerly secretary of the British Medical Association, is to be the first full-time holder of the post.

The WMA represents freely elected national medical associations, independent of their governments, whereas the WHO represents ministries of health and, therefore, governments. Based in France at Ferney-Voltaire, the WMA has a budget of US $1 million.

As outgoing secretary-general Dr André Wynen noted in an emotional address, the BMA played an important part in the WMA in its early days. The BMA broke away in 1985, largely over doubts about the WMA's representativeness and over its recognition of the Medical Association of South Africa. Its application to rejoin was received enthusiastically. The BMA will pay for 51 000 members, which will entitle it to a seat on the Council (Field's appointment was made before the decision to rejoin). In addition, the Ethiopian, Latvian, Lithuanian, Mexican, and Nigerian Medical Associations affiliated, bringing the total up to 60.

Since 1947, the WMA has made many declarations and statements, among others, on biomedical research involving human subjects; death, torture, and other cruel, inhuman or degrading treatment; the rights of patients; in-vitro fertilisation; euthanasia; abuse of the elderly; therapeutic substances; hunger strikes; adolescent suicide; the human genome project; body searches of prisoners; female genital mutilation.

This year, the WMA obtained non-voting status with the WHO, which means that it can bring the concerns of its constituent national medical associations to the attention of the WHO and receive information. The WMA has also made representations to several governments about unjust imprisonment of doctors, or the poor health of prisoners.

The 1994 assembly dealt with several fresh concerns. It started to update its document on the rights of children; it asserted the right of women to control their own fertility; it battled about whether human rights should be taught in medical schools as separate courses (which might not seem important to students) or by the bedside, or as studies of case-histories; it noted the increasing treatment in free countries of victims of torture in repressive regimes; it preferred breast feeding to artificial milk; it called on medical associations to strengthen their opposition to transplantation of organs from orphans, execution victims, poor people, and persons with HIV, who might not have given their consent—it even suggested that medical associations should discipline their members who acted against the 1987 declaration requiring that the patients consent should be sought; it urged planning in the event of medical disaster; it initiated a world-wide discussion on a policy for allocation of health-care resources.

Much time was spent discussing ways in which these pious pontifications could be translated into everyday practice. Dr W J Appleyard, representing the BMA, suggested that a good start could be made by requiring all newly qualified doctors throughout the world to sign the Geneva Declaration of the WMA, which updates the Hippocratic Oath.

How will a declaration or a statement made in the comfort of a Stockholm hotel influence a doctor typing organs of a man about to be executed or contemplating taking organs out of orphans who have died under suspicious circumstances in their care? In principle, such a medico-political event has a natural history. The international body adopts the declaration as best practice; it is communicated to the national medical associations; those doctors who agree with it try to use the prestige of the international organisation to encourage the miscreants to reform their ways; a change in government occurs; and the abuse is stopped, fundamentally because medical abuse is un-democratic as well as unjust.

The next assembly is to be held next September in Bali, Indonesia, which the Portuguese Medical Association was not able to convince its peers derogates human and medical rights.

Harold Hillman

Priscilla Kincaid-Smith

You can't imagine her as anything but a professor. Tall and strong (she represented her native South Africa in swimming and hockey), Priscilla Kincaid-Smith AC, CBE exudes authority and learning.

If Kincaid-Smith has a profile outside the medical world, it is for her consistent and forceful and repeated arguments that aspirin-phenacetin-caffeine combinations—Bex, Vincents, and other combination headache powders so common in the 50s and 60s—caused kidney disease and prematurely killed many Australian women. "People used to buy them by the large box, a gross at a time", she says. Hospitals had to build renal units to cope with the demand for dialysis. After more than a decade of pushing and shoving governments, the National Health and Medical Research Council and other doctors, Kincaid-Smith finally saw legislation ban combination powders in the late 70s. Without the cause, the effect faded.

As a renal specialist and medical politician, Kincaid-Smith has been active in almost every professional organisation open to her. She has been president of the International Society of Nephrology and the Royal Australian College of Physicians and, in Stockholm, became the first Australian to preside over the World Medical Association. She earned a world-wide reputation for having the strength of character to survive and prosper so notably in a man's world.

Kincaid-Smith has been an innovative medical scientist. Colleagues say she has opened areas of research in glomerulonephritis and reflux nephropathy. She has also contributed to knowledge of the relation between hypertension and the kidney, renal transplantation, and the kidney in pregnancy. She has been prolific, writing 487 original articles in medical journals, 103 book chapters, and 13 books, her latest being *A Colour Atlas of Urine Microscopy*.

Despite age-related compulsory retirement from Melbourne University, Kincaid-Smith continues to care for patients and carry out research. She still chairs the federal council of the Australian Medical Association and is active as the senior medical adviser to Marie Tehan, the Victorian Health Minister, and a variety of government committees and councils.

Her agenda for the World Medical Association? "Not surprisingly, I'm going to follow up a couple of women's issues. There haven't been a lot of women involved in the World Medical Association [she will be the first female president], so it's a good time," she says. "We have to convince people that women in the Third World should have a choice of contraception. If I can achieve that, it will be good. But I'm president for only a year."

Mark Ragg

UK doctors rally over mooted pay change

British Medical Association officials have urged clinicians to stand firm against attempts by their local managers to implement the government's plans to change radically how clinicians' pay is determined. But they have also warned doctors not to be goaded into behaviour that could be construed as industrial action.

Senior doctors were brought together by the BMA at a conference in London last week to find out how best to fight the government's determination to introduce performance-related pay to the health service. To date, doctors' pay has been set centrally, after advice from the Review Body on Doctors' and Dentists' Remuneration. This independent group makes its recommendations in the light of, among other things, the earnings of other professionals and workload.

The government proposes that as of April next year the review body will recommend "exceptionally modest" pay increases to which local employers can make additions according to their own performance-related pay schemes. But, BMA officials and speakers reiterated at the conference that local employers have been given no guidance on how these top-up schemes might be set up and that, even if it were possible to convert clinical performance into pounds and pence, most trusts simply do not have the money to make additional payments. (The government has made it clear that no central funds will be made available for local negotiated pay increments.)

Various speakers repeated arguments that the BMA and other doctors' representatives have made before on why local performance-related pay would be a disaster for the national health service. But delegates, already convinced that performance-related pay schemes would bring them no benefits wanted instead practical advice and discussions on how the profession is to resist this latest initiative. Representatives of the police federation and senior civil servants, two public-sector professions that have fought government plans to introduce performance-related pay, advised delegates on tactics such as winning public sympathy, lobbying parliament when health-related questions are to be raised in the House, and using European law to their advantage.

Sir Anthony Grabham, a former chairman of the BMA council, did not mince his words when called upon to summarise the day's events. He urged those present not to settle for what he saw as being the very worst solution—ie, to try the new system and see what happens. He warned that the government would try to suck the profession into a compromise by making the changes to pay seem attractive at first.

Doctors and their advocates have a fierce battle ahead. The government will explain that it is trying to increase the accountability of those whose salaries come out of the public purse. Doctors will argue that clinicians' participation in local negotiations would drain resources away from patient care and might inhibit them from commenting publicly on the health service. Of key importance will be which group can win the public over in the coming months.

Sarah Ramsay

Gaps in UK research into elderly

The exclusion of elderly people from epidemiological studies and trials of prophylactic or therapeutic measures could be contributing to inequities in health care for this age-group, says a Medical Research Council report produced by its Health Services and Public Research Board. The review, intended to identify scientific opportunities, points out the dearth of information on the incidence, prevalence, and determinants of disease in the elderly and on trends in their health status, which are important for determining health-care policy and resource allocation. It also explains that the setting of upper age-limits for trial participants could mean that clinical decisions concerning the older age-groups might not be as appropriate as for those included in the trials.

One reason for the scarcity of information on health status of elderly people in the UK is that the data sources—the General Household Survey and the Office of Population Censuses and Surveys—are not adequate for monitoring the health of older people. But, there are opportunities for improving and supplementing these data, says the report. The OPCS data indicate a fall in age-specific mortality, but do not separate out period effects from birth-cohort effects. Moreover, the fall has not been accompanied by a decline in health-care utilisation rates. However, since GHS data rely on self-reported illness, health-care utilisation rates derived from GHS findings may reflect people's expectations and the services available rather than absolute morbidity.

If information on health is to be used for determining health-care policy and provision, studies on the effectiveness of care should include cost-benefit analyses, argues the report. Since the primary aim of interventions in elderly people is usually to improve quality of life (QOL) rather than to postpone death, further research is required to determine when QOL assessment techniques can be applied to older people and their health care. Another measure of health for which there are no good data in Britain is that for assessing active life-expectancy and its modification HALE (healthy active life-expectancy). Similarly, the relation between HALE (a public health measure based on epidemiological data) and the QALY (quality adjusted life year, an economist's tool) needs to be explored.

The report acknowledges the existence of implicit rationing of health care for the elderly—ie, not resulting from an agreed policy. The topic has been researched in the USA, and ought to be in the UK, where there is evidence to suggest that it is widespread, says the report. It describes as unsubstantiated the pervasive view that older people benefit less than younger ones from medical and surgical interventions. Elderly people ought to be considered part of the continuum of the age spectrum, so in choosing criteria for offering health care, the emphasis should be on physiological status, not chronological age, concludes the report.

Vivien Choo

1 The health of the UK's elderly people. London: Medical Research Council. 1994. Pp 72.

Presidential veto on Polish abortion law amendment

Poland's lower house of Parliament (Sejm) last week failed to overturn a Presidential veto on amending the 1993 Act on the Protection of Unborn Life, which forbids abortion on grounds of economic or social hardship. As soon as the Act came into force in January, 1993, pressure began for its amendment, to once again permit "social" abortion.

President Walesa, a loyal traditional Catholic, invoked his powers as president to veto the resolution. The Sejm then referred the issue to three of its standing committees—on health, justice, and legislation. On Aug 24, these reported back that the Sejm should try to overrule the veto. (At the same time, they criticised Poland's exclusively Catholic stance at this week's Cairo population conference, saying that it should instead reflect the "diversity" of views in Poland.) Accordingly, last week, the Sejm once again voted on the proposed amendment. 232 voted in favour of rejecting the President's veto, 157 against, and 22 abstained. Without the required two-thirds majority, Walesa's veto remains in force.

Meanwhile, Barbara Labuda, leader of the women's group in the Sejm, was last week expelled by her party, the moderate-right Union of Freedom for, among other breaches of party rules, neglect of the party's parliamentary business, to concentrate exclusively on religious and ethical issues—in other words, the abortion campaign.

Vera Rich