COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

CPME Newsletter

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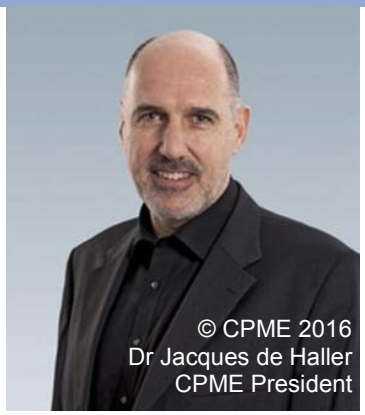
This issue

WELCOME MESSAGE

MESSAGE FROM THE CPME PRESIDENT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Dr Jacques de Haller
CPME President

Dear Colleagues and friends,

Welcome to the 25th edition of the CPME newsletter.

In the beginning of 2018, the global medial community is facing worrying developments in Turkey. Following a public statement of the Turkish Medical Association (TMA) on 24th of January, stressing that war is a public health problem and calling for peace, its leaders have been confronted to a campaign of intimidation and threats that culminated in the arrest of eleven physician leaders. The Turkish Medical Association has only expressed its opinion in support of human rights and peace: this is not a criminal offence. Moreover, filing a criminal complaint against the TMA on the basis of the peaceful exercise of freedom of expression constitutes a flagrant infringement of human rights as stated in the International Covenant on Civil and Political Rights that Turkey ratified in 2003, hereby establishing its consent to be bound by its provisions. The Standing Committee of European Doctors together with the global medical community sent a letter to President Recep Tayyip Erdoğan to ask for immediate release of the physician leaders and to end the campaign of intimidation. CPME also informed the European Institutions and the EU Representation in Turkey asking them to take action and to supervise what will happen during the upcoming trial. Our thoughts and efforts are with our colleagues in Turkey and we will always stand on their side to defend the respect of human rights and the principle of medical neutrality.

In Brussels, the coming months will be especially busy and important in the context of the upcoming debate on the next long-term EU budget. CPME is following with great attention all the discussions around the so called Multiannual Financial Framework (MFF), and has raised concerns that health doesn't appear on the EU agenda. Although we recognise the need for budgetary restraints, we also acknowledge that there can be no economic growth without investments in health and that budget cuts affect important healthcare services in terms of access to and quality of care, health technologies and innovation.

The EU public health agenda for 2018 includes actions on vaccinations, the only health priority recognised by President Juncker. The first EU activity on this will explore ways for member countries to work together on vaccinations. CPME has already set out its views on the European Commission's process of drafting a proposal for the Council recommendation on national vaccination policies, addressing immunisation record systems, vaccine hesitancy and shortages. From a legislative perspective, negotiations on the proposed regulation on health technology assessment (HTA) will start in the coming weeks in the EU council and the European Parliament. Before issuing its proposal, the Commission consulted stakeholders on their preferred option for EU cooperation beyond 2020. In its response, CPME expressed its support to the establishment of a sustainable EU framework on HTA which would guarantee a high level of independence and transparency.

In this edition you will also find a guest article from the Pontifical Academy for Life reporting on the extraordinary decision of Pope Francis to ban any sale of cigarettes within Vatican City, updates on the ongoing negotiations towards a Directive for proportionality tests and CPME perspectives on the upcoming communication on digital transformation of health and care.

Furthermore, five CPME members and other relevant stakeholders in the health sector report on their current policies, developments and priorities.

I hope you enjoy reading this edition.

Best regards,

Dr Jacques de Haller, President of CPME

FEATURE

WHERE IS HEALTH IN THE NEXT EU BUDGET?

The debate on the next long-term EU budget – the Multiannual Financial Framework (MFF) – is about to start in the EU council and the parliament. Lively discussions are expected between Member States on the future priorities of the EU and how they will be translated in an EU budget. In this respect, the Commission already emphasised the importance of allocating resources in areas where the EU sees a clear added value. Security and defence, migration and competitiveness already emerged as priority areas. However, as economic growth should go hand in hand with health protection, it is not clear what this means for EU health policy. So far, this has never been mentioned in the debate.

When the Juncker Commission took office, the mantra of '*big on big things and small on small things*' raised concerns as regards an excessively growth-driven agenda for EU policies (see our article, March 2016). Since then, trends can be observed towards: 1/ applying a logic from industrial and commercial policy to healthcare services, for example by introducing **standards in healthcare services** developed by industrial standardisation bodies, which have neither the necessary professional, ethical and technical competencies nor a public mandate to do so (CPME Position paper on the standardisation of healthcare services, adopted in May 2014); 2/ requesting Member States to increasingly justify the suitability and **proportionality of new regulation on the basis of economic indicators, for example for professional regulation**, including for healthcare professions. Here too, the implementation of a policy agenda directed at completing the internal market for business services conflicts with the objectives and responsibilities of health policy (CPME Position on the Proposal for a Directive on a proportionality test for adoption of new regulation for professions, adopted in April 2017); 3/ not renewing public health-oriented strategies, including the 2006 EU strategy on **alcohol**; 4/ closing some valuable and sustainable platforms for cross-border exchange of expertise, such as the **Patient Safety and Quality of Care** Working Group. These trends underline a continuous and increasing downgrade of health policy on the European agenda over the years. In the light of recent developments, health professions and the health community are increasingly wondering what the future of EU health policy will be. Will there be any health programme in the next EU budget? If not, what does it mean for the future of EU health policy? In respect of the 'one commissioner for each member state' principle, will the Brexit impact the organisation of the next Commission? Is it likely that the DG Santé will pay the price?

> *"Will there be any health programme in the next EU budget? If not, what does it mean for the future of EU health policy? In respect of the 'one commissioner for each member state' principle, will the Brexit impact the organisation of the next Commission? Is it likely that the DG Santé will pay the price?"*

Meanwhile, the health status of the population is facing social challenges, such as the ageing of the population and the rise of chronic diseases, which cannot be contained without systematic actions and require the topic of health to be maintained high on the EU agenda. While Europe is facing an unprecedented demographic trend, the European Commission has identified **active and healthy ageing** as a major societal challenge, which presents considerable

FEATURE

potential for Europe to show leadership in providing innovative responses. This will also require long-term **health workforce planning** and investment in employment and education in order to prepare the next generation of highly-qualified healthcare professionals. Only if the health workforce receives high quality education and training throughout its career and can rely on safe and attractive working conditions will patients be able to enjoy high quality healthcare. High standards of quality and safety must also drive the development of new **medicinal products and health technologies** with the ultimate objective of ensuring their availability for all patients. Furthermore, without **research and innovation**, by 2050 **antimicrobial resistance** (AMR) could lead to 10 million deaths globally and have a major impact on the economy. In this context, **prevention and promotion** will play a major role, not only in tackling AMR, but also in facing future public health threats and social challenges. **Vaccination** is a key solution to ensuring a healthy society and reducing costs related to avoidable healthcare interventions. In fact, rising threats to health can sometimes also be prevented through the implementation of focused programmes, as in the case of childhood vaccinations.

"Since there is no economic growth without investments in health, we call on EU policy-makers and Member States to make sure that health is adequately taken into account in the next EU budget."

The health community welcomes those initiatives which address health needs to prevent disease and promote health across society. However, the trends in the European landscape are raising several concerns among the health professions. Although the need to respect budgetary restraints is recognised, it is equally important to assess the impact that any budgetary plan can have upon health policy. Since **there is no economic growth without investments in health**, we call on EU policy-makers and Member States to make sure that health is adequately taken into account in the next EU budget.

Miriam D'Ambrosio, Communication and Project Officer

LATEST NEWS

TRILOGUE, COMPROMISE, ADOPTION – NEXT STEPS FOR THE PROPORTIONALITY DIRECTIVE

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In November 2017, the European Parliament's Committee for Internal Market and Consumer Protection (IMCO) adopted its Report on the draft Directive for a proportionality test before adoption of new regulation of professions. Despite urgent calls from CPME and indeed the vast majority of the healthcare professions for an exemption from the scope of the Directive, the final parliamentary position falls short of this. Instead the Report prepared under the lead of MEP Andreas Schwab references the need to ensure a high level of human health protection, as provided in the treaties. The question of whether or not to include health professions in the legislation was a topic of controversial debates for several months: while the SD group continuously supported the exemption of health professions from the proportionality test, MEP Schwab's position shifted from proposing a full exemption in his draft Report to supporting the provisions adopted by IMCO. In a next step, the trilogue negotiations aim to find a compromise between the Council position and the European Parliament's Report. The question of health professions was not addressed in the Council position and will therefore be an important point of negotiations. Other issues for discussion include the role of independent scrutiny bodies in the process and the requirements as to the evidence which must be provided in support of the proportionality assessment. There will also be a discussion on the specific requirements and criteria for the assessment of the proportionality of a regulatory provision. The trilogue starts in January 2018 and is scheduled to be concluded by June 2018. CPME and other health professions are continuing to monitor the process closely to ensure the best possible outcome for health regulation can be achieved.

Sarada Das, Deputy Secretary General

LATEST NEWS

UPCOMING COMMUNICATION ON DIGITAL TRANSFORMATION OF HEALTH AND CARE WHAT MATTERS TO EUROPEAN DOCTORS?

In the past six months, the Estonian Presidency of the EU Council focused on advancing digital innovation in health, which led to the adoption of council conclusions in December 2017. The Commission is now expected to release its communication on the digital transformation of health and care in the context of the Digital Single Market in the coming days. A broad public consultation was held last year to prepare this communication.

In its response, CPME emphasised that, if medical research using health data can contribute to the better understanding of diseases and to improving the quality and effectiveness of diagnostic and therapeutic interventions, it is equally important to guarantee patients' autonomy and their right to self-determination. This requires ethical guidelines to ensure that personal health data are used for a meaningful purpose in a manner which is scientifically sound and ethically acceptable. To that end, European doctors consider that the WMA declaration of Taipei on ethical considerations regarding health databases and biobanks provides the necessary safeguards.

With the increasing provision of cross-border healthcare services, it is also important to address interoperability issues at EU level to reduce fragmentation. The aim should not only be technical interoperability, but also the maintenance of the highest possible standards of usability and, most crucially, data protection and confidentiality. Moreover, specific cybersecurity measures should be taken in the healthcare sector in order to prevent hacking of IT infrastructures, including hospital information systems, practice management systems and control systems for medical devices.

The CPME response to the public consultation on the transformation of health and care in the Digital Single Market was adopted by the CPME Executive Committee on 10 October 2017, and can be found here: **CPME 2017/058 FINAL**.

Carole Rouaud, EU Senior Policy Adviser

NEWS FROM CPME MEMBERS

THE ICELANDIC MEDICAL ASSOCIATION CELEBRATES ITS 100TH ANNIVERSARY

On 14 January 1918 the Icelandic Medical Association (IMA) was established by 39 Icelandic physicians and the Association adopted its first bylaws and a Codex Ethicus for all its members. This was not the first effort to establish a national Association in Iceland but previous attempts made in the 1890s were futile.

The first years of the IMA were difficult, not least due to the fact that Icelandic physicians worked all around the country and transport was not easy.

Annual meetings could not be held every year, as the bylaws stipulated, but the board usually managed to meet. The annual meetings were usually held in Reykjavík, where the majority of physicians lived, but in the early 1920s an annual meeting was held in Akureyri, the largest town in the north of Iceland. For the last fifty years or so the IMA's annual meetings have regularly been held outside of the capital area. For many years, the minutes of the annual meetings of the IMA were published in the Icelandic Medical Journal. The minutes from the early years illustrate that the IMA was very involved with health policy along with issues related to the working conditions of physicians and the remuneration of their work.

> *"The Standing Committee of European Doctors congratulates Icelandic Medical Association for its 100th Anniversary and looks forward to continuing their excellent collaboration to bring together results for the best possible quality of health, access to healthcare for everyone and a strong, independent medical profession at European level."*
>
> *Dr Jacques de Haller,*
> *President of the Standing Committee of European Doctors*

© 2018, Icelandic Medical Association
Dr. Katrín Fjeldsted former President of CPME selected Honorary Member of the IMA

It goes without saying that the IMA has grown considerably over its 100 year history. Its members now number around 1250.

1918 was a memorable year in the history of Iceland. January 1918, when the IMA's first meeting was held, was one of the coldest months ever experienced in recorded Icelandic history. Day after day the temperature in Reykjavík was -20°C, with -30°C in the north of the country. In October 1918, one of Iceland's most fierce volcanos, Katla in the Mýrdal Glacier that usually erupts once a century, started one of its biggest eruptions in history. A few weeks later, the Spanish Flu Epidemic arrived in Iceland with two ships, one from Copenhagen, the other from the US. The epidemic reached its peak in November and ended up killing close to 500 Icelanders, more than half of them living in the capital, Reykjavík. On 1 December 1918 Iceland became a sovereign nation under the King of Denmark, thus concluding this remarkable year in Iceland's history.

The IMA will celebrate its 100th anniversary in various ways throughout 2018. The celebrations started on 15 January with a special Anniversary Meeting in connection with the beginning of the IMA's annual week-long conference. The Icelandic President, along with hundreds of Icelandic physicians and their guests, attended this Anniversary Meeting and enjoyed lectures on Physicians and the Environment as well as music presented by various Icelandic musicians. A mixed choir of more than 70 physicians performed at the Meeting to the great delight of all attendees. In addition, 15 outstanding physicians were made honorary members of the IMA, 2 women and 13 men.

Dr Katrín Fjeldsted, former President of CPME, was awarded honorary membership of the IMA at the meeting for her outstanding work for the IMA and within CPME.

The centenary celebrations will also include a spring dance for physicians in May, where a band made up entirely of doctors will be responsible for the music. An outdoor festival for physicians and their families will be held in June. During the summer, two mountain climbing events for physicians and their families will be on the programme. In October, the IMA hosts the WMA's General Assembly, and the milestone will be celebrated further at the IMAs own Annual Meeting in November.

Ms Dögg Pálsdóttir, Legal Adviser of IMA

ORDER OF PHYSICIANS OF ALBANIA (OPA): GREAT DEMOCRATIC CHANGE IN THE HEALTH CARE SYSTEM IN OUR COUNTRY

Before and during the dictatorship there was no tradition or experience of having a medical professional regulatory body in Albania. Against the background of great democratic changes to systems, society and the state, the rise of civil society was a new development within Albania. This led to the creation of independent bodies, which play very important roles in social, economic, cultural, professional, scientific and political life. The OPA is part of this new society. It represents the common interests of the medical profession and regulates its relations through its public function. Its slogan is: "Lead the doctors and defend the patients."

The OPA was founded in 1993 by Law no.7708 of 18/05/1993 and enhanced by Law no.8615 of 1/06/2000, which was repealed in September 2014 under the new Law of the OPA. Only doctors may be members of the Order. The National Council has 25 members, the Regional Councils have 12 members.

Membership of the OPA is obligatory. No physician can practice the profession without being a member of the Order. The OPA awards the right to practice medicine to doctors who practice their professions in public and private health care institutions. The highest authority of the Order of Physicians of Albania is the General Assembly; the Regional Councils have regional assemblies. The General Assembly elects the National Council and the regional assemblies elect the Regional Councils. The mandate of the national and regional councils is 5 years.

The OPA carries out main activities, such as the registration of all doctors who practice the profession on Albanian territory (National and Regional Register) and the administration of the National and Regional Register of doctors with periodical updating. Consequently, awarding the right to practice as a doctor providing public and private medical services through the registration process. In addition, monitoring the professional standards and doctors' to fitness to practice on the basis of medical ethics and the Deontological Code. Moreover, the OPA acts as a medical court regarding the professional liability of physicians. Last but not least, the OPA cooperates with the main national and international stakeholders in the health sector.

As regards the aims and the objectives of the OPA, the main challenge for the OPA is taking responsibility for ensuring high and stable ethical and deontological standards in medical practice; increasing the moral and professional attributes of doctors in their relations with their patients and the public. Another key objective is, building the capacity and institutional effectiveness for stimulating good medical practice. As well as protecting patients and the public from medical malpractice. Furthermore the OPA promotes good conduct, protects and represents the mutual interests of doctors for good medical practice and independent practice of the profession. Finally, building the credibility of the OPA among the public, the profession and its partners within and outside the Order is vital.

Nowadays, the OPA has defined its position among the actors and other factors operating in the Albanian health care system. During all its progress, from foundation to consolidation, the OPA has had to confront many difficulties and challenges, the most important of which we could specify as follows:

- Those related to lack of public awareness
- False perceptions regarding the importance of the OPA's mission and functions.

In order to realise this, the new staff members prepared new bylaws on registration/licensing, professional judgement, etc., and created a new electronic register, and so on.

"The new law in 2014 caused the dentists to separate from the Order and create their own order. As a consequence, 2015 saw new elections to all structures of the OPA. The newly elected representatives had three important objectives:
- Preservation of the independence of the OPA;
- Financial stability;
- To preserve partnerships with all the stakeholders in our country and with international counterparts."

In the first years of the new mandate we sought to deal with some very sensitive topics in the interests of our members, such as the migration of doctors, sensitising politicians and society to legal changes (civil and penal code), the defense of doctors and so on.

Our experience and achievements so far have provided a good basis for trust and optimism in our success.

Dr Fatmir Brahimaj
President of the Order of Physicians of Albania National Council
Kontilia Rapo
Secretary General of the Order of Physicians of Albania National Council

DANISH PILOT PROGRAMME WITH MEDICAL CANNABIS

Lægeforeningen
DANISH MEDICAL ASSOCIATION

On 1 January 2018, a 4-year pilot programme with medical cannabis started in Denmark. This programme allows doctors to prescribe new types of cannabis products that previously were not legal in Denmark. The Danish Medical Association has fought against the implementation of this programme as it disregards the usual effectiveness and safety requirements for new pharmaceutical products and is not based on clinical trials.

The aim of the pilot programme is to give patients - if they have not benefitted from approved medicines - the possibility to legally try out treatment with medical cannabis. The aim is that the pilot programme, at the end of the trial period, will provide a better basis to evaluate the use of medical cannabis. It is expected that approximately 1,500 patients will participate in the programme.

Two products are initially available on the pilot programme

The cannabis products included in the pilot programme are not licensed as medicine, neither in Denmark nor in other countries. They have not been tested in clinical trials and we do not have the same knowledge about reactions and side-effects as we have about licensed medicines.

Two products are included in the pilot programme from the start. These can be bought at Danish pharmacies with a prescription. Both products are imported from the Netherlands. Bedrocan contains 220 mg of the euphoriant substance in cannabis, THC, and consists of clean, dried, quality buds. Bediol contains 63 mg of THC and 80 mg CBD of granulated cannabis flower. The Danish Medicines Agency recommends that patients drink both products as tea. A reimbursement system has been established to enable all patients to be part of the pilot programme.

The supply of medical cannabis is expected to increase in the coming years when Danish production of medical cannabis is established.

Four indications where some documentation for effectiveness exists

The Danish Medicines Agency finds that it is relevant to consider medical cannabis for the following indications, where there is some documentation of the positive effects of medical cannabis:

- Painful spasms caused by multiple sclerosis
- Painful spasms caused by spinal cord injury
- Nausea after chemotherapy

Neuropathic pains (pain caused by sickness in the brain, the spinal cord or nerves)

The Danish Medicines Agency strongly recommends that children and young people under 18 years old are not treated with medical cannabis. This recommendation is based on, among other things, the lack of knowledge about long-term effects, including concern about how medical cannabis affects the brain.

These indications were selected after the Danish Medical Agency read and evaluated relevant scientific tests that have been carried out worldwide to examine the effects of medical cannabis. The specific products in the pilot programme have not necessarily been tested and the possible side-effects, both in the short and the long term, have not been sufficiently mapped – a fact that both doctors and patients should be made aware of and consent to.

Prescription – the doctor's full responsibility

The lack of knowledge about medical cannabis means that each doctor must take full responsibility for the prescription and, for example, assess the appropriate dosage for each patient. The doctor neither has a product leaflet nor a product summary as a basis upon which he/she can assess the possibility of positive effects or the risk of side-effects for the patient.

No doctor is obliged to prescribe medical cannabis. Based on the lack of knowledge about medical cannabis, the Danish Society for General Medicine has recommended that general practitioners do not prescribe medical cannabis.

Call for clinical trials

Together with a number of patient organisations, the Danish Medical Association calls for a pilot programme based on specific clinical trials in a scientific setting. As a result of this call, the Government has allocated 5 million DKK to carry out clinical trials with medical cannabis. A further 5 million DKK have been allocated to collect knowledge through the examination of protocol-based studies and through the systematic collection of reports on side-effects.

"No doctor is obliged to prescribe medical cannabis. Based on the lack of knowledge about medical cannabis, the Danish Society for General Medicine has recommended that general practitioners do not prescribe medical cannabis."

A half-way stage evaluation is planned to take place in 2 years and a final evaluation is planned at the end of the pilot programme.

An irresponsible experiment with patients' health

The message from the Danish Medical Association to Danish politicians has been – and still is – that enabling access to an untested drug with possible serious side-effects is a step that should be taken very seriously. Also, it is almost farcical to launch a highly irresponsible experiment with the health of patients and, at the same time, allocate a very small amount of money for research. It is out of touch with reality to believe that such a small sum can contribute to clarifying the large and very serious questions on effectiveness, side-effects, dosage and the safe production of products - all questions that should be answered through solid scientific protocols.

Dr Andreas Rudkjøbing,
President, Danish Medical Association

RADICAL CHANGES IN HEALTH CARE FINANCING NEWLY ADOPTED IN LATVIA

Latvijas Ārstu biedrība

In recent years, after the financial and economic crisis of 2008-2010 when health financing was cut by 25%, the dissatisfaction of the population with healthcare in Latvia has grown. Public funding reached 4% in the pre-crisis year, with total health financing fluctuating slightly above 6%.

According to the classification of the OECD, Latvia has a general state tax-based health care system with a significant proportion of out of pocket expenditures from private households (about 40%). Private supplementary voluntary insurance accounts for a small share of total funding. Health care providers come in various forms and combinations: public capital, municipal enterprises, private companies and practices. There is a purchaser-provider split and each service provider must conclude an agreement with the National Health Service under the Ministry of Health. It also sets the service tariffs that are approved by the Cabinet of Ministers.

After independence in 1991, Latvia initially moved to create a social health insurance type system, but in fact it has always been funded by general tax revenues. Latvia has been constantly reforming its health care system for over

25 years. In 2011, a National Health Service type system was established, but it did not bring the expected rapid improvements. According to the most important core indicators of public health, e.g. amenable and preventable mortality, average life expectancy at birth, indicators of inequity in access and health status etc., Latvia is still ranked last among EU countries. In this context, it is quite easy for politicians to put forward the idea that a radical reform of the system is needed. It is planned to implement this with the newly adopted Health Financing Law, which focuses on the introduction of a health insurance system.

The purpose of this law is to ensure sustainable financing of health care based on the solidarity of the whole society with the involvement of taxpayers in order to promote good universal healthcare financing and its efficient use, thus contributing to the availability of healthcare and the improvement of public health indicators. This law determines the general principles and structure of the health financing system and regulates the financial and organisational structure of the compulsory national health insurance, which is thereby introduced. The Cabinet of Ministers will determine the minimum amount of state-funded medical assistance, including emergency medical services, childbirth assistance, family doctors' assistance, treatment of diseases that have a significant impact on public health (including mental illness, tuberculosis etc.). However, further within the framework of compulsory state health insurance, in addition to the minimum amount of medical services funded by the state, people have the right to receive primary, secondary and tertiary health care services, as well as medicines and medical devices intended for outpatient treatment. Those who have paid compulsory social insurance contributions will have health insurance through social insurance. In addition, there are many groups of people who are insured by the state, e.g. children, pensioners, people with disabilities, etc.

"The Cabinet of Ministers will determine the minimum amount of state-funded medical assistance, including emergency medical services, childbirth assistance, family doctors' assistance, treatment of diseases that have a significant impact on public health."

The Latvian Medical Association is very worried about this turning away from the principles of universal health coverage. Our position against the proclamation of the law was not taken into account. It appears that family doctors will become the gatekeepers of further access to the system with their first question to the patient being: have you paid compulsory social insurance contributions? It seems completely wrong that doctors will become revenue officers. Obviously, implementation of the law will not be easy.

Dr Dzintars Mozgis, Associate professor, MD, PhD

CHALLENGES FOR SERBIAN HEALTHCARE IN THE PROCESS OF HARMONISATION WITH EUROPEAN LEGISLATION

The process of European integration and Serbia proceeding towards European Union membership entails numerous healthcare system reforms. In addition, harmonisation with European legislation has led to changes to almost all laws regulating the field of healthcare.

In the past two years, the Ministry of Health of the Republic of Serbia has been working on a Draft Law on Healthcare, which the National Parliament of the Republic of Serbia will announce in the spring of 2018. This will bring, among other things, changes to the organisation of work in healthcare services, working hours, defining the issue of on-call time, night work and the additional work of healthcare professionals. Although legislative changes are aimed at harmonising domestic legislation with the EU Working Time Directive, the Serbian Medical Chamber holds the opinion that the Serbian healthcare system is not yet ready for the changes proposed in this area.

The Serbian Medical Chamber has repeatedly drawn the attention of the competent Ministry to the fact that harmonising domestic legislation with EU regulations on working hours could undermine the healthcare system due to the

current deficit in the numbers of doctors, and that it will be necessary to make it legally possible for doctors to work even longer hours than the current European Union average in order to maintain the system.

Serbian Medical Chamber data shows that over 30 000 doctors in Serbia possess the license to practice medicine and that this number of doctors is within the European Union average. Taking into account only on the number of doctors working in the public healthcare system, Serbia has 264 doctors per 100 000 inhabitants. If all doctors who have a license (private, unemployed, active retirees) were to be included, there would be an average of 400 doctors per 100 000 inhabitants.

However, a ten-year period in which the specialty training of doctors in Serbia was frozen has led to a situation in which 9 000 general practitioners are waiting to begin specialty training while healthcare institutions are facing a shortage of specialists in various areas. At present, we have a situation in which about 1 500 general practitioners are unemployed, whereas there is not a single unemployed specialist. Specialist education is no longer frozen, however it will take some time to eliminate the shortages that have arisen as a result of this policy.

"Serbia, like many countries in the region, faces an upward trend in the migration of doctors to developed countries. A concrete state strategy is needed in order to reduce the outflow of professionals from the country."

In addition, the age structure of doctors in Serbia indicates that, if adequate measures are not taken, the healthcare system, could face a new wave of shortages in certain specialisations in the coming years because it will not be possible to replace those retiring. Serbia, like many countries in the region, faces an upward trend in the migration of doctors to developed countries. A concrete state strategy is needed in order to reduce the outflow of professionals from the country.

Another major problem is internal migration to large cities, above all to Belgrade, leading to sustainability problems in work and human resources in general hospitals in smaller towns. Additionally, our large private sector resources and over 4 000 doctors working in the private healthcare system of Serbia are currently not sufficiently recognised by the state. The inclusion of the private healthcare system into the state system could contribute significantly to raising the quality of healthcare services in Serbia.

Due to all of the above, the Serbian Medical Chamber insists that a detailed human resources analysis should be carried out and a professional development plan developed in order to provide a clear picture of healthcare needs. Only once this has been done should the process of reforming the organisation of healthcare services begin.

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The project initiated by the World Health Organization of drafting a national staffing plan for healthcare in Serbia, including the Serbian Medical Chamber, started in October 2017. The Serbian Medical Chamber, being in charge of licensing doctors and having the most accurate data on the number of doctors in Serbia, last year carried out an analysis of healthcare staff by age, specialisation and demography that was submitted to the Ministry of Health of the Republic of Serbia. Next on the agenda of the Serbian Medical Chamber is the development of predictions in terms of healthcare staff for the next five to ten years.

The Serbian Medical Chamber also communicates with other European Union medical professional chambers in order to familiarise itself with other practices and ways in which the problems of working hours and a deficit of medical doctors have been resolved in different countries, as well as the functioning of healthcare services in rural areas where there is an insufficient number of doctors in order to achieve the best solutions applicable in Serbia. The position of the Serbian Medical Chamber, which we actively advocate in public, is that the harmonisation of Serbian legislation with EU regulations should be done in such a way as to protect the best interests of the medical profession and to prioritise improvements in the quality of healthcare services for citizens.

Dr Milan Dinić, M.D.
General Manager of the Serbian Medical Chamber

GUEST ARTICLE

Joint Action
Antimicrobial Resistance and
Healthcare-Associated Infections

EUROPE FOSTERING SYNERGIES TO KEEP ANTIBIOTICS WORKING

The European Union Joint Action on Antimicrobial Resistance and Healthcare-Associated Infections (EU-JAMRAI) brings together participating EU Member States, international organizations, institutes, and universities to contribute to tackling microbial resistance to antibiotics. It will capitalize on existing initiatives and propose concrete steps to lessen the burden of Antimicrobial Resistance (AMR) and reduce Healthcare-Associated Infections (HCAI).

AMR is a major public health challenge responsible for thousands of deaths each year. In 2007 alone, multiresistant bacterial infections caused 25,000 deaths and 2.5 million extra hospital days across Europe[1]. AMR does not recognize geographic borders and is present in every country of the world. If nothing is done, it might become the greatest global killer by 2050[2].

EU-JAMRAI is an EU-funded project that will contribute to tackling this problem. Given the many international and European initiatives on AMR, such as the WHO Global Action Plan, the recently adopted EU Action Plan and the Council Conclusions on AMR, EU-JAMRAI aims to ensure that policies to control Antimicrobial Resistance (AMR) and reduce Healthcare-Associated Infections (HCAI) are adopted and implemented across EU Member States in a harmonised way.

Coordinated by the French National Institute of Health and Medical Research (Inserm), with the support of the French Ministry of Health, EU-JAMRAI brings together 44 European participating partners from 28 countries and more than 30 collaborating stakeholders to ensure that the Joint Action is strategically connected to the global challenges and developments in the AMR field. EU-JAMRAI is funded by the participating partners and the Health Programme of the European Union with a total budget of 6 963 604€, of which 4 178 162€ is provided by the EC. This first European Joint Action in the field started in September 2017 and its implementation will last for 36 months.

The Joint Action will strive to foster behavioural change at individual and community level and tackle this pressing issue within the holistic and multisectoral “One Health” approach, which recognizes that human health, animal health and the environment are interconnected.

Under the motto “bridging the gap between declarations and actions”, EU-JAMRAI will propose concrete steps to implement best practices to tackle AMR and HCAI, so that good intentions lead to practical actions shared by Member States. To efficiently implement concrete actions, the participation and commitment of policy makers and competent authorities of all the European Union countries in the different project working areas is crucial to ensure that the national political contexts of AMR and HCAI status are taken into account in all the planned activities.

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Vytenis Andriukaitis, European Commissioner for Health and Food Safety, said "*The EU-JAMRAI Joint Action is a vital part of the EU 'One Health' Action Plan on AMR, launched this June. By ensuring that policies for the control of AMR as well as healthcare-associated infections are adopted and implemented across EU countries in a coordinated way, this ambitious pan-European, multi-stakeholder, project is vital to achieve the goal of making the EU a best practice region. AMR is indeed one of the biggest public health threats we face today, and the most pressing priority spanning both pillars of my portfolio. I would like to wish all participants every success with this indispensable joint collaboration*."

As one of the collaborating stakeholders supporting EU-JAMRAI, the Standing Committee of European Doctors (CPME) is committed to tackling AMR and reducing HCAI. CPME contribution is crucial to ensure that the Joint Action is in touch with the European doctors’ community and to the challenges they face in their daily activity. Working

together on their shared mission, CPME and EU-JAMRAI will strive to promote the highest standards in antibiotic use in order to achieve the highest quality of health care for all patients in Europe.

EU-JAMRAI Communication & Coordination Teams

[1] European Centre for Disease Prevention and Control (ECDC) and European Medicine Agency (EMEA). The bacterial challenge: time to react. Technical report. Stockholm: ECDC; 2009. Available from: http://ecdc.europa.eu/en/publications/Publications/0909_TER_The_Bacterial_Challenge_Time_to_React.pdf

[2] O'Neill J. Tackling drug-resistant infections globally: Final report and recommendations. Review on Antimicrobial Resistance. London; 2016. Available from: http://amrreview.org/sites/default/files/160518_Final%20paper_with%20cover.pdf

GUEST ARTICLE

SCOTLAND TO INTRODUCE MINIMUM UNIT PRICING

On the 1st May 2018 Scotland will introduce a minimum price for alcohol. The Government is proposing that the price level will be 50p, around 55 euro cent, per UK unit of alcohol, which is 10mls or 8g of alcohol. It will be illegal to sell below this price, which will apply to all alcohol products, wherever they are sold.

Behind the simple statement above there has been 10 years of planning, research, legal work and advocacy by a wide range of people in Scotland, the UK, the rest of Europe and internationally. Scottish Health Action on Alcohol Problems (SHAAP) was the first organisation to call for a Minimum price in our report "Price Policy and Public Health" at the end of 2007.

In the years prior to that report Scottish alcohol policy, like many places across the world, had been characterised by a partnership approach which included the alcohol industry. Actions that weren't supported by all stakeholders were set aside and only consensus policies were taken forward. The WHO sponsored book Alcohol: No Ordinary Commodity, which summarised the evidence base for alcohol policy, was first published in 2003 and made it clear that the policies being adopted were far from being the most effective.

Alcohol related deaths for Scotland (population around 5m) had risen from approximately to 700 in the mid 1990s to 1500 per year 10 years later. This mortality data was published annually but received little interest outwith the alcohol field, until a Lancet paper in January 2006 drew international attention to Scotland's situation with alcohol deaths, in particular those due to liver disease.

The medical Royal Colleges in Scotland agreed to set alcohol as a priority issue and established SHAAP in 2006 as a medical advocacy group to work alongside existing alcohol NGOs. Front line doctors reported that the drinks their patients were consuming were not those prestige products which were discussed in Government committee rooms or sold in Scotland's famous pubs, but were the lowest cost products sold by supermarkets who had increasingly come to dominate alcohol sales in Scotland. In Scotland these drinks were high strength ciders, which have very low tax rates for historical reasons and vodka, mostly made in Scotland and sold in bulk with very low profit margins. SHAAP settled on action on the cheapest products as the most important pricing measure, so minimum price, which had been in place in various forms in some US states, Canadian provinces, Russia and the Nordic alcohol monopolies, became the favoured approach.

On presenting the idea of MUP to the public and policy makers, SHAAP found that some grasped the value of the idea immediately, whereas others took more time and reflection to understand the concept and this "two phase support" has been a regular feature of the policy development. Modelling research supported the clinicians' view that

action on the cheapest alcohol would offer the greatest health benefits, political support grew and the Minimum Price Bill was passed unopposed by the Scottish Parliament in 2012.

Parts of the alcohol industry, such as the independently owned pubs and smaller brewers, had supported MUP throughout and SHAAP took the decision to work with these industry supporters. These businesses favoured regulation to prevent the high volume, low profit approach of the big retailers and multinational producers. However, the Scotch Whisky Association had made it clear that they would challenge the measure in Court and they did so, joined by Spirits Europe and a wine makers organisation CEEV. This challenge in Scottish, UK and European courts delayed the implementation of the measure for 6 years.

In November 2017 their final appeal to the UK Supreme Court failed, allowing MUP to be implemented. The judgment of the Court, which considered the issue under EU law, was that the Scottish Government had a right to introduce a measure to protect the health of its citizens and any issue of market distortion could not be regarded as outweighing the health benefits, which had been very carefully considered by the Scottish Parliament and Government. This is likely to be an influential judgement for other public health interventions in Europe.

So the introduction of alcohol Minimum Unit Price in Scotland has been a long journey, but it now feels like a worthwhile one. The support of international colleagues, including CPME, has been very important for local campaigners. The role of clinicians in winning political and public support has been crucial. We hope that the lengthy legal process has clarified some key issues for health policy and we look forward to lives being saved and health improved by Minimum Unit Price.

Dr Peter Rice, MB ChB, FRCPsych, FRCPE
Chair of the Scottish Health Action on Alcohol Problems (SHAAP)

A NEW TERM FOR EMSA

The members of the 2017/2018 EMSA European Board began their term on 1st November 2017. During the first week of November, EMSA officials worked on their annual plans and set their priorities for the term. They also started working on projects based on the pillars of our organization, such as eHealth for European health policy; doctors' mobility for European integration and culture; a campaign on HIV/AIDS with the African Students Association and the Dry January Challenge (no alcohol intake for the whole of January) for the Public Health Pillar. From 12th to 16th January, the EMSA European Week of Ethics took place in Istanbul, Turkey on the topic of "End Of Life Issues" where discussions and debates took place regarding different approaches from ethical and juridical points of view.

Moreover, EMSA officials attended various meetings in Brussels and Europe related to topics correlating with EMSA External Priorities such as Refugee Health, eHealth, a meeting on vaccination upon the request of the Director General for Health and Food Safety, Mr Xavier Prats-Monné. The EMSA President was also part of an expert panel debate hosted by the European Institute of Women's Health talking about the importance of including sex and gender in Medical Education. The EMSA European Board is now making its final preparations for the upcoming EMSA Spring Assembly 2018 in Ohrid, Macedonia on the topic of "Disaster in Medicine", an increasingly important topic on the European and Global agenda.

Teuta Azizi, EMSA President

GUEST ARTICLE

Fédération Européenne des Médecins Salariés
European Federation of Salaried Doctors

FEMS COLLECTIVE BARGAINING CONFERENCE AND OUTCOMES

On 5th October 2017, FEMS organised a short conference in Malaga (Spain) on the various collective bargaining practices across Europe in order to identify challenges and good practice. It seems that collective bargaining follows the same principles everywhere, but that experiences are very different. In conclusion, we performed a short survey and found that:

In Turkey and Slovenia there is general collective bargaining for the whole public sector, but that doctors can negotiate separately on specific issues. In Bulgaria, bargaining takes place at the level of the health sector, doctors included. In Romania and Spain there is national coordination of bargaining, but the health sector has some bargaining autonomy. In France, Portugal and the Netherlands doctors negotiate separately from others.

The interaction among the unions is a challenge everywhere and dependent upon the culture of social dialogue and traditions. In France and Portugal there is no interaction with non-doctors' unions, which is in line with their separate bargaining processes. Cross-sectoral confederations exist in Slovenia and Romania, again in line with the lack of possibility for doctors to bargain autonomously. Intra-sectoral confederations exist in Turkey and the Netherlands. In Spain, Bulgaria and Poland there are unions representing doctors and other healthcare professionals.

"European Commission, after having completed an in-depth analysis of the jurisprudence of the European Court of Justice and the situation across EU members, is not going to propose any modifications to the European Working Time Directive."

In the opinion of the participants of the conference, in several countries (Turkey, the Netherlands and Poland) the social dialogue for doctors does not satisfy ILO standards. The social dialogue was characterised as adequate by representatives of the Portuguese, Spanish and Slovenian unions. It must be emphasized that these results are based on an ad-hoc questionnaire among the participating medical unions at the Malaga conference, so not all EU countries and EU candidate countries are represented in the results.

The European Working Time Directive

FEMS was invited to attend a conference, held jointly by the European Trade Union Confederation (ETUC) and the European Public Service Union (EPSU) on 26th October 2017 in Brussels, concerning developments in working time legislation in the EU. Representatives of the European Commission (EC) DG Employment also participated in the conference. The most important message from the conference was that the EC, after having completed an in-depth analysis of the jurisprudence of the European Court of Justice and the situation across EU members, is not going to propose any modifications to the European Working Time Directive. For physicians this means that the possibility of opting out remains at the discretion of each EU Member State. However, it also means that all forms that have already been recognised by the jurisprudence as working time remain considered as working time. This is particularly important for countries where on-call duty still exists and where the governments would like to re-introduce inactive periods in one way or another. However, it has also become clear that not all forms of working time must be paid equally, even if all of them are regarded as "active".

Later, an initiative to reduce weekly working time to below 40 hours per week was discussed. Several projects have indicated that such a reduction could be beneficial to family life, the health of employees, and overall well-being etc., but some concerns were also raised. A reduction in working time could increase the intensity of work, meaning more stress at work. In addition, in the EU states with lower salaries, a reduction in working time could bring about very different results, giving way to secondary jobs on atypical contracts.

Dr Bojan Popovič
Secretary-General of FEMS

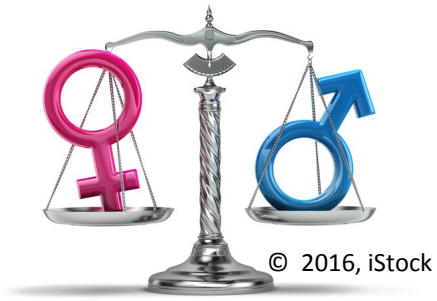
GUEST ARTICLE

GENDER IN MEDICAL EDUCATION IN EUROPE

The overall aim of our work in the last ten years was to establish gender medicine as an academic discipline. For this purpose, we planned to develop a teaching concept to be implemented at the Charité university hospital in Berlin, which would also be transferable to other European institutions. During our European GENCAD project we collected information on coronary artery disease mechanisms among women and men and disseminated this information in the form of factsheets for both healthcare professionals and the general public in all 24 official EU languages.

Methods and results:

In order to establish gender medicine (GM) as an academic discipline we first sought to establish an adequate database. For this purpose, GenderMedDB (http://gendermeddb.charite.de/) was generated, a systematic collection of the literature in all areas of GM. The result is now a database with 13,000 validated publications in gender medicine. The most important results have been summarized in two landmark teaching books. Together with other books on GM, they are now the basis for teaching GM. The aim was to develop a curriculum for GM that would be valid in European contexts. For this purpose the European FP6 project "EUGIM", funded by EU FP6, was set up. Together with partners from seven different European countries, we developed a curriculum for GM. In order to make it available to a larger group of stakeholders, the content of this curriculum was transferred into an eLearning programme. This is now available in the German language as eGender Medicine at the Charité, and in English for all users worldwide (http://egender.charite.de/). The e-learning part of this knowledge sharing platform is based on a modular structure and its use is therefore very flexible for users and those responsible for the implementation of GM into curricula. It is under continuous further development for use in medical education, vocational training and as an important tool for information on GM for clinicians, researchers, students, all other health professionals and policy makers. Contributing to this European approach, CPME published a policy on sex and gender in medicine (CPME 2016/036) as part of the EUGENMED project.



Finally, we aimed to introduce gender into the medical curriculum. This was first done in the form of an interdisciplinary elective course where different institutions contributed with gender aspects in their different disciplines. This elective was later transformed into an element of the regular curriculum. This was made possible by the introduction of a change agent who introduced gender aspects in all fields of the regular medical curriculum. This was done in two ways: Firstly, by developing gender as its own discipline with an introductory lecture in the first year and a series of lectures in the fifth year. Secondly, we introduced elements of GM into as many other disciplines as possible. Thus, teaching in cardiovascular diseases, pharmacology, inflammatory diseases, metabolic diseases, neurology, orthopaedic surgery and others would integrate aspects of GM. By acting along these lines there are now more than 100 small format teaching units that have included gender aspects. Gender is also included in exam questions. We are now at the stage where we can also provide factsheets on specific topics, such as on coronary artery disease mechanisms amongst women and men for the whole of Europe, and e-learning modules for seven disciplines, as well as a general module in the English language. With these factsheets, we have been able to reach not only those in the academic field, but also decision-makers in the European political sphere and representatives of NGOs, as well as experts in gender-related fields, ensuring the sustainability of educating individuals on gender in medicine.

In a ten year process, a database was built, two teaching books were published, a curriculum and an eGender learning programme were developed. These include teaching materials for an elective course and teaching materials for the integration of gender into lectures, seminars and into the regular medical curriculum. These steps considerably enhanced the awareness of gender aspects at German medical faculties, and the materials may now be used by other European medical faculties and medical associations.

Dr Ute Seeland, Nicholas Alexander, A.T.Nauman, Prof. Dr. Vera Regitz-Zagrosek

GUEST ARTICLE

POPE FRANCIS BANS CIGARETTE SALES WITHIN VATICAN

Pope Francis has instituted a ban, effective from 1 January 2018, on the sale of cigarettes within Vatican City.

PONTIFICIA ACADEMIA PRO VITA

According to the Magisterium of the Catholic Church, the use of tobacco products is governed by the virtue of temperance which, as the Catechism of the Catholic Church teaches, "...disposes us to avoid every kind of excess: the abuse of food, alcohol, tobacco, or medicine." (CCC 2290). "Moderation" is called for mainly because of the negative consequences that an excessive use of these substances can have upon health - respect for which is a necessary aspect of respect for the dignity of the human being.

Over the last few decades, there has been a considerable increase in awareness of the harmful consequences of tobacco use for smokers' own health and the health of others. According to the World Health Organization, the tobacco epidemic is one of the greatest threats to public health the world has ever faced, killing more than seven million people a year. More than six million of those deaths are the result of direct tobacco use, while approximately eight hundred and ninety thousand are the result of non-smokers being exposed to second-hand smoke.

Research has now identified a number of tobacco-related threats to life and health. Obviously, damage varies according to the quantity of tobacco used every day, how deeply cigarette smoke is inhaled, how long cigar smoke or smokeless tobacco is in contact with oral/nasal tissues, what additives are in the products or are used in tobacco production, and the length of time the habit persists. Consideration must also be given to the fact that tobacco use harms not only the user, but also others who unintentionally inhale ambient tobacco smoke, especially in closed environments.

"According to the World Health Organization, the tobacco epidemic is one of the greatest threats to public health the world has ever faced, killing more than seven million people a year."

At present, it appears that cigarette usage is slowly decreasing. Many former smokers quit after becoming aware of the damage to health that tobacco use causes.

Governments have also begun to take measures aimed primarily at protecting the health of non-smokers, such as prohibiting smoking in public places, including public transport and the workplace. On the other hand, from a legal point of view, there is generally no governmental limitation of an individual's right to freely decide about his or her own behaviour, even if harmful. From an ethical point of view, however, this approach is deficient because tobacco use is a form of "dependence" and therefore the user's choice might not be truly free. In addition, the recognition of a "right to personal freedom" does not take into account the risk to the health of others, especially when the "other" is an unborn child in the smoker's womb. There is, in fact, documentation showing that tobacco use during pregnancy leads to an increase in miscarriages, premature births and intrauterine growth restriction. Some conditions, such as increased perinatal morbidity and mortality and a greater incidence of fetal malformations, are even reported when the father rather than the mother is a tobacco user.

In addition to the damage done to the health of individuals, the societal costs of tobacco use must also be taken into account, namely the costs incurred for the treatment of diseases linked to tobacco use, and the benefits lost to society by reason of disabilities resulting from diseases attributable to tobacco use.

From an ethical point of view there is a real, serious and clearly identifiable responsibility with respect to the consequences of tobacco use. First of all, there is the responsibility of the individual user, even if such responsibility is often diminished when tobacco use becomes habitual early on, during a phase of psycho-affective fragility that does not allow for appropriately responsible consideration of the consequences of a given course of action. And

GUEST ARTICLE

even later on, if the tobacco habit has become ingrained, the responsibility of the individual user may be diminished by reason of the dependence referred to above. In fact, while today there may be many ex-smokers, there are probably many more who want to quit but can't, even though counseling and medication can more than double the chance that a smoker who tries to quit will succeed.

In addition to the question of individual responsibility for behaviour that might endanger one's own health or that of others, we should also point out the responsibility that governments have when they support tobacco use. Currently, Western nations realize significant revenues from either tobacco monopolies or from taxes on the production or sale of tobacco or tobacco products. In these circumstances, there is a clear contradiction between professed civic values and the values that actually affect the social fabric whenever governmental power allows for the cultivation, production and sale of tobacco products. As for the Vatican, smoking in public areas and in the workplace is already prohibited, and there are fines for the violation of this prohibition. The Vatican Healthcare Directorate and the offices responsible for workplace safety sponsor educational programs that discourage tobacco use and promote health care initiatives, especially initiatives for the prevention of complications related to tobacco use.

There remains, however, the direct responsibility incurred by those involved in the production and sale of tobacco products. This responsibility is of growing concern to governments - including Vatican City State - which must give serious attention to the problems attributable to the use of tobacco products.

In this context the reason for Pope Francis' prohibition of the sale of cigarettes within Vatican City is very clear - the Holy See cannot be part of an activity that is harmful to health. The lesson to be learned is that while the sale of cigarettes has been a significant source of revenue, financial benefit at the cost of human life or dignity is wrong.

Nunziata Comoretto,
M.D. PhD, L.R.S, Research area, Pontifical Academy for Life, Vatican

EVENTS - UPDATES

EU INSTITUTIONAL NEWS

17 November 2017	The European Commission launched a public consultation on the initiative to limit industrial trans fats intakes in the EU. CPME has already contributed to the public consultation and provided its views on the key elements of the impact assessment. The Commission is expected to give its solution on how to limit industrial trans fats intakes after the open consultation comes to a close on the 9 February 2018
8 December 2017	The Council of the EU adopted Council conclusions on cross-border aspects in alcohol policy – tackling harmful use of alcohol, highlighting several areas of action. They invite the European Commission to produce and adopt a new, long-awaited, EU Alcohol Strategy, to initiate a new Joint Action on harmful use of alcohol, and to propose better provisions for alcohol labelling by the end of 2019. Moreover, they call on the Commission to continue monitoring the development of new media and evaluating the adequacy of the current measures aimed at reducing exposure, particularly of children and young people, to alcohol advertising transmitted through digital media, including social media. Health ministers also adopted council conclusions on Health in the Digital Society – making progress in data-driven innovation in the field of health. These conclusions call on Member States to pursue ongoing initiatives that support digital innovation in the health sector. They also call on Member States, together with the Commission, to continue and streamline existing work on eHealth standards and interoperability and to reinforce actions to improve data security and data infrastructure.
01 January 2018	On 1st January 2018 Bulgaria took over the rotating six-month presidency of the Council of the European Union from Estonia. More information on the presidency's priorities can be found here.
31 January 2018	The European Commission adopted and published its proposal for a regulation on health technology assessment. This aim of this proposal is to boost cooperation amongst EU Member States in the context of the assessment of health technologies (pharmaceuticals, medical devices and in vitro diagnostics).

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Guest commentary

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Miriam D'Ambrosio

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13-14 April 2018

09-10 November 2018

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STANDING COMMITTEE OF EUROPEAN DOCTORS