“World Congress Report” by the Secretary General

It is only eight months until the Bali World Congress on Medical Law, which will cover the latest developments in Legal Medicine, Health Law and Bioethics. The Conference Chairman has provided an overview of the arrangements, which appears as a separate article in this Newsletter. Professor Muh’s article should allay any fears that there will be anything other than an impressive, high calibre meeting. This should provide a most stimulating exchange of ideas, knowledge, motivation and satisfaction. It is the last of the old format World Association for Medical Law (WAML) conferences before we go into the annual meetings centrally co-ordinated by our Meeting Management Team. For those of you who have not been to Bali, you are in for a treat. Bali is a gem and offers something for everyone. As someone who has been there a number of times, I can fully recommend it and encourage each of you, reading this Newsletter, to plan not just an educative and enlightening trip but combine it with a holiday that you will remember for a lifetime.

The natural beauty of Bali is breathtaking and the shopping should mean that all accompanying partners will thank the WAML for choosing such a great destination. Nusa Dua, where the Conference will take place, is an oasis of tranquillity with a level of peaceful calm that our bustling world has trouble remembering. The food in Bali is both exquisite and cheap. The people are friendly and helpful and always happy to bargain. The facilities are world class and the mood conducive to a great environment, to combine learning with pleasure. Before you make any decisions you should read Professor Muh’s summary of his organising committee’s plans for the conference. It includes all the relevant topics within the mantle of a humanitarian approach, which epitomises Professor Muh’s attitude to life. This venue and its location combine the best of all worlds: top programs; great speakers; excellent venue; unbelievable location; and an opportunity to network with the best minds of Legal Medicine, Health Law and Bioethics. Treat yourself to the ultimate conference within our discipline and share your research, knowledge and expertise with like-minded individuals in a setting where even the hardest and most arduous exchange will be remembered as a holiday of a lifetime.

See you there.

Roy G Beran
Secretary-General
World Association for Medical Law
Message from the Guest Editor

Health has been defined in 1948 by the World Health Organization “as the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Is it individual governments’ role to achieve Health for all or is there a need for Courts to act with the adoption of Constitutional rights to Health or an implementation of International Human Rights Law approach?

This Newsletter will highlight the plight of right and access to health and the approaches to a Constitutional Right to Health by three very different Countries and health care systems; South Africa, Canada and the United States of America.

Four Professors of Law, Professor Charles Ngwena, Professors Colleen Flood co-authored by Bryan Thomas, and Professor John Blum that give their perspectives and opinions on the advantages and perils of a legal or Constitutional solution to the right to Health.

South Africa has a Constitutional right to health; Canada and the United States do not. The South Africa contribution thoughtfully speaks to the development of a Constitutional democracy from apartheid, yet inequality and poverty remain.

Canada has a Universal Health care system, but no Constitutional right to health. The contribution eloquently speaks to benefits, but also perils leading to inequity of health.

The United States of America has one of the most expensive health care systems in the world and had a large segment of their population without health care coverage until Obamacare. The author nicely brings Obamacare into focus for our readership.

Nothing is clearer, the World Association of Medical Law and the leaders of medicine and law should continue to advocate for the rights of all persons and patients across the globe’s to solve problems and create solutions.

I am sure the readers will be inspired and enjoy the contributions in this Newsletter.

20th World Congress on Medical Law

Constitutionalising the right to health: South Africa

Professor Charles Ngwena*
Centre for Human Rights, University of Pretoria South Africa

1 Introduction
In 1996, for the first time in its legal history, South Africa inscribed into its Constitution, a universal right to health. The right to health finds its clearest expression in section 27 which states that:
(1) Everyone has the right to have access to-(a) health care services, including reproductive health care;
(b) sufficient food and water; and
(c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
(2) The state must take reasonable legislative and other measures, within its available resources, to achieve a progressive realisation of each of these rights.
(3) No one may be refused medical treatment (emphasis added).

This commentary provides brief overview of the significance of section 27 for South Africa as well as an appraisal of its implementation.

2 Significance

Section 27 is part of the country’s transformation from apartheid to democratic governance. Historically, income, geographical location and, above all race, have been the arch determinants of the quantity and quality of health care received by South Africans. Similar to other sectors, health care was used by the State as an instrument for shoring up the political doctrines of white supremacy and racial segregation which were nurtured during colonialism but reached their zenith under apartheid. The idea of equality for all was anathema to colonial and apartheid dispensations precisely because they drew their sustenance from the political oppression and economic exploitation of black Africans in particular. In 1991, the South African Medical Research Council’s described the South African health care system as ‘a bureaucratic entanglement of racially and ethnically fragmented services; wasteful, inefficient and neglectful of the health of more than two thirds of the population’. Against this backdrop, section 27 brings to the health care sector values of egalitarian social justice that ultimately coalesce around the objective of achieving substantive equality in access to health care services within a broader political transformation.

In three respects, section 27 acknowledges that access to health care is a fundamental right. Firstly, everyone is accorded a right
of access to health care services. Secondly, the State is under an ongoing obligation to take positive measures to achieve a progressive realisation of the right to access health care services. Thirdly, everyone is accorded a right not to be refused emergency medical treatment. By conferring on everyone a right of access to health care services, section 27 lays the constitutional edifice for an inclusive health care system which seeks to ensure that the poor and historically vulnerable social groups are not excluded from the promise of the Constitution.

Significantly, section 27 takes the form of a justiciable socio-economic right rather than a directive of state policy which would otherwise be vulnerable to being interpreted restrictively by the courts as merely exhortatory. Early in the life of the post-apartheid dispensation, the South African Constitutional Court confirmed that socio-economic rights in the Bill of Rights are justiciable. It underscored that socio-economic rights impose positive obligations and not merely obligations of restraint on the State. Despite their budgetary implications, they are no less justiciable than their civil/political counterparts. Moreover, the Court does not regard the justiciability of socio-economic rights as necessarily incompatible with the principle of separation of powers. Indeed, section 27 itself, has been the subject of litigation and adjudication.

3 Implementation
Section 27 has served as a constitutional mandate for a wide range of major policy, legislative and programmatic reforms in the healthcare sector. At a policy level, the White Paper for the Transformation of the Health System of South Africa has been the flagship policy for overhauling the apartheid health care system. The White Paper is premised on creating a unified health care system. It is a system organized around district-based primary health care (PHC) and a package of essential services that draw from the World Health Organisation’s Alma-ATA Declaration.

PHC reforms entail ongoing redistribution of health resources in favour of equitable geographical allocations. In a juridical sense, the reforms prepare the ground for fulfilling the constitutional guarantee of universal accessibility of services along the lines envisaged by General Comment 14 of the Committee on Economic, Social and Cultural Rights. The policy goal is to ensure that PHC is rendered not only in a non-discriminatory manner. The services it provides must also meet the requirements of availability, geographical accessibility, economic accessibility, information accessibility, cultural acceptability and good quality.

Until the adoption of the National Health Act of 2003, the White Paper was the main domestic source for practical guidance on standards for implementing the constitutional right to health. The National Health Act gives legal effect to the policy reforms in the White Paper. Above all, it provides a legal framework for a restructured and unified health system. The Act sets out the rights and duties of health care providers and commits to respecting, protecting and fulfilling the fundamental right to health in line with the provisions of the Constitution.

The National Health Act aside, a plethora of other legislation has been passed since 1994 to respond to section 27 as well as other provisions of the Bill of Rights that guarantee rights which intertwine with section 27. A notable early example is the Choice on Termination of Pregnancy Act of 1996. This Act radically reformed abortion law, including recognising a woman’s right to abortion on request in the first trimester. Abortion services are free at the point of access. Furthermore, to assure equitable access, in addition to doctors, abortions in the first trimester can also be performed by mid-level providers who have undergone a prescribed training. In this way, the Act seeks to ensure that lack of means or scarcity of doctors do not serve as veritable barriers to services in the public sector, especially.

4 Current Challenges
For a country seeking to make a decisive break from the legacy of colonialism and apartheid and its impoverishing effects on the majority of South Africans, the language of constitutional rights, including the right to health, is patently in keeping with collective national aspirations. However, the constitutionalisation of the right to health, as with all socio-economic rights, requires assiduous nurturing, commitment of resources and efficient implementation to avoid becoming mere rhetoric. South Africa offers a mixed picture on the effective implementation of the right to health. On the positive side, the country has instituted an admirable constitutional, legal and policy framework for the respect and protection of the right to health. However, what is missing is sustainable fulfillment. This is partly because the gains that were made in the first ten years or so, following the transition from apartheid in 1994, have been considerably compromised by a heavy burden of disease and health systems that are largely weak and poorly managed so as to result in poor health outcomes. While significant strides
have been made in redressing the legacy of unequal distribution of health care resources in the public sector, the gains have been increasingly offset by a high burden of disease. One of the country’s many health challenges is an extraordinarily high prevalence of HIV. An estimated 6.1 million people are living with HIV in South Africa. The government’s initial unwarranted skepticism over the efficacy of antiretroviral therapy (ART) and ‘AIDS denialism’ under President Mbeki’s leadership needlessly accentuated the burden of HIV/AIDS. But above all, it is the legacy of structural inequality inherited from apartheid that remains deeply rooted and manifests in highly discrepant health status and health outcomes for different social groups. Major discrepancies in access to health care remain between the public and the private sectors, the poor and the economically better endowed, the urban and the rural populations, and between genders and the country’s racial groups. Black Africans, who account for 79% of the population that is poor, bear the highest burden of diseases associated with poverty and exhibit the worst health outcomes.

Redressing abiding socioeconomic disparities implicates much more than guaranteeing a fundamental right to health in a constitution. Even in the post-apartheid era, South Africa remains a deeply unequal society. At best, section 27 and other complementary provisions in the Constitution can play a catalytic juridical role in promoting health but cannot supplant the more immediate political struggle for distributive justice. Redressing inequalities in health requires lasting political commitment to reducing gross inequality and improving the standards of living of the poor and marginalised sections of the population who happen to be the majority of South Africans.

Professor Charles Ngwena*
Centre for Human Rights, University of Pretoria South Africa

Courts as Gatekeepers of Equitable Access?

Colleen M. Flood, BA, LLB
Doctor of Medical Sciences
Professor & Canada Research Chair in Health Law and Policy
And Dr. Bryan Thomas

The Office of the U.N. High Commission for Human Rights reports that at least 115 constitutions around the world speak to the right to health or health care; but they can have varying degrees of legal force. This global popularity speaks to the hope that a rights-based approach will accelerate advancement in equity, particularly in countries where there have been great disparities in access to health care (for example, in South Africa). Global experience with health rights to date has not unequivocally confirmed this wishful thinking. So much depends on how health rights are interpreted by courts, who can afford to exercise the right to health, how courtroom victories and defeats translate at the level of policymaking and so on.

Perhaps surprisingly, countries with robust health care systems in developed countries generally do not have a constitutional right to health. Countries that do have such constitutional rights are frequently more middle-income countries. This correlation does not speak to the negative effect perse of health rights but likely reflects the fact that establishment of a constitutional right to health is part of so-called “second generation” rights, which appear mostly in newer constitutions of emerging democracies. The key question is whether enshrining health care rights in a constitution will move a country more quickly towards equity in access to health care. Although it is virtually impossible to answer this question, given the paucity of existing social science evidence, there are some warning signs that litigation of health care rights may not be unequivocally beneficial. The difficulty with a right to health, focused on an individual right, is that it can be readily divorced from the larger social goal of ensuring a robust public health care system that provides security to all citizens. Thus, litigation of health care rights, in countries like Brazil and Colombia, has resulted in a swath of individual rights claims for costly and at times unproven pharmaceuticals, using up scarce resources, skewing overall equity and/or imposing unsustainable costs on strained health systems. The regressive effect is worsened inasmuch as the poor lack the resources or wherewithal to litigate their access challenges. Colombia solved, to a significant extent, this access to justice problem through employment of the tutela system (offering a quick and cheap means by which to assert one’s constitutional right to health care)—but the resulting torrent of claims almost bankrupted the public health care system. Apart from the dislocation effects of health rights litigation, in some countries constitutional rights are being used to directly challenge commitments to universal public health care. In Canada, interpretation of s. 7 of the Canadian Charter and the right to life, liberty and security of the person has favoured a ‘negative’ reading of the right to health.
The examples just offered contemplate the right to health being used to safeguard accessibility and ensure accountability for rationing decisions within established universal health systems. In countries that lack universal health care, right to health jurisprudence will ideally focus on holding governments accountable for this very failing. Particularly in low-income countries, governments may reply that resource constraints stand in the way of universal health care—a justification that in some cases may meet a standard of reasonableness. (Though it bears noting that the cost savings and health benefits of universal health systems do scale down to developing economies.)

Short of nudging towards universal health care, courts might also, within the scope of reasonableness review, scrutinize governments’ efforts to provide a ‘minimum core’ of care, or its efforts to establish programs targeting particular epidemics (such as the HIV/AIDS epidemic). On its face at least, this would be consistent with the purposive approach to interpreting the right to health, proposed above, which focuses on upholding health systems, ensuring their accessibility and promoting accountability and transparency in rationing.

Even where these considerations are addressed, courts will be poor guardians of accessible health care, if their own services suffer from systemic problems of accessibility. There are familiar strategies for overcoming barriers to access to the courts, including, funding for public interest lawyers or affordable forums of adjudication, such as a Health Services Ombudsman.

Finally, assuming access to justice issues are addressed, and courts adjudicate in a manner that supports the right of universal access to public health care, there remains the issue of enforcement. Paradoxically, court rulings that correct systematic barriers to access may be at greatest risk of under-enforcement. Canada has seen only one Charter victory, securing a positive right of access to health care at a systems level: in Eldridge v. British Columbia (1997) the Supreme Court of Canada ruled unanimously, under the Charter’s s.15 equality guarantee, that sign language translation services must be provided to deaf patients where necessary for the delivery of medical care. Yet this resounding victory at the country’s high court has been a disappointment on the ground: to date, only British Columbia and Ontario have complied with the ruling and there have been complaints of chronic under-funding of translation services, even in these provinces.

The promise of health
Rights is contingent on a variety of contextual factors—some very hard to gauge in advance. It may be possible to hedge these risks, as through precise language in crafting a right to health, and linking the enactment of health rights to measures ensuring access to justice. If these variables are not carefully strategized, the entrenchment of a right to health will deliver little by way of improved access, or worse, impede equitable access to universal health care.

Colleen M. Flood, BA, LLB
Professor & Canada Research Chair in Health Law and Policy
Dr. Bryan Thomas

Reflections on Reform and the Right to Health in the American Context

Within one month of each other, two significant events occurred in American health policy. One event was widely heralded, the October 1, 2013 opening of the regional, state health insurance exchanges, so-called marketplaces where an estimated 15 million uninsured Americans can purchase health care coverage with government subsidies. The second event was a vote by the U.S. Congress on September 24, 2013 to cut $40 billion dollars from federal food support payments to 15 million Americans, a far less publicized event. These two events were not linked in US health policy circles, but individually and collectively demonstrate both how disjointed public health decision making has become and more fundamentally, raise the need for a legal framework that rests on a recognition of health as a fundamental right. The United States stands out in the world community as the lone developed nation that has not recognized health as a legal right. The siloed, and overly politicized nature of American health policy, typified by the two noted events, underscores a need for promotion and adoption of such a right to recognize individual liberty, and to serve as a guidepost for public policy.

The October 1st opening of the health insurance exchanges is only one of many noteworthy events that represents America’s latest foray into health reform. The Affordable Care Act (ACA), so-called, Obamacare, is the crowning domestic achievement of the presidency of Barack Obama, representing a 75-year struggle to pass an American universal health plan. Obamacare is first and foremost a health insurance program; it creates an elaborate webbing of public/private insurance coverage, a scheme in four parts tying together expansions of Medicare (elderly), and Medicaid (poor), with a large overhaul of private sector small/individual market insurance, combined with a continued reliance on large employer health coverage. The ACA health insurance reforms, supported by individual and employer mandates to purchase health insurance, were broadly directed to providing health care coverage to America’s 32 million uninsured and more specifically were targeted to correcting abuses in health insurance, such as denial of coverage due to pre-existing medical conditions or arbitrary termination in the event of illness. Accompanying the health insurance reforms in the ACA is an elaborate array of measures directed at reducing costs, improving quality and reinventing the health care delivery system through promotion of more unified formats for providing health services within structures that strongly link provider reimbursement with clinical performance measures. While population health does not lie at the heart of Obamacare, there are a series of initiatives in the law that mandate insurance coverage for health promotion and prevention activities. While the ACA will enhance access to health insurance, addressing one of America’s biggest social problems, and in doing so attempt to reframe the health care delivery system, it is by no means a perfect piece of legislation. The U.S. health reform law reflects many tortured compromises and acquiescence to powerful special interests that have promoted the commercialization of American medicine. The law itself is complex, disjointed and anything but transparent, as the provisions of reform are embedded in over 1200 pages of legislation and to date, 8000 pages of accompanying regulation. On the political side, Obamacare, by its very name, can trigger vitriolic criticisms, so bitter that they go beyond the need for any reasoned discourse, much less any expectation that such criticisms be accompanied by constructive proposals for more meaningful health reforms. The ACA, passed by a majority composed only of Democrats, has been under continual challenge, as it has been the subject of opposition Republican efforts aimed at repeal, and defunding, as well as an unsuccessful legal challenge to have the law overturned on constitutional grounds. The vigor of the opposition to the ACA has not subsided with its roll out, but if anything, each new implementation measure serves as a springboard for renewed attacks. Food stamps in the United States
States have had a long history and are now used by 47 million people a month, a benefit that goes to 1 in 7 Americans, fluctuating with food prices, inflation and income. In 2009 the Congress, in the face of a severe recession, increased the Supplemental Nutrition Assistance Program (SNAP) by 45.2 billion dollars but is now in the process of letting the expansion lapse, and adding onto that, recommending deeper cuts. With more Americans living in poverty food insecurity has becoming an increasingly serious and pervasive reality among poor populations. With reduced access to food support, low-income people are inevitably pushed into a world where choices are limited to cheap processed foods, high in energy and low in nutritional value. There are many anecdotes about poor children whose only real meals are eaten at school and whose parents are forced to choose between rent, transportation and food. Political opponents of food stamps see such supports as perpetuating dependence on public aid and sparking massive fraud. One high ranking state official, the Secretary of the Human Services Department of New Mexico, publically stated that hunger is a non-issue in her state, contrary to national statistics demonstrating that jurisdiction is the most food insecure place in America. The SNAP program, and other public food aid initiatives, are not just welfare support programs, but are long-standing human nutrition initiatives, central to individual and public health. Health prevention and promotion are integral to meaningful health reform, and are more critical to the cost, quality goals of the ACA than reimbursement machinations. The failure of politicians to see the food stamp issue, as first and foremost, a matter of public health does a disservice to human needs and ignores this major lever in the fight against the doubled sided epidemic in the ranks of poor people, hunger and obesity. A fundamental problem with both the ACA and SNAP is that is not being captured in the related political debates lies in the fact that these laws, either in substance or implementation, lack a central guiding vision of health. Undoubtedly there are many visions for health care in the ACA. Intrinsic to certain of its reforms are initiatives to direct future medical delivery into integrated structures such as accountable care organizations (ACO) or patient centered medical homes (PCMH). The core ACA provisions drive a cost/quality equation by enhancing the role of the insurance sector, as well as strengthening the businesses of medicine and the pharmaceutical industry. The ACA does not offer a long-term vision of health, nor is it a law that is driven by a commitment to basic human rights. In the case of SNAP, it maybe argued that the legislation has unfolded, and developed, with a keen awareness of its role in hunger and nutrition. But where the SNAP story falls short is in the current climate of governance, in which the links between food support and the success of health reform are not seen as interrelated efforts that will play critical roles in the ultimate success of the ACA.

It would be naïve to think that adoption of a legal right to health would resolve overnight the American conundrums of health and food insecurity, in the face of daunting economic realities, and a gauntlet of special interests. Nevertheless, the adoption of a foundational right to health impacting all citizens from cradle to grave is a valuable and necessary effort. Establishing health as a legal right could drive a more efficient policymaking process, resulting in a more cohesive set of reforms. A legally enforceable right to health would force the U.S. Congress to do better than create a patchwork of insurance options, and hopefully push the legislature to craft a more unified national plan. The U.S. Supreme Court’s deference to individual states to accept or reject broader government sponsored health care coverage under the ACA leaves large numbers of the most needy people without care, an unacceptable reality in a rights based initiative. Not only would a right to health result in uniform coverage, but such undertaking would need to be clearly defined in a way that is realistic and sustainable. It may be a tall order, but a rights-based health reform, would invariably lead to a system more focused on population health and less on sustaining and justifying high cost, technical medical interventions. Establishment of a universal, basic right to health would force policy makers to consider health more broadly, and to use this legal mandate to eliminate the silos within which this enterprise has been entrapped. Adopting a broader, more fundamental vision of health would not mitigate the pressures of cost and quality, but the requisite need for universal access would force policy makers to be more creative in approaching health issues and less willing to simply rearrange the deck chairs of the current biomedical system. Driven by an individual rights imperative, public authorities ought to consider interdiscipliary solutions. The American Affordable Care Act is ambitious and noteworthy in many regards, but it is not an easy platform on which to improve population health and achieve individual equities. Genuine health reform requires integrated approaches along the lines of the European Health in All Poli-
As the holiday season is approaching, Hisako, my wife, and I wish a happy holiday to you and your family.

For the next year, Bali, Indonesia World Congress in 2014
I recommend that you visit the 2014 Congress Web site www.2014wcmcl.com
The proposed program lists the following:
The registration begins in the afternoon of Thursday, August 21, 2014 while the WAML Board of Governors is meeting.
The registration desk will be open from 1400 until 1800 at the Bali Nusa Dua Convention Center.
Friday, August 22, 2014 registration will begin at 0700 – 0830 followed by all day scientific meetings with plenary sessions, debates, and symposia and then from 1900 – 2100 there will be the Welcome Reception open to all delegates.
Saturday, August 23, 2014, begins with the Indonesia class during the poster session followed by daylong scientific sessions.
Sunday, August 24, 2014, begins with the Indonesia class during the poster session with scientific meetings and the closing ceremony scheduled at 12 noon followed by a half day city tour. There will be a spectacular culture night beginning at 1900. We anticipate an outstanding performance. Monday, August 25, 2014 is devoted to an all day tour. We will enjoy beautiful Bali.
The theme for 2014 is “Does Health Law Protect Dignity and Save Lives”, Abstracts are being solicited. We encourage all attendees to submit abstracts which represent your current interests and research and let us discuss these during the Congress.
The WAML formally enters collaboration agreements
The WAML is interested in strengthening collaboration with WAML affiliated associations. We have begun to exchange specific agreements with a number of affiliate Associations.
We realize that it is a more formal approach, but we feel it is appropriate to exchange a specific ‘Memorandum of Understanding’ and agreement between a particular affiliated association and the WAML. The Center of Law and Bioethics of the University of Coimbra offers a perfect example of this. Further, we also are interested in having collaboration with medical and law students who are interested in medical law, legal medicine and ethics. In this regard we have investigated the establishment of a formal agreement with the European Law Students’ Association (ELSA). Periodically we will review the results of these formal collaborations.
We encourage all affiliated associations to consider specific proposals with the WAML to foster greater collaboration.
Seeking Collaboration with German Associations
Our affiliated associations and WAML members are looking for closer affiliation with the German medical and law association as there is a program being planned in Germany. Please contact me if you have any suggestion for a contact person(s) in Germany, as we are interested in establishing collaboration in that region.
WAML established the WAML Journal Committee
In order to improve our journal, I appointed our Secretary General, Prof. Roy Beran, to chair the WAML Journal Committee. In addition to Roy Beran, the Committee members include Dr. Mohammad Wattad, Editor-in-Chief of Medicine and Law, Education Committee Chair, Dr. Oren Asman, Dr. Richard S. Wilbur, Editor in Chief of the WAML Newsletter, Prof. Andre Pereira and Adv. Admila Hrevtsova.
I am sure that all members enjoy reading the articles which appear in our journal ‘Medicine and Law’. Some members are interested in having a digital version of articles and the Journal Committee is look-
ing into this. If you have any suggestions, please let us know and we will convey these to the Journal Committee, for their attention.

WAML Newsletter Guest Editors for 2014

The quarterly WAML Newsletter publication is now in its fifth year. Every issue carries significant new information. We would like to express our appreciation to the following guest editors of the publication:

- March 2014 - Maria Luisa Arcos - Tenured Professor of Civil Law, Faculty of Legal Sciences, Public University of Navarra, Spain
- June 2014 - Ms. Rosa Teresa Meza Vasquez and Mr. Giancarlo Jimenez Bazan, ASOLADEME PERU, Peruvian Affiliate of the Latin American Association of Medical Law
- September 2014 – Dr. Tal Bergman-Levy, Senior Psychiatrist, General Secretary of the Israeli Psychiatric Association, WPA Section of Psychiatry Law and Ethics, Israel
- December 2014 – Dr. John Conomy, Health Systems Design, Cleveland, Ohio, USA

Bioethics for Forensic Pathologists

After I took the Intensive Bioethics Course (IBC39), offered by the Georgetown University Kennedy Institute of Ethics, in June 2013, I was accepted as Visiting Researcher at the Kennedy Institute. Vice President Oren Asman joined me for our collaborative study of bioethics for forensic pathologists. We acknowledge that there has been very little literature on bioethics for forensic pathologists and believe the time is ripe to rectify this.

Should you have any suggestions to improve the services of the WAML, I look forward to hearing from you and working with you.

Thomas T. Noguchi
WAML President

WAML Secretary General’s Report

As we approach the holiday season, we say goodbye to Diwali and approach other festivals of lights, with Chanukah and Christmas just around the corner. The Executive Committee has been meeting regularly on Skype and I still marvel at the technology, which allows us to see our friends around the world, share our ideas in real time and plan for the future of the World Association for Medical Law (WAML). I thank Oren Asman, our computer literate Executive Vice President, for ensuring that the technology works and that he can make contact with me in the middle of the night (Sydney time).

Reading and editing this newsletter has reinforced my impression of how fortunate and rich we all are. The contributions to this newsletter are very appropriate for a final edition in 2013. The overarching theme is one of equality and mutual respect in healthcare and access to services.

We take so much for granted, especially in my home country of Australia, where we have universal health coverage, which provides for the whole community. With informative articles from Hong Kong, Canada, South Africa and the USA, we learn how important it is to respect our fellow human beings and to provide for each other. As a healthcare professional, I am so fortunate to be able to give that healthcare as well as to receive its benefits when I need them.

Professor Noguchi decided that I really needed something extra to fill my free time and created a Journal Club, which he asked me to chair. The purpose is to assist Dr Wattad to promote the stature and interest in our journal, Medicine and Law. Dr Wattad, as editor-in-chief of the Journal, has done a great job ensuring that articles are peer-reviewed and of sufficient standard. Those on the Journal Committee: Oren Asman – Israel; Andre Pereira – Portugal; Richard Wilbur - United States of America; Radmila Hrevtsova – Ukraine; Mohammed Wattad and I are going to actively seek to have the Journal recognised with a credible “impact factor” so that it becomes even more enticing for academic authors. An “impact factor” is an important consideration for those for whom their funding institution seeks adequate recognition.

We are also looking at publishing all the abstracts of journal articles for open access on the WAML web pages, while concurrently publishing a protected full electronic version of the whole journal which will be sequestered to dues paying members of the WAML and will be accessed only via using a password. This should further enhance interest and raise the Journal’s profile and hopefully also its citation index.

You can see that the Executive has not been idle in trying to provide for your needs. We have actively created Memoranda of Understanding with a number of national organisations. This should ensure cross-fertilisation and is the way forward for the Council of Presidents. The WAML is seeking continuing medical and legal education accreditation for its educative programs for our members. We are also trying to establish reduced registration fees for our members, not only for WAML’s more specific activities, but also for those activities of affiliated organisations. This
is seen as an effective step forward to establish better networking and educational experiences. We are always open to overtures from interested parties and actively encourage feedback.

When attending the recent Annual Scientific Meeting of the Australasian College of Legal Medicine, I was encouraged when Dr Allan Hunt, the ACLM President, actively promoted the WAML meeting in Bali in August 2014. It can be seen that affiliated organisations are the backbone of the WAML with our members belonging to more than a single organisation.

“Time waits for no man” (or woman) and it is a pleasure to realise that the WAML is going from strength to strength. Not a week goes by without the Credentialed Committee reviewing applications from highly qualified individuals wishing to join our WAML family. I must publicly thank Denise McNally for her great organisational skills in maintaining the momentum of the WAML. Now it is up to you, our members, to stand up and be counted. This is your WAML and the more you contribute then the better WAML will be and the more you will get out of it.

I wish you all the very best for the festive season and for the calendar year ahead. Whether you are celebrating Chanukah or Christmas or another festival that is part of your religion, we in the WAML respect it and wish you a safe journey through life.

Roy G Beran
Secretary-General
World Association for Medical Law

WCML Indonesia Update

Muh Nasser, M.D.

The 2014 WCML meeting is coming closer and the Organizing Committee is working hard to offer all WAML members and attendees an unforgettable experience. The Congress’ website (www.2014wcml.com) is operational and we expect to start accepting registrations next month, in January, 2014. Registrations will be accepted online through credit card or Paypal. An alternative option will be to pay by wire bank transfer and in rare cases, on-site registration will be possible but this would be more expensive, to encourage early registration. For those interested in submitting an abstract, the abstract submission deadline is June 28, 2014.

Please note that the dates for Bali have changed from the 25th of August to the 22nd of August. This was unavoidable due to the high demand for occupancy in Bali at this time and my wish to offer all the delegates to the Bali meeting the great experience that is possible on our wonderful island. Conference dates are 22-24 August, 2014.

The Congress program will be held at the BALI NUSA DUA CONVENTION CENTER which is where the APEC CEO Summit took place and delegations from more than 20 nations joined last October. We are investigating a number of hotels of differing standards, from 3 to 5 star rating, to offer various alternatives to accommodate all financial brackets. These hotels will be within a close distance of the congress venue and shuttle bus arrangements will be provided each morning and evening. Hotel rates will range between 80 – 250 USD/night.

The Scientific Program Theme is “Does Health Law Protect Dignity and Save Lives?” Topics will include: A new era of health law: exploring the connection with human rights and health care; Public health law; Patient safety, health professional and hospital credentialing; Woman, gender and reproductive health issues; AIDS, HIV, epidemic and ethics; Bioethics, health law in relation to pediatrics; Medical dispute resolution and restorative justice; Health victims, crimes and protecting patient rights; Health professional misconduct, medical negligence, omission and penal code; Doctor’s autonomy versus patient rights; Medical error, medical negligence and law; Hospital law; Nursing law; Dental law; Stem cell, genetics and health law; Mental illness law; Food and drugs law; Children rights and health law; Ethical codes and health law and Health care in welfare system relating to law.

This Congress will invite 6 speakers to talk in plenary sessions, 2 (two) guest speakers, 108 parallel symposia will take place in 7 – 8 rooms and will include Indonesian language sessions, poster presentations and also young scientific award.

The organizing committee has prepared 6 rooms for presentations, and each has capacity of 250 people. Sessions will begin every day at 8:30 AM and end by 5 PM.

A Congress Promotional tour will be arranged for the first 200 registrants. We will offer a free half day congress around Bali at the end of the WCML. Information about different interesting sites in Bali will be available on the website from the very moment it is launched (under “tourism in Bali” or something similar. This is to show the wonders and beauty of Bali to our international guests for them to experience what we have to offer.
Social events during the Congress will include: 2 Gala dinners: a welcome reception on August 22 and cultural night on August 24.

Congress Fees will be decided within a month. WAML members will receive a 100 USD registration discount, there will be extra discounts for big groups from specific countries and all registered participants will be covered with basic health insurance in Indonesia for accidents should a problem occur. It is recommended that participants also get their own basic travel health insurance as accepted world-wide.

In order to facility visa’s in Indonesia it is vital to have the names and details of participants a few months before the event. The Committee believes it will be possible to get visa’s to all WAML members and guests wishing to participate in the Congress. Please visit the website, and send us your contribution. Bali is waiting for YOU!!!!

Muh Nasser, M.D.

WAML 2014 Membership Dues
Membership in WAML is Annual and for 2014 the fee is $100. Benefits received are a discounted registration rate to the Congress Meetings which include voting rights, quarterly Newsletters and a quarterly Journal “Medicine and Law”. You recently received a notice that your 2014 membership dues were owed by January 1, 2014. We encourage you to log into the WAML website www.thewaml.com and pay.

As the World Association for Medical Law (WAML) assumes conference management responsibilities, I will ensure the venues meet the needs of the WAML membership along with its financial considerations. As of April, 2013, the WAML has gone Green, so all handouts/information will be sent electronically.

SAVE THE DATES!
The 20th World Congress on Medical Law (WCML)
NEW DATE - August 22-24, 2014
Bali, Indonesia

Registration will begin January 2014 and WAML members will receive $100 registration discount. The Congress will commence with an opening ceremony August 22, 2014 at 8:30 AM. The conference will close on August 24 at 7:00 PM followed by the Gala Dinner.

The Congress venue is Bali Nusa Dua Convention Center and hotel information will be forthcoming. Following the Bali meeting the WAML will move to Annual WCMLs with the first of these being: The 21st Annual WAML World Congress Lisbon, Portugal August 2 – 6, 2015

The Congress will commence with a Welcome Reception Sunday evening August 2, 2015. The Welcome Reception is the perfect venue to meet with colleagues and visit the exhibits. We encourage everyone to attend. The Opening Ceremony will be the morning of Monday, August 3, 2015. The Congress will conclude Thursday, August 6, 2015, followed by a Gala Dinner. WAML has secured the Lisbon Marriott hotel http://www.marriott.com/hotels/travel/lispt-lisbon-marriott-hotel/ as your Congress venue. Congress attendees will receive a special room

Do You Have an Idea, Comment, or Suggestion?
Please contact Denise McNally mcnallyd@iowalaw.net

Future Meeting Planning for the WAML
rate of EUR85.00 Single, EUR97.00 Double, and EUR205.00 Junior Suite which includes a buffet breakfast at the restaurant located in the hotel and complimentary internet. André Dias Pereira will be your Program Chairman and we look forward to seeing you in Lisbon, Portugal.

The 22nd Annual WAML World Congress Los Angeles, California (USA) August 7 – 11, 2016

The Congress will commence with a Welcome Reception Sunday evening August 7, 2016, followed by the Opening Ceremony the morning of Monday, August 8, 2016 and concluding August 11, 2016 followed by a Gala Dinner. We encourage everyone to attend.

WAML has secured the Millennium Biltmore Hotel http://www.millenniumhotels.com/millenniumbiltmorelosangeles/ as your Congress venue. Congress attendees will receive a special room rate of $199 USD single or double and complimentary guest room wireless internet. WAML recommends staying at the Millennium Biltmore Hotel where the program and all functions will be provided. Everyone enjoys meetings in a comfortable conference venue, offering quality service and support, where you will be in the center of the conference activity.

Thomas Noguchi will be your Program Chairman and we look forward to seeing you in Los Angeles, California (USA).

Congress hotel rates are negotiated based on the number of the expected attendees and the meeting space, to ensure the best value per dollar for WAML and those attending. If the Congress does not meet the sleeping room commitment, WAML will incur additional expenses, so please plan to stay the hotel selected.

Denise McNally
WAML Administrative Officer and Meeting Planner

Hong Kong Community Psychological Medicine Association

Aaron Lee Fook Kay, M.D.

Our Group is a government registered organization set up in year 2003 with the following purposes:

Objectives of the HKCP-MA:
1. To further our clinical knowledge of psychiatry through continuous medical education seminars and workshop.
2. To disseminate knowledge of Community psychiatry to fellow primary care doctors through conjoint meetings with other associations like the Hong Kong Society of Biological Psychiatry, Society for the Advancement of Bipolar Affective Disorder, Institute of Brain Medicine, Lundbeck Institute, Hong Kong Medical Association, Hong Kong College of Family Physicians, etc.
3. To promote awareness of mood disorders and common psychological problems to the public through talks to schools, teachers, Non-government Organizations, etc.
4. To inform the public that mood disorders and mild to moderate psychiatric problems can be adequately dealt with by their family doctors with further training in psychiatry.
5. To alleviate the pressure of long waiting time in Public Psychiatric Specialist Outpatient clinics by offering better public-private partnership Programmes with Hospital Authority.
6. To promote communication between the specialists of psychiatry and general practitioners.
7. To advise the Government on relevant issues in community mental problems.

Our members are mainly private practitioners with special interests in community psychological medicine and received postgraduate training in psychiatry at the Family Medicine Unit (FMU) of Hong Kong University (HKU).

After one year of part-time teaching programme, with a vision to provide high quality continuing medical education for practising doctors to upgrade their knowledge and skills in areas relating to their day-to-day practice, the Family Medicine Unit of Faculty of Medicine, HKU has launched this pioneering postgraduate course attended by over 200 doctors since 2000. Not only does the course aim to provide practical and update medical knowledge and skills, but it also emphasize how to help practitioners understand their patients better and improve their practice which in turn enhances treatment outcomes.
To achieve these, FMU of HKU adopted an interdisciplinary approach to conduct the course which draws together the expertise of different specialties including family physicians, psychiatrists, and clinical psychologists. Moreover, by substituting traditional campus-based group teaching with individual self-study/distance learning component as well as interactive seminars, workshops, electronic forum and small-group clinical teaching at various districts in Hong Kong, The course is hoped to allow flexibility and maximum opportunities for students to engage in reflective thinking of past clinical experience and developing insights into new frontiers.

The course is committed to offer the best and most up-to-date postgraduate teaching that meet the training needs of primary care doctors and doctors of different specialties including Chinese medicine practitioners and healthcare professionals.

Hong Kong Community Psychological Medicine Association will work to promote patient privacy and confidentiality, as our Government is going to implement city-wide electronic patient record by the year 2014, It is our belief that by protecting psychiatric patients' sensitive personal health data from being disclosed to unrelated hospital staff would be an important step in maintaining patients' trust in their healthcare providers. Only with informed consent from these patients suffering from mood disorders could allow his or her healthcare provider to disclose essential patient health data to those people involved in the direct care of them in the community. For this important legal aspect, we believe the World Association for Medical Law (WAML) could assist us by writing to the Food and Health Bureau of the Hong Kong Special Administrative Region, China, on this urgent topic and express your support of patient autonomy and privacy in our region by the year 2014, so that Human Rights could be respected in terms of drafting the legislation concerning electronic sharing of patient information in the coming years.

As an affiliated organization of WAML, we would like to support you in organizing future activities and meetings to be held in Hong Kong or the Asia-Pacific Region in the coming years. We believe a healthy development of Legal Medicine in Hong Kong is essential to maintain the relationship between doctors and people of Hong Kong, as we have witnessed more clinical negligence lawsuits for the past ten years here. Your active participation in organization of educational activities to promote legal medicine as a new specialty in Hong Kong would be very much appreciated and we could be a middle-man to liaise with other disciplines in our healthcare profession in Hong Kong.

Dr Aaron LEE Fook Kay, MBBS, MSc, LLM
Chairman of HKCPMA
FUTURE MEETINGS
Of Affiliated National Associations and Collaborating Organizations

66th Annual Scientific Meeting of the American Academy of Forensic Sciences
February 17-22, 2014
Seattle, Washington
Website: www.aafs.org

National Association of Medical Examiner’s Interim Meeting
February 18, 2014
Seattle, Washington
Website: www.thename.org

54th Annual Meeting of the American College of Legal Medicine
February 27 – March 2, 2014
Dallas, Texas
Website: www.aclm.org

2nd International Conference on Ethics Education
May 21-23, 2014
Ankara, Turkey
Website: www.iaee2014ankara.org

9th International Symposium on Advances in Legal Medicine
June 16 – 20, 2014
Fukuoka, Japan
Website: www.c-linkage.co.jp/isalm2014

20th WAML World Congress
August 22-25, 2014
Bali, Indonesia
Website: www.2014wcml.com

20th World Congress on Medical Law
Indonesia
August 22-24, 2014