SOME PRINCIPLES AND METHODS OF INTERNATIONAL HEALTH WORK

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Increasing numbers of the medical and related professions of all countries are taking part in the work of the World Health Organization. They do so as W.H.O. consultants and advisers to the large number of countries which seek assistance from the Organization; as members of W.H.O. panels and committees giving the necessary technical guidance to the Organization; as contributors of technical information; and as members of the large number of national institutions contributing to world services concerning epidemiology, health statistics, therapeutic substances, medical education, communicable diseases, and many other subjects.

This relationship is different from that of the full regular staff members. It is also a much more comprehensive relationship. At December 31, 1955, for example, W.H.O. had 152 medical and related scientists on its regular staff. These occupied mostly medical and technical administrative posts, as the Organization does not have its own clinical, laboratory, or other medical institutes. On the other hand, at the same date W.H.O. was using 295 senior consultants, advisers, and demonstrators in 63 countries and territories, and during 1955 appointed 59 specialists to serve on eight of its expert committees. In addition, large numbers of medical and other associated scientists from the majority of countries attended a variety of meetings, conferences, seminars, study groups, etc., sponsored by the Organization. There were representatives from every branch of medicine—clinical, institutional, laboratory, and administrative. Such a relatively large number of medical people helping W.H.O. each year makes some of its arrangements and methods especially important to the medical and related professions.

Constitution of W.H.O.

There is no need here to give the history of international health co-operation or to consider the detail of the W.H.O. constitution or organization. Much of this has been given previously in the *British Medical Journal*.¹ It is perhaps enough to say that the overwhelming need for an international health body developed not only from medical but also from welfare, social, and economic requirements in all countries. The consequent formal association of countries already has a history of over a hundred years, of which W.H.O. is the present expression.

The countries of the world created W.H.O. to do on their behalf such things as providing appropriate international health services; giving technical information and counsel; assisting governments to meet their health needs; and, of especial importance in view of events, co-ordinating international health work. Arrangements were made for universal membership of States. To-day, with 81 Member States and four Associate Members, such universality has almost been obtained (though a certain few governments do not take an active part). The governments also authorized the basis for W.H.O.'s administration, including authorities for staff, finance, regionalization, and relations with other organizations.

It is in the Constitution that the principles are found which explain the arrangements and methods used by W.H.O. The

Constitution is itself based on the concept of an association of sovereign States. If this principle is constantly recalled, the way W.H.O. works will usually be understood. Put conversely, W.H.O. is not a form of supranational organization. As Mr. Hammarskjöld, the Secretary-General of U.N., put it at the Pilgrims' Dinner in London on March 18, 1954, when referring to the United Nations: "We need to think of the institutions of the United Nations not as parliamentary in character but as a framework within which the Governments can, by trial and error, build up traditions of world community. . . ."

The important consequence of this is often overlooked—namely, that an international organization like W.H.O. does not itself directly control or undertake medical and health programmes in countries. It is the national services assisted by W.H.O. that give effect to the field programmes adopted by the World Health Assembly.

Nature of the Organization

The Constitution provides for an intergovernmental policy-making organ—the World Health Assembly. This has an Executive Board of eighteen individuals designated by as many governments, and there is then an administrative machine—the Secretariat—to carry out the instructions of the policy-making bodies. The constitutional character, and the developing mode of operation of these two, the Assembly and the Board, are themselves worthy of study, but, for present purposes one emphasis is required. The World Health Assembly is a meeting of governments. It is not a gathering of medical men in a professional congress or conference. It is essential, therefore, and quite legitimate, for the Health Assembly in establishing international health programmes to take note of many factors—economic, administrative, and even political—which a purely medical or technical meeting could perhaps ignore. As W.H.O. is an intergovernmental and not a supragovernmental body its resolutions are normally recommendations to governments for action. It is to be noted, with a few specific exceptions, that even the decisions of the Health Assembly are not automatically binding on governments.

The Secretariat, headed by the Director-General, operates in and from seven offices—the Headquarters in Geneva and the six Regional Offices: temporarily in Geneva (presently to be in Copenhagen) for Europe; Washington, D.C., for the Americas; Manila for the Western Pacific; New Delhi for South-East Asia; Alexandria for the Eastern Mediterranean; and Brazzaville for Africa. The Secretariat is an international civil service. It is not a policy-making body, and it is not its own master.

These are further facts which, if always remembered, would simplify understanding and avoid frustrations among some medical and technical groups associated with W.H.O. It is the governments, not the Secretariat, which prescribe policies, define programmes, and provide the means. However, the young international public service which exists in W.H.O. can claim to have something of the nature of such a national civil service accorded the descriptions: "Permanent, Independent and Influential," and " . . . Growth without Bureaucracy."²

It is permanent in the sense that it does not come and go with annual decisions of the Health Assembly. It is independent in its constitutional obligations, set out in Article 35 of the Constitution:

"The paramount consideration in the employment of the staff shall be to assure that the efficiency, integrity and internationally representative character of the Secretariat shall be maintained at the highest level,"

and further elaborated in Article 37:

"In the performance of their duties the Director-General and the staff shall not seek or receive instructions from any Government or from any authority external to the Organization. They shall refrain from

¹ *British Medical Journal*, 1950, 1, 1021-51.

² The British Civil Service, *The Times*, November 23 and 26, 1953.

any action which might reflect on their position as international officers. Each Member (that is, Member State) of the Organization on its part undertakes to respect the exclusively international character of the Director-General and the staff and not to seek to influence them."

In that the W.H.O. Secretariat is not a direct operative civil service it cannot have a direct type of "influence." However, apart from the opportunity for "influence" which follows respect for the honesty and efficiency of any service, the W.H.O. Secretariat has several significant formal rights. For example, Article 32 of the Constitution says: "The Director-General shall be the *ex-officio* Secretary of the Health Assembly, of the Board, of all commissions and committees of the Organization and of conferences convened by it." Further, the Director-General may make proposals for the agendas of the Health Assembly and the Executive Board, and, apart from formal reports to these bodies, he may make statements, oral or written, before them.

A frequent misunderstanding would be avoided if another constitutional provision was remembered. Article 71 reads:

"The Organization may, on matters within its competence, make suitable arrangements for consultation and co-operation with non-governmental international organizations and, with the consent of the Government concerned, with national organizations, governmental or non-governmental."

This contains a remarkable principle pregnant with opportunity. It means that W.H.O. is not limited to "official" interests only, important though these are. It has been given the privilege of associating both official and non-official organizations in international health and medicine. In W.H.O. the professional, medical, and other similar groups of the world, through both their international and their national associations, take their essential part. Thus they may have a direct say, under certain conditions in the governing bodies—the World Health Assembly and the Executive Board—in influencing major policy and administration. This is in addition to the contributions they make to the technical arrangements of the Organization. Such international medical professional bodies as the World Medical Association, International Association of Microbiological Societies, World Federation of Mental Health, International Unions against Cancer, Tuberculosis, and Venereal Diseases, International Dental Federation, International Council of Nurses, and many others in medical, social, and health fields are associated with W.H.O. in this way. To take one example only, the World Medical Association has greatly assisted W.H.O. by its authoritative guidance on a variety of subjects, including industrial medicine, pharmacopoeias, and medical education.

The basically advisory nature of W.H.O.'s relationship with governments on the operative side in connexion with the execution of programmes is one safeguard against some bureaucratic faults. Generally W.H.O. may not exercise central administrative control of, nor direct or supervise, local country activities. It has no right to interfere in any way in the internal affairs of any country or community. There are, however, other tests of the absence of bureaucracy, and these too, I think, can be met.

Some W.H.O. Policies

The work of W.H.O. may be conveniently divided into its direct advisory services to governments requesting assistance, and into certain technical services of general international interest, though there is inevitably an overlap on occasions. In the first group are the projects in most countries covering practically the whole range of public health and medicine. Yaws control in Haiti and the Philippines; trachoma studies in Iran and North Borneo; advice on medical administration in Burma and Panama; nutrition surveys in Brazil and Indonesia; maternal and child health in India and Thailand; assistance to nursing schools in Malaya and Syria; are examples of these services. At December 31, 1955, there were 218 such programmes in 63 countries and territories being assisted by W.H.O. It is

these programmes which at present are of most interest to the medical and other professions, as it is to work in them that most of the consultants and advisers come to serve W.H.O. for short periods.

Certain policies governing these advisory services may therefore be usefully discussed because of their general professional interest. W.H.O. operates a project only on the request of a government, and only by providing assistance to the government. For example, a country desiring help to develop a programme of venereal diseases control submits a request to W.H.O. The consultants sent out by W.H.O. then work by advising and assisting the local services. They do not establish a separate W.H.O. venereal diseases service in the country.

Governments retain entirely the right to express their own wishes regarding the type of international health assistance they desire. This partly explains the disappearance of the original "priorities" established by the First World Health Assembly in 1948. Planning at that early stage being unavoidably somewhat academic, the Assembly had prepared a world programme giving priority to six subjects: malaria, maternal and child health, tuberculosis, venereal diseases, nutrition, and environmental sanitation. Further, countries have increasingly extended their requests to cover integrated health and medical services rather than to limit them to the isolated subjects of the "priorities." To-day, therefore, these "priorities" can no longer be followed in developing the advisory services. However, the Health Assembly and Executive Board have defined certain principles in the selection of requests. Some of these have become fundamental not only in W.H.O. but in many other international organizations when giving technical assistance to governments.

One of these principles is now almost enshrined as a philosophy in all work where governments receive assistance. It is that projects should be designed "to strengthen national health administrations." This may sound like a simple platitudinous phrase. It is not. In the earlier years some people argued that W.H.O. should meet government requests by itself dealing directly with the particular local problems. For example, using this latter method to help a malarious population, W.H.O. would go in and develop its own *ad hoc* malarial organization and conduct a direct anti-malaria campaign. This call for direct so-called practical action had, understandably, much appeal.

However, the importance of self-help and local responsibility; the avoidance of extreme centralization of direction and technical planning, and of remote control; the need to adapt medical arrangements to local social and economic circumstances, and to resist the creation of a large permanent international civil service, were amongst the compelling arguments against the system. These, added to the recognition of national sovereignty, determined the policy that W.H.O. should assist countries by "strengthening national health administrations." This bald statement of the policy has occasionally been misinterpreted. It does not mean that W.H.O. services are available only to a central official governmental service. They can provide assistance through governments to any form of institution, organization, or service fitting into the local pattern. It is fortunate that an early Assembly took a decision to adopt this fundamental principle, which is sound administratively and in harmony with most accepted views on good public health and medical practice.

The abandonment by the Health Assembly of "priorities" has not meant rejection of the need for W.H.O.'s assistance to be distributed sensibly. The Health Assembly and Executive Board require some tests to be applied in both the Central and the Regional Organizations before acceptance of projects. Such criteria³ to be met include, in general terms: international feasibility and acceptability; benefit to the largest possible number of Member States and people; availability of qualified person-

³ *Off. Rec. Wld Hlth Org.*, 1951, 32, 55-63.

nel; preliminary studies and preparations have been made; the ability of the national government to continue and complete the work; full account has been taken of related possibilities of financing and action by other agencies and integration with related projects; and financial feasibility.

Vague though the language of some of these criteria may be, there is enough indication of several important principles to be followed. In the preliminary stages of negotiation on programmes between W.H.O. regional directors and governments and of discussion at the regional committees, some classification of government medical requests thus becomes feasible. Patently unsuitable projects are now rejected—indeed, are being less frequently presented. A country suffering heavy mortality and morbidity from more easily preventable conditions for which “outside” technical assistance is suitable is now not likely to demand as more urgent an electron microscope or a highly specialized hospital.

In certain regions the development of “country projects” is now following a pattern of study and application. An identified health problem often first needs examination internationally by a study group, by one or more experts visiting several countries concerned in the matter, or by simultaneous and co-ordinated studies in selected countries, before methods of dealing with it can be determined. The results of such an examination can then be disseminated on a wider basis through seminars, conferences, symposia. From this phase there often emerges a need for a new type of training suitable to be organized on an inter-country basis where controlled experiments can be arranged on new curricula, team training, etc.

Another general policy influencing the system of advisory services to governments is for W.H.O. to support the training of medical and health workers. This purpose is met in two general ways. Firstly, by a system of international W.H.O. fellowships, and, secondly, by helping countries to establish or improve their own medical training institutions. These two methods, owing much to earlier international experience, have combined to give W.H.O.’s programme of professional and technical education both success and popularity. In 1955 W.H.O. provided 1,028 fellowships, almost all postgraduate. The fellows came from 108 countries and territories and visited 75 countries and territories to receive their training. In keeping with the principle of “strengthening national health services,” W.H.O. fellows are obliged to return for a minimum period of three years’ service in their own country.

A significant feature of this international medical policy is that both “receiving” and “giving” countries and their medical professions contribute and benefit. A country like the United Kingdom, through W.H.O., is each year the source of numbers of senior medical teachers from its leading universities, who go to other countries to assist the development of their medical faculties and training institutions. Conversely, the well-known institutions of the United Kingdom, also through W.H.O., in 1955 gave advanced training in all branches of medicine to 206 doctors and scientists from other countries. Here, indeed, is a mutually beneficial process both to the countries sending fellows and receiving consultants and to the United Kingdom in having its institutions linked with developments in many countries. It extends, too, good will and even material advantage far beyond strictly medical circles.

A further expression of the various principles mentioned above is that W.H.O. does not possess its own medical institutions or operative medical services. Reference is not intended here to the long-established and accepted general international services connected with epidemiological and health statistical reporting, biological standardization, and other similar subjects, but to the fact that W.H.O. does not have its own hospitals, field medical services, or research institutions. This policy is an expression of the view that variety, freedom, and elasticity of conditions are needed by science and medicine in both investigation and application. These are more likely to be found in a number of different country institutions than in a centralized uniform official organization.

This method of working through the institutions of others is sometimes misunderstood by medical and other scientists, individualistic by training and experience. Accustomed to work in the laboratory, at the bedside, or in the field directly on their own programmes, the change to the more detached role of adviser or of medical administrator is often disturbing. It is a further facet of the position of indirect relationship, mentioned above, which W.H.O. has with its constituent governments which, once realized, enables suitable adjustment by the staff to be possible in most cases.

Co-operative Arrangements

Co-operation, co-ordination, and integration are words of common currency, if not yet debased to jargon, in international life. Yet they have more urgency and importance than in national operations. If international work is to mean anything, then co-operation and co-ordination are fundamental principles. To ignore their importance leads to inefficiency, waste, and even the disrepute of the concept of governments working harmoniously together through the existing system of international agencies. This is certainly true of international health work. The W.H.O. Constitution and numbers of policy decisions of the World Health Assembly and the Executive Board emphasize the development of all programmes by co-operation with all other interested agencies, and their integration into associated arrangements, international and national.

Achievement of the ideal is not yet here. There are the difficulties in co-ordination of work by the various international administrations themselves, with interests overlapping in many places. Interdepartmental and inter-organizational problems are not peculiar to national services. Indeed, the interests to be reconciled are more numerous.

In actual country work the problems for international agencies of co-ordination and integration are accentuated. Each agency can achieve there no more and no less than the authority and administration of the local government provides. Each faces, too, the additional complexity that there are usually other international agencies assisting the same government in related fields of work.

A disease control programme, for example, can be influenced by decisions taken by: (a) the United Nations General Assembly, the Economic and Social Council, the Technical Assistance Committee, the World Health Assembly, the Food and Agriculture Conference, and others; (b) the executive organs of the various agencies; and (c) the numerous national bodies concerned in local administration, agriculture, labour, health, etc.

This complex background to health work gives the principle of co-operation and co-ordination its importance. It calls for negotiation, adjustment, and considerable compromise before international health programmes are planned, provided for, and finally undertaken. Qualities of diplomacy, persistence, tolerance, and patience are required in the staff of the Organization to a greater extent perhaps than in any national situation.

One of the lessons, perhaps hesitantly learned by many medical men accepting the role of advisers to governments, is that more “medicine” is not necessarily the most urgently desirable step to improve general health. The dependence of community health on economic, social, and political interplay, in which more hospitals, clinics, and medical specialists do not always figure prominently, is sometimes hard for doctors to acknowledge. Then, too, it is sometimes unpalatable to accept the view that the cost of health should be measured against other claims. This need, described for instance by Ffrangcon Roberts in the *British Medical Journal* and elsewhere,⁴ is occasionally overlooked in situations where national resources are limited. It is forgotten that the application of medicine is not outside economic laws.

Nevertheless, in all governmental developments—social, economic, industrial, or agricultural—medical advice is essential to put standards of living on a sound, durable basis.

⁴ *The Cost of Health*, 1952. Turnstile Press, London.

Though sometimes he may be denied his hope of medical institutions being immediately established, the medical adviser has yet an important role in international assistance to all types of country. Often he will be helping the cause of health more by giving medical advice in relation to an agricultural scheme or an industrial enterprise than by limiting himself to a purely medical institutional programme.

Some Administrative Arrangements

There are many other policies influencing type and method of work, but only one more is selected for reference here. Article 35 of the Constitution, mentioned above, gives the importance of efficiency and integrity of the staff, but it further says: "Due regard shall be paid also to the importance of recruiting the staff on as wide a geographical basis as possible." The problem of securing geographical distribution in origin of staff has been a recurring problem for all intergovernmental agencies. The League of Nations found that "a decision to think only of building an efficient staff and to let the blows to national *amour-propre* fall where they may, would be defensible in theory. But the results would be serious. A system which depends upon the co-operation of Member States cannot ignore the factor of national prestige and interest."

A regular staff originating from a single region and culture and/or with technical experience in certain "advanced" countries only, could not sponsor successfully a world-wide health and medical programme in which adaptation to local needs and co-operation with innumerable national and social groups are fundamental. It is fortunate, therefore, that the arrangements for the advisory technical staffs on the one hand, and the regular form of appointment for the central and regional administrations on the other, provide elasticity. This helps to satisfy the call for wide geographical distribution without necessarily neglecting technical standards in recruiting staff. Results of recruitment have to bear analysis by national delegations, diplomatic services, country administrations, and, perhaps the most important, by the medical and scientific professions of the world. Whether the technical standards and achievements of W.H.O., dependent upon the ability and skill of its staff, merit respect, will be judged by the medical groups of all countries.

Constitutions and policies are ultimately revealed in administrative action. Much of this outcome has been given above, but certain other administrative methods are selected for examination.

There is the type of public service created by W.H.O. to carry out its work. Several of the facts about it have been mentioned. It is already clear that W.H.O. does *not* have a large centralized force of permanent officials, doctors, sanitarians, nurses, laboratory people, and their administrative and clerical assistants. The intention of its constitution and of its legislative authority to advise governments, and not to assume supragovernmental status, is secured through two groups. Firstly, there is the regular staff who, as already indicated, perform the essential continuing technical and administrative functions and who assist in providing certain advisory and "permanent" general technical services. Then, secondly, as also previously mentioned, there is a large specially recruited technical staff to give direct assistance to governments. While they are on W.H.O. projects these people are under its general service code, which naturally requires, *inter alia*, observance of objectivity, and loyalty to the Organization.

The use of temporary and not "permanent" staff in this work has certain advantages. The technical problems vary from year to year and some conditions are unlikely to require continuing W.H.O. assistance. Only a very large permanent technical staff could meet such continually changing demands. Further, W.H.O.'s indirect method of work would mean almost insuperable difficulty in a truly

"permanent" staff retaining a specialized technical skill. An "expert" can continue as such only by constant direct practice in his special work.

Specially recruited staff, on the other hand, enables W.H.O. to seek the best available adviser for each particular local problem, to adjust country technical staff continuously to the needs of the moment, to avoid staff redundancy when programmes end, and to guard against an international organization depriving national services permanently of their own essential technical staff. In practice, most consultants and advisers have adjusted themselves well as international officers in new spheres of work. This type of service indeed enriches all concerned—the "receiving" and "giving" countries, the "expert," and W.H.O.

There is another extensive arrangement by which W.H.O. draws on the technical resources of the world. This is the wide use of expert advisory panels and committees. The Health Assembly and Executive Board rely on such bodies for the general technical guidance needed to prepare programme policy. Serving on them are large numbers of the world's eminent medical scientists and health administrators in the W.H.O. fields of work. This expert panel and committee system has considerable advantages. Again, W.H.O. is able to draw quickly, efficiently, and economically on the best skills and knowledge required for the problems of the moment. It has its technical policies governed by a wide range of experience and knowledge, unlikely to be concentrated in a permanent official full-time staff. These advantages, generally, more than balance certain well-recognized weaknesses of the committee system in technical subjects.

On the whole the W.H.O. expert committees are forming a suitable instrument for their purpose. They have provided the scientific guidance and stimulus for the adoption of the international health statistical nomenclatures, international sanitary regulations, pharmacopoeia, and biological standards. They too have advised the Organization on public health, clinical and laboratory aspects of tuberculosis, child health, nutrition, malaria, and many other subjects.

The expert opinion, whether from the panel, committee, or individual, is integrated into W.H.O. programmes by the Executive Board and the Director-General. The fact that the full views of the expert are not automatically endorsed is occasionally questioned. Quite naturally the expert does not always accept happily a decision allotting more weight to other than technical considerations. But any organization concerned in problems with political, economic, administrative, as well as technical features, is obviously unable on occasion to adopt immediately all the desirable proposals put to it.

Numerous medical institutions in many countries are linked with W.H.O. There are long-established international centres, such as those at London and Copenhagen holding the accepted international biological standards, the influenza centres in London and Washington linked with a world-wide network, and others in health statistics, virus, blood work, and a variety of subjects.

Relatively small money grants are the material contribution that W.H.O. makes to such centres—a contribution which in no way measures the valuable two-way interchange that occurs. On the one hand, through W.H.O. countries everywhere draw on the resources of the central system, with many medical, economic, and industrial advantages. On the other hand, medical institutions and professions of an increasing number of countries become active partners with W.H.O., thereby contributing and gaining many things.

Many critics, especially such individualists as medical men, will wonder if W.H.O. can avoid the more serious evils of over-organization and over-administration. They will think with Sir J. F. Wolfenden, Vice-Chancellor of the University of Reading, that "a cure must be found for the modern scourge of 'organization.'"

⁵ *The International Secretariat of the Future*, p. 22, 1944. The Royal Institute of International Affairs, London.

⁶ Wolfenden, J. F.—Address to Conference of Education Association, London, January 3, 1952.

Bureaucratic Risks

Some of the answers have been given in this article when the Constitution and legislative policies were quoted as a protection against W.H.O. becoming an exaggerated, ever-expanding international civil service, busying itself with too much detail. However, there are bureaucratic risks. Meetings—legislative, expert, or liaison—are multiplying in international work, and correspondingly absorb staff, time, energy, and money. Meetings there must obviously be in any representative organization, but when does their number cause too much diversion from progressive work? A round of meetings, tours, and reports in national or international life too easily becomes an end instead of a means.

The meetings involving W.H.O. are only to a limited extent under the control of the Secretariat. Through its obligations and agreements W.H.O. must send representatives to numbers of both international and national meetings. To decline invitations is also too often a cause of aggravement. Thus the Secretariat itself is restricted in its power to control meetings and travel. This must largely come from the Member States of the various international organizations themselves.

Another administrative element exposed to bureaucratic exaggeration is the production of reports and documents. As Jules Romains puts it: "The peculiar symptom that betrays the bureaucrat is an unslakable thirst for paper." Paper now pours forth in both national and international work—reports, publications, questionnaires, documents, and working papers. Many services use much of their time and energy merely to read and initial correctly this volume of paper. Again, the best administrator, not to be confused with the bureaucrat, desiring to treat paper as but a means to an end, can himself only partly cut off the flow. Much of it is demanded by assemblies, conferences, and committees, which it is his duty to serve. This could become an insidious evil if governing bodies and their servants accepted the report as the completion of a task instead of an item to reach that end.

This is but one of the many problems the modern organized world has in dealing with the method of communication. Much of the recent examination made by the University of London of the difficulties of communication applies to an international form of organization. A relevant example from this study is where Sir Geoffrey Vickers says: "The transmission of information is limited in the first place by logistics. The sender is absolutely limited by what the receiver can absorb in the time which he can spare from action. Volumes of paper which are circulated 'for information' are pulped without ever informing those for whom they were chiefly intended, simply because these recipients did not have or make time to read them."

The Executive Board of W.H.O. has been conscious of the obstruction to purposeful work of excessive meetings, travel, and paper. These problems, too, are under continuous scrutiny by the staff. This vigilance is to some extent the assurance that such flowerings of bureaucracy will be regularly pruned.

Medical and other scientists coming to work directly or indirectly with W.H.O. will perhaps find one administrative principle particularly reassuring. It is that the Secretariat operates on a basis of delegation of responsibility. The individual units manage their own affairs with the minimum of interference from others. The technical officers and groups are free, too, in their respective technical fields. Their proposals, translated to the administrative sphere, may be subject to administrative and financial influences, but intrinsic scientific and technical data and opinions are protected.

Conclusion

This brief account has but superficially given some of the main elements determining the methods of work of W.H.O. likely to interest the medical and similar

professions. These circumstances explain both the limitations and the opportunities of those doctors and scientists from all countries assisting the Organization on its regular or temporary staffs. They cannot always have the full satisfaction of following all their own inclinations in what they do, nor of running their own institutions, nor of ignoring elements they may dislike.

They do have the reward of playing a worthy part in giving of their technical and human knowledge and skill to assist mankind everywhere; of joining with colleagues of all countries in the extension and diffusion of medical experience; and of presenting and advocating the cause of medicine in the international and intergovernmental counsels of the world. Perhaps no other group has such opportunity, indeed responsibility, for showing the possibilities for good in international association and work. Here is an important way to the inherent universality of the science and humanitarianism of medicine.

SYMPOSIUM ON ARTERIOSCLEROSIS

[FROM A SPECIAL CORRESPONDENT]

A conference on arteriosclerosis organized by the Swiss Academy of Medical Sciences was held in Basle from August 8 to 10. The president of the Academy, Professor A. GIGON, invited to the meeting research workers from 10 countries and 4 continents who are actively engaged in problems associated with arteriosclerosis.

Professor GIGON, opening the proceedings, outlined the basic idea behind the symposium. The programme was divided into two major sections. The first day was devoted to papers on blood vessel factors and arteriosclerosis, including all generalizations on morphological changes in the vessel walls and problems on the haemodynamics of the coronary system, and so on; these subjects were considered in a series of 10 papers. The second and third days were occupied by a series of 26 papers on the problems of metabolism and arteriosclerosis. This rather wide category was further subdivided into three sections—the blood lipids and lipoproteins, dietetic factors in arteriosclerosis, and hormonal factors in arteriosclerosis. The conference was completed by a discussion on the papers and additional discussion on the problem in general.

Professor Gigon explained that Professor G. Lyman Duff (Montreal) was to have presented the opening paper under the title of "A Survey of Recent Experimental Investigations of Arteriosclerosis," but with regret he had to announce that Professor Duff was unable to be present. Consequently he called upon Professor WILLIAM DOCK (New York) to give the opening lecture.

Problems Outlined

Professor DOCK, who had originally been scheduled to speak towards the end of the congress, chose for his lecture the provocative title "Are There Effective Ways of Managing Arteriosclerosis?" In a spirited address he made it quite clear at the outset that the answer to this question at the present time appeared to be definitely in the negative. He quickly gave a skilful outline of the many morphological and metabolic problems which confront the investigator in the field of arteriosclerosis, and drew attention to the anatomical difference which exists between the intima of the newborn male infant compared with the female infant as one possible factor predisposing the male to coronary atherogenesis. The well-known sex difference in the incidence of the clinical presentation of this disease between males and females in the white population was reviewed by the speaker, and he commented on the loss of immunity by females after the menopause. Professor Dock went on to say that one of the most striking results in the field of sex hormones in

¹ Vickers, Sir G., *Studies in Communication*, p. 82, 1955. Martin Secker and Warburg, London.