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OFFICIAL JOURNAL OF THE WORLD MEDICAL ASSOCIATION

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Editorial

Over the past year, our global medical community reflects on the valuable contributions to clinical and surgical practice, as shown through successful research initiatives, stakeholder communication, and knowledge sharing and networking at professional meetings. Physicians also recognise their dedicated efforts to strengthen medical education and training in clinical and community settings, where they prepare medical trainees to identify and manage endemic and emerging risks to population health. Hence, they understand the urgent need to develop multidisciplinary collaborations that incorporate novel data and technology and community stakeholder engagement to examine the determinants of health that influence global morbidity and mortality rates.

As we celebrate the 70th anniversary of the *World Medical Journal*, we commend World Medical Association (WMA) members who have published high-quality scientific articles related to adhering to evidence-based clinical practices to reduce risk of antimicrobial resistance, delivering medical care in conflict settings, ensuring safe work environments, exploring the use of novel technologies in education and clinical care, and fostering training opportunities for health professionals. In fact, three interviews with 12 national medical association (NMA) presidents representing the African, European, and Latin America and Caribbean regions have presented strengths and existing challenges in medical education and shared future perspectives toward strengthening regional and international collaborations. Notably, WMA members from 19 countries have contributed to workgroup discussions at regional and global expert meetings over the past 30 months, resulting in the unanimous adoption of the revisions to the WMA Declaration of Helsinki at a historical moment (60 years after the adoption of the original declaration). They have also participated in scientific discourse on emerging health risks at United Nations and World Health Organization events, demonstrating the critical role of physicians at these global meetings. As we reflect on these WMA accomplishments, one question remains: How can WMA members stimulate regional and global collaborations that tackle medical education and training challenges across our regions?

We recognise the Finish Medical Association for their leadership to organize the 75th WMA General Assembly in Helsinki, Finland, from 16-19 October 2024. The event provided a timely opportunity for WMA members to discuss and debate timely medical ethics and global health topics and network with other NMAs. It is a tremendous honour to share this issue of the *World Medical Journal*, where WMA leadership presents the adoption of 14 WMA declarations, guidelines, statements, and resolutions, ranging from epidemic and pandemic preparedness to ethical use of medical technology, at the 75th WMA General Assembly.

In this issue, Ms. Janice Blondeau summarised the event proceedings, and Dr. Lujain Alqodmani and Dr. Ashok Philipp shared their invigorating valedictory and inaugural speeches on WMA milestones, respectively. Dr. Liene Sile, Dr. Māris Taube, Ms. Zane Egle, and Ms. Linda Šeldere provided a historical overview of mental healthcare services in the post-socialism era. Dr. Michael Mncedisi Willie and Mr. Mfana Maswanganyi prepared a comparative analysis of healthcare coverage trends in South Africa and similar middle-income countries. Dr. Mhlengi Vella Ncube presented a brief overview of HIV/AIDS epidemic in South Africa. Dr. Yujin Song, Dr. Wunna Tun, Dr. Merlinda Shazellenne, Dr. Shiv Joshi, Dr. Minku Kang, Dr. Aravind Swamy, and Dr. Poorvaprabha Patil highlighted workplace challenges experienced by junior doctors in the Asia-Pacific region. Dr. Cara Lembo, Dr. Daniel Mendoza, and Dr. Shana Godfred-Cato underscored the effects of climate change on children's health. Finally, Dr. Helena Chapman and Dr. Muge Akpinar-Elci described challenges and proposed best practices in using the One Health concept to strengthen environmental health communication.

Across the globe, WMA members are admired for their daily contributions to medical practice, advocacy efforts to increase awareness of inequalities and injustices, empathetic listening and humanistic touch in patient care, and leadership at national and international meetings. Their compassionate service to patients' health is exemplified by the words of Sir William Osler: "*The good physician treats the disease; the great physician treats the patient who has the disease.*" In this issue, the German Medical Association and the Belgian Association of Medical Unions prepared two obituaries that recognise the scholarly achievements, caring nature, and passionate service of Dr. Karsten Vilmar and Dr. Vincent Lamy, respectively. Furthermore, WMA members representing 12 countries of the African, Americas, Asian, European, and Pacific regions shared perspectives and reflections on physicians' indispensable role in caring for patients and communities, as part of a commemoration to the International Day of the Medical Profession and International Doctors' Day.

We wish you and your families a healthy, restful, and reflective holiday season, and we are excited to connect at the 229th WMA Council Meeting in Montevideo!

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Valedictory Speech by the WMA President, Dr. Lujain Alqodmani

Helsinki, Finland, 18 October, 2024

Lujain Alqodmani

Distinguished colleagues, honoured guests, and friends,

I remember one day my daughter Yasmin, at just five months old, was the reason for a major security alert at the United Nations headquarters in New York. We were there for the multi-stakeholder consultation on universal health coverage.

So, at the gate, the UN security force had everything ready for Michele, my husband, who would be taking care of Yasmin while I was on stage, but they didn't have a digital pass for my baby. "We're not used to having babies in the UN premises," they said, as if my tiny Yasmin could pose a security threat to the building. After a lot of back-and-forth, and a few chuckles, we finally made it inside. The whole situation caused quite a stir, but in the end, everyone smiled as they saw her.

I remember breastfeeding her in the nursing room, a surreal but tender reminder that even amidst complex negotiations and international discourse, the most simple and profound moments of care are what connect us all.

My presidency journey hasn't been without its struggles. Navigating the inherent gender imbalance within our organisation-one that is still very male-dominated-was challenging. As only the fifth woman president of the WMA, I was deeply aware of the honour and responsibility of representing so many others who still lack a seat at the table.

We need to make leadership accessible for women and mothers, and create support structures and leadership avenues that are gender equal and accessible to all.

Let us establish more flexible meeting arrangements, providing childcare support during key events, and creating mentorship opportunities specifically targeted at young women physicians.

These steps can ensure that the voices of women are not just heard but are leading the conversation.

Reflections on Achievements and Challenges

Throughout my tenure, I have seen both incredible progress but also daunting challenges.

These challenges were a constant reminder that we as physicians, as leaders and as advocates for health, must constantly challenge the status quo.

We must transform the long-standing systems to equal ones that accommodate all with no discrimination. I take pride in the *Leadership Through Mentorship* initiative that connects members of our Junior Doctors Network with the experience of our Past Leaders Network, bridging generations to create a continuum of learning and growth. We also made great strides through the Women-in-Medicine Luncheon, creating a space for mentorship, peer learning, and celebrating women leaders in organised medicine.

However, our advocacy did not stop there.

We raised our collective voices through open letters-one to safeguard healthcare personnel during conflicts and another urging world leaders to divest away from fossil fuel divestment on behalf of 46 million health professionals.

These were not mere formalities; they were calls for action, for safeguarding lives, and for upholding our ethical duty to future generations.

We faced resistance in implementing some of these initiatives, but it was through resilience, collaboration, and unwavering belief in our mission that we overcame these obstacles.

Current State of Global Healthcare and Progress

The challenges facing global healthcare today are immense. Conflicts rage, climate change, economic crises, and violations of human rights continue.

We have not learned enough from the devastations of the past, and the world is more fragmented than ever. Despite the shared experience of COVID-19, we have yet to reach a pandemic accord, and we still lag behind on the Paris Agreement and the Sustainable Development Goals, including Universal Health Coverage.

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This year, healthcare has faced immense dangers, with over 980 attacks reported by the WHO surveillance system in areas such as Lebanon, Ukraine, Sudan, and Gaza.

Doctors from Kenya to Korea, the UK to India, took to the streets demanding safer working environments. These are not isolated incidents; they are cries for systemic change, for respect, and for their right to serve their moral duty.

During my tenure, we successfully brought together stakeholders to discuss safer working environments for healthcare personnel, ensuring healthcare system resilience to climate change, and bringing important voices to demand actions to combat antimicrobial resistance.

We also played a role in fostering international collaboration to advance the goals of all the SDGs, particularly the Universal Health Coverage, ensuring that health remains a right, not a privilege.

Core Reflections and Moral Duty

As physicians, our duty is not just to our patients but to the health and well-being of all. No matter how bleak the world may seem, we must not lose our passion for this moral duty.

This GA is historic. Following a long and extensive review process, we have an updated draft of the Declaration of Helsinki for your approval. This document embodies our commitment to integrity, respect, and the highest standards in medical ethics, reminding us that our duty extends beyond individual patients to the broader advancement of health, and we eagerly await its adoption.

Future Plans and Support for Incoming Leadership

My journey is far from over.

I will continue advocating for gender equality, for action on climate and health, and for the rights of health for all and the rights of physicians everywhere. You will still see me around-because there is still much work to be done, and I am far from finished.

To the incoming president, I offer my wholehearted support. This is not a solitary journey; it is one that we walk together.

Acknowledgments and Thanks

I want to take a moment to thank those who have been instrumental during my presidency.

To the Executive Council, to our Secretary General, and to the Secretariat members–your dedication and support have been the backbone of our achievements.

To the National Medical Associations (NMAs), associate members and Junior Doctors Network, thank you for your unwavering support and for being the pillars of our global efforts.

To my family, my friends, and especially my mother, who is here with me in Helsinki to care for Yasmin, thank you for your unending love and strength.

And to Michele, my husband, and Yasmin - my travel companions and my heart. Michele, thank you for being my rock and all the sacrifices you made to help me fulfil my role. And to Yasmin, thank you for being my little source of joy and for your patience and presence throughout this journey.

Calls to Action for Global Health

We live in a troubled world, with more conflicts now than at any time since 1944. The importance of our call for peace cannot be overstated. Speaking today, with representatives from over 50 countries gathered here in the form of NMAs, I see a symbol of unity–a reminder of what the world should strive to be. Our strength lies in our shared commitment, in our unity, and in our determination to act, regardless of the political complexities involved.

I would like to leave you one final message as this is the last time I stand before you today as the WMA President:

Let us continue to fight - for our rights, for our safety, for the right to a safe working environment, and for the dignity of every individual. The WMA must take the lead in this fight and continue to advocate for stronger health protections, resilient healthcare infrastructure, equal capacity building opportunities and most importantly right to health, and right to healthy environment. Let us be loud about our call to peace as a public health priority and an important determinant of health.

Let us be the voice that speaks for those who cannot, and the hands that heal those who are forgotten.

Thank you.

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Inaugural Address by the WMA President, Dr. Ashok Philip

Helsinki, Finland, 18 October, 2024

Ashok Philip

My dear friends and colleagues, I am very grateful to you for the honour you have bestowed upon me by allowing me to assume this prestigious post. In particular, my gratitude goes to my long-suffering wife, Premah, and my somewhat bemused children, Mira, Anila, and Rohan. I would also like to mention Andrew Gurman and Leah Wapner, who helped to clarify my mind about seeking this post. The Presidents before me also helped me make this decision. I also thank the Malaysian Medical Association for their nomination and support.

What I say now represents my own views, but I believe many of you, my colleagues, will hear my words and recognise the problems I speak of, and perhaps agree with my sentiments. The issues that face the profession are many and serious. For instance, antimicrobial resistance threatens to push us back to an age when the slightest scratch or sniffle might presage death. Climate change has begun to affect our health and may threaten the continued thriving of our species and many others. The security and future development of the health workforce faces challenges around the world. Non-communicable diseases are sweeping the world. The next pandemic is coming. You will be relieved to know that I have been given 10 minutes to talk, so I must set these topics aside for another time.

Instead, I would like to focus on another topic, which I believe is fundamental to the entire practice of medicine – professional autonomy. We have all heard of it, we all want it, we all have some restrictions preventing us from having full autonomy. To a greater or lesser extent, I believe most of us feel it is under threat. I agree with that assessment.

Before we can discuss it, we should define what we mean by it. Professional autonomy means primarily the freedom to make clinical decisions about the care of individual patients. This is what most of us think of when we mention autonomy, and in my opinion, it is the aspect most under threat. However, the right to have a voice in health policy development and healthcare system change is also a part of professional autonomy. These aspects are perhaps not under such threat. The WMA Declaration of Seoul goes into great depth and detail about why autonomy is important, and I recommend this document to you if you get into an argument or discussion with administrators or insurers.

Professional autonomy developed and continues to exist because it serves the interests not of the profession but of the patients. We, as doctors, wield this autonomy for the benefit of patients, and we stand in a fiduciary relationship to them, always considering what investigations, interventions, and treatments are best for them – not for us, the healthcare authority or insurance company. If we let this autonomy be taken away or diminished, our patients will suffer – and eventually everyone will be a patient, so everyone will suffer. When you are sick, the extra profit that you made for your company, the bigger bonus you got, the political agenda you helped advanced will not help you when your doctor's hands are tied.

Why is autonomy threatened? A major reason is that it is becoming more and more expensive to treat patients. In part, this is a result of the success of medical science. People live longer, so we have an increasing pool of sick elderly people who can be quite expensive to manage.

Diseases that were impossible or difficult to treat even a few decades ago are now manageable, if not curable. Unfortunately, though, these new treatments are often extremely expensive. Healthcare systems may end up paying more and more to treat fewer and fewer patients.

Financing these treatments will be difficult whether the government or private insurers do the paying. When governments are the payers, profit is not a consideration. However, issues of accessibility and rationing may arise, and again it is our responsibility to bring evidence to the table to help guide policymakers in making their decisions. We must also be alert for the intrusion of political agendas into healthcare.

When private enterprise pays for medical care, the situation can be

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complicated by the profit motive. This is not to disparage something that has helped build the world, but we should very carefully consider if profit-seeking as seen in the commercial arena should be allowed free rein in medical situations. Nobody chooses to get sick. Patients have little choice but to take the treatments available. Allowing supply and demand to set prices seems unkind, even cruel, and may lead to some patients not getting the treatments they need. There must be guidelines, independent of purely financial considerations, to decide how patients are treated, and these guidelines must be drawn up by doctors. Additionally, flexibility to vary treatments and avenues for appeal must be built in and must be responsive. Ill health cannot wait for five to seven working days.

Delivery of care has always involved teams of healthcare professional led by doctors. We have noticed movements towards removing or excluding doctors in some situations, ostensibly to handle shortages of doctors, but more obviously to reduce costs. This is also an abridgement of our autonomy and must be resisted at all costs. Every team member is valuable, but a leaderless team is ineffective. The natural leaders in healthcare should be those who can look at the whole picture, and that generally means doctors. It is not in the best interests of patients individually or systems as a whole that doctors be removed from their leadership roles.

We have not yet lost our professional autonomy, but I believe the chains to bind us are being forged. They might be chains of gold, but they will bind us none the less, and our profession and our patients will suffer. We must be on the alert. Those seeking to bind us will do so covertly, under the benevolent guise of improving healthcare access. Let us always look deeply into any such moves, and let us always remain involved in policy and guideline development. It may be tedious and take us away from direct patient care, but in the long term it protects our patients, and that is what we have sworn to do.

Please note that I am not advocating carte blanche for doctors in everything. Our autonomy only applies to the management of patients, broadly construed. It must be based on agreed professional opinion. There may be varying opinions, but these must rest on sound scientific and ethical foundations. Doctors are entitled to their own opinions, of course, but where they differ significantly from the accepted professional view or views, this must be made clear, and it should be understood that the shield of professional autonomy no longer protects them in such a situation. Where maverick doctors use professional autonomy to advance non evidence-based (or even anti evidence-based) views, associations, such as ours, must be prepared to speak out and correct public perceptions. If we hesitate to do so, the public can rightly ask if it is our patients or our colleagues who are our priority.

I know I can count on every one of you, as associations and individuals, to do the right thing and lead the way to a better future for our patients, our communities and our profession. I look forward to working with you, in the next year and beyond.

Thank you again, and to our hosts, kiitos.

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Information about the 229th WMA Council Session, Montevideo 2025

Dear colleagues of the World Medical Association,

On behalf of the Sindicato Médico del Uruguay (SMU), we cordially invite you to participate in the 229th Council Session of the World Medical Association, which will be held on 24-26 April 2025, in Montevideo, Uruguay. The SMU is honored and humbled to serve as the host for this event, and we know that the event will be successful.

In addition to preparing an agenda of significant themes relevant to our medical profession, including diverse global health issues, rest assured that there will be sufficient time to get to know and enjoy our city, its culture, and its hospitality.

Please mark your calendars and join us in Montevideo for this important event.

Sindicato Médico del Uruguay
Montevideo, Uruguay
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Information about the World Federation for Medical Education Conference 2025

We are thrilled to invite you to the World Federation for Medical Education conference 2025, which will be held in the vibrant city of Bangkok. Thailand, on 25-28 May 2025. The conference will be organised in cooperation with the Institute for Medical Education Accreditation (IMEAc).

Mark your calendars, and stay tuned for more details on registration, speakers, and programme highlights. For more information, please visit the event website.

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Information about the 17th World Conference in Bioethics, Medical Ethics & Health Law

Start Date: November 24, 2025

End Date: November 26, 2025

Location: Ljubljana, Slovenia

The International Chair in Bioethics (ICB), in collaboration with the World Medical Association Cooperating Centre, will host this prestigious event covering bioethics, medical ethics, and health law in Ljubljana, Slovenia, on 24-26 November 2025.

For more information, please visit the event website.

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WMA General Assembly Report

Helsinki, Finland, 16-19 October 2024

Janice Blondeau

The 77th General Assembly of the World Medical Association (WMA), which took place in Helsinki, Finland, from 16-19 October 2024, brought together delegates from 46 National Medical Associations (NMAs) (Photo 1).

Wednesday, 16 October

Council Session

The 227th Council Session was called to order by the Chair of Council, Prof. Jung Yul Park (Korean Medical Association). The Secretary General, Dr. Otmar Kloiber, welcomed Prof. Steve Robson (Australian Medical Association) and Dr. Mary McCarthy (British Medical Association), as newly attending Council members.

The Council approved the Summary Minutes of the 226th Council Session held in Seoul, Republic of Korea, from 18-20 April 2024. The Secretary General informed the Council that the members selected for the Credentials Committee were Dr. Wonchat Subhachaturas (Medical Association of Thailand), Dr. Philip Cathala (Conseil National de l'Ordre des Médecins), and Dr. Carlos Serrano (Brazilian Medical Association), as three individuals from constituent members covering each of the three official WMA languages: English, French, and Spanish. Dr. Serrano was elected Chairperson of this Committee. The Council approved the appointment of the Credentials Committee.

President's Report

The Council received the report of the WMA President, Dr. Lujain Alqodmani (Kuwait Medical Association), on her activities from May to September 2024. Dr. Alqodmani referred to her written report, categorised according to the key priorities of her presidency: support for NMAs, relations with the World Health Organization (WHO), climate change, gender equality, universal health coverage, and safety of healthcare personnel and facilities in conflicts.

Dr. Alqodmani spoke to two specific priorities. Firstly, she thanked NMAs who responded to the survey initiated by the International Federation of Medical Students' Associations (IFSMA) intern to the WMA Secretariat, Ms. Matilda Sabljak, on women's presence in leadership positions in NMAs. She noted that the results of the survey would be announced at the Women in Medicine lunch on Saturday, 19 October. Secondly, Dr. Alqodmani outlined WMA's work on the climate and health agenda with several civil society organisations, particularly regarding the COP30 which will be held in Brazil in November 2025. She stated that this will be a key moment to ensure that the Paris Agreement targets (including the 1.5°C target) are not missed.

In closing, Dr. Alqodmani said that the past six months of her Presidency have included intense, enriching experiences with engaging dialogues, networking opportunities, and collaborative ventures, showcasing the impactful work of the WMA to the global community. She thanked the Secretary General and the WMA Secretariat staff for their support during her leadership term in office.

Secretary General's Report

The Council received the oral report of the Secretary General to the Council, complementing the written Council Report. Dr. Kloiber stated that the WMA had two opportunities this year to be part of the health section of the Organization for Economic Co-operation and Development (OECD) surveys, as OECD makes extremely influential recommendations concerning the structuring of health policies and health systems. The first and second surveys focused on artificial intelligence and the financialisation of outpatient services, respectively. Dr. Kloiber urged WMA members to take advantage of opportunities (like these surveys) to have our voices heard in the international health agenda setting.

Dr. Kloiber also said that there would be a special session on Friday, 18 October, on health workforce migration, a topic which is at the heart of the collaborative work between the WMA and WHO. He reminded WMA members that updates on WMA external activities and international policies will be presented on Saturday, 19 October, during the General Assembly plenary session.

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Chair of Council's Report

The Council received the report by the WMA Chair of Council from May to September 2024. Prof. Park referred to his written report, noting the many local and global challenges that WMA members face, such as violence against health professionals, climate change, achieving universal health coverage, racism and other human rights abuses, and polarisation. He urged WMA members to continue to tackle these challenges with determination and collective wisdom. He called on more junior doctors to come together within the larger WMA family, saying that together we can make a stronger future.

The Council meeting was adjourned.

Finance and Planning Committee

Dr. Jack Resneck Jr., Chair of the Finance and Planning Committee, called the meeting to order and welcomed the committee members. He advised that the committee would follow the same voting procedure as the Council. The committee approved the report of the previous meeting held in Seoul in April 2024.

Financial Statements

The committee agreed that the Audited Financial Statement for 2023 be approved by the Council and forwarded to the General Assembly for adoption, and that the proposed WMA Budget for 2025 be approved by the Council and forwarded to the General Assembly for adoption. The committee received the WMA Dues Categories 2025 document, which would be forwarded to the General Assembly for information. The committee considered the oral report of the Finance Group, which met on 15 October. Prof. Jung Yul Park, Chair of the Finance Group, reported that the group had a comprehensive discussion on the WMA's financial situation. The committee recommended that the Council appoint KPMG as the auditor of the 2024 WMA Financial Statement.

WMA Strategic Plan

Dr. Kloiber reported that current activities are in line with the WMA Strategic Plan for 2020-2025. The Finance and Planning Committee Chair stated that there will be a dedicated open session, as part of the next strategic planning session, for a more inclusive planning process.

WMA Statutory Meetings

Dr. José Minarrieta (Sindicato Médico del Uruguay) extended an invitation to all members to attend the Council Session in April 2025 in Montevideo, Uruguay. Prof. Alberto Caldas Afonso (Portuguese Medical Association) extended an invitation to all members to attend the General Assembly in October 2025 in Porto, Portugal.

WMA Special Meetings

Dr. Kloiber thanked member associations and individuals who have engaged in the process of the revision of the Declaration of Helsinki (DoH). He thanked WMA partner organisations and ethics advisers, who provided invaluable help and input to the process. He highlighted the contributions of those who hosted the series of regional meetings, especially the American Medical Association, Dr. Jack Resneck Jr. and his office team, who worked tirelessly stemming this huge task in an outstandingly transparent, open, and respectful manner.

Membership

The committee recommended that the Hungarian Medical Chamber (HMC) be admitted to the WMA Constituent Membership.

Associate Membership

The committee received the Report of the WMA Associate Membership 2023 and the Report of Chair of Associate Members, presented by Dr. Jacques de Haller, Chair of the Associate Members.

The committee received the Report of the Junior Doctors Network (JDN) presented by Dr. Sazi Nzama (Associate Member from South Africa), on behalf of Dr. Marie-Claire Wangari (Associate Member from Kenya), outgoing JDN Chair. Dr. Resneck Jr., FPL Chair, congratulated Dr. Pablo Estrella Porter, the newly elected JDN Chair, on his election, and thanked Dr. Wangari and her team for their term contributions.

The committee received the Report of the Past Presidents and Chairs of Council Network (PPCN) presented by Dr. Kati Myllymäki (Finnish Medical Association), PPCN Chair. Dr. Myllymäki stated that the database of the PPCN expertise is available at the WMA Secretariat, and it can be shared when needed by the members. Dr. Jón Snædal (Associate Member from Iceland) reported that he had met with junior doctors as part of the mentorship program between the JDN and the PPCN, and that the group will have an in-person meeting on 18 October in Helsinki.

Dr. Kloiber thanked all these voluntary activities from the individual members.

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Review Committee

The committee received the report from the Chair of the Review Committee, Ms. Elizabeth LaRocca (American Medical Association).

Rules Applicable to WMA Associate Membership

The committee considered the proposed revisions of the Rules Applicable to WMA Associate Membership, presented by Dr. Kloiber and Dr. de Haller, and recommended that these revisions be approved by the Council and forwarded to the General Assembly for adoption.

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The committee received the *World Medical Journal* (WMJ) Report by the WMJ Assistant Editor, Ms. Maira Sudraba (Latvian Medical Association). Ms. Sudraba spoke on behalf of the WMJ Editor-in-Chief, Dr. Helena Chapman, thanking contributors to the most recent issues of the journal and encouraging members to actively share their ideas and articles for future issues.

Public Relations

The committee received the Public Relations Report by the WMA Communications and Media Consultant, Ms. Janice Blondeau. Ms. Blondeau encouraged members to use the WMA communications materials for their own advocacy and media activities.

Medical Ethics Committee

The Chair called the meeting to order and welcomed the new Committee Members. The committee approved the report of the previous meeting held in Seoul, Republic of Korea.

Declaration of Helsinki

The committee considered the proposed revision of the WMA Declaration of Helsinki. Dr. Steinnun Thordardottir (Icelandic Medical Association), Chair of the MEC committee, thanked everyone involved for their contributions. Dr. Jack Resneck Jr. (American Medical Association), Chair of the workgroup, thanked all the members of the workgroup, the WMA constituent members who have hosted the regional and topical meetings, external experts, and especially his American Medical Association team. He highlighted the main principles of the Declaration, which were discussed during the revision process and the reasoning for the suggested amendments. The committee recommended that the revision of the proposed WMA Declaration of Helsinki be approved by the Council and be forwarded to the General Assembly for adoption.

Assisted Reproductive Technologies

The committee considered the proposed revision of the WMA Statement on Assisted Reproductive Technologies and comments. The committee recommended that the proposed WMA Statement on Assisted Reproductive Technologies be approved by the Council and be forwarded to the General Assembly for adoption.

Ethical Guidelines for the International Migration of Health Workers

The committee considered the proposed major revision of the WMA Statement on Ethical Guidelines for the International Migration of Health Workers. The committee recommended that the WMA Statement on Ethical Guidelines for the International Migration of Health Workers, as amended, and be circulated to constituent members for comments.

Conflict of Interest

The committee considered the proposed minor revision of the WMA Statement on Conflict of Interest. The committee recommended that in view of the large number of amendments, the proposed revision of the WMA Statement on Conflict of Interest be considered a major revision, and that the German Medical Association would be the rapporteur.

Promotional Mass Media Appearance by Physicians

The committee considered the proposed minor revision of the WMA Statement on Promotional Mass Media Appearance by Physicians. The committee recommended that the proposed revision of the WMA Statement on Promotional Mass Media Appearance by Physicians be sent to the Council for approval and to the General Assembly for information.

New Items

Medical Neutrality

The committee considered the WMA Statement on the Protection of Medical Neutrality in Times of Armed Conflict and other Situations of Violence. The committee recommended that the proposed WMA Statement on the Protection of Medical Neutrality in Times of Armed Conflict and other Situations of Violence be circulated to constituent members for comments.

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WMA Human Rights

The committee received the Report of the Council to the General Assembly, Helsinki 2024.

Socio-Medical Affairs Committee

The meeting was called to order by the Chair of the Socio-Medical Affairs Committee (SMAC). The committee approved the report of the previous meeting of the Socio-Medical Affairs Committee held in Seoul, South Korea, in April 2024.

Health and Environment

The committee received the report from Dr. Yassen Tcholakov (Associate Member from Canada), in the absence of the Chair of the Workgroup on Environment and Associate Member, Dr. Ankush Bansal. The workgroup has been active since the 226th Council meeting in April in Seoul, and members have coordinated two virtual meetings.

Global Advocacy

At the World Health Assembly, in collaboration with other international health stakeholders, the workgroup members and JDN successfully advocated for the adoption of a resolution on actions related to climate change and health.

In September 2024, the WMA President, Dr. Lujain Alqodmani, was present at New York Climate Week in conjunction with the 79th UN General Assembly and represented the WMA on several climate-related issues.

In November 2024, the WMA plans to have a delegation of five members attending the meeting of COP29 in Baku, Azerbaijan.

In March 2025, Dr. Alqodmani will represent the WMA at the Second WHO Conference on Air Pollution and Health in Cartagena, Colombia.

The workgroup started a thorough review of the WMA policies on environment and health, particularly mapping these policies for duplication, revision or replacement with the help of Ms. Sabljak, IFMSA intern to the WMA Secretariat. The goal of the workgroup is to review these policies over the next several months to present to this committee in future Council meetings.

Medical Technology

The committee received the report of Dr. Jesse Ehrenfeld (American Medical Association), in the absence of Dr. Leah Wapner (Israeli Medical Association), Chair of the workgroup on Medical Technology. The workgroup is currently planning a webinar series on artificial intelligence, which will begin by focusing on some key areas of its application in medicine.

The workgroup is planning to propose a revision of the WMA Statement on Augmented Intelligence in Medical Care. The workgroup aims to have a draft revision to submit at the next Council Meeting in April 2025.

The OECD conducted a survey of WMA members on artificial intelligence and the healthcare workforce in 2023, and the report of the survey is available on the website (https://www.oecd.org/en/publications/artificial-intelligence-and-the-health-workforce_9a31d8af-en.html). As part of this research, the OECD Digital Health division is organising a follow-up webinar by early November 2024, and is seeking physicians with experience in the field of artificial intelligence as webinar panelists.

Epidemics and Pandemics

The committee considered the proposed revision of the WMA Statement on Epidemics and Pandemics and comments. The committee recommended that the proposed revision of the WMA Statement on Epidemics and Pandemics, as amended, be approved by the Council and forwarded to the General Assembly for adoption.

Air Pollution

The committee considered the proposed revision of the WMA Declaration on Prevention and Reduction of Air Pollution to Improve Air Quality and comments. The committee recommended that the proposed revision of the WMA Declaration on Prevention and Reduction of Air Pollution to Improve Air Quality, as amended, be approved by the Council and forwarded to the General Assembly for adoption.

Adolescent Suicide

The committee considered the proposed (minor) revision of the WMA Statement on Adolescent Suicide. The committee recommended that the proposed revision of the WMA Statement on Adolescent Suicide, as amended, be approved by the Council and forwarded to the General Assembly for information.

Abuse of the Elderly

The committee considered the proposed (minor) revision of WMA Declaration of Hong Kong on the Abuse of the Elderly. The committee recommended that the proposed revision of the WMA

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Declaration of Hong Kong on the Abuse of the Elderly, as amended, be approved by the Council and forwarded to the General Assembly for information.

Support of the Turkish Medical Association

The committee considered the proposed (minor) revision of WMA Resolution in support of the Turkish Medical Association. The committee recommended that the proposed revision of the WMA Resolution in support of the Turkish Medical Association, as amended, be approved by the Council and forwarded to the General Assembly for information.

WHO Guidelines on Opioid Use

The committee considered the proposed (minor) revision of the WMA Resolution on the Revocation of WHO Guidelines on Opioid Use. The committee recommended that the proposed revision of the WMA Resolution on the Revocation of WHO Guidelines on Opioid Use be approved by the Council and forwarded to the General Assembly for information.

Non-Discrimination in Professional Membership

The committee considered the proposed (minor) revision of the WMA Statement on Non-Discrimination in Professional Membership. The committee recommended that the proposed revision of the WMA Statement on Non-Discrimination in Professional Membership, as amended, be approved by the Council and forwarded to the General Assembly for information.

Mental Health of Physicians

The committee considered the proposed revision of the WMA Statement on Specific Care for the Mental Health of Physicians and comments. The committee recommended that the proposed revision of the WMA Statement on Specific Care for the Mental Health of Physicians and comments be circulated within the membership for further comments.

Aging Physicians

The committee considered the proposed revision of the WMA Resolution on Aging Physicians and Comments. The committee recommended that the proposed revision of the WMA Resolution on Aging Physicians, as amended, be circulated within the membership for further comments.

Task Shifting

The committee considered the proposed (major) revision of WMA Resolution on Task Shifting from the Medical Profession. The committee recommended that the proposed revision of the WMA Resolution on Task Shifting from the Medical Profession be circulated within the membership for comments.

Physicians' Well-Being

The committee considered the proposed (major) revision of the WMA Statement on Physicians' Well-Being. The committee recommended that the proposed revision of the WMA Statement on Physicians Well-Being be circulated within the membership for comments. As part of the consultation process, the committee recommended that the rapporteur of the proposal (American Medical Association) coordinate with the rapporteur of the proposed WMA Statement on Specific Care for the Mental Health of Physicians (Spanish Medical Association), to avoid duplication and ensure consistency between the two texts.

Health Support to Street Children

The committee considered the proposed (major) revision of the WMA Statement on Providing Health Support to Street Children. The committee recommended that the proposed revision of the WMA Statement on Providing Health Support to Street Children, as amended, be circulated within the membership for comments.

Obesity

The committee considered the proposed revision of the WMA Statement on Obesity, as merging the WMA Statements on Obesity in Children and on the Physician's Role in Obesity). The committee recommended that the proposed revision of the WMA Statement on Obesity, as amended, be circulated within the membership for comments.

Reproductive Health

The committee considered the proposed revision of the WMA Statement on the Protection of Reproductive Health Rights of Women and Girls, which extends the scope of the WMA Resolution on Legislation against Abortion in Nicaragua to reproductive health worldwide. The committee recommended that the proposed revision of the WMA Statement on the Protection of Reproductive Health Rights of Women and Girls be circulated within the membership for comments.

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Vitamin D Insufficiency

The committee considered the proposed (major) revision of the WMA Statement on Vitamin D Insufficiency. The committee recommended that the proposed revision of the WMA Statement on Vitamin D Insufficiency be circulated within the membership for comments.

Aging

The committee considered the proposed (minor) revision of the WMA Statement on Aging. In view of the large number of amendments, the committee recommended that the proposed revision of the WMA Statement on Aging be considered as a major revision and be circulated to members for comments.

Aesthetic Treatment

The committee considered the proposed (minor) revision of the WMA Statement on Aesthetic Treatment. In view of the large number of motions to amend, the committee recommended that the proposed revision of the WMA Statement on Aesthetic Treatment, as amended, be considered as a major revision and be circulated to members for comments.

Global Medical Electives

The committee considered the proposed (minor) revision of the WMA Statement on Ethical Considerations in Global Medical Electives. The committee recommended that the proposed revision of the WMA Statement on Ethical Considerations in Global Medical Electives, as amended, be considered as a major revision to be circulated to members for comments, and that the advisor to the committee, Dr. Caline Mattar, serve as rapporteur for this proposed revision.

Transgender People

The committee received the oral report from the German Medical Association, as rapporteur, on the revision of the WMA Statement on Transgender People. The German Medical Association has held discussions with experts in this field over the last few months and plans to submit a proposal for revision to the next Council meeting in April 2025. They invited WMA members wishing to contribute to the revision to join an informal group to discuss the draft proposal. The medical associations from the following countries expressed interest: France, Tunisia, United Kingdom, United States, and Uruguay, as well as Associate Members.

New Items

Nuclear Weapons

The committee considered the proposed revision of the WMA Statement on Nuclear Weapons. The committee recommended that the proposed revision of the WMA Statement on Nuclear Weapons be circulated to members for comments.

Plastics and Health

The committee considered the proposed revision of the WMA Resolution on Plastics and Health. The committee recommended that the proposed revision of the WMA Resolution on Plastics and Health be circulated to members for comments. In view of the upcoming intergovernmental meeting in November 2024, to develop an international instrument on plastic pollution, the Kuwait Medical Association and the Royal Dutch Medical Association submitted an urgent motion for a resolution to the Council Plenary Session on Friday, 18 October, to enable the WMA to advocate on the impact of plastics on health and the role of plastic products in the health sector.

Thursday, 17 October

Associate Members Meeting

The Plenary Meeting of the WMA Associate Members was called to order by the Chair, Dr. Jacques de Haller. The Chair announced that Dr. Ankush Bansal had sent apologies for his absence. The minutes of the previous report and the report on Associate Membership for 2023 were approved.

Elections

Election (via mail) of a Member of the Steering Committee (Student Member-at-large)

The Chair informed the Associate Members that the election of the Student Member to the Steering Committee took place electronically in September 2024, under the supervision of the WMA Legal Advisor. Mr. Eugene Opiyo (Associate Member from Kenya) was elected as the Student Member-at-large.

Election of a Member of the Steering Committee (Independent Member-at-large)

The Associate Members received applications from three candidates: Dr. Mahesh Bhatt (India), Dr. Parth Patel (Malawi), and Dr. Natalia Solenkova (United States). Dr. Natalia Solenkova was elected to the Steering Committee as an Independent Member-at-large.

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Reports

The Associate Members received the reports of the Chair of Associate Members, JDN, and PPCN, as well as the reports from Associate Members active in WMA taskforces and workgroups:

- Workgroup on Environment, reported by Dr. Yassen Tcholakov, in the absence of the Chair of the workgroup, Dr. Ankush Bansal
- Workgroup on the Revision of the Declaration of Helsinki, reported by Dr. Natalia Solenkova
- Workgroup on Epidemics and Pandemics, reported by Dr. Yassen Tcholakov
- Dr. Caline Mattar outlined the WMA's activities on antimicrobial resistance over the past year

Rules Applicable to WMA Associate Membership

The Chair of Associate Members reported that the proposed revision of the Rules Applicable to WMA Associate Membership had been considered the previous day by the Finance and Planning Committee. The committee had recommended that the Council approve the revision at its next plenary session on 18 October, and forward it to the General Assembly for adoption.

Assembly Business

The Associate Members elected Dr. Julie Bacqué and Dr. Yassen Tcholakov, by acclamation as representatives to the WMA General Assembly 2024, as well as Dr. Pablo Estrella Porter as alternate. The Associate Members thanked Dr. Ankush Bansal for his major contribution to the work of the Steering Committee during the past year.

Other Business

Associate Members had a follow-up discussion on the Statement on Registration fees adopted by the Steering Committee last Spring and sent to the WMA Secretary General. The Chair concluded that the Plenary Meeting supported further action by the Steering Committee.

The Associate Members thanked Dr. Brenda Obondo (Kenya Medical Association) and Dr. Helen Gofwan (Associate Member from Nigeria) for their important contribution as members of the Associate Members Steering Committee for the term 2023-2024.

Scientific Session

The Scientific Session incorporated the topic, "Inequalities in health and healthcare – How to tackle them?" Opening remarks were given by the WMA President, Dr. Lujain Alqodmani, while the President of the Finnish Medical Association, Dr. Niina Koivuviita, gave welcome and introductory words.

In his keynote speech, the WMA Past President, Sir Michael Marmot, presented the topic, "Social justice and health equity." Prof. Marmot examined the questions of the global context for health equity, the Commission on Social Determinants of Health conceptual framework, the context in the United Kingdom over time, and England's widening health gap. He spoke about inequalities in mortality and social inequalities in mortality rates in various countries and areas. The impacts of the COVID-19 pandemic on life expectancy in various regions were also examined. He illustrated concrete actions that have been implemented with partnerships and cooperation between local government, healthcare providers, public services, business and the private sector, and national governments and institutions.

Following the keynote speech, panel discussions addressed relevant topics for WMA members. The first panel session was moderated by Dr. Juha Mikkonen, the Executive Director of the Finnish Association for Substance Abuse Prevention (EHYT), highlighting the topic, "How can prevention provide more equity in healthcare?" The first panelist, Prof. Dr. Carlos Vicente Serrano Jr., Director of International Relations of the Brazilian Medical Association, presented the topic, "How can prevention and primary healthcare provide more equity in healthcare?" Next, Dr. Koji Watanabe, Executive Board Member of the Japan Medical Association, described the theme, "Health checkup system in Japan – Contributing to equity on healthcare". The final panelist, Dr. Sofia Rydgren Stale, President of the Swedish Medical Association, discussed the topic, "How to bring equitable access to maternal and new-born care – The Swedish experience".

The second panel session was moderated by Dr. Ashok Philip (Malaysian Medical Association), the WMA President-Elect, addressing the topic, "Advancements in healthcare – how to make access to health care more equitable?" The first speaker was Dr. Markku Satokangas, Senior Researcher, Finnish Institute for Health and Welfare, who presented the subject, "Structural inequities in the Finnish health system: Universal coverage but parallel pathways to care". Next, Dr. Diana Marion Secretary

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General of the Kenya Medical Association, explored the theme, "The evolution of health financing in Kenya: A transformative journey towards health equity". The final panelist, Dr. Jesse Ehrenfeld, Past President of the American Medical Association, spoke on "Techquity: Enabling health equity through innovation".

The third panel session was moderated by Dr. Muha Hassan, WMA Associate Member and JDN member, examining the topic, "How to mitigate the effects of climate change on inequalities?". After Dr. Lujain Alqodmani, WMA President, presented the introduction, an open discussion was held with three panelists: Dr. Hector M. Santos Jr., President of the Philippine Medical Association, Dr. Stephen Robson, Immediate Past President of the Australian Medical Association, and Dr. Mvuyisi Mzukwa, Chairperson of the South African Medical Association.

Concluding remarks of the scientific session were given by Dr. Janne Aaltonen, CEO of the Finnish Medical Association.

Friday, 18 October

Briefing Session on Human Resources for Health

Dr. Caline Mattar, WMA Advisor, and Dr. Julia Tainijoki, WMA Senior Medical Advisor, presented this session, outlining the importance of engagement in the Human Resources for Health (HRH) agenda. They described the global policy scene for HRH and opportunities for engagement through the WMA. Specifically, they highlighted the WMA Migration project, which aims to provide national perspectives from physicians on physician migration, which is largely absent from global conversations. Through country case studies and data collection via an online form, the report will inform key advocacy messages for WMA. They encouraged NMAs to participate in this project.

Main Meeting of the 227th Council Session

The Council reconvened to consider the reports of the Standing Committees.

Item to be considered as a Matter of Urgency

Plastic and Health

The Council considered and approved the proposed urgent Resolution on Plastics and Health and forwarded it to the General Assembly for adoption.

Committee Reports

The Council agreed to use a consent calendar to consider the Committee reports.

Medical Ethics Committee

The Council considered the report of the Medical Ethics Committee. No items were extracted, and the Council approved the report.

Items approved via the Consent Calendar:

Declaration of Helsinki

The proposed revision of the WMA Declaration of Helsinki was approved and forwarded to the General Assembly for adoption.

Assisted Reproductive Technologies

The proposed revision of the recommendation 14 of the WMA Statement on Assisted Reproductive Technologies was approved and forwarded to the General Assembly for adoption.

Promotional Mass Media Appearance by Physicians

The proposed (minor) revision of the WMA Statement on Promotional Mass Media Appearance by Physicians was approved and forwarded to the General Assembly for information.

The following documents are to be circulated within the membership for comments:

- WMA Statement on Ethical Guidelines for the International Migration of Health Workers
- WMA Statement on the Protection of Medical Neutrality in times of Armed Conflict and Other Situations of Violence
- WMA Statement on Conflict of Interest

Finance and Planning Committee

The Council considered the Report of the Finance and Planning Committee. Items on WMA Budget and Membership Dues Payments were extracted for individual consideration. All the other items were accepted, and the Council approved the report.

Items approved via the Consent Calendar:

Financial Statement

The Audited Financial Statement for 2023 was approved and forwarded to the General Assembly for adoption.

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WMA Budget and Membership Dues Payments

The Council approved the waiver of the membership dues of the Myanmar Medical Association (MMA) and the Ukraine Medical Association (UMA) for the year 2023 and forwarded it to the General Assembly for approval.

The Council approved the increase of the membership dues rates for all categories over a three-year term, i.e. increase in 2025 by 2.5%, then in 2026 by 2.5% and in 2027 by 2.5%, and forwarded it to the General Assembly for approval.

Auditor

The Council appointed KPMG as the auditor of the 2024 WMA Financial Statement.

Constituent Membership

The Council approved the Hungarian Medical Chamber (HMC)'s admission to the WMA Constituent Membership and forwarded it to the General Assembly for approval.

Rules Applicable to WMA Associate Membership

The Council approved the proposed revisions of the Rules Applicable to WMA Associate Membership and forwarded them to the General Assembly for adoption.

Socio-Medical Affairs Committee

The Council considered the Report of the Socio-Medical Affairs Committee. Items on Adolescent Suicide and Plastics and Health were extracted for individual consideration.

Adolescent Suicide

The proposed (minor) revision of the WMA Statement on Adolescent Suicide, as amended, was approved and forwarded to the General Assembly for information.

Plastics and Health

The proposed WMA Resolution on Plastics and Health was withdrawn by the proposer. The Kuwait Medical Association and the Chair of Council accepted it.

All the other items were accepted, and the Council approved the report.

Items approved via the Consent Calendar:

Epidemics and Pandemics

The proposed revision of the WMA Statement on Epidemics and Pandemics was approved and forwarded to the General Assembly for adoption.

Air Pollution

The proposed WMA Declaration on Prevention and Reduction of Air Pollution to Improve Air Quality was approved and forwarded to the General Assembly for adoption.

Support of the Turkish Medical Association

The proposed (minor) revision of the WMA Resolution in support of the Turkish Medical Association was approved and forwarded to the General Assembly for information.

Abuse of the Elderly

The proposed (minor) revision of the WMA Declaration of Hong Kong on the Abuse of the Elderly was approved and forwarded to the General Assembly for information.

WHO Guidelines on Opioid Use

The proposed (minor) revision of the WMA Resolution on the Revocation of WHO Guidelines on Opioid Use was approved and forwarded to the General Assembly for information.

Non-Discrimination in Professional Membership

The proposed (minor) revision of the WMA Statement on Non-Discrimination in Professional Membership was approved and forwarded to the General Assembly for information.

The following documents were approved to be circulated within the membership for further comments:

- The proposed WMA Statement on Specific Care for the Mental Health of Physicians
- The proposed WMA Resolution on Aging Physicians
- The proposed WMA Statement on Obesity
- The proposed WMA Statement on the Protection of Reproductive Health Rights of Women and Girls
- The proposed revision of the WMA Statement on Nuclear Weapons
- The proposed (major) revision of the WMA Statement on Physicians' Well-Being
- The proposed (major) revision of the WMA Statement on Providing Health Support to Street Children

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- The proposed (major) revision of the WMA Statement on Vitamin D Insufficiency
- The proposed (major) revision of the WMA Resolution on Task Shifting from the Medical Profession. As part of the consultation process, the rapporteur of the proposal (American Medical Association) should coordinate with the rapporteur of the proposed WMA Statement on Specific Care for the Mental Health of Physicians (Spanish Medical Association), to avoid duplication and ensure consistency between the two texts.
- The proposed revision of the WMA Statement on Aging be considered as a major revision
- The proposed revision of the WMA Statement on Aesthetic Treatment be considered as a major revision
- The proposed revision of the WMA Statement on Ethical Considerations in Global Medical Electives be considered as a major revision with Dr. Caline Mattar, advisor to the committee, as the rapporteur.

World Veterinary Association Address

Dr. John De Jong, President of World Veterinary Association, gave his presentation, which was originally scheduled on 19 October.

The Chair asked for the volunteer rapporteurs on the WMA Statement on Aging and the WMA Statement on Aesthetic Treatment, to be considered as major revisions, as stated in the Socio-Medical Affairs Committee report. Although there were no confirmed volunteers during the Council meeting, Associate Members and the Swedish Medical Association volunteered to serve as rapporteurs for the WMA Statement on Aging and the WMA Statement on Aesthetic Treatment, respectively.

The Secretary General informed the Council that the translations of the Declaration of Helsinki into French and Spanish will be finalised after the adoption of the English version. It would take some time since they will be circulated to the French- and Spanish-speaking members, to ensure the translations are consistent with the adopted English version.

Dr. Jacques de Haller informed that Dr. Sebnem Fincanci, former President of the Turkish Medical Association, has been nominated as one of the supported human rights activists for the European continent in a campaign by Amnesty International. This campaign will start on 10 December, recognised as Human Rights Day, and Dr. de Haller asked for support from the WMA membership.

Ceremonial Session

The Assembly Ceremonial Session at the Scandic Marina Congress Center was called to order by the WMA President, Dr. Lujain Alqodmani (Kuwait Medical Association).

Dr. Otmar Kloiber, the WMA Secretary General, introduced the official delegations from each of the 46 constituent members present, as well as the observers from the non-member medical associations and international organisations. Reverend Ramón Goyarrola Belda, the Bishop of the Diocese of Helsinki, was welcomed as a special guest.

Then, Dr. Niina Koivuviita, President of the Finnish Medical Association, extended a warm welcome to WMA leadership, colleagues, and distinguished guests. She stated that the health sector's capacity to address current and future challenges is deeply rooted in medical research, development, and innovation. Highlighting the importance of public trust and a positive attitude toward clinical research, Dr. Koivuviita referred to the Declaration of Helsinki, which has guided ethical standards for medical research involving humans for six decades. She emphasised that ethical guidelines in medical research must remain steadfast in protecting individuals while adapting to an evolving global landscape. She highlighted that the significance of medical research and innovation lies in the benefits they deliver. Concluding her remarks, Dr. Koivuviita underscored the importance of close collaborations and information sharing to transform these advancements into improved care and health outcomes for everyone.

Next, at the start of his address, the Honorable Mr. Alexander Stubb, President of Finland, welcomed attendees of the General Assembly to Finland and to Helsinki. He noted that 60 years ago, the WMA had convened in Helsinki to adopt the ethical principles that continue to guide medical research today. Mr. Stubb said that these principles became known as the Declaration of Helsinki, and during this General Assembly, the WMA was poised to adopt an updated version of the Declaration. Drawing from his perspective in international relations, he remarked that we are living in a time that demands greater multilateral cooperation and compromise, yet many nations are stepping back from such a course. He highlighted that the medical

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profession is a prime example of how international collaboration can foster agreement on shared principles and establish frameworks that benefit everyone.

Mr. Stubb pointed out that trust in physicians ranks consistently high worldwide, including in Finland, which he attributed this to the core mission of the medical profession: to improve and save lives. He described this vocation as one of the most noble professions a person can pursue. He concluded by wishing attendees a successful meeting, wise decisions, and a bright future for the medical profession, adding that he deeply admires their work.

Then, Dr. Riku Metsälä, a junior doctor from Finland, led the General Assembly in reciting the Declaration of Geneva: The Physician's Pledge in Finnish, as it was displayed on the screen in the three official WMA languages.

Prof. Jung Yul Park, Chair of Council, said that he was privileged to pay tribute to Dr. Lujain Alqodmani as the 74th President of the WMA, who has presided with great distinction over the affairs of the WMA for the past year. He stated that there were many highlights during the period of her Presidency, and that Dr. Alqodmani has shown passion and enthusiasm as well as whole-hearted empathy and sympathy, coupled with tireless commitment and dedication. Prof. Park noted that this leadership has provided much inspiration and insight to WMA members and to the medical profession worldwide. He paid tribute to Dr. Alqodmani, mentioning her ability to keep perfect balance between the position of WMA President with many tasks at hand. As the mother of a small daughter, with an ever-supportive husband, she has managed to successfully finish her WMA Presidency with very important and memorable achievements.

In her Valedictory Address, the outgoing WMA President, Dr. Lujain Alqodmani, highlighted the immense challenges that physicians face, citing international conflicts, climate change, economic crises, and violations of human rights. She stated that this year, healthcare has faced immense dangers, with over 980 attacks reported by the WHO surveillance system in conflict areas such as Lebanon, Ukraine, Sudan, and Gaza. Doctors from Kenya to Korea, the United Kingdom to India, are taking to the streets to demand safer working environments. Dr. Alqodmani noted that these are not isolated incidents; they are cries for systemic change, for respect, and for their right to serve their moral duty.

Dr. Alqodmani spoke about the role of WMA to foster international collaboration to advance progress to attain the sustainable development goals (SDGs), particularly universal health coverage, ensuring that health remains a right, not a privilege. She said that as physicians, our duty is not just to our patients, but also to the health and well-being of all. She added that no matter how bleak the world may seem, we must not lose our passion for this duty.

On a personal note, Dr. Alqodmani said that as only the fifth woman to be elected President of the WMA in 77 years, she was deeply aware of the honour and the responsibility of representing so many others who still lack a seat at the table. Balancing duties as a mother and as WMA President was not always easy, she said, adding that these challenges only strengthened her resolve to create a more inclusive and equitable environment.

Following Dr. Alqodmani's address, Prof. Park presented her with the Past President's medal, which entitles her to lifetime membership in the WMA, with all the rights and privileges afforded by the WMA Bylaws.

Prof. Jung Yul Park invited Dr. Ashok Philip to the rostrum. Dr. Philip took the oath of office and was installed as the 75th President of the WMA. In his Inaugural Address as the new President, Dr. Ashok Philip highlighted the necessity of the medical profession to stay actively engaged in the evolution of healthcare delivery and health systems, to ensure the best outcomes for patients and to safeguard professional autonomy. He explained that while policy and planning could be seen as be tedious work and "take us away from direct patient care, but in the long term, it protects our patients, and that is what we have sworn to do." He detailed threats to the professional autonomy of physicians, which have been exacerbated by increasing healthcare costs as life expectancy increases.

Continuing, Dr. Philip stressed the importance of guidelines, independent of purely financial considerations, to decide how patients are treated, and said that these guidelines must be developed by physicians. He added that steps towards removing or excluding physicians from healthcare delivery teams, ostensibly to handle shortages of medical professionals, but as cost-cutting measures, must be resisted. In conclusion, Dr. Philip called on medical professionals to lead the way to a better future for patients, communities, and the profession.

The Ceremonial Session then adjourned.

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Saturday, 19 October

General Assembly Plenary Session

The Plenary Session of the 2024 General Assembly was called to order by the Chair of Council, Prof. Jung Yul Park.

The Declaration of Helsinki: Development of the Current Proposed Revisions

Dr. Jack Resneck Jr., Chair of Workgroup on the Declaration of Helsinki, explained the key highlights in the proposed revision of the Declaration of Helsinki to the Assembly and thanked those who contributed to this 30-month revision process.

Report of the Credentials Committee

The Chair invited Dr. Carlos Serano (Brazilian Medical Association), Chair of the Credentials Committee, to deliver the report of the Credentials Committee. The other members of the Credentials Committee were Dr. Wonchat Subhachaturas (Medical Association of Thailand) and Dr. Philip Cathala (Conseil National de l'Ordre des Médecins).

The Committee reported that 46 WMA Constituent Members were duly registered and recognised. Of these, 45 Constituent Members present at the Assembly were in good standing and entitled to full voting rights. The total number of votes for those constituent members registered as Assembly delegations was 127.

Approval of the Minutes of the 2023 WMA General Assembly, Kigali, Rwanda

The General Assembly approved the minutes of the 2023 WMA General Assembly held in Kigali, Rwanda, from 4-7 October 2023.

Election

The Secretary General informed the General Assembly that two candidates had been nominated for President. These candidates were Dr. Jaqueline Kitulu (Kenyan Medical Association) and Prof. Alberto Caldas Afonso (Ordem dos Médicos). The election was carried out by paper ballot following the two candidate's speeches. A total of 43 Constituent Members cast votes out of 45 eligible Constituent Members. Dr. Kitulu was elected with a majority of votes (100 out of 125 votes). The Secretary General and Chair thanked both candidates and congratulated Dr. Kitulu on being elected to serve as WMA President in 2025-2026. She will take up the post at the General Assembly in Porto, Portugal, in October 2025.

In her acceptance speech, Dr. Kitulu said that she was filled with immense gratitude and humility, and that this moment symbolised the collective power of collaboration, dedication, and shared vision within the global medical community. She presented heartfelt thanks to the delegates from the General Assembly, regional caucuses, and NMAs for their confidence. Dr. Kitulu confirmed that she was committed to fostering inter-regional collaboration and gave her support to mentorship and capacity-building for junior physicians through the JDN and NMAs. She also reaffirmed her dedication to global policy advocacy for robust primary healthcare systems. She said that she was deeply honoured to serve as President and pledged to lead with transparency, compassion, and unwavering commitment to the principles of medical ethics and health equality.

Report of the Council to the General Assembly

The Chair reviewed the process for proceeding through the Report of the Council to the WMA General Assembly, explaining that action items for the General Assembly were contained in the Action Items document, which had been finalised during the Council meeting. Then, the Chair informed participants of the importance of adhering to the WMA Bylaws with its rules and procedures. He reiterated that he would begin each agenda point by asking if there was any opposition. In the absence of opposition, he would consider the point as having been accepted unanimously.

Action Items for the General Assembly

Council

The following documents were adopted:

- Council Resolution on Anti-LGBTQ Legislation as a WMA Resolution
- Council Resolution on Organ Donation in Prisoners as a WMA Resolution
- Council Resolution on the Protection of Healthcare in Israel and Gaza as a WMA Resolution
- WMA Resolution on Plastics and Health

Medical Ethics Committee

The following documents were adopted:

- WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human

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Participants, as amended with one editorial error correction on paragraph 19

- WMA Declaration on the Ethical Use of Medical Technology, renamed to the 'WMA Declaration of Kigali'
- WMA Statement on Assisted Reproductive Technologies

The following document was sent to the Assembly for information

- WMA Guidelines on Promotional Mass Media Appearance by Physicians

Socio-Medical Affairs Committee

The following documents were adopted:

- WMA Declaration on Prevention and Reduction of Air Pollution to Improve Air Quality
- The revision of the WMA Statement on Human Papillomavirus Vaccination
- The revision of the WMA Statement on Epidemics and Pandemics

The following documents were presented to the Assembly for information

- WMA Resolution in Support of an International Day of the Medical Profession, October 30
- The minor revision of the WMA Statement on Adolescent Suicide
- The minor revision of the WMA Declaration of Hong Kong on the Abuse of the Elderly, renamed Declaration of Hong Kong on the Abuse of Older People
- The minor revision of the WMA Resolution in support of the Turkish Medical Association
- The minor revision of the WMA Resolution on the Revocation of WHO Guidelines on Opioid Use
- The minor revision of the WMA Statement on Non-Discrimination in Professional Membership

Report of the Council

Report of the Treasurer

WMA Treasurer, Mr. Rudolf Henke, presented a report on the financial results for 2023 and the budget for 2025. He reported that the WMA finished 2023 with a solid surplus, and that expenses were well-regulated, monitored, and controlled. The Audited Financial Statement for the year ending 31 December 2023 was adopted.

Finance and Planning Committee

The following items were adopted:

WMA Statutory Meetings

- The proposal that the 79th General Assembly in 2028 will be held from 18-21 October 2028.
- The theme, "The Impact of Artificial Intelligence on Medical Practice", as amended, was selected for the Scientific Session at the General Assembly in Porto, Portugal, in October 2025.

Constituent Membership

- The waiver of the membership dues of the Myanmar Medical Association (MMA) and the Ukraine Medical Association (UMA) for the year 2024
- The increase of membership dues rates for all categories over a three-year term, i.e. increase in 2025 by 2.5%, then in 2026 by 2.5% and in 2027 by 2.5%
- The Hungarian Medical Chamber (HMC) was admitted to the WMA Constituent Membership. The General Assembly welcomed the HMC with applause, and Dr. Péter Álmos, President of the HMC, thanked for the admission.

Rules Applicable to WMA Associate Membership

- The proposed revision of the Rules Applicable to WMA Associate Membership

The following items were presented to the Assembly for information

WMA Statutory Meetings

- The Council informed the General Assembly that the date for the 238th Council Session in 2028 is 27-29 April 2028.
- The Council informed the General Assembly that the invitation from the Pakistan Medical Association (PkMA) for Karachi, Pakistan. to host the 235th Council Session in 2026 was declined, because Pakistan does not issue visas to one of the countries represented in the WMA Council, according to the questionnaire responses provided by the Pakistan Medical Association.

Membership Dues, Categories

- The WMA Dues Categories 2025
- The Report on Membership Dues Payments for 2024

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WMA Procedures and Operating Policies

- The Council informed the General Assembly that the proposed revision of WMA Procedures and Operating Policies to include a Code of Conduct during WMA meetings was approved.

Council Report

The General Assembly adopted the Council Report in its entirety.

Report of WMA External Activities and International Policy

Dr. Caline Mattar, Dr. Julia Tainijoki, Dr. Yassen Tcholakov, and Dr. Lujain Alqodmani presented the WMA external activities on antimicrobial resistance, human resources for health, non-communicable diseases, pandemic preparedness, the Intergovernmental Negotiating Body (INB), and WHO Civil Society Commission. Members were encouraged to contact the WMA Secretariat for any questions or future collaboration.

Report of the 2024 Associate Members Meeting

Dr. Jacques de Haller, the Chair of Associate Membership, delivered a report on the Associate Members meeting. The General Assembly approved the Associate Members Report.

Presentations from International Organisations

Dr. Christian Keijzer, President of the Standing Committee of European Doctors (CPME), gave a presentation which focused on how CPME represents the medical profession's point of view to European health policymaking through proactive cooperation. Dr. Keijzer explained that the CPME brings the voice of European doctors to the European Union´s health policy.

Dr. Catharina Boehme, Assistant Director-General for External Relations and Governance of the WHO, said that it was an honour and pleasure to address the General Assembly and be present for the adoption of the revised Declaration of Helsinki. In terms of the WHO, she said that the meaning that the Declaration of Helsinki has brought over the years cannot be overstated. In her presentation, Dr. Boehme spoke of WHO's work on the global health agenda, and she outlined future priorities, including strengthening and protecting the global health workforce, reinforcing global health security, and strengthening pandemic preparedness.

Dr. Kati Juva, Co-President of the International Physicians for the Prevention of Nuclear War (IPPNW), and Ms. Stella Ziegler, medical student and International and German Student Representative, shared information about the history and work of IPPNW. They highlighted how physicians have an important role to play in the prevention of nuclear war and its devasting effects, as there is still much to be achieved.

Dr. John de Jong, President of the World Veterinary Association (WVA), gave his presentation that introduced the WVA's activities during the 227th Council Session on 18 October, due to his travel plans.

Open Session

Dr. Péter Álmos, President of the Hungarian Medical Chamber, explained the current challenging situation in Hungary, in regards to physicians' autonomy and self-governance. He reported that the Hungarian Government had cancelled the obligatory membership of Physicians to the Chamber and stripped the Chamber of Physicians of its role as supervising and regulating body. Fortunately, the Chamber was able to retain the majority of members on a voluntary basis. The Secretary General responded that a similar attack on physician self-governance has recently been seen in Albania.

Dr. Sanjeeb Tiwari, General Secretary of the Nepal Medical Association, gave a short presentation entitled, "Recent Floods in Nepal Response and Relief". He explained how the Nepal Medical Association had been instrumental in flood relief actions following the serious flooding that occurred from late September to early October 2024.

Dr. José Harmon Huerta, Spanish Medical Association (CGCOM), thanked the Assembly for reaffirming the WMA Resolution in Support of an International Day of the Medical Profession, adopted in October 2020, to recognise October 30 as the International Day of the Medical Profession. He expressed that this day demonstrates a tribute to the commitment of physicians to the service of humankind, to the health and well-being of their patients, in the respect the ethical values of the profession. The CGCOM plans to celebrate this International Day through a series of press conferences and media activities. Dr. Huerta encouraged all WMA members to celebrate the International Day of the Medical Profession, so that it can become internationally recognised.

Dr. Latifa Patel, Chair of the representative body of the British Medical Association, thanked the

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WMA for organising the strategic planning session on 17 October, giving members the opportunity to engage in the planning process. She requested that the Association consider holding the WMA meetings in a hybrid format so that they are more inclusive and so that more members who cannot travel can participate. Dr. Patel offered to share the BMA's experience and expertise on the technical challenges of hybrid meetings. The Chair of Council acknowledged Dr. Patel's request, which was supported by other members, and he will bring it to the ExCo's further consideration and try to find a possible solution within WMA's capacity.

Any Other Business

Dr. René Héman, President of the Royal Dutch Medical Association (RDMA), shared that the RDMA is hosting the CPME meeting in Amsterdam on 7-9 November 2024, including the Conference on the European Doctor and Digital Health. He also welcomed the members' participation to celebrate RDMA´s 175th anniversary. He stated that, as the 172nd President of RDMA, he has attended the WMA meetings for the last nine years, and that this meeting would be his last one, thanking all WMA members for their support and cooperation. The Chair of Council expressed his gratitude, on behalf of the WMA members, to Dr. Héman for his contributions to the WMA.

The Ordem dos Médicos shared a video in anticipation of the 76th General Assembly, which will be held in October 2025 in Porto, Portugal.

Adjournment

The Chair of Council thanked all members for their active engagement. He also expressed thanks to the Finnish Medical Association, the Secretary General, and the WMA Secretariat staff for their tireless efforts to make this General Assembly such a success.

The Secretary General continued, thanking the Finnish Medical Association and its president, Dr. Niina Koivuviita, CEO Dr. Janne Aaltonen, Ms. Mervi Kattelus, Ms. Riikka Rahkonen, and other staff members for hosting this General Assembly. He expressed his special thanks to Ms. Ana Rodrigues and Ms. Carla Febrónio, seconded by the Portuguese Medical Association, the host of the General Assembly next year. He thanked other guests from partner organisations for their attendance and contributions on the Declaration of Helsinki revision process. He recognised the valuable contributions of WMA delegates and officers, speakers of the Scientific Session, WMA officers, Associate Members (including past presidents and the JDN), Dr. Rudolf Henke (WMA Treasurer), Mr. Adi Hällmayr (WMA Financial Advisor), Ms. Mervi Kattelus (WMA Legal Advisor), Ms. Michelle Glekin (facilitator), Ms. Janice Blondeau (Communications and Media Consultant), interpreters, and the entire WMA staff.

228th Council Session

The meeting was called to order by the Chair of Council, and as there was no business arising from the General Assembly and no other business, the meeting was adjourned.

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Photo 1. Group photo during the 77th General Assembly in Helsinki. Credit: WMA

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WMA DECLARATION OF HELSINKI – ETHICAL PRINCIPLES FOR MEDICAL RESEARCH INVOLVING HUMAN PARTICIPANTS

Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964 and amended by the:

29th WMA General Assembly, Tokyo, Japan, October 1975

35th WMA General Assembly, Venice, Italy, October 1983

41st WMA General Assembly, Hong Kong, September 1989

48th WMA General Assembly, Somerset West, Republic of South Africa, October 1996

52nd WMA General Assembly, Edinburgh, Scotland, October 2000

53rd WMA General Assembly, Washington DC, USA, October 2002 (Note of Clarification added)

55th WMA General Assembly, Tokyo, Japan, October 2004 (Note of Clarification added)

59th WMA General Assembly, Seoul, Republic of Korea, October 2008

64th WMA General Assembly, Fortaleza, Brazil, October 2013 and by the 75th WMA General Assembly, Helsinki, Finland, October 2024

PREAMBLE

1. The World Medical Association (WMA) has developed the Declaration of Helsinki as a statement of ethical principles for medical research involving human participants, including research using identifiable human material or data.

   The Declaration is intended to be read as a whole, and each of its constituent paragraphs should be applied with consideration of all other relevant paragraphs.

2. While the Declaration is adopted by physicians, the WMA holds that these principles should be upheld by all individuals, teams, and organizations involved in medical research, as these principles are fundamental to respect for and protection of all research participants, including both patients and healthy volunteers.

GENERAL PRINCIPLES

3. The WMA Declaration of Geneva binds the physician with the words, "The health and well-being of my patient will be my first consideration," and the WMA International Code of Medical Ethics declares "The physician must commit to the primacy of patient health and well-being and must offer care in the patient's best interest."

4. It is the duty of the physician to promote and safeguard the health, well-being and rights of patients, including those who are involved in medical research. The physician's knowledge and conscience are dedicated to the fulfilment of this duty.

5. Medical progress is based on research that ultimately must include participants.

   Even well-proven interventions should be evaluated continually through research for their safety, effectiveness, efficiency, accessibility, and quality.

6. Medical research involving human participants is subject to ethical standards that promote and ensure respect for all participants and protect their health and rights.

   Since medical research takes place in the context of various structural inequities, researchers should carefully consider how the benefits, risks, and burdens are distributed.

   Meaningful engagement with potential and enrolled participants and their communities should occur before, during, and following medical research. Researchers should enable potential and enrolled participants and their communities to share their priorities and values; to participate in research design, implementation, and other relevant activities; and to engage in understanding and disseminating results.

7. The primary purpose of medical research involving human participants is to generate knowledge to understand the causes, development and effects of diseases; improve preventive, diagnostic and therapeutic interventions; and ultimately to advance individual and public health.

   These purposes can never take precedence over the rights and interests of individual research participants.

8. While new knowledge and interventions may be urgently needed during public health emergencies, it remains essential to uphold the ethical principles in this Declaration during such emergencies.

9. It is the duty of physicians who are involved in medical research to protect the life, health, dignity, integrity, autonomy, privacy, and confidentiality of personal information of research participants. The responsibility for the protection of research participants must always rest with physicians or other researchers and never with the research participants, even though they have given consent.

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10. Physicians and other researchers must consider the ethical, legal and regulatory norms and standards for research involving human participants in the country or countries in which the research originated and where it is to be performed, as well as applicable international norms and standards. No national or international ethical, legal or regulatory requirement should reduce or eliminate any of the protections for research participants set forth in this Declaration.

11. Medical research should be designed and conducted in a manner that avoids or minimizes harm to the environment and strives for environmental sustainability.

12. Medical research involving human participants must be conducted only by individuals with the appropriate ethics and scientific education, training and qualifications. Such research requires the supervision of a competent and appropriately qualified physician or other researcher.

    Scientific integrity is essential in the conduct of medical research involving human participants. Involved individuals, teams, and organizations must never engage in research misconduct.

13. Groups that are underrepresented in medical research should be provided appropriate access to participation in research.

14. Physicians who combine medical research with medical care should involve their patients in research only to the extent that this is justified by its potential preventive, diagnostic or therapeutic value and if the physician has good reason to believe that participation in the research will not adversely affect the health of the patients who serve as research participants.

15. Appropriate compensation and treatment for participants who are harmed as a result of participating in research must be ensured.

Risks, Burdens, and Benefits

16. In medical practice and in medical research, most interventions involve risks and burdens.

    Medical research involving human participants may only be conducted if the importance of the objective outweighs the risks and burdens to the research participants.

17. All medical research involving human participants must be preceded by careful assessment of predictable risks and burdens to the individuals and groups involved in the research in comparison with foreseeable benefits to them and to other individuals or groups affected by the condition under investigation.

    Measures to minimize the risks and burdens must be implemented. The risks and burdens must be continuously monitored, assessed, and documented by the researcher.

18. Physicians and other researchers may not engage in research involving human participants unless they are confident that the risks and burdens have been adequately assessed and can be satisfactorily managed.

    When the risks and burdens are found to outweigh the potential benefits or when there is conclusive proof of definitive outcomes, physicians and other researchers must assess whether to continue, modify or immediately stop the research.

Individual, Group, and Community Vulnerability

19. Some individuals, groups, and communities are in a situation of more vulnerability as research participants due to factors that may be fixed or contextual and dynamic, and thus are at greater risk of being wronged or incurring harm. When such individuals, groups, and communities have distinctive health needs, their exclusion from medical research can potentially perpetuate or exacerbate their disparities. Therefore, the harms of exclusion must be considered and weighed against the harms of inclusion. In order to be fairly and responsibly included in research, they should receive specifically considered support and protections.

20. Medical research with individuals, groups, or communities in situations of particular vulnerability is only justified if it is responsive to their health needs and priorities and the individual, group, or community stands to benefit from the resulting knowledge, practices, or interventions. Researchers should only include those in situations of particular vulnerability when the research cannot be carried out in a less vulnerable group or community, or when excluding them would perpetuate or exacerbate their disparities.

Scientific Requirements and Research Protocols

21. Medical research involving human participants must have a scientifically sound and rigorous design and execution that are likely to produce reliable, valid, and valuable knowledge and avoid research waste. The research must conform to generally accepted scientific principles, be based on a thorough knowledge of the scientific literature, other relevant sources of information, and adequate laboratory and, as appropriate, animal experimentation.

    The welfare of animals used for research must be respected.

22. The design and performance of all medical research involving human participants must be clearly described and justified in a research protocol.

    The protocol should contain a statement of the ethical considerations involved

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and should indicate how the principles in this Declaration have been addressed. The protocol should include information regarding aims, methods, anticipated benefits and potential risks and burdens, qualifications of the researcher, sources of funding, any potential conflicts of interest, provisions to protect privacy and confidentiality, incentives for participants, provisions for treating and/or compensating participants who are harmed as a consequence of participation, and any other relevant aspects of the research.

In clinical trials, the protocol must also describe any post-trial provisions.

Research Ethics Committees

23. The protocol must be submitted for consideration, comment, guidance, and approval to the concerned research ethics committee before the research begins. This committee must be transparent in its functioning and must have the independence and authority to resist undue influence from the researcher, the sponsor, or others. The committee must have sufficient resources to fulfill its duties, and its members and staff must collectively have adequate education, training, qualifications, and diversity to effectively evaluate each type of research it reviews.

    The committee must have sufficient familiarity with local circumstances and context, and include at least one member of the general public. It must take into consideration the ethical, legal, and regulatory norms and standards of the country or countries in which the research is to be performed as well as applicable international norms and standards, but these must not be allowed to reduce or eliminate any of the protections for research participants set forth in this Declaration.

    When collaborative research is performed internationally, the research protocol must be approved by research ethics committees in both the sponsoring and host countries.

    The committee must have the right to monitor, recommend changes to, withdraw approval for, and suspend ongoing research. Where monitoring is required, the researcher must provide information to the committee and/or competent data and safety monitoring entity, especially about any serious adverse events. No amendment to the protocol may be made without consideration and approval by the committee. After the end of the research, the researchers must submit a final report to the committee containing a summary of the findings and conclusions.

Privacy and Confidentiality

24. Every precaution must be taken to protect the privacy of research participants and the confidentiality of their personal information.

Free and Informed Consent

25. Free and informed consent is an essential component of respect for individual autonomy. Participation by individuals capable of giving informed consent in medical research must be voluntary. Although it may be appropriate to consult family members or community representatives, individuals capable of giving informed consent may not be enrolled in research unless they freely agree.

26. In medical research involving human participants capable of giving informed consent, each potential participant must be adequately informed in plain language of the aims, methods, anticipated benefits and potential risks and burdens, qualifications of the researcher, sources of funding, any potential conflicts of interest, provisions to protect privacy and confidentiality, incentives for participants, provisions for treating and/or compensating participants who are harmed as a consequence of participation, and any other relevant aspects of the research.

    The potential participant must be informed of the right to refuse to participate in the research or to withdraw consent to participate at any time without reprisal. Special attention should be given to the specific information and communication needs of individual potential participants as well as to the methods used to deliver the information.

    After ensuring that the potential participant has understood the information, the physician or another qualified individual must then seek the potential participant's freely given informed consent, formally documented on paper or electronically. If the consent cannot be expressed on paper or electronically, the non-written consent must be formally witnessed and documented.

    All medical research participants should be given the option of being informed about the general outcome and results of the research.

27. When seeking informed consent for participation in research the physician or other researcher must be particularly cautious if the potential participant is in a dependent relationship with them or may consent under duress. In such situations, the informed consent must be sought by an appropriately qualified individual who is independent of this relationship.

28. In medical research involving human participants incapable of giving free and informed consent, the physician or other qualified individual must seek informed consent from the legally authorized representative, considering preferences and values expressed by the potential participant.

    Those persons incapable of giving free

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and informed consent are in situations of particular vulnerability and are entitled to the corresponding safeguards. In addition to receiving the protections for the particularly vulnerable, those incapable of giving consent must only be included if the research is likely to either personally benefit them or if it entails only minimal risk and minimal burden.

29. When a potential research participant who is incapable of giving free and informed consent is able to give assent to decisions about participation in research, the physician or other qualified individual must seek that assent in addition to the consent of the legally authorized representative, considering any preferences and values expressed by the potential participant. The potential participant's dissent should be respected.

30. Research involving participants who are physically or mentally incapable of giving consent (for example, unconscious patients) may be done only if the physical or mental condition that prevents giving informed consent is a necessary characteristic of the research group. In such circumstances the physician or other qualified individual must seek informed consent from the legally authorized representative. If no such representative is available and if the research cannot be delayed, the research may proceed without informed consent provided that the specific reasons for involving participants with a condition that renders them unable to give informed consent have been stated in the research protocol and the research has been approved by a research ethics committee.

    Free and informed consent to remain in the research must be obtained as soon as possible from a legally authorized representative or, if they regain capacity to give consent, from the participant.

31. The physician or other researcher must fully inform potential participants which aspects of their care are related to the research. The refusal of a patient to participate in research or the patient's decision to withdraw from research must never adversely affect the patient-physician relationship or provision of the standard of care.

32. Physicians or other qualified individuals must obtain free and informed consent from research participants for the collection, processing, storage, and foreseeable secondary use of biological material and identifiable or re-identifiable data. Any collection and storage of data or biological material from research participants for multiple and indefinite uses should be consistent with requirements set forth in the WMA Declaration of Taipei, including the rights of individuals and the principles of governance. A research ethics committee must approve the establishment and monitor ongoing use of such databases and biobanks.

    Where consent is impossible or impracticable to obtain, secondary research on stored data or biological material may be done only after consideration and approval of a research ethics committee.

Use of Placebo

33. The benefits, risks, burdens, and effectiveness of a new intervention must be tested against those of the best proven intervention(s), except in the following circumstances:

- If no proven intervention exists, the use of placebo, or no intervention, is acceptable; or

- If for compelling and scientifically sound methodological reasons the use of any intervention other than the best proven one(s), the use of placebo, or no intervention is necessary to determine the efficacy or safety of an intervention; and the participants who receive any intervention other than the best proven one(s), placebo, or no intervention will not be subject to additional risks of serious or irreversible harm as a result of not receiving the best proven intervention.

    Extreme care must be taken to avoid abuse of this option.

Post-Trial Provisions

34. In advance of a clinical trial, post-trial provisions must be arranged by sponsors and researchers to be provided by themselves, healthcare systems, or governments for all participants who still need an intervention identified as beneficial and reasonably safe in the trial. Exceptions to this requirement must be approved by a research ethics committee. Specific information about post-trial provisions must be disclosed to participants as part of informed consent.

Research Registration, Publication, and Dissemination of Results

35. Medical research involving human participants must be registered in a publicly accessible database before recruitment of the first participant.

36. Researchers, authors, sponsors, editors, and publishers all have ethical obligations with regard to the publication and dissemination of the results of research. Researchers have a duty to make publicly available the results of their research on human participants and are accountable for the timeliness, completeness, and accuracy of their reports. All parties should adhere to accepted guidelines for ethical reporting. Negative and inconclusive as well as positive results must be published or otherwise made publicly available. Sources of funding, institutional affiliations, and conflicts of interest must be declared in the publication. Reports of research not in accordance with the principles of this Declaration should not be accepted for publication.

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Unproven Interventions in Clinical Practice

37. When an unproven intervention is utilized in an attempt to restore health or alleviate suffering for an individual patient because approved options are inadequate or ineffective and enrollment in a clinical trial is not possible, it should subsequently be made the object of research designed to evaluate safety and efficacy. Physicians participating in such interventions must first seek expert advice, weigh possible risks, burdens, and benefits, and obtain informed consent. They must also record and share data when appropriate and avoid compromising clinical trials. These interventions must never be undertaken to circumvent the protections for research participants set forth in this Declaration.

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WMA RESOLUTION ON ANTI-LGBTQ LEGISLATION

Adopted by the 223rd WMA Council Session, Nairobi, Kenya, April 2023

Revised and adopted by the 74th WMA General Assembly, Kigali, Rwanda, October 2023

Revised as Council Resolution by the 226th WMA Council Session, Seoul, Korea, April 2024 and adopted by the 75th WMA General Assembly, Helsinki, Finland, October 2024

PREAMBLE

The WMA is gravely concerned about the "Anti-Homosexuality law" that was passed in the Ugandan parliament on March 21, 2023, and signed into law by Ugandan President Yoweri Museveni in May 2023. The WMA originally condemned the bill in a press release issued on March 24, 2023.

While the Uganda Constitutional Court did strike down sections of the law that restricted healthcare access for LGBT people, criminalised renting premises to LGBT people, and an obligation to report alleged acts of homosexuality, on April 3, 2024, the court upheld the abusive and radical provisions of the Anti-Homosexuality Act, including sections which criminalise certain consensual same-sex acts and makes them punishable by death or life imprisonment. A provision on the "promotion" of homosexuality is also of grave concern, exposing anyone who "knowingly promotes homosexuality" to as much as twenty years in prison.

Similarly, an "Anti-Gay" bill was passed by the parliament of Ghana on February 28, 2024. The bill has its origins in British colonial law which criminalizes "unnatural sex", and broadens the scope of criminal sanctions against lesbian, gay, bisexual, transgender, transsexual, and pansexual people, including their allies.

The so-called "Human Sexual Rights and Family Values" bill also allows for criminalizing medical professionals' work. The bill prohibits the provision of or participation in the provision of surgical procedures for sex or gender reassignment, as punishable by fines or imprisonment. Distribution and other broadcast of any information that promote activities that are prohibited under bill, including teaching children any gender or sex beyond male and female, could result in 10 years imprisonment. The bill would also require anyone with knowledge of prohibited activities to report these activities to the police or other authorities.

In July 2024, the Ghana Supreme Court upheld the bill. Ugandan President Nana Akufo-Addo has not yet signed the bill into law.

Similar troubling legislation and laws have arisen in countries including but not limited to Georgia, the United States, Bulgaria and Iraq.

These kinds of laws and bills challenge the role of physicians to objectively provide information to patients and, where appropriate, those close to them. Physicians could face disciplinary action or retribution for pointing out in the context of treatment that homosexuality is a natural variation of human sexuality. This can impact the professional practice of a physician, as can be seen in other countries that have implemented similar legislation. It can also impact the health of individuals and the population as a whole if patients of the LGBTQ+ community are fearful of accessing healthcare or of being forthcoming with information when they require medical care.

As stated in its Statement on Natural Variations of Human Sexuality and supported in its Statement on Transgender People, the WMA condemns all forms of stigmatisation, criminalization of and discrimination against people based on their sexual orientation.

The WMA reasserts that being lesbian, gay, or bisexual are natural variations within the range of human sexuality and that discrimination, both interpersonally and at the institutional level, anti-homosexual or anti-bisexual legislation and human rights violations, stigmatisation, criminalization of same-sex partnerships, peer rejection and bullying continue to have a serious impact upon the psychological and physical health of lesbian, gay or bisexual people.

Further, the WMA emphasises that everyone has the right to determine one's own gender, recognises the diversity of possibilities in this respect and calls for appropriate legal measures to protect the equal civil rights of transgender people.

RECOMMENDATIONS

Therefore, the WMA, reaffirming its statements on Natural Variations of Human Sexuality and Transgender People, calls on:

Ugandan authorities to immediately repeal the Anti-Homosexuality law in its entirety;

Ghanaian authorities to immediately veto or rescind the Human Sexual Rights and Family Values bill; and

WMA Constituent members to condemn the Ugandan law and Ghanaian bill, and advocate against any similar legislation that is proposed or enacted.

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WMA RESOLUTION ON PLASTICS AND HEALTH

Adopted by the 75th WMA General Assembly, Helsinki, Finland, October 2024

PREAMBLE

Plastic poses an ongoing challenge to human and planetary health, which will inevitably worsen unless coordinated global action is taken. Global production of plastics has grown to 400 million metric tons in 2022 and is projected to quadruple by 2050. In 2019, global plastics production released 1.8 billion tons of greenhouse gases and 22 million tons of plastic solids into the environment.

Plastics are used in all aspects of healthcare, and there has been a dramatic shift towards single-use items in recent decades.

Referring to the WMA Statement on Environmental Degradation and Sound Management of Chemicals, which also deals with plastic waste leading to environmental degradation and potentially harmful effects on health, it is important to consider the potential health impacts at every stage of the plastic life cycle.

RECOMMENDATION

The World Medical Association urges countries, and especially those present at the fifth session of the Intergovernmental Negotiating Committee (INC-5), to commit to a just Plastic Treaty to end plastic pollution, address the impacts of plastics on human and planetary health and consider the role of plastic products in the health sector.

WMA DECLARATION ON PREVENTION AND REDUCTION OF AIR POLLUTION TO IMPROVE AIR QUALITY

Adopted by the 75th WMA General Assembly, Helsinki, Finland, October 2024

PREAMBLE

The impact of air pollution on health – especially among vulnerable populations – necessitates targeted guidelines for healthcare professionals. By recognising air pollution's unique characteristics, this declaration aims to advocate for better health, foster cross-border collaboration, and reinforce the connection between environmental quality and human well-being.

Air pollution and its impact on health

Air pollution poses a major global environmental risk to human health, contributing significantly to avoidable morbidity and mortality worldwide. 8.1 million premature deaths occur each year due to the combined effects of ambient and household air pollution.

Air pollutants are a leading risk factor for the burden of non-communicable diseases, leading to stroke, myocardial infarctions, lung cancer as well as chronic respiratory illnesses. It also increases the risk of childhood asthma and asthma severity.

Air pollutants are a diverse range of harmful substances that contaminate the air we breathe. These include gases such as sulphur dioxide, nitrogen oxides, carbon monoxide, methane, and volatile organic compounds, as well as particulate matter like smoke, soot (black carbon), and fine dust.

In 2022, WHO estimated that 99% of the global population was exposed to air pollution concentrations that exceeded WHO's air quality limits.

While no region of the world has been spared, low and middle-income countries bear the largest burden of premature mortality associated with air pollution.

Without implementation of aggressive interventions, the number of premature deaths caused by ambient air pollution is projected to rise by over 50% by the year 2050.

The sources of air pollution

Fossil fuel combustion, petrol- and diesel-powered vehicle emissions have been highlighted as the major contributor to air pollution-related mortalities, particularly in urban areas.

Diesel soot is a proven carcinogen with toxic effects on cardiovascular and respiratory systems.

Household air pollution, caused largely by open cooking fires and inefficient stoves, is a leading risk factor for childhood mortality, contributing to approximately 50% of deaths from acute lower respiratory infections, including pneumonia, in

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children under the age of five.

Beyond traditional airborne pollutants, biological air pollution – airborne pathogens such as bacteria, viruses, and fungi, particularly indoors – has gained attention.

Infected individuals can contribute to such air contamination, emphasizing the need for appropriate prevention strategies and comprehensive air quality control.

Plastics contribute to air pollution directly through its open-air combustion and through microplastics carried by wind and air currents.

RECOMMENDATIONS

The WMA acknowledges the severity of consequences stemming from air pollution and urges the following stakeholders to promptly take action to achieve clean air:

The WMA and its constituent members should:

1. Engage with local, regional, and national authorities to raise public awareness about the health impacts of air pollution and the importance of its prevention.

2. Work together with governments to develop and implement strategies to improve air quality, as identified in the WHO air quality guidelines, and mitigate the effects of air pollution. These strategies should consider the local context and reflect the latest scientific evidence.

3. Advocate for and support the integration of health impacts of air pollution and its solutions into medical curricula and professional educational programs, fostering a comprehensive understanding and proactive approach among healthcare professionals.

4. Encourage collaboration between organised medicine and other stakeholders, including government agencies and international organizations, to develop best practices for minimising greenhouse gas emissions and plastic use in healthcare settings.

The WMA urges governments to:

5. Recognise that air pollution negatively impacts human health and environmental sustainability and that existing health inequities exacerbate susceptibility to environmental hazards.

6. Recognise the important role of social and environmental determinants of health and strive to include these in policy-making processes, for example by conduction of health equity impact assessments.

7. Allocate resources and funding for reducing and monitoring air quality and implement effective pollution prevention and control measures, particularly in densely populated areas, in line with WHO's air quality standards.

8. Enhance early warning systems for anticipated poor air quality periods and prepare health systems to handle air pollution-related health impacts effectively.

9. Implement measures that improve air quality, such as increasing access to clean energy and creating green spaces.

10. Take measures toward sustainable healthy transport by implementing strategies to decarbonise the transportation sector, such as enforcing stricter vehicle emission standards, promoting public transportation and implementing cycling and walking infrastructure.

11. Invest in and support research and innovation for cleaner healthcare sector technologies and practices.

12. Establish guidelines and standards for acceptable levels of biological contaminants in indoor air, including policies to reach those objectives such as by ensuring adequate ventilation and air filtration.

13. Strive towards good environmental governance by developing sustainable strategies, policies, and measures to address environmental hazards and take a precautionary principle approach to protect health.

The WMA recommends that international and intergovernmental agencies:

14. Recognise and promote access to clean, breathable air free from harmful pollutants as a basic human right for all people worldwide.

15. Work with governments to update public health policies, prioritize air pollution control and strengthen efforts in health promotion and pollution reduction.

16. Advocate for the maximum reduction of all sources of air pollution, recognising that it is critical for sustainability that anthropogenic (human) activities operate within the safe limits of the Earth's ecosystem.

17. Promote and support governments in conducting health impact assessments across relevant policy sectors, empowering them to proactively reduce exposure to air pollution and safeguard public health.

The WMA urges individual physicians to:

18. Stay informed regarding health effects of air pollution.

19. Consider air pollution as a potential environmental risk factor in relevant patient consultations and where relevant, promote lifestyle modifications and preventive measures that minimize exposure to pollutants.

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WMA RESOLUTION ON THE PROTECTION OF HEALTHCARE IN ISRAEL AND GAZA

Adopted by the 226th WMA Council session, Seoul, Korea, April 2024 and adopted by the 75th WMA General Assembly, Helsinki, Finland, October 2024

PREAMBLE

In response to the ongoing conflict in Israel and Gaza, the WMA is gravely concerned by the deepening healthcare and humanitarian crisis in Gaza, the growing starvation and the lack of medical care and deeply concerned about the continued imprisonment and abuse of hostages.

RECOMMENDATIONS

The WMA Council and its constituent members call for:

1. A bilateral, negotiated and sustainable ceasefire in order to protect all civilian life, secure the release and safe passage of all hostages and to allow the transfer of humanitarian aid for all those in need.
2. The immediate and safe release of all hostages.
3. Pending their release, humanitarian aid and healthcare attention to be provided to the hostages.
4. All parties to abide by international humanitarian law and the principle of medical neutrality to safeguard the rights and protection of healthcare facilities, healthcare personnel and patients from further threat, interference and attack.
5. Unimpeded and accelerated humanitarian access throughout all of Gaza, including the entry of humanitarian aid and safe passage of medical personnel. This also includes the evacuation of urgent medical cases to reduce secondary morbidity and mortality, public health risks, and alleviate pressure on hospitals inside Gaza.
6. The re-establishment of access to healthcare and the creation of a safe working environment for healthcare personnel to work in through the restoration of medical capacity and essential services.
7. Verified investigations into alleged gross violations and abuses of human rights and international humanitarian law including attacks on healthcare staff and facilities and the misuse of those facilities for military purposes.
8. The upholding by physicians of the principles in the WMA Declaration of Geneva and other documents that serve as guidance for medical personnel during times of conflict.

WMA STATEMENT ON EPIDEMICS AND PANDEMICS

Adopted by the 68th General Assembly, Chicago, October 2017 and revised by the 75th WMA General Assembly, Helsinki, Finland, October 2024

PREAMBLE

History demonstrates that new diseases will emerge, and old diseases re-emerge unpredictably and pose significant threats to global health.

Epidemics and pandemics highlight deep-rooted inequalities, hitting less-resourced regions hardest due to their constrained resources, fragile health systems, and significant disease burdens. The common but differentiated responsibilities (CBDR) principle can be applied to pandemic prevention, preparedness and response (PPPR) in order to bring equity and justice in cooperation between states.

The accelerating pace of epidemic-prone diseases, compounded by the repercussions of geopolitical conflicts, environmental degradation, climate change, increased human encroachment into natural ecosystems, antimicrobial resistance, widening socio-economic disparities, global travel, and the intrinsic link between the health of humans, animals, and our shared environment, underscores the vulnerability of global health security.

Integrating the One Health approach acknowledges the critical interdependence of all living organisms and their habitats, essential for understanding the emergence and spread of diseases and highlighting the need for a multisectoral, interdisciplinary and evidence-based approach to global health threats.

Robust and effective global surveillance is pivotal for improving the prevention and response to infectious diseases, enabling earlier detection and identification of emergent threats. The rapid spread of epidemics and pandemics in regions with underfunded and underdeveloped public health infrastructures highlights the urgent

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need for a global cooperative framework. Such a framework must prioritise the development of resilient health systems capable of withstanding the challenges posed by infectious diseases, thereby safeguarding the health and well-being of populations worldwide.

An investment in strengthening public health, primary care and other aspects of health systems is crucial for enhancing the capacity to prevent, detect, contain, and manage disease outbreaks, laying a solid foundation for core public health functions essential.

Particular attention should be paid to individuals in fragile, conflict-affected, and vulnerable settings; additionally other individual vulnerabilities factors should also be addressed including but not limited to disability, age, gender, indigeneity, ethnicity, etc..

RECOMMENDATIONS

The WMA calls on the following stakeholders to:

WHO and United Nations

1. *Global Pandemic Infrastructure:* Strengthen global infrastructure for preventing, monitoring, and responding to pandemics under the leadership of the World Health Organization (WHO). Ensure that this bolsters WHO's pivotal role in leading international health efforts, while fostering a comprehensive commitment across all levels of government and society.

2. *Political Commitment:* Ensure engagement at the highest level in each country for political commitment to pandemic prevention and preparedness between emergencies and to respond during emergencies.

3. *Global Health Equity:* Promote global equity by addressing social determinants of health and tackling inequalities that may drive epidemics and pandemics. Put in place mechanisms to ensure timely and equitable access to countermeasures for all, while prioritizing resource allocation to public health needs. Strengthen health systems and continue broader societal efforts to enhance equity and the effectiveness of the global response.

4. *Communication and Misinformation:* Ensure consistent public messaging and monitor public discourse including on social media and combat misinformation and disinformation.

5. *Legal Frameworks:* Strengthen means of implementation and enforcement of international legal instruments for pandemic response, ensuring the effectiveness of the International Health Regulations and developing a comprehensive international pandemic legal instrument.

6. *Data Collection, Sharing, and Universal Reviews:* Strengthen data collection on infectious diseases and ensure its sharing across stakeholders, including health personnel, non-state actors (NSAs), and governments. Implement Universal Health and Preparedness Reviews with strengthened independent monitoring. Define benchmarks for equitable resource distribution, healthcare access, and outcomes across populations. Monitor disparities to guide equitable interventions.

7. *Stakeholder Collaboration:* Broaden partnerships with governments and NSAs for an effective multi-sectoral response, focusing on pathogen and benefits sharing, and addressing intellectual property regulations for equitable resource distribution.

8. *Other Sources of Pandemic Risk:* Enhance global health security by integrating climate change, environmental degradation, and conflict risk into pandemic preparedness giving particular attention to vulnerable populations through health system strengthening in climate and conflict-affected regions to improve resilience and response capabilities.

National Governments

9. *Preparedness, Response, and Governance:* Develop a robust national preparedness architecture by learning from previous pandemics, including local and regional manufacturing of health products, local stockpiling, and enhance national governance with anti-corruption measures. Medical associations and physicians from all specialties must be involved in epidemic planning, preparedness, and response at all levels to enhance health system effectiveness during crises.

10. *Financing:* Provide sufficient and sustainable funding for global PPPR including for the WHO, for research and development, and for national health systems strengthening.

11. *Equitable Resource Allocation:* Use a common but differentiated approach in establishing obligations for financing. Ensure resources are directed to those most in need while maintaining critical health services in order to mitigate the severity and duration of pandemics.

12. *Health Workforce Strengthening:* Support the health workforce with appropriate education on PPPR and support for response, including mental health, safe working environments including access to protection measures, and sufficient human and material resources to deliver the services required.

13. *Health System Strengthening:* Ensure health system continuity so that regular healthcare services continue to be provided and that the viability of services is not compromised by public health measures.

14. *Mental Health Service:* Expand mental health services to ensure comprehensive support for all affected populations

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during and after pandemics including integrating mental health care into primary health services, establishing dedicated mental health teams, and facilitating access to psychological support for patients, health personnel, and communities.

15. *Digital Technology:* Continue to develop digital health infrastructure to enhance PPPR capabilities while ensuring equitable and secure access to digital health services for all populations, with particular attention to remote and underserved communities.

16. *Social Protection:* Implement socio-economic support measures during pandemics to protect populations from the adverse effects of health crises.

17. *Manufacturing infrastructure:* Develop infrastructure for pandemic-related research and production of critical equipment, diagnostics, therapeutics, vaccines and personal protective equipment (PPE).

18. *Science-Guided Response:* Guide response measures by scientific and expert recommendations, adapting to local contexts as necessary. Develop National Pandemic Preparedness Plans.

19. *Communication Management:* Invest in public health education to improve health literacy. Implement laws, regulations, and administrative rules targeting the spread of disinformation. Provide prompt, accurate and transparent crisis communication guided by science.

Medical associations and scientific societies

20. *Education and Training:* Promote the integration of pandemic preparedness and response into higher education curricula and continuous professional development education for health personnel, including courses to integrate knowledge and skills related to emerging infectious diseases.

21. *One Health:* Collaborate with organizations in the animal environmental health fields to implement a One Health approach to epidemic risk management in order to establish new methods for surveillance and control of epidemics and pandemics.

22. *Research and Innovation Dissemination*: Advocate for information sharing platforms that foster collaborative research and the exchange of data across the global scientific community.

23. *Partnerships in innovation:* Promote partnerships between public institutions and private entities as appropriate to drive innovation, ensuring that the management of intellectual property rights promotes universal access to crucial medical technologies and treatments. Advocate for equitable and affordable access to innovations including medicines and patient-oriented technology.

24. *Community Involvement:* Promote strong relationships between the public and healthcare providers for inclusive pandemic management.

25. *Resource Forecasting:* Assist governments in resource forecasting and advocate for safe work environments and the access to quality assured PPE, and countermeasures with a specific focus on the protection in all clinical workplaces.

26. *Misinformation Counteraction:* Support the fight against misinformation and disinformation including by partnering with social media and online platforms to effectively identify incorrect information and disseminate accurate, evidence-based information. Treat the spread of disinformation by healthcare professionals as an unethical behavior with relevant sanctions.

27. *Health Literacy:* Organize campaigns to increase health literacy and awareness about medical misinformation and disinformation.

28. *Research Acceleration:* Encourage investment in research and fast-track ethical and peer review processes for pandemic-related research, while ensuring full respect for the principles in the WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Participants.

Physicians

29. *People-Centred Communication Skills:* Physicians should cultivate clear, empathetic communication skills to effectively convey accurate and evidence-based medical information, address misconceptions, and educate patients on identifying credible information in accordance with the WMA Declaration of Cordoba on Patient-Physician Relationship.

30. *Advocacy:* Report critical resource shortages, health system failures, misinformation and disinformation, and inequities in access to health and public health.

31. *Contribution to public health:* Stay informed about epidemics and collaborate with public health authorities on PPPR while meeting obligations of declaring pathogens of concern and facilitating appropriate interventions in the communities served.

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WMA RESOLUTION IN SUPPORT OF THE TURKISH MEDICAL ASSOCIATION

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020 and reaffirmed with minor revisions by the 227th WMA Council, Helsinki, Finland, October 2024

The WMA and its members are deeply concerned about the continuing coercion of the Turkish Medical Association by the Turkish authorities.

The Turkish Medical Association is a dedicated member of the WMA, recognised for its commitment to serve public health interests and to protect patients and physicians with respect for the ethical values of the profession.

Recalling its Resolution on the Independence of National Medical Associations, the WMA opposes such governmental interference with the independent functioning of a medical association and urges the government of Turkey and the members of the parliament to:

1. Protect the establishment of the Turkish Medical Association as a national independent association and main representative of all physicians in the country, and prevent any legal regulation that will harm its professional autonomy;

2. Respect the universal professional values of medicine, which were built upon thousands of years of experience and aim to prioritise patient and public health;

3. Comply fully with international human rights instruments that Turkey is a State Party to.

WMA STATEMENT ON HUMAN PAPILLOMAVIRUS VACCINATION

Adopted by the 64th General Assembly, Fortaleza, Brazil, October 2013 and revised by the 75th WMA General Assembly, Helsinki, Finland, October 2024

PREAMBLE

Human papillomavirus (HPV) vaccination presents a unique and valuable opportunity for physicians to substantially prevent morbidity and mortality from certain cancers in all populations, and to improve maternal health. This may result in economic benefits for countries who achieve widespread HPV vaccination in their population in the current move towards preventive and promotive healthcare. The HPV vaccine therefore merits consideration by the World Medical Association (WMA) separately from other vaccines.

HPV is, for the most part, sexually transmitted virus and is so common that most sexually active adults become infected at some point in their lives. Most infections are asymptomatic and resolve without medical intervention. However, HPV is the cause of nearly 100% of cervical cancer cases. Thirteen of the 40 types of HPV are oncogenic and, when they cause a persistent infection can produce cervical cancer as well as cancer of the vagina, vulva, anus, penis, the head and neck, oropharynx and anogenital area.

Few diseases reflect global inequities as much as cancer of the cervix. It is the fourth most common cancer in females globally, and most cervical cancer cases and deaths are in low and middle-income countries.

HPV vaccines protect against infections caused by targeted HPV types. All available vaccines afford protection against types 16 and 18, which are the most oncogenic types and can also offer protection against anogenital warts. HPV vaccination is recommended for females and males from 9-45 years of age and the immunocompromised people. HPV vaccines are safe, effective, and well tolerated.

WHO recommends a one or two-dose schedule HPV vaccination for females between 9-14 and 15-20 years old. Females older than 21 years require two doses with a 6-month interval.[1] Benefits of vaccinating young males include protection against genital warts and cancer in addition to preventing transmission of HPV to sexual partners.

In 2020 the World Health Assembly adopted the Global Strategy for cervical

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cancer elimination. To achieve accelerated elimination of cervical cancer, by 2030, 90% of girls will be fully vaccinated with the HPV vaccine by the age of 15, screening programs using a high-performance test will be running to screen 70% of women by the age of 35 and again by the age of 45 and 90% of women with invasive cancer will be managed.

School-based vaccination or systematic community programs are strategies that will increase vaccine accessibility to the appropriate age groups, particularly targeting youths prior to the commencement of sexual activity to ensure maximum benefit.

RECOMMENDATIONS

1. Reaffirming its Statement on Access of Women and Children to Healthcare and its Statement on the Prioritisation of Immunisation, the WMA insists on the rights of all women, children, and indeed all people to adequate, safe medical care and urges governments to commit resources to immunisation programs.

2. The WMA encourages expedited development and funding of programs to make safe, high quality HPV vaccines widely available to both females and males.

3. The WMA strongly advocates for the provision of reliable, fast, and accessible cervical cancer screening programs for the detection and treatment of precancerous lesions in all countries, especially in those that have high mortality rates from cervical cancer.

4. WMA clearly points out that HPV vaccination should not replace cervical cancer screening programs.

5. WMA advises that cancer treatment and palliative care should be accessible to all individuals diagnosed with cervical cancer.

6. A key recommendation is for school-based vaccination or systematic community programs to increase vaccine accessibility to the appropriate age groups, particularly targeting youths prior to the commencement of sexual activity to ensure maximum benefit.

7. The WMA urges national health authorities, in collaboration with health professionals' associations and other relevant health actors, to carry out intensive education and advocacy to:

   - In all individuals regardless of sex, improve awareness and understanding of HPV and associated diseases (such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer), the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public;

   - Improve awareness that condoms do not provide sufficient protection against HPV infection because they do not cover the entire anogenital area and that HPV also causes cancers of the oropharynx, anus and penis;

   - Communicate the availability and efficacy of HPV vaccines to educate the population about the importance of getting the HPV vaccination;

   - Recommend HPV vaccination and routine cervical cancer screening and treatment for all eligible people regardless of the socioeconomic, cultural, or religious background, including those that are hard to reach (including for example those with disability, refugees and asylum seekers, and people of diverse sexual orientation and gender identity);

   - Support the availability of the HPV vaccine and routine cervical cancer screening for patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations;

   - Integrate HPV vaccination (either primary or catch-up immunisation) into all appropriate health care settings and visits involving eligible people; Routine cervical examination (whether vaccinated or not against HPV) should also be incorporated;

   - HPV vaccination and routine cervical cancer screening should also be offered to people who are incarcerated;

   - Integrate and understand the crucial need for routine cervical cancer screening in all appropriate health care settings and visits, and the enhanced sensitivity and effectiveness of HPV based screening compared with Pap smears, VIA (visual assessment with acetic acid), and VILI (visual assessment with lugols iodine);

   - Integrate HPV cancer prevention methods, early detection, early screening, diagnosis, treatment and palliative care into existing programs and pre-service training. Such training will leverage existing support for HPV programs and help to increase vaccination efforts;

   - Fund research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers;

   - Encourage and provide training for cervical cancer survivors to advocate for HPV vaccination and screening;

   - Sustain vaccination efforts to work towards and raise awareness of the WHO's 90-70-90 Global Strategy to accelerate the elimination of cervical cancer as a public health problem;

   - Support and promote advocacy for HPV vaccination campaigns.

8. The WMA urges physicians to educate themselves and their patients about HPV, associated diseases, HPV vaccination and routine cervical cancer screening.

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WMA STATEMENT ON ADOLESCENT SUICIDE

Adopted by the 43rd World Medical Assembly, Malta, November 1991, revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006 by the 67th WMA General Assembly, Taipei, Taiwan, October 2016 and reaffirmed with minor revisions by the 227th WMA Council, Helsinki, Finland, October 2024

PREAMBLE

The past several decades have witnessed a dramatic change in causes of adolescent mortality. Previously, adolescents mostly died of natural causes, whereas now they are more likely to die from preventable causes. The suicide rate among adolescents has risen in all regions of the world. In the adolescent population, suicide is currently one of the leading causes of death. Suicides are probably under-reported due to cultural and religious stigma attached to self-destruction and to an unwillingness to recognise certain traumas, such as some automobile accidents, as self-inflicted.

Adolescent suicide is a tragedy that affects not only the individual but also the family, peers and larger community in which the adolescent lived. Suicide is often experienced as a personal failure by parents, friends and physicians who blame themselves for not detecting warning signs. It is also viewed as a failure by the community, serving as a vivid reminder that modern society often does not provide a nurturing, supportive and healthy environment in which children can grow and develop.

Factors contributing to adolescent suicide are varied and include: affective disorders, trauma, emotional isolation, low self-esteem, excessive emotional stress, eating disorders, physical disease, discrimination and harassment (school bullying, cyber bullying and sexual harassment), romantic fantasies, thrill-seeking, drug and alcohol abuse, the availability of firearms and other agents of self-destruction, and media reports of other adolescent suicides, which may inspire imitation acts. In addition, the prolonged exposure to electronic media, which predominantly affects adolescents through their use of computer games and social media, can contribute to social isolation, school failure and malaise amongst young people.

Youth within correctional facilities are at a higher risk for suicide than the general population, yet they have fewer resources available to them. The lack of resources makes it difficult to identify those at risk for suicide.

The incidence of adolescent suicide is observed to be greater in the "first peoples" of some nations. The reasons for this are complex.

The health care of adolescents is best achieved when physicians provide comprehensive services, including both medical and psychosocial evaluation and treatment. Continuous, comprehensive care provides the physician the opportunity to obtain the information necessary to detect adolescents at risk for suicide or other self-destructive behaviour. This service model also helps to build a socially supportive patient-physician relationship that may moderate adverse influences adolescents experience in their environment.

In working to prevent adolescent suicide, the World Medical Association recognises the complex nature of adolescent bio-psycho-social development; the changing social world faced by adolescents; and the introduction of new, more lethal, agents of self-destruction.

In response to these concerns, the World Medical Association recommends that its constituent members adopt the following guidelines for physicians. In doing so, we recognise that many other players – parents, governmental agencies, schools, communities, social services – also have important roles in this area.

RECOMMENDATIONS

1. All physicians should receive, during medical school and postgraduate training, education in child psychiatry and adolescent bio-psycho-social development, including education in the risk factors for suicide.

2. Physicians should be educated to identify early signs and symptoms of physical, emotional, and social distress of adolescent patients. They should also be educated to identify the signs and symptoms of psychiatric disorders, like depression, bipolar disorder and substance use disorders, that may contribute to suicide as well as other self-destructive behaviours.

3. Physicians should be taught how and when to assess suicidal risk in their adolescent patients, taking into account the adolescent's environment, including the potential availability of firearms.

4. Physicians should be taught and keep up-to-date on the treatment and referral options appropriate for all levels of self-destructive behaviours of their adolescent patients. The physicians with the most significant education in adolescent suicide are child and adolescent psychiatrists, so the patient should be referred to one if available.

5. Physicians should collaborate with the families or guardians of the adolescents as well as other relevant stakeholders, such as social workers, school officials, and psychologists who bear expertise in child and adolescent behavior.

6. When caring for adolescents with any type of trauma, physicians should

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consider the possibility that the injuries might have been self-inflicted.

7. When caring for adolescents who demonstrate deterioration in thinking, feeling or behaviour, the possibility of substance abuse and addiction should be considered, and the threshold should be lower, with reference to adequate scientific evidence, for urine toxicology assessment.

8. Health care systems should facilitate the establishment of mental health consultation services aimed at preventing suicide and should pay for the socio-medical care given to patients who have attempted suicide. Services should be tailored to the specific needs of adolescent patients. A medical consultation for adolescents is highly recommended to enable doctors to detect any disorders in their patients.

9. Epidemiological studies on suicide, its risk factors and methods of prevention should be conducted, and physicians should keep up-to-date with such studies.

10. When caring for adolescents with psychiatric disorders or risk factors for suicide, physicians should educate parents or guardians to watch for the signs of suicide and about the options for evaluation, and encourage them to seek support for themselves.

11. Physicians should advocate for the identification of at-risk groups of adolescents with the mobilization of specifically targeted resources directed at prevention and risk reduction.

WMA RESOLUTION ON ORGAN DONATION IN PRISONERS

Adopted by the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006 and reaffirmed by the 203rd WMA Council Session, Buenos Aires, Argentina, April 2016 and revised by the 226th WMA Council Session, Seoul, Korea, April 2024 and adopted by the 75th WMA General Assembly, Helsinki, Finland, October 2024

PREAMBLE

Whereas the WMA Statement on Human Organ and Tissue Donation and Transplantation stresses the importance of free and informed choice in organ donation and

Whereas the statement explicitly states that prisoners and other individuals in custody are not in a position to give consent freely, and therefore, their organs must not be used for transplantation and

Whereas, prior to 2014, there were reports of Chinese prisoners being executed and their organs procured for donation; and

Whereas the WMA reiterates its position that organ donation be achieved through the free and informed consent of the potential donor; and

Whereas the WMA General Assembly in Copenhagen in 2007 was informed that the Chinese Medical Association (ChMA) stated in a letter by Dr. Wu Mingjang, (then) Vice President and Secretary General of the ChMA that

1. *the Chinese Medical Association agrees to the WMA Statement on Human Organ Donation and Transplantation, in which it states that organs of prisoners and other individuals in custody must not be used for transplantation, except for members of their immediate family. The Chinese Medical Association will, through its influence, further promote the strengthening of management of human organ transplantation and prevent possible violations made by the Chinese Government."[1]*

Whereas the Chinese Medical Association (ChMA) gave a statement regarding the proposed WMA Declaration on Organ Donation for Transplantation from Executed Prisoners at the 223rd Council meeting in Nairobi 2023, stating:

1. *"The Chinese Medical Association (ChMA) fully supports China's complete prohibition on the use of organs from death penalty prisoners for transplantation, implemented on January 1st, 2015. This policy has significantly contributed to the successful development of voluntary deceased organ donation in China, propelling the nation to rank second globally in annual deceased organ donation and benefiting numerous Chinese patients.*

2. *ChMA firmly supports and adheres China's comprehensive legal and regulatory system, as well as the technical capacity developed to facilitate the legal enforcement, ensuring the continued prohibition of using organs from executed prisoners and the ongoing success of the national organ donation program.*

3. *ChMA encourages all her members (to) actively participates (in) China's efforts to*

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establish a self-sufficient organ donation system in line with WHO guiding principle, condemns the practice of using organs from executed prisoners for transplantation. ChMA will continue, and also call upon all national medical associations, particularly those with legislation permitting the practice of the use of organs from executed prisoners, to educate physicians on ethical values and conduct in order to prevent such a practice."

Whereas the WMA reiterates paragraphs 17, 18 and 19 of the undisputed WMA Statement on Organ and Tissue Donation, last revised at the WMA 68th. General Assembly in Chicago, United States, October 2017, which read:

1. *17. Prisoners and other people who are effectively detained in institutions should be eligible to donate after death where checks have been made to ensure that donation is in line with the individual's prior, un-coerced wishes and, where the individual is incapable of giving consent, authorisation has been provided by a family member or other authorized decision-maker. Such authorisation may not override advance withholding or refusal of consent.*
2. *18. Their death is from natural causes and this is verifiable.*
3. *19. In jurisdictions where the death penalty is practised, executed prisoners must not be considered as organ and/or tissue donors. While there may be individual cases where prisoners are acting voluntarily and free from pressure, it is impossible to put in place adequate safeguards to protect against coercion in all cases.*

Whereas there have been reports of purported inappropriate organ procurement from prisoners within several nations and the WMA should remain firmly on record to condemn inappropriate organ procurement from prisoners and other people who are effectively detained in institutions in all nations.

The WMA will amend the title of the WMA Council Resolution on Organ Donation in China (2006) to the WMA Council Resolution on Organ Donation in Prisoners.

Therefore, the Workgroup on Organ Procurement (November 2023) proposes to amend the WMA Council Resolution on Organ Donation in China (2006), to read as follows:

The WMA reiterates its position that organ donation be achieved through the free and informed consent of the potential donor.

The WMA calls on its Constituent member associations to condemn any practice of using prisoners and other people who are effectively detained in institutions as organ donors in any manner that is not consistent with the WMA Statement on Organ and Tissue Donation and ensure that physicians are not involved in the removal or transplantation of organs from executed prisoners, and

the WMA demands all national governments to immediately cease the practice of using prisoners and other people who are effectively detained in institutions as organ donors in any manner that is not consistent with the WMA Statement on Organ and Tissue Donation.

[1] WMA News, Chinese Medical Association reaches agreement with WMA against transplantation of prisoner's organs. Copenhagen, 2007 replace by original message.

WMA DECLARATION OF KIGALI ON THE ETHICAL USE OF MEDICAL TECHNOLOGY

Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002, and revised by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012 and by the 74th WMA General Assembly, Kigali, Rwanda, October 2023, and renamed "Declaration of Kigali" by the 75th WMA General Assembly, Helsinki, Finland, October 2024

PREAMBLE

Medical technology has come to play a key role in modern medicine. It has helped provide significantly more effective means of prevention, diagnosis, treatment and rehabilitation of illness, for example through the development and use of information technology, such as telehealth, digital platforms and large-scale data collection and analyses, or the use of advanced machinery and software in areas like medical genetics and radiology, including assistive, artificial, and augmented intelligences.

The importance of technology for medical care will continue to grow and the WMA welcomes this progress. The continuous development of medical technologies – and their use in both clinical and research settings – will create enormous benefits for the medical profession, patients, and society.

However, as for all other activities in the medical profession, the use of medical technology for any purpose, must take place within the framework provided by the basic principles of medical ethics as stated in the WMA Declaration of Geneva: The Physician's Pledge, the International Code of Medical Ethics and the Declaration of Helsinki.

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Respect for human dignity and rights, patient autonomy, beneficence, confidentiality, privacy and fairness must be the key guiding points when medical technology is developed and used for medical purposes.

The rapidly developing use of big data has implications for confidentiality and privacy. Using data in ways which would damage patients' trust in how health services handle confidential data would be counterproductive. This must be borne in mind when introducing new data driven technology. It is essential to preserve high ethical standards and achieve the right balance between protecting confidentiality and using technology to improve patient care.

Additionally, bias through for example social differences in the collection of data may skew the intended benefits of data driven medical treatment innovations.

As medical technology advances and the potential for commercial involvement grows, it is important to protect professional and clinical independence.

RECOMMENDATIONS

Beneficence

1. The use of medical technology should have as its primary goal benefit for patients' health and well-being. Medical technology should be based on sound scientific evidence and appropriate clinical expertise. Foreseeable risks and any increase in costs should be weighed against the anticipated benefits for the individual as well as for society, and medical technology should be tested or applied only if the anticipated benefits justify the risks.

Confidentiality and privacy

2. Protecting confidentiality and respecting patient privacy are central tenets of medical ethics and must be respected in all uses of medical technology.

Patient autonomy

3. The use of medical technology must respect patient autonomy, including the right of patients to make informed decisions about their health care and control access to their personal information. Patients must be given the necessary information to evaluate the potential benefits and risks involved, including those generated by the use of medical technology.

Justice

4. To ensure informed choices and avoid bias or discrimination, the basis and impact of medical technology on medical decisions and patient outcomes should be transparent to patients and physicians. In support of fair and equitable provision of health care, the benefits of medical technology should be available to all patients and prioritized based upon clinical need and not on the ability to pay.

Human rights

5. Medical technology must never be used to violate human rights, such as use in discriminatory practices, political persecution or violation of privacy.

Professional independence

6. To guarantee professional and clinical independence, physicians must strive to maintain and update their expertise and skills, i.e., by developing the necessary proficiency with medical technology. Medical curricula for students and trainees as well as continuing education opportunities for physicians must be updated to meet these needs. Physicians shall be included in contributions to research and development. Physicians shall remain the expert during shared decision making and not be replaced by medical technology.

7. Health care institutions and the medical profession should:

   - help ensure that innovative practices or technologies that are made available to physicians meet the highest standards for scientifically sound design and clinical value;
   - require that physicians who adopt innovations into their practice have relevant knowledge and skills;
   - provide meaningful professional oversight of innovation in patient care;
   - encourage physician-innovators to collect and share information about the resources needed to implement their innovations safely, effectively, and equitably; and
   - assure that medical technologies are applied and maintained appropriately in accordance with their intended purpose.

8. The relevance of these general principles is stated in detail in several existing WMA policies. Of particular importance are:

   - WMA Declaration of Seoul on Professional Autonomy and Clinical Independence
   - WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects
   - WMA Declaration of Taipei on Ethical Considerations regarding Health Databases and Biobanks
   - WMA Statement on Augmented Intelligence in Medical Care
   - WMA Statement on Digital Health
   - WMA Statement on Cyber-Attacks on Health and Other Critical Infrastructure
   - WMA Statement on Access to Health Care
   - WMA Declaration of Lisbon on the Rights of the Patient
   - WMA Declaration of Oslo on Social Determinants of Health

The WMA encourages all relevant stakeholders to embody the ethics guidance provided by these documents.

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WMA STATEMENT ON ASSISTED REPRODUCTIVE TECHNOLOGIES

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006, revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022, and revised in its recommendation 14 by the 75th WMA General Assembly, Helsinki, Finland, October 2024

PREAMBLE

Assisted Reproductive Technology [ART] encompasses a wide range of techniques designed primarily to aid individuals unable to conceive without medical assistance.

ART is defined as any fertility treatment in which either gametes or embryos are handled.

Assisted reproductive technologies may raise profound ethical and legal issues. Views and beliefs on assisted reproductive technologies vary both within and among countries and are subject to different regulations in different countries.

Central to much of the debate in this area are issues around the moral status of the embryo, the way in which ART is viewed morally, societally and religiously, the child/ren born from ART, and the rights of all participants involved, i.e. donors, surrogates, the child/ren and the intended parents are just some of the issues central to the debate in ART. Whilst consensus can be reached on some issues, there remain fundamental differences of opinion that are more difficult to resolve.

Assisted conception differs from the treatment of illness in that the inability to become a parent without medical intervention is not always regarded as an illness. Notwithstanding, the inability to conceive may also be a result of prior illness.

In many jurisdictions, the process of obtaining consent must follow a process of information giving and the offer of counselling and might also include a formal assessment of the patient in terms of the welfare of the potential child.

Faced with the progress of new technologies of assisted reproduction, physicians should keep in mind that not everything that is technically feasible is ethically acceptable. Genetic manipulation that does not have a therapeutic purpose is not ethical, nor is the manipulation on the embryo or foetus without a clear and beneficial diagnostic or therapeutic purpose.

RECOMMENDATIONS

1. Physicians involved in providing assisted reproductive technologies should always consider their ethical responsibilities towards all parties involved in a reproductive plan, which may include the future child/ren, donor, surrogate or parents. If there is compelling evidence that a future child, donor, surrogate or parent would be exposed to serious harm, treatment should not be provided.

2. As with all other medical procedures, physicians have an ethical obligation to limit their practice to areas in which they have relevant expertise, skill, and experience and to respect the autonomy and rights of patients.

3. In practice this means that informed consent is required as with other medical procedures; the validity of such consent is dependent upon the adequacy of the information offered to the patient and their freedom to make a decision, including freedom from coercion or other pressures or influences to decide in a particular way.

4. The consent process should include providing the participant/s with understandable, accurate and adequate information about the following:

   - The purpose, nature, procedure, and benefits of the assisted reproductive technology that will be used.
   - The risks, burdens and limitations of the assisted reproductive technology that will be used.
   - The success rates of the treatment and possible alternatives, such as adoption.
   - The availability of psychological support for the duration of the treatment and, in particular, if a treatment is unsuccessful.
   - The measures protecting confidentiality, privacy and autonomy, including data security measures.

5. The following should be discussed during the informed consent process:

   - Detailed medical risks;
   - Whether or not all biological samples involved in ART, including but not limited to donor eggs, sperm, gametes and genetic information, may be used for research purposes;
   - The risks of multiple donations and donating at multiple clinics;
   - Confidentiality and privacy issues;
   - Compensation issues.

6. Donors, surrogates and any resulting child/ren seeking assisted reproductive technologies are entitled to the same level of confidentiality and privacy as for any other medical treatment.

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7. Assisted reproductive technology involves handling and manipulation of human gametes and embryos. There are different levels of concern with the handling of such material, yet there is general agreement that such material should be subject to specific safeguards to protect from inappropriate, unethical, or illegal use.

8. Physicians should uphold the principles in the WMA Statement on Stem Cell Research, WMA Statement on Human Genome Editing, the WMA Declaration of Helsinki, and the WMA Declaration of Reykjavik – Ethical Considerations Regarding the Use of Genetics in Health Care.

9. Physicians should, where appropriate, provide ART in a non-discriminatory manner. Physicians should not withhold services based on nonclinical considerations such as marital status.

Multiple pregnancies

10. Replacement of more than one embryo will raise the likelihood of more than one embryo implanting. This is offset by the increased risk of premature labour and other complications in multiple pregnancies, which can endanger the health of both the mother and child/ren. Practitioners should follow professional guidance on the maximum number of embryos to be transferred per treatment cycle.

11. If multiple pregnancies occur, selective termination or fetus reduction will only be considered on medical grounds and with the consent of all participants involved to increase the chances of the pregnancy proceeding to term, provided this is compatible with applicable laws and codes of ethics.

Donation

12. Donation should follow counselling and be carefully controlled to avoid abuses, including coercion or undue influence of potential donors. Explicit instructions should be provided about what will be done with any donated samples if the donor is known to have died prior to implantation.

13. The WMA holds the view that gamete donation should at best not be commodified, thus serving a humanitarian benefit.

14. Appropriate controls and limits on methods used to encourage donations should be ensured. All donations must comply with national legislation and appropriate ethical guidance, including the maximum amount of gamete donations per person. Guidance on the maximum number of children allowed through donation from a single donor should be developed and adhered to, to avoid unintended incest, inbreeding and psychological harm to those involved. Physicians should advocate for and contribute to the development of such ethical guidance, if such guidance does not exist.

15. Due to the widespread use of genetic technology and registries, it has become possible to identify donors, despite clinics and donors' attempts to maintain strict confidentiality.A child/ren born as a result of donation may in future contact donors. Potential donors must be made aware of this possibility as part of the consent process.

16. Where a child is born following donation, families should be encouraged and supported to be open with the child about this, irrespective of whether or not domestic law entitles the child to information about the donor. This may require the development of supportive materials, which should be produced to a national normative standard.

Surrogacy

17. Where a woman is unable, for medical reasons, to carry a child to term, surrogate pregnancy may be used to overcome childlessness unless prohibited by national law or the ethical rules of the National Medical Association or other relevant organizations. Where surrogacy is legally practiced, great care must be taken to protect the interests of all parties involved.

18. Prospective parents and surrogates should receive independent and appropriate legal counsel.

19. Medical tourism for surrogacy purposes should be discouraged.

20. Commercial surrogacy should be condemned. However, this must not preclude compensating the surrogate mother for necessary expenses.

21. The rights of surrogate mothers must be upheld, and great care must be taken to ensure that they are not exploited. The rights of surrogate mothers include, but are not limited to:

    - Having her autonomy respected;
    - Where appropriate, having health insurance;
    - Being informed about any medical procedure and the potential side effects;
    - Where possible, choosing her medical team if side effects develop;
    - Having psychological help at any point during the pregnancy;
    - Having medical expenses such as doctor visits, the actual birthing process, fertilization and any examinations related to the surrogacy covered by the intended parent/s;
    - Loss if income covered if unable to work during the pregnancy;
    - Receiving the compensation and/or reimbursements agreed to in any legal agreement

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Pre-implantation Genetic Diagnosis (PGD)

22. Pre-implantation genetic diagnosis (PGD) and pre-implantation genetic screening (PGS) may be performed on early embryos to search for the presence of genetic or chromosomal abnormalities, especially those associated with severe illness and very premature death, and for other ethically acceptable reasons, including identifying those embryos most likely to implant successfully in women who have had multiple spontaneous abortions.

23. It is recommended to encourage screening for infectious diseases in sperm donors and to determine whether to inform donors of positive tests.

24. Physicians must never be involved with sex selection unless it is used to avoid a serious sex-chromosome related condition, such as Duchenne's Muscular Dystrophy.

Research

25. Physicians have an ethical duty to comply with such regulation and to help inform public debate and understanding of these issues.

26. Research on human gametes and embryos should be carefully controlled and monitored and in accordance with all applicable national laws and ethical guidelines.

27. Views and legislation differ on whether embryos may be created specifically for, or in the course of, research. Physicians should act in accordance with the declarations of Taipei and Helsinki, as well as all applicable local laws and ethical and professional standards advice.

28. The principles of the Convention on Human Rights and Biomedicine should be followed.

WMA RESOLUTION ON THE REVOCATION OF WHO GUIDELINES ON OPIOID USE

Adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019 and reaffirmed with minor revisions by the 227th WMA Council, Helsinki, Finland, October 2024

The World Medical Association remains concerned about the abrupt discontinuation of WHO 2011 guidance *"Ensuring balance in national policies on controlled substances: Guidance for availability and accessibility of controlled medicines"*, as well as its 2012 *"WHO guidelines on the pharmacological treatment of persisting pain in children with medical illnesses."*

This revocation, which took place in June 2019 without consulting the medical community, deprives many physicians of support and regulation in countries without related national legislation, thus endangering their medically justified use of such substances. Ultimately, suffering patients will not have access to proper medication.

The WMA notes that the withdrawal was decided unilaterally, without providing any supporting evidence and without including any replacement or substitution. Moreover, the discontinued guidelines were fully removed from the WHO online publications portal, thus impeding the ability of physicians to justify and validate retrospectively the use of controlled substances, exposing them potentially to criminal prosecution.

The WMA demands the adherence to the principle of evidence-based development of treatment guidelines. This should apply to the definition, amendment and discontinuation of such guidance, in addition to the application of a precautionary principle. Evidence supporting the revocation of the opioid-guidelines must be published and made available for scientific scrutiny.

The WMA demands that the announced revision process by WHO for the two discontinued guidelines be promptly completed in an open and transparent process, including a reliable mechanism to ensure the disqualification of experts with conflicts of interest.

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WMA GUIDELINES ON PROMOTIONAL MASS MEDIA APPEARANCES BY PHYSICIANS

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015 and reaffirmed with minor revisions by the 227th WMA Council, Helsinki, Finland, October 2024

PREAMBLE

Mass media, including social media, can effectively play diverse roles in medical communication. Physicians, as professionals and experts, can contribute to improved public health by providing the public with accurate health related information. Mass media provides a channel through which physicians may contribute to society by leveraging mass media appearances in positive ways.

However, the increase in instances of physicians' frequent appearances on mass media to recommend unproven treatments or products and to use such appearances for marketing purposes is posing a serious concern. The public may readily accept groundless recommendations by physicians and may develop unrealistic expectations. The subsequent confusion and disappointment can damage the patient-physician relationship.

This issue is more serious in some countries where there are different systems of medicine, including alternative medicine.

GUIDELINES

1. The WMA recalls its Statement on the Professional and Ethical Use of Social Media and recommends the following guidelines regarding mass media appearances by physicians to prevent them from being involved in commercial activities that may compromise professional ethics and to contribute to patient safety by ensuring physicians providing accurate, timely, and objective information.

Accurate and Objective Delivery of Scientifically Proven Medical Information

2. When appearing in media, physicians shall provide objective and evidence-based information and shall not recommend medical procedures or products that are not medically proven or justified.

3. A physician shall not use expressions that may promote unrealistic patient expectations or mislead viewers about the function and effect of medical procedures, drugs or other products.

4. Physicians shall include important information, such as possible adverse effects and risks, when explaining medical procedures, drugs, or other products.

Not Abusing Mass Media as a Means of Advertisement

5. Physicians should not recommend specific products by either specifically introducing or intentionally highlighting the name or trademark of a product.

6. Physicians shall practice prudence regarding personal appearances on home shopping programs. The physician should have no financial stake in the products being sold.

7. Physicians shall not be a part of mass media advertisement on any product which is harmful to humans and/or the environment.

Maintaining Professional Integrity

8. Physicians shall not require or receive economic benefits for mass media appearances other than a customary appearance fee.

9. Physicians shall not provide economic benefits to broadcasting personnel in order to secure mass media appearances.

10. Physicians shall not engage in the promotion, sale or advertising of commercial products and shall not introduce false or exaggerated statements regarding their qualifications, such as academic background, professional experience, medical specialty and licensure as a specialist, for the benefit of the economic interests of any commercial entity.

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Entering the Fourth Decade of Independence: Post-Socialism Development of Mental Healthcare

Liene Sile

Zane Egle

Maris Taube

Linda Seldere

Mental healthcare in Latvia has a long and eventful history, after gaining independence from the Soviet Union in 1991. The country has undergone significant policy reforms, changes in public attitudes, and efforts to align with European Union (EU) standards. Joining the EU in 2004 and Organization for Economic Co-operation and Development (OECD) in 2016 was crucial in shaping psychiatric care policies and attracting EU funding for mental healthcare services, which required shifting away from institutional care, developing outpatient services, improving standards of care, and emphasising patient rights. To enhance the development of professionals trained in psychiatry and addiction psychiatry, strong healthcare system leadership is needed to identify gaps in academic and clinical training, financial resources, and stakeholder support, to meet the needs of the 1.9 million residents.

Development of the Mental Healthcare System in Latvia

Although the restoration of Latvia's independence occurred more than 30 years ago, some features of the Soviet Union system are still visible today. For example, patients arrive without appointments and form waiting lines at doctors' offices, resulting in limited confidentiality, and physicians tend to work individually without collaborating with other specialists in patient care management. Despite these challenges following the restoration of Latvia's independence, Latvian psychiatry rapidly and irrevocably entered the European and world psychiatric communities. The Latvian Psychiatric Association became a member of the World Psychiatric Association, European Psychiatric Association, and Nordic Psychiatric Association, demonstrating the active and productive cooperation with psychiatrists from Germany, Canada, Sweden, Norway, and other countries. On 6-7 June 2024, Latvia hosted the Congress of the Nordic Psychiatric Association for the first time with speakers and audience members from Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway, and Sweden.

Mental Health as a Public Health Priority

As a country with a high-income level and 1.9 million residents, strengthening mental health services in Latvia has remained a top public health priority in recent years. During the coronavirus disease 2019 (COVID-19) pandemic, national support for mental health services was forefront in public discourse, when society experienced direct and indirect challenges to mental health, such as increased anxiety about the unknown reality, socialisation restrictions, workplace changes, decreased access to healthcare services, and worsening socio-economic situations. To help mitigate the mental health impacts of the COVID-19 pandemic, the Latvian government expanded government-funded services in May 2021, where citizens could seek consultations for state-funded psychological and psychotherapeutic support, upon referral from general practitioners

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or psychiatrists. Various community activities were coordinated to encourage the public to become more aware of their mental health, recognise the importance of promoting and preserving their mental health across the lifespan, and gain confidence to discuss these topics with healthcare professionals [1].

Psychiatry Nowadays

Until the 2000s, psychiatry in Latvia was hospital-based to provide healthcare services to manage acute and severe mental health disorders. Over the past two decades, modern psychiatry in Latvia has transitioned to a biological, psychological, and social approach, providing patients with medical treatment, social support, and psychotherapeutic help. This approach recognises that assistance to psychiatric patients promotes patients' maximum inclusion in society while respecting their autonomous wishes and interests. With advancements in pharmaceutical agents based on evidence-based research, the global availability of these modern medications has enhanced the capacity to manage clinical symptoms with fewer side effects and hence improve patients' quality of life.

Mental healthcare services are provided in outpatient and inpatient settings, and social stigma is still associated with the need for psychiatric care. Patients with milder conditions are frequently treated in primary care. Outpatient psychiatric care in Latvia is provided by independent psychiatric practices, outpatient departments at psychiatric and general hospitals, and municipal psychiatric consulting rooms in primary care centres (Figure 1) – with a total of 50 outpatient psychiatric care providers in 2022 [1,2].

Psychiatric hospitals are government funded and function as self-sufficient institutions, where healthcare providers help manage acute- and long-term treatment (including addition) of psychiatric patients, and hospital admissions are by referral from a psychiatrist, general practitioner or emergency physician.

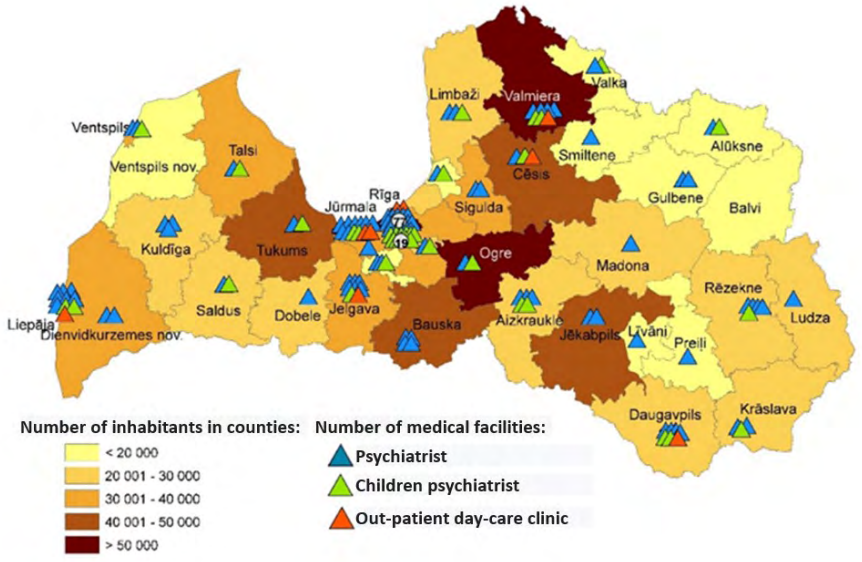

Figure 1. Coverage of mental health care facilities in Latvia, 2022. Credits: Cabinet of Ministers of Latvia Regulation No. 939 (adopted 13 December 2022) [2]

Long-term treatment, which is considered social care provided by the Ministry of Welfare of the Republic of Latvia, aims to stabilise treatment-resistant patients with psychiatric diagnoses that cannot be managed in acute or subacute hospital settings or at home [3,4]. For example, the National Centre of Mental Health, State LTD, as the largest mental healthcare provider in Latvia, provides laboratory testing, electrocardiography, electroencephalography, x-ray examinations, and specialist consultations (e.g. gynaecology, dentistry, neurology), which facilitates the supervision of financial resources.

As out-patient departments have a long waiting time (e.g. up to two months), the organisation of emergency care represents an existing regulatory framework that allows walk-in consultations in hospital emergency care departments. Notably, this framework can increase the workload and risk of burnout for emergency psychiatrists. If patients arrive at the emergency department with health conditions that do not require hospitalisation or 24-hour observation, these services are covered by the government [5].

Mental healthcare has traditionally focused on inpatient care, and attempts to move towards outpatient, community-based mental health services were mainly triggered by calls from the World Health Organization (WHO) [6]. Over the past few decades, the number of psychiatric hospital beds in Latvia has decreased, and treatment time has shortened. For example, the average number of inpatient beds (per 100,000 habitants) has decreased from 114 in 2010 to 101 in 2022, and the average number of bed days per one patient day has decreased from 39.6 in 2010 to

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29.2 in 2022 [7]. The number of patients attending day care clinics is increasing, as it facilitates a timely start of treatment and cooperation during the post-hospitalisation period and promotes continuity of treatment.

To reduce the number of hospital admissions and length of hospital stays, the Ministry of Health of the Republic of Latvia established three outpatient centres in Riga in 2005, 2013, and 2024, covering a care area of approximately 700,000 habitants. These centres provide outpatient psychiatric appointments, multi professional team treatment in out-patient setting, and day clinics with rehabilitation. Notably, two centres have an open-door inpatient ward [8].

Mental Healthcare Pilot Projects

Pilot projects and community-based treatment methods are successfully implemented, such as early intervention programme for first-time schizophrenia spectrum psychosis patients, transition of children to adult psychiatry, and a mobile methadone unit [9]. On 1 June 2023, the National Centre of Mental Health, State LTD, implemented an important pilot project to strengthen mental health care in Latvia: the state-funded early intervention program for patients with schizophrenic spectrum disorders. This six-month program provides patients with outpatient mental healthcare, active involvement of a multiprofessional team of specialists, and patient transfer from psychosis inpatient treatment to outpatient care without any waiting time.

Policies and National Plans

Over the past two decades, the Government of Latvia has been working on mental health reforms to improve the quality and accessibility of care, including deinstitutionalisation and the development of community-based services. As a member of the European Union (EU), Latvia's psychiatric care system is influenced by EU policies and standards, pushing for modernization and alignment with best practices in mental healthcare. The first national mental healthcare guideline (*Improving Mental Health of the Population, 2009-2014*) was adopted in 2008, with funding from the European Social Fund, marking a significant breakthrough for mental healthcare in Latvia. It highlighted challenges related to limited access to high-quality mental healthcare, lack of community-based mental health services, insufficient number of medical personnel, and uneven regional distribution [10]. After the launch of these guidelines, the first national planning document was issued for 2013-2014.

Since 2008, mental healthcare has been one of the main priorities in Latvian healthcare system. In December 2022, the latest plan for the improvement of the organisation of mental healthcare services (*Plan for Improving the Organization of Mental Healthcare in Latvia, 2023-2025*) was approved, but not yet implemented due to limited funding resources [2,4]. As the plan intends to reduce the number of psychiatric hospital beds, it also focuses on the development of outpatient and community-based mental health services, promoting early diagnosis of mental illnesses, ensuring timely and subsequent treatment, and providing high-quality medical rehabilitation.

Financing

After regaining independence, Latvia experimented with introducing Social Health Insurance, but later moved to a National Health Service (NHS)-type system, with a purchaser-provider split and a mix of public and private providers. The NHS is the central national institution for administering the public budgetary funds of the health sector, and contracting services from health service providers. Regulatory functions are concentrated mainly in the central government (e.g. Parliament, Cabinet of Ministers, Ministry of Health of the Republic of Latvia, government agencies), and financing is mainly through general taxation. The total current health expenditure remains among the lowest in Europe, as state financing comprises only 54% of total health expenditure, and the rest is financed by out-of-pocket (OOP) payments [3].

A detailed range of services and regulations for the provision of services and tariffs for state-paid healthcare interventions are defined by the Cabinet of Ministers, in accordance with *Regulation No. 555*. The scope of services included in the state-paid services is determined by a number of explicit inclusion and exclusion lists as well as by certain implicit criteria. Mental healthcare in outpatient and inpatient settings is included in state-funded services. Although healthcare service users pay co-payments (fixed amount per consultation visit or hospital stay), where mental healthcare services are exempt from co-payments, the NHS reimburses providers for these co-payments [5]. However, limited state financing leads to long waiting lists for outpatient visits, especially in Riga and for paediatric psychiatrists. Depending on the diagnosis,

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medications for patients with mental and behavioural disorders are fully or partially (75%) compensated from the state budget.

Medical Education and Shortage of Specialists

The undergraduate medical education program in Latvia is six years long and leads to the award of the Medical Doctor (MD) degree (EQF Level 7), preparing highly qualified clinicians, scientists, and academicians to serve the Latvian healthcare system. The medical education system in Latvia is being constantly evaluated, adjusted, and updated based on recent technological and biomedical advancements [11]. Upon the successful completion of state examinations, students can continue their medical education through a residency programme in more than 70 specialties, subspecialties, and additional specialties. The Ministry of Health of the Republic of Latvia determines the annual availability of government-subsidised positions for each specialty, considering the demand for the specialties from hospitals, health needs of the society, and existing and projected supply of doctors in each specialty. Upon completion of medical residency, students become licensed specialists, commence their professional careers in their respective specialty, and participate in continuing professional development opportunities.

Currently, there are three basic specialities in mental health with four-year residency programs (psychiatry, child psychiatry, addiction psychiatry) and one subspeciality with an additional two-year residency program (forensic psychiatry). Starting in 2025, the educational reform will transition to two basic specialities (psychiatry and child psychiatry with four-year residency programs) and two additional subspecialities (forensic psychiatry with an additional two-year residency program and addiction psychiatry with an additional one-year residency).

For medical residents, policies related to the order of admission, distribution of residency specialities, and financing are set in accordance with the regulations of the Cabinet of Ministers. Although many factors are considered when confirming the annual number of residency positions, the number of psychiatry residency positions remains insufficient [12]. In 2023, a total of 70 adult psychiatrists were providing outpatient consultations in five mental health hospitals, and together covering 26.3 shifts. However, to improve quality and extend direct time with patients, there should be 64 full time shifts covered. In 2024, a total of 66 adult psychiatrists in these five hospitals covered 72.6 shifts (or one doctor per 23 inpatient beds). Hence, by reducing the number of patients, one doctor must cover an additional 73 shifts.

Community-Based Mental Healthcare

Although progress has been slow over the past few years, Latvia has been transitioning towards a community-based approach to psychiatric care, reflecting broader trends in mental healthcare reform across Europe. Similar to other post-socialism countries, Latvian psychiatric care was heavily institutionalised, with a focus on large psychiatric hospitals. However, in recent years, there has been change towards deinstitutionalization and the development of community-based services aimed at better integrating mental healthcare into the community. These changes include reducing long-term beds in psychiatric hospitals, improving outpatient services, inventing mobile mental health teams, working on primary care integration and rehabilitation services, transitioning from long-term social institutions to group apartments, and providing more social assistance. Despite these advances, existing challenges are limited funding, insufficient number of mental health professionals, stigma, and regional disparities related to healthcare service access and availability. Furthermore, one primary problem is that patients are receiving basic healthcare services in tertiary-level hospitals, leading to overworked specialists and high healthcare expenditure.

Mental Healthcare System Registry

In Latvia, the mental healthcare system includes a centralised mental health registry with data from various healthcare institutions, as an official record of mental health diagnoses, treatments, and outcomes. The registry operation is governed

Diagnosis (ICD-10)	Percentage of Latvian population (%) [8,13]	Percentage of global population (%) [14]
Bipolar disorders (F31)	0.05	0.5
Depressive disorders (F32, F33)	0.57	4 .0
Anxiety disorders (F40-F48)	0.72	4.4
Eating disorders (F50)	0.01	0.2

Table 1. Data from the Latvian Mental Health Registry, compared to global data, 2021 [8,13,14]

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by national laws and regulations that define how data are collected, stored, and used. Specifically, government-funded institutions have mandatory reporting obligations, where doctors must add patients' names to the registry. The general society (especially low-income populations) fears visiting psychiatrists, as these reports may restrict their rights to attain drivers' licences or seek job opportunities. Health professionals have engaged, albeit unsuccessfully, in dialogue with the Ministry of Health of the Republic of Latvia to close the government registry.

Like many mental health systems globally, the mental health registry in Latvia faces challenges such as stigmatising individuals with mental health issues, underreporting, and ensuring data accuracy and reporting timeliness. When comparing data between the Latvian and global registries about mental health diagnosis, it suggests that a significant percentage of patients has left government-funded healthcare and chose to pay OOP for private sector psychiatrist consultations in the private sector (Table 2).

Narcology to Addiction Psychiatry

Psychiatrists are collectively advocating for replacing the terms "narcology" and "narcologist" with "addiction psychiatry" and "addiction medicine", as a broader shift toward more scientifically grounded and internationally recognised specialties. The term "narcology", has fallen out of favour in most parts of the world. Historically, the term "narcology" was traditionally used in Russia and some post-socialism countries to describe the medical disciplines dealing with substance abuse. However, it has been associated with outdated or ineffective treatment practices like detoxification and "coding" (form of aversive therapy). These practices have contributed to the field's reputation as being regressive and isolated from global advances in addiction treatment [15].

In contrast, the terms "addiction medicine" and "addiction psychiatry" have gained recognition as modern, evidence-based specialties that address substance use disorders through a combination of medical, psychological, and social approaches. This evolution reflects a growing understanding of addiction as a complex, chronic condition that requires comprehensive care rather than just punitive or simplistic treatment methods. Countries outside of Russia have adopted these newer terms, emphasising a more holistic and research-based approach to treating addiction, as a transition that aligns with the WHO's recommendations for treating substance use disorders [16].

Latvia has reported the highest per capita registered alcohol consumption rate among the EU and OECD countries [17]. The rate of illicit drug use is increasing within society, reflecting the youth's low health literacy [18]. These statistics suggest that addiction medicine has not been previously effective, whether managed by hospital-based services for acute cases or outpatient services for routine consultations. Notably, health professionals working in addiction psychiatry within the government sector use the Minnesota model (known as the abstinence model) of addiction treatment. With dedicated efforts and hope for the future, albeit existing challenges, they recognise that improvements in this field, including robust psychosocial interventions, are urgent.

Professional Medical Associations and Methodological Institutions

The Latvian Medical Association and its professional associations have led efforts to evaluate and update professional standards in mental health. The Latvian Psychiatric Association, which commemorates its 100th anniversary this year, has published guidelines on key psychiatry disorders, including anxiety disorders, bipolar disorders, depression, schizophrenia, and sleep disorders. In 2019, Latvia participated in a project co-financed by the European Social Fund, which resulted in the publication of quality indicators as well as clinical algorithms and pathways on diverse mental health topics. These topics included alcohol addiction treatment, double diagnoses in addiction medicine and psychiatry, and treatment of opioid-dependent patients, as well as diagnosis and treatment of clinical disorders in all ages (schizophrenia, depression, dementia, autism spectrum disorder) and in children and adolescents (eating disorders, neurodevelopmental disorders, suicidal and non-suicidal self-harm, attention deficit hyperactivity disorder) [19]. These achievements are attributed to voluntary contributions from health professionals; however, there are no formal policies to ensure that these standards and guidelines (including quality criteria) are implemented in clinical practice.

In 2024, the Ministry of Health of the Republic of Latvia supported a leadership paradigm shift with government and EU financial support to designate nine priority professions (oncology, cardiology, psychiatry, paediatrics, traumatology, family medicine, rehabilitation, gynaecology, radiology) – with selected clinicians (without

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pharmacological or private sector conflicts) – to serve as methodological experts and lead the development of standards for clinical practice. These national steps aim to support that evidence-based standards are implemented by all Latvian healthcare providers with long-term sustainability across institutions.

Conclusion

Since the 1990s, Latvia's psychiatric care system has made substantial progress, with the transition from institutionalisation to community-based mental healthcare services, marking mental health as a national priority. Despite existing challenges such as stigma, limited resources, and the need for expanded community-based services, mental healthcare services continue to move towards a more modern, humane, and patient-centred approach. National reform in medical education and training has highlighted that additional medical residency positions in adult and child psychiatry as well as forensic and addiction psychiatry are required to support the healthcare system. Successful implementation of pilot projects and government-funded reforms (e.g. financing methodological expert teams) will reinforce the role of the psychiatrists and other mental health professionals to serve the 1.9 million residents. As the experience in Latvia demonstrates that every healthcare system experiences changes over time, the most important driving force is that professionalism and enthusiasm can truly make a positive difference in psychiatry medicine.

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Comparative Analysis of Healthcare Coverage Trends in South Africa and Similar Middle-Income Countries

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Mfana Maswanganyi

South Africa's healthcare system operates on a dual structure, comprising a relatively well-funded private sector and an overburdened public sector [1]. The private health care industry only serves a small part of the population, mostly wealthy people with medical plan coverage [2]. In contrast, the public sector provides services to most citizens, often with limited resources and varying quality of care [2]. This duality underscores significant inequalities in healthcare access, with stark disparities in service delivery between urban and rural areas.

Even though South Africa has made a lot of progress since the end of apartheid, there are still significant challenges with the health system. These problems are mostly caused by socioeconomic issues that make it hard for poor communities to obtain optimal care [3,4]. To address these disparities, the government has initiated transformative National Health Insurance (NHI) reforms aimed at achieving Universal Health Coverage (UHC) (https://www.health.gov.za/nhi/) [5]. The NHI aims to give all South Africans, no matter their income, equal access to high-quality medical care by combining public and private healthcare providers into a single system and sharing their resources.

Considering these reforms, this paper explores the evolution of healthcare coverage in South Africa from 2005 to 2022. It focuses on trends in public sector utilisation, medical scheme enrolment, and the mixed use of public and private healthcare services. Using data from Statistics South Africa (StatsSA), the Council for Medical Schemes (CMS), and the General Household Survey (GHS), the author investigates how healthcare access and utilisation patterns have shifted over nearly two decades [6].

Between 2005 and 2022, South Africa experienced both demographic growth and significant shifts in healthcare access, as depicted in Figure 1 below. The population increased from 47 million in 2005 to 62 million in 2022, while public sector healthcare coverage expanded from 64.3% (30 million people) in 2005 to 73.6% (45.6 million people) in 2022. Despite this growth in public sector utilisation, private medical scheme enrolment remained relatively static, covering 14.9% (7 million) of the population in 2005 and only slightly declining to 14.6% (9 million) by 2022. A noticeable trend is the reduction in the proportion of individuals who use both public and private healthcare services, which decreased from 20.9% (9.8 million) in 2005 to 12% (7.3 million) in 2022. This decline indicates an increasing reliance on public healthcare services, likely driven by economic constraints and limited access to private healthcare, especially in rural areas.

Data also reveal stark disparities in healthcare expenditure between the

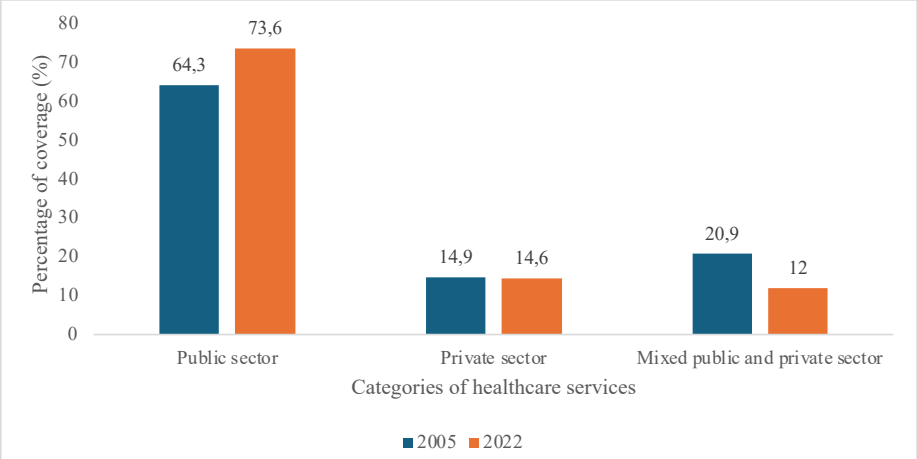

Figure 1. Population health coverage by sector in South Africa, 2005 and 2022. Sources: Statistics South Africa (Stats SA), National Treasury, Council for Medical Schemes (CMS), and McLoed cited in Willie, Masekela, and Iyaloo (2024) [7].

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public sector and private medical schemes. In 2005, the public sector expenditure per person was R1,300 (estimated US$72.39), compared to R9,500 per person (estimated US$529.33) for those covered by private medical schemes. By 2022, public sector spending increased to R5,400 per person (estimated US$300.88), while private medical scheme spending surged to R25,700 per person (estimated US$1,391.91). These disparities underscore the inequities in resource allocation and access to healthcare services, with those covered by private schemes receiving substantially higher spending and potentially better-quality care.

Policy Implications

Despite a growing population, the stagnation in medical scheme enrolment suggests that affordability and accessibility remain significant barriers to private healthcare access. The rising dependence on public healthcare indicates a need for urgent policy interventions to strengthen the public health sector's capacity. As South Africa moves towards implementing the NHI, these insights highlight critical areas for reform. The significant expenditure gap between public and private healthcare needs to be addressed to reduce inequalities. The enactment of the *NHI Act*, signed into law by President Cyril Ramaphosa in May 2024, represents a commitment to addressing healthcare disparities by pooling resources to guarantee equitable access to healthcare services for all South Africans [6]

Comparative Perspectives

To provide a comparative perspective, South Africa's healthcare coverage patterns are examined alongside those of Brazil, India, and Thailand – three middle-income countries with similar challenges related to healthcare access, socio-economic disparities, and resource constraints. Brazil, Thailand, and India encounter healthcare challenges akin to those in South Africa, marked by socio-economic disparities and unequal access between urban and rural regions, despite initiatives to broaden universal coverage. Similarly, the United States, despite its high healthcare expenditure, faces substantial coverage gaps due to its largely privatised system, underscoring persistent inequities in access to care.

Brazil: The Unified Health System (SUS)

Brazil operates the Unified Health System (Sistema Único de Saúde, SUS), instituted in 1988, as a dual healthcare system with both public and private sectors that guarantees universal access to healthcare [8,9]. As of 2022, approximately 75% of Brazilians relied on the SUS, paralleling South Africa's 73.6% dependence on public healthcare [6,8]. About 25% of Brazilians hold private health insurance for access to private facilities, in contrast to only 14.6% of South Africans covered by medical schemes [6,8]. Lessons for South Africa from Brazil include leveraging a decentralised healthcare model that empowers local governments to enhance service delivery.

India: The Ayushman Bharat Scheme

India's fragmented healthcare system has historically resulted in disparities between public and private sector service delivery [10]. The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY), which was unveiled in 2018, expanded health insurance coverage to more than 100 million families [11]. Public healthcare utilisation in India stands at 65%, compared to South Africa's 73.6% reliance on public services [6,12]. With only 20% of Indian residents using private health insurance, the focus on ensuring vulnerable populations has substantially increased coverage [12].

Thailand: Universal Coverage Scheme (UCS)

Implemented in 2002, Thailand's Universal Coverage Scheme (UCS) has achieved nearly universal health coverage [13]. Around 75% of Thai residents rely on public healthcare services, surpassing South Africa's 73.6% rate [6,14]. Thailand's success is mainly due to its capitation-based funding model and a strong emphasis on primary healthcare services, which ensures optimal resource utilisation [15]. Additionally, the UCS prioritises preventive care, enabling early intervention and reducing long-term healthcare costs [15]. This system's strong regulatory framework and efficient allocation of resources have been pivotal in maintaining equitable access to essential health services across the country [13,14].

Conclusion

South Africa's ongoing journey towards achieving UHC through the NHI framework highlights both the progress made and the challenges that persist. Despite significant strides in expanding public healthcare access, there remain substantial inequities, particularly between public and private healthcare expenditures. The comparative analysis with Brazil, Thailand, and India underscores that while these countries also face socio-economic disparities, their innovative health system reforms such as decentralisation,

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capitation-based funding, and targeted insurance schemes offer valuable lessons that could inform South Africa's NHI strategy. To close the gaps, South Africa needs to address systemic inefficiencies and resource imbalances. Equitable funding, expanded primary healthcare, and insights from global models are key to strengthening the NHI, ensuring that all South Africans, regardless of socio-economic status, have access to high-quality healthcare.

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HIV/AIDS in South Africa: Understanding the Present to Strengthen Future Efforts

Mhlengi Vella Ncube

South Africa, a nation of 63 million residents, has the largest number of people living with HIV (PLHIV) in the world, estimated at 8 million individuals or 12.7% of the population in 2024 [1]. In 2024, the overall HIV prevalence in adults aged 15-49 years is 16.7%, and with a growing population in KwaZulu-Natal and Mpumalanga provinces, which share borders with Mozambique and Swaziland. The government should remain vigilant in the implementation of relevant HIV/AIDS policies and programs and of the impacts of international migration on the HIV/AIDS programs [1]. Notably, the country is in line to achieving the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 targets, as among South Africans aged 15 years and older living with HIV, 90% knew their HIV status, 91% of those who knew their status were receiving antiretroviral therapy (ART), and 94% of those on ART had achieved viral suppression in 2022 [2].

The history of HIV/AIDS in South Africa is intertwined with the colonial activities that began 1652, the diamond rush of 1866, and the gold rush of 1876. A shift of indigenous African tribesman from subsistence farmers to migrant labourers occured so as to meet colonial obligations such as monetary taxes and pursuit of economic well-being [3]. Labourers worked in mines and cities far from home (for almost an entire year) and lived in male-only hostels, with a small income and limited transportation [3]. The added migration of some African females to serve in the homes of European families (for almost an entire year) created a fertile ground for multiple sexual partnerships and indeed sexually transmitted infections [3,4]. These circumstances persisted into the Apartheid era during which the first HIV case was recorded in 1982 [3].

The year 1982 is recognised as the beginning of the first HIV/AIDS epidemic which was driven by Clade B. More cases of HIV were reported later in 1982, mostly among homosexual men, although there some cases diagnosed between 1982 and 1985 had a suspected transmission via blood transfusion [5]. The second epidemic (driven by Clade C) was identified in 1989, predominantly affecting black people [6]. Since the conservative apartheid government perceived that HIV/AIDS only affected Africans and men sleeping with men (MSMs), no federal support or services were prioritised for these population groups [3]. As a result, the stage was set for the massive spread of HIV/AIDS in South Africa. The first antenatal HIV survey was conducted in 1990, reporting HIV prevalence in mostly African pregnant women of 1%, and the epidemic grew with a prevalence reaching 22.8% in 1998 [6].

HIV/AIDS as a Policy Priority

South Africa's democratic government inherited an HIV/AIDS crisis, following years of inaction and social stigma toward AIDS in South Africa. Prior to South Africa's independence, some political parties established the National AIDS Convention of South Africa (NACOSA) in 1993 [7]. Upon establishing its independence in 1994, NACOSA created a comprehensive plan to control the HIV/AIDS epidemic, recognising the need for urgent HIV prevention and control measures [8]. However, the implementation of this plan faced major challenges, including financial constraints, limited resources, and uneven provincial capabilities, which hampered the rollout of preventive measures and education campaigns.

In 2000, the South African National AIDS Council (SANAC), chaired by the Deputy President of South Africa, was launched, providing a platform for collaborative policy development, strategic planning, and resource mobilisation (https://sanac.org.za). The council included representatives from government, civil society, private sector, and other key stakeholders. SANAC developed the *HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005*, to address the epidemic with a multi-sectoral approach, and continues to support the implementation of progressive Strategic Plans for HIV, tuberculosis (TB), and sexually transmitted infections (STIs) in South Africa [9].

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Antiretrovirals for HIV/AIDS Control in South Africa

The role of ART has helped curb the HIV epidemic, which had already cost the country millions of lives, and now South Africa has the largest ART program in the world [10]. The Universal Test and Treat policy (UTT) which was adopted in 2016, encourages all HIV-positive persons to initiate treatment that prevents progression of HIV to AIDS regardless of their CD4 count or viral loads. The country hopes to adhere to the UTT policy and hence achieve the UNAIDS 95-95-95 targets [11]. Interestingly, more women than men are seeking HIV diagnostic testing and treatment, most likely due to societal norms where women stay at home and can benefit from health promotion programs and access to healthcare services. HIV programs targeting men are being implemented. Challenges in adherence to ART have been observed and are being resolved through adherence strategies which include adherence clubs, where people on ART can engage in peer support activities, and the Central Chronic Medicine Dispensing and Distribution (CCMDD) program, which makes ART medication accessible at convenient pickup points. As research advances, the country looks forward to the discovery and implementation of the long-acting injectable ART.

HIV Prevention in South Africa

Over the years, South Africa has championed non-chemotherapeutic prevention of HIV, including condoms as the preventative option of choice. The government provides free condoms at strategic points, such as public and university bathrooms, and sponsors widespread community health campaigns on the use of both male and female condoms. These campaigns, while targeted at the general population, are often enhanced to target key vulnerable populations, including MSMs, transgender individuals, commercial sex workers, and young women and girls.

Presently, these initiatives are anchored on the *SANAC National Strategic Plan, 2023-2028*, which aims to ensure fair and equal access to services and solutions for these diseases as well as remove obstacles to achieving positive outcomes for HIV, TB, and STIs. The strategic plan also intends to integrate HIV, TB, and STIs within health, social protection, and pandemic response frameworks and hence strengthen resilient systems. It also proposes to secure federal funding to sustain an effective national strategic plan, led by renewed, inclusive, and accountable institutions (https://sanac.org.za).

The South African HIV Clinicians Society has developed clinical guidelines for the use of post-exposure prophylaxis (PEP) for occupational and non-occupational exposures. The society advices that individuals who repeatedly request PEP should be given the pre-exposure prophylaxis (PrEP), as the PrEP policy was approved in 2016 [12]. In the future, South Africa hopes to have introduced a tri-month anti-HIV ring by 2026. To date, most PrEP programs target key vulnerable populations, including young women and girls, as the HIV transmission cycle in South Africa has been observed from men (aged 25-34) to young girls (under the age of 20) in transactional relationships [13]. These young girls then can transmit HIV to their romantic partners who are typically their own age [13].

Role of Development Partners in HIV/AIDS Control in South Africa

The government and development partners have supported the widespread roll out of ART. The Department of Health has ensured the availability of nursing training on Nurse-Initiated and Managed Antiretroviral Therapy (NIMART) to improve access to HIV care. The Departments of Health are also mandated to report on HIV/AIDS, TB, and STIs at different administrative levels, to ensure timely interventions to curb HIV transmission. Development partners, with funding by the Global Fund, U.S. Agency for International Development (USAID), UNAIDS, the Global Fund and the Bill and Melinda Gates Foundation are among the several development partners that provide invaluable expertise and human resources support to promote the UTT policy and the country's efforts towards achieving the 95-95-95 targets.

South Africa has made major gains in educating HIV/AIDS patients about the importance of ART adherence. These efforts are a result of strong political will, collaborative role of civil society, and dedicated healthcare professionals. Although HIV incidence rates remain difficult to control, the number of people who progress to AIDS has declined, and PLHIV are living longer, quality lives. Notably, the coronavirus disease 2019 (COVID-19) pandemic slowed some gains of the HIV programs, but effective catch-up plans were implemented. Doctors and other healthcare professionals must continue to play a crucial role in curbing the HIV/AIDS epidemic by providing comprehensive testing, early diagnosis, and consistent ART management to ensure viral

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suppression. Additionally, through patient education, preventive care, and reducing stigma, they must empower individuals and communities to take proactive steps in preventing new HIV infections and improving overall health outcomes.

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Navigating the Complex Labyrinth: Multifactorial Challenges Experienced by Asian Junior Doctors in the Workplace

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The Asian continent, with a population of 4.8 billion people or 60% of the global population, is recognised as the most populated geographic region. Within the Asia Pacific region, there is an unequal number and distribution of doctors, such as South Asian countries with 0.9 doctors per 1,000 people, and East Asian and Pacific countries with 1.6 doctors per 1,000 people [1]. Most doctors work in metropolitan regions, which leaves rural areas with a paucity of doctors [2]. The World Health Organization (WHO) reported that between 8% and 38% of healthcare professionals suffer physical violence at some point in their careers, with some being threatened or exposed to verbal aggression, while others experience acts perpetrated by patients and visitors.

As the region adapts to shifting demands of health services, Asian junior doctors experience unique and common challenges throughout their clinical training. This article aims to describe the obstacles that Asian junior doctors currently face across their countries, including workplace bullying and harassment, violence and mental health, excessive working hours and maldistribution of the workforce, poor working conditions, workforce shortage in rural health, task shifting, doctor's migration, and hardships to participate in international conferences. It offers a platform for World Medical Association (WMA) and Junior Doctors Network (JDN) members to discuss potential solutions to address this burden across health systems in the Asia-Pacific region.

Workplace Bullying and Harassment

Within health systems, junior doctors frequently report bullying and harassment, often stemming

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from inappropriate interactions with senior department and management leadership. These incidents range from verbal and mental abuse to sexual harassment. Extreme micromanagement, verbal criticism, name-calling and shaming, insults, hearsay victim blaming, and gossip are all common experiences of workplace bullying. However, many junior doctors choose to remain silent about these mistreatments, due to the fear of losing training opportunities or being expelled from their post-graduate training program. In addition, the strict and rigid workplace environment present in many Asian cultures further inhibits junior doctors from speaking up and confronting these bullying issues.

Republic of Korea. The Confucian value of hierarchy still widely influences social interactions within Korean society, and medical professionals are no exception. Implemented in 2019, the workplace anti-bullying law has helped decrease the number of workplace harassment reports, but cases continue to be reported across health institutions [3]. Junior doctors have requested assistance from the Korea Intern Resident Association (KIRA) for reporting workplace bullying and harassment. Although national hospitals have planned immediate investigations, the ability to switch junior doctors' training hospitals is challenging, especially with limited resources in the middle of the year.

Myanmar. As a common trend across Myanmar hospitals, senior-level doctors often take advantage of their younger colleagues' lack of expertise or knowledge with fundamental elements of the job, and they verbally rant in front of patients. The widespread power difference causes a justifiable fear of reprisal, which might ruin years of hard work and jeopardise post-graduate careers. If department heads and supervisors are the prevalent culprits, junior doctors believe that reporting these unpleasant experiences would harm their career prospects.

Malaysia. Over the past 10 years, the independent Malaysian Medical Association and the Malaysian Ministry of Health have implemented significant efforts to overcome workplace bullying and harassment [4]. They have administered surveys on bullying and harassment, launched a helpline, and organised two town hall meetings with the Ministry of Health and the Malaysian Medical Association [5]. Despite these actions, conditions are worsening, as drones of junior doctors are quitting government service and transferring to other fields, private practice or international employment.

India. Incidents of being physically bullied and harassment have long been a troubling issue in the Indian medical fraternity. In the clinical workplace, if patients perceive that medical negligence has occurred, they commonly respond by assaulting the doctors, rather than filing an official complaint with the relevant medical department. One situation was reported in mainstream media in February 2018, when relatives of a patient in Kolkata, who died due to alleged medical negligence, physically assaulted the attending doctors. In response, the doctors alleged that the patient had been attended appropriately, and they referred the patient to the relevant medical department [6].

Violence and Mental Health

Workplace violence is the intentional use of power, threatened or actual, against another person or a group in work-related circumstances that may result in injury, death or psychological harm [7]. It jeopardises the victim's health, safety, and well-being and can have mild, moderate or severe effects on physical and mental health, morale, and productivity. Although many measures have been taken to prevent workplace violence, it remains a persistent issue, especially in healthcare settings. According to the U.S. Occupational Safety and Health Administration (OSHA), it is reported that more than 11,000 cases of assaults by persons in the United States had occurred in 2010, as a 13% increase compared to 2009. As junior doctors have been increasingly exposed to workplace violence in their working institutions, these acts negatively impact their personal safety and mental health during their clinical training.

Republic of Korea. Over the past five years, 2,610 individuals have been arrested for inflicting physical assaults or threatening medical professionals in emergency rooms [8]. Some perpetrators were under the influence of drugs or alcohol, while others were dissatisfied with the services (including treatment) that they received. Standing on the frontline of patient treatment, junior doctors easily become the target of these imprudent actions. Lawmakers at the National Assembly have recently proposed the revision of the *Emergency Medical Service Act*, to find measures to prosecute offenders, even when they are under the influence of alcohol [9]. In 2018, KIRA conducted a survey on workplace violence, which revealed that 10% of junior doctors had experienced violence from a colleague [10]. Given the gravity of the status quo, KIRA developed the *Guidelines for the Prevention and Management of*

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Violence and Sexual Harassment for Residents in 2020, which acts as a legal base against offenders, especially fellow doctors.

Myanmar. Since February 2021, as a result of the Myanmar military coup, civilian areas including hospitals have been heavily bombed, and this unsafe environment has hindered how the Myanmar populace can seek medical attention [11]. Junior doctors in Myanmar face immense danger while trying to provide care during these ongoing violent attacks, and many have been forced to flee or work in secret, which severely disrupts their training and compromises patients' safety [12]. This demanding schedule and workload places junior doctors' physical and emotional health at risk, especially as they are burdened by anxiety over the potential arrest of loved ones. This stress is compounded by compassion fatigue from witnessing colleagues' imprisonment or death, which can impede the provision of effective care and lead to emotional exhaustion.

Malaysia. Violence against junior doctors in Malaysia is significant, despite the fact that the police are quick to respond upon any reported violent acts [13]. Reports indicate that a significant percentage of healthcare professionals experience physical violence at some point in their careers, with many also facing threats or verbal aggression, predominantly from patients and visitors. However, as the incidence of this violence increases each year, there is a risk of increasing mental health concerns. If not addressed proactively, this growing trend will continue to negatively affect the wellbeing of junior doctors as well as threaten to impact the overall quality of healthcare service delivery.

India. In India, workplace violence, including verbal and physical assaults, is alarmingly present, ranging from 40-78% across various healthcare settings [14]. Research studies have shown that the vast majority of resident doctors have experienced or witnessed some form of workplace violence during the past 12 months, with the highest number of incidents in emergency departments and wards [15]. Although no central legislation or act prevents violence against doctors in India, albeit repeated demands made by the JDN of the Indian Medical Association, 19 states have adopted legislation for the protection of medical professionals and healthcare facilities. To date, few cases have been reviewed in the courts, and no person who has been convicted of assault on a medical professional has been penalised under such acts until 2015. Notably, a total of 30 suicides, where 80% were in doctors younger than 40 years, were reported between March 2016 and 2019, raising questions related to mental health and well-being during medical training [16].

Excessive Working Hours and Maldistribution of Workforce

During their training, junior doctors often endure long clinical shifts, unpaid working hours or overtime, poor living conditions, and detrimental work environments. Studies have shown that prolonged working hours are associated with higher risks of mental health issues, including depression and burnout among junior doctors [17]. The negative impacts of poor working conditions and excessive working hours can extend beyond individuals themselves, as it can also compromise patient safety.

Republic of Korea. With the introduction of the *Special Act on the Resident Training Environment* in 2015, junior doctors are required to work a maximum of 80 hours per week. However, due to intense workplace schedules and understaffing problems, the upper limit of working 80 hours per week is frequently surpassed. Although many junior doctors have 36-hour consecutive shifts at least two or three times each week, this overtime payment is not paid to junior doctors. Furthermore, these longer-working junior doctors are expected to see more patients and work more night shifts than specialists, and hence hospitals naturally want to recruit more junior doctors to manage patient care. Currently, KIRA is working to revise the *Medical Residents Act*, to provide the appropriate overtime payment to junior doctors.

Myanmar. Even before the military coup, junior doctors at Myanmar public hospitals were required to complete their daily clinical weekday schedules as well as work consecutive 24-hour shifts for five to 15 days depending on staff availability. Junior doctors at station-level public hospitals are required to be on call every day, defined as 24 hours a day in case of any emergency, since only one doctor is usually available at these hospitals. The maldistribution of the workforce contributes to excessive working hours, compelling young doctors to work in unsocial hours under immense pressure. Despite the ongoing fear of violence, these dedicated individuals strive to uphold the Physician Pledge and their commitment to patient care, often prioritising their patients' needs over their own.

Malaysia. The Malaysia health system faces challenges toward improving the work-life balance for doctors. Long, unpaid working

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hours are the norm, especially in larger hospitals, as there is a maldistribution of the workforce across the nation. Although House Officers (trainee doctors) have a cap (61 hours per week) on the minimum number of work hours, House Officers and Medical Officers do not have a cap on the maximum number of work hours. With doctor shortages, junior doctors frequently work 80 to 100 hours a week, and most Medical Officers at tertiary-level centres work between 100 to 120 hours. Notably, Medical Officers are assigned several on-call periods (e.g. three to eight periods per month of 32- to 36-hour shifts), sometimes working back-to-back shifts that leave 12 hours in between shifts for rest before returning to duty the next day. Although various studies have demonstrated an underpaid, understaffed, and overworked workforce, significant efforts are needed to overcome these issues, especially as many doctors are leaving clinical practice after the coronavirus disease 2019 (COVID-19) pandemic [18].

India. Junior doctors in India experience poor working conditions that are influenced by the higher mean number of working hours (80 hours), when compared to their counterpart faculty members (53 hours) [19]. The Post-Graduate Medical Education Regulations (PGMER) has no specific working hour maximum for junior doctors, but rather states that medical institutions should allow junior doctors to work only for 'reasonable' hours and rest for 'reasonable time' in one day. Since junior doctors typically work 24 hours per day during their posting in Casualty wards, and even up to 48 hours in some departments like surgery and emergency medicine, the JDN of the Indian Medication Association has demanded (without resolution) that junior doctors should not be required to work beyond 60 hours per week with at least 30 vacation days per year. This excess work schedule can lead to work-related burnout for junior doctors, along with impacts on physical and mental health due to limited access to food, water, and rest [20].

Workforce Shortage in Rural Health

Access to healthcare services is a crucial element of good health, yet the healthcare workforce is usually concentrated in cities, leaving the rural areas with limited staff [21]. This shortage impacts rural community members who may face barriers to healthcare that negatively impact their general physical, social, and mental health status, as well as their quality of life and life expectancy. They may face financial barriers to paying for the services, finding transportation to reach medical facilities, and securing enough time to use such services.

Republic of Korea. Male junior doctors, who are required to fulfil their mandatory military service duty, are usually dispatched as public health doctors to geographic areas with poor health infrastructure. Since these job posts are temporary and last three years, the cyclic turnover hinders the ability to preserve the continuity of patient management in these rural areas. Nonetheless, these public health doctors remain pivotal leaders in supporting rural health across the country.

Myanmar. Myanmar junior doctors lead public health interventions, support disease control programs, and offer clinical services in their assigned stations, regardless of the remote location or workload. Although double pay has been offered to civil servant doctors who serve in marginalised locations, there are no incentive programs for junior doctors. Doctors are usually appointed as the charge in these rural areas, and if junior doctors take on these supervising roles, they are likely to face much frustration and disappointment from the lack of resources and support that may lead to further neglect of rural communities.

Malaysia. Several strategies have been implemented to encourage junior doctors to serve in rural Malaysia communities, including offering permanent employment positions for those who volunteer to serve at the rural areas, shortening the waiting time from Housemanship to Medical Officer-ship placements, and increasing chances of obtaining a postgraduate degree after completing the rural posting [22]. Medical Officers are doctors who are confirmed in their service (after two years of serving as Housemanship trainee doctors) and prior to becoming a specialist, they are addressed as Medical Officers. Medical Officers usually choose to work in major hospitals, located mostly in large cities as these are highly specialised and will ensure good training in their fields of choice. Hence, this timeline further fuels the lack of Medical Officers working in the rural healthcare facilities.

India. Recognising that 65% of the population resides in rural areas, the shortage of healthcare professionals poses a significant challenge for India. To address this challenge, state governments have implemented service bonds for medical and postgraduate students to serve a designated period (up to 10 years) in state-run hospitals or peripheral health centres upon completion of their undergraduate

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or postgraduate training [23]. These health centres, however, often lack adequate infrastructure and resources, leading to poor quality healthcare service delivery. Failure to comply with this service requirement may result in penalties, such as forfeiting a predetermined bond amount or degree cancellation.

Task Shifting

The term 'task shifting' is used to describe a situation where a task normally performed by a doctor is transferred to a healthcare professional with a different or lower level of education and training, or to a person specifically trained to perform a limited task only, without having a formal health education. It involves the delegation of specific healthcare tasks from highly skilled professionals, such as doctors, to a wider array of healthcare professionals with less extensive training, including nurses, community health educators, and pharmacists. This delegation is founded on the principles of efficiency, cost-effectiveness, and improved access to healthcare services, especially in regions where healthcare resources are scarce or unevenly distributed. Task shifting can occur in countries regardless of whether they are facing shortages of doctors [24].

Republic of Korea. Due to a chronic shortage of doctors in several areas of medicine, namely paediatrics and surgery (e.g. general, cardio-thoracic, trauma, neurosurgery, obstetrics and gynaecology), hospitals have either suspended services or have resorted to employing physician assistants (PA). The PAs in the Republic of Korea are usually registered nurses who are trained to assume the clinical workload of junior doctors, ranging from inpatient care to surgical procedures. Recently, KIRA has conducted several surveys that have highlighted how junior doctors have felt overlooked during their training, as more hospitals have demonstrated a preference for PAs over junior doctors. Once PAs have been trained, they can work longer hours and more closely with senior doctors. However, PAs in the Republic of Korea are not explicitly incorporated into the current medical law, making their status unlawful and unqualified [25]. Moreover, they do not receive formal education or training, which differs from PA programs in other countries like the United States or Canada. The conflicts between PAs and junior doctors, the legal liability of PAs, and the lack of PA training programs are key task shifting issues that should be promptly addressed.

Myanmar. With few competent doctors providing healthcare services in rural Myanmar communities, tasks are delegated to less qualified healthcare professionals [26]. If health leaders do not monitor health service delivery, task shifting will pose a double burden on an already fragile health system. Over time, financial restrictions and the amount of participation by external players are placing a double pressure on the health infrastructure and provision of essential services to the populace. The military coup has exacerbated these challenges, jeopardising the access to reliable and high-quality healthcare services.

Malaysia. Despite the human resources for health shortage, the Malaysia Ministry of Health continues to complete administrative tasks in silo, without communicating or collaborating with other ministries on similar tasks. During the COVID-19 pandemic, triage and contact tracing were completed by the Ministry of Health staff, requiring a diverse team of healthcare professionals (nurses, medical assistants, doctors, ambulance drivers, hospital attendants) [27]. This contact tracing job, however, could have been conducted by the Telecommunications and Multimedia Department, rather than solely by the Ministry of Health, since staff were actively managing acute COVID-19 cases, and hence reduce the workload for all parties.

India. The Ministry of Health and Family Welfare in India created a cadre of community health officers of nursing or traditional medicine graduates who can practise limited modern medicine after taking a six-month bridge course [28]. The move has received criticism from the Indian Medical Association and the JDN, as it has the potential to develop crosspathy (practice of modern medicine by traditional medicine doctors) and unregulated medical practitioners without adequate training in modern medicine. While junior doctors practising modern medicine have always supported the consultations between and within different systems of medicine, an attempt to allow cross-pathy is strongly condemned.

Doctor Migration

The global health system faces a deficit of 6.4 million doctors necessary to achieve universal health coverage (UHC) goals. Specific data reveal a 10-fold variation in the density of healthcare professionals across and within regions worldwide. Significant shortages are observed in South Asia, with a gap of 2.57 million doctors; Southeast Asia, East Asia, and Oceania lacking 995,000 doctors; sub-Saharan Africa with a shortfall of 1.91 million doctors; and North Africa and the Middle East

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with a deficit of 636,000 doctors [29]. The migration of junior doctors from low- and middle-income countries (LMICs) to high-income countries (HICs), such as Australia, the United States, and the United Kingdom, is driven by a range of factors, including the pursuit of better career opportunities, safer workplace environments, and higher salaries.

Additionally, the attraction of advanced training programs, the desire for better work-life balance, economic instability in LMICs, access to research opportunities, professional development, and inadequate health infrastructure also compel doctors to migrate. This migration allows some HICs to draw as much as one-fifth of their doctor workforce from LMICs. Consequently, this global trend highlights the broader systemic issues in LMICs' healthcare systems, raising concerns about equity, sustainability, and the long-term impact on healthcare delivery in vulnerable regions.

Republic of Korea. Although doctor migration is an uncommon practice in the Republic of Korea, some doctors choose to migrate to the United States and Japan. Junior doctors tend to finish their training at their alma mater university hospital and prioritise establishing a good balance between life and clinical training, despite the hardships of overcoming language barriers and adjusting to different cultures. Many prestigious Korean university hospitals aim to expand the size of their hospitals by opening branches in other countries, such as China, Saudi Arabia, Singapore, and Vietnam [30]. These proposed actions help expand the global market to export the expertise of Korean healthcare, which can also encourage Korean junior doctors to work abroad.

Myanmar. Myanmar junior doctors recognise the unsafe work environments and frequently migrate to HICs, like Australia, South Africa, the United Kingdom, and the United States, although lower migration rates when compared to other countries [31]. Some junior doctors, however, feel a sense of duty and commitment and choose to provide essential medical treatment and support colleagues amid the military coup and deteriorating healthcare system. Many doctors who leave Myanmar for improved working conditions may experience "survivor guilt", witnessing the ongoing violence and chaos from afar, which prompts them to return home out of a sense of responsibility. Their dedication reflects a profound ethical belief in prioritising the health and well-being of their community, often above personal safety or career opportunities abroad.

Malaysia. A large number of Malaysian doctors are moving to other countries to pursue training, further studies, and employment opportunities. The worsening working conditions coupled with poor wages are further fueling the brain drain, with doctor migration increasing annually [32]. This migration not only depletes the country of its skilled healthcare professionals, but also strains the healthcare system as it struggles to meet the needs of its population. Although the Malaysia Ministry of Health has recognised this brain drain, leaders are working with the Malaysian Medical Association to develop a policy reform specifically to address this situation at hand. Although these efforts will publicly increase awareness of the brain drain, they are still inadequate to fully overcome the problem.

India. After India gained independence in 1947, the post-liberalization era occurred in the 1990s, and the private sector investments led to the expansion of the healthcare sector. Notably, the number of registered medical colleges (86 in 1965 to 539 in 2019), and now, more than 67,200 students begin medical school each year. With limited residency placements upon graduation, medical graduates are seeking training and employment opportunities outside of India, which has now become one of the world's top exporters of doctors. The India Ministry of Health and Family Welfare has implemented measures to limit the migration of doctors, including halting the issuing of the No Obligation to Return to India (NORI) certificate, which is necessary for medical graduates to J-1 visa applications to the United States. These mere bureaucratic efforts remain futile, however, and the migration of Indian junior doctors is expected to continue. Hence, systemic reform should consider the underlying employment context as well as the demographic and healthcare workforce shortage challenges across the Organization for Economic Cooperation and Development (OECD) countries [33].

Hardships to Participate in International Conferences

Junior doctors in Asia encounter challenges when participating in WMA events and serving on WMA delegations for World Health Assembly events. The official registration announcement for these events often open three months prior to the scheduled event, posing significant logistical difficulties for participants to arrange travel, accommodations, and other necessary preparations. The WMA meetings are also expensive – for example, registration of 400 Euros for junior doctors – whether held in Africa or Europe. From

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2014-2023, more than 70 percent of WMA General Assemblies and Council Meetings were held in Europe and Africa, and less than 10 percent were held in Asia. Without the support of national medical associations, junior doctors are often unable to afford travel and join the in-person WMA meetings. Further inflation and the lower rate of currencies of various Asian countries add to this significant financial burden.

Republic of Korea. Over the past few years, KIRA members have been enthusiastic and passionate to participate in JDN and WMA activities, although most conferences have been located outside of the Asia region. Their participation, however, has been generally recognised as a low priority and not directly related to their training. Although KIRA has encouraged junior doctors to attend conferences with partial financial support, competing challenges remain such as gaining permission to travel, allocating vacation time to attend a conference, finding a colleague to perform their assigned clinical duties, and covering any incidental expenses.

Myanmar. High conference registration costs to attend WMA meetings present hardships to Myanmar junior doctors. For example, conference fees are equivalent to approximately one month's salary of a junior doctor working in a public hospital or two weeks' salary of a junior doctor working in a private hospital in Myanmar. Additional logistical concerns include approvals from departmental heads, visa appointments, and visa processing time (3-4 months).

Malaysia. Registration costs to participate in WMA meetings is estimated at one-third to one-half of the salary of a Malaysia junior doctor. In order to travel internationally, government doctors need to apply for special permissions at least 60 days prior to the proposed departure date. Despite these logistical challenges, applications can also be cancelled by the Head of the Department or other higher administrators, as deemed necessary. Late notices, invitations, and announcements add to the challenges in travelling to in-person meetings.

India. Junior doctors from India actively participate in the conferences and meetings in India and neighbouring countries. However, their participation in international conferences or WMA meetings that are organised in HICs represents challenges due to the high costs of travel, accommodation, and registration fees, especially as these costs do not consider the national purchase power parity parameters. Additionally, requests to secure permission to attend these conferences and meetings are often dismissed in view of understaffing and high patient loads in hospitals, with variable support from faculty.

Conclusion

In the realm of global medical activities, Asian junior doctors encounter formidable challenges rooted in societal expectations and prevailing bureaucratic cultures. These challenges pose significant barriers, impeding their full and meaningful participation in the international medical arena. This article shines a light on these obstacles, advocating for increased awareness and proactive measures to address and mitigate the adverse impacts on the promising trajectory of Asian junior doctors in the global health landscape. As a call to action, the WMA and JDN should advocate for policies and programs that create more opportunities for junior doctors in Asia.

First, providing clear guidelines on working hours and staffing in healthcare settings can establish a foundation for the robust enforcement of regulations in these areas. The development of WMA or JDN standards or guidelines would offer stronger tools to national member associations for their advocacy and reform efforts. Second, establishing a comprehensive WMA/JDN mentorship program can offer invaluable guidance and role models for junior doctors. While the recent WMA initiative, the Past Presidents and Chairs of Council Network (PPCN) mentorship program, is a step in the right direction, we recommend implementing mentorship programs at a regional level. This would address unique challenges in the region, such as issues stemming from generational hierarchies and bureaucratic structures. Regional mentorship programs would promote better communication and understanding among junior doctors and other healthcare professionals in clinical settings.

Finally, fostering WMA/JDN networking among Asian national member countries would help Asian junior doctors broaden their perspectives, exchange knowledge, and forge meaningful professional connections. These networks could also advocate for financial aid, sponsorships, or reduced fees, enabling junior doctors to attend conferences, engage in discussions, and build relationships with colleagues at both national and international levels. These three initiatives – setting standards, establishing mentorship programs, and encouraging networking – will

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empower junior doctors to excel and thrive in the global medical landscape.

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Climate Change and Children's Health: An Overview and Call to Action

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The science on climate change is clear. According to the Sixth Assessment Report (AR6) of the Intergovernmental Panel on Climate Change, *"human activities, principally through emissions of greenhouse gasses, have unequivocally caused global warming, with global surface temperature reaching 1.1°C above 1850-1900 in 2011-2020"* [1]. Adverse global impacts from human-induced climate change will continue to intensify, and the health effects of the global surface temperature rise are extensive and clear [1].

Children, particularly socially disadvantaged children, are uniquely susceptible to the health effects of climate change. In comparison to adults, children spend more time outside, have less efficient thermoregulation, and have higher respiratory rates. They also are growing and developing immunity, resulting in this susceptibility. As physicians, we have a unique responsibility to advocate for practices that mitigate the effects of climate change on children, our most vulnerable patients [2]. To address this challenge, it is critical that we understand climate stressors like extreme heat, changing seasons, air quality, severe weather events, and expansion of vector habitats, and their disproportionate health effects on children [3].

Extreme heat. An increasing body of worldwide evidence suggests that high temperatures during the prenatal period are correlated with increased rates of preterm birth, low birth weight, and stillbirth [4]. In Spain, infant mortality (particularly in the first week of life) was 25% higher on extremely hot days, when compared to all deaths (1986-2006) in the Catalonia region [5]. In the United States, extreme heat was associated with a 17% increase in emergency department visits by children for all complaints, with heat-related illness, bacterial enteritis, and otitis media and externa showing significant increases [6]. Furthermore, urban heat islands in the United States disproportionately impact non-white and economically disadvantaged children, resulting in both increased physical health effects and decreased school performance [7]. Physician awareness of heat and its impact on children's health is critical for both advising families on safe practices on hot days as well as preparing for heat-related conditions that present to the clinic or hospital.

Changing seasons. The warming planet will result in shorter cold seasons and longer hot seasons. Birch, oak, and grass pollen are all projected to increase substantially with longer hot seasons [8]. As there is a significant association between the birth month and the risk of allergic sensitization or asthma later in life, children exposed to high allergen levels during the first three months of life are more likely to develop early wheezing and allergic sensitization [8-10]. Primary care physicians, therefore, should be prepared to manage allergies and asthma cases, while emergency providers should be aware of increased asthma complications as the surrounding environment continues to change.

Air quality. Changes in temperature, precipitation, and wind patterns are contributing to worsening air quality. Air pollution impacts children by increasing preterm birth, pneumonia and other respiratory infections, asthma, cancer, and neurodevelopmental disorders [11]. In 2021, for children under five, 15% of all global deaths were linked to poor air quality, and the air pollution related death rate in Sub-Saharn Africa was 100 times higher than the rate reported in high-income countries [12]. As physicians, we need to educate families on the

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health effects of harmful emissions and strategies to improve air quality in the home and limit outdoor exposure on poor air quality days.

Severe weather events. As temperatures rise, natural disasters, such as floods, droughts, wildfires, and intense storms, are increasingly displacing children from their homes [1]. The United Nations Children's Fund (UNICEF) found that weather-related disasters were linked to an estimated 43.1 million internal displacements of children worldwide (approximately 20,000 per day) from 2016-2021 [13]. People in low- and lower-middle-income countries are approximately five times more likely to be displaced [14]. Child displacement exposes children to the elements (e.g. heat, cold, poor air quality, infectious disease) as well as causes negative impacts on mental health, underscoring the need for awareness and advocacy in reducing these impacts.

These climate stressors can increase children's risk of exposure to infectious diseases and negative psychological health outcomes. Shifts in seasonal weather patterns and more frequent flooding, including the influence of anthropogenic factors like human mobility and land use changes, can lead to an associated increase in vector-borne diseases spread by flies, mosquitoes, and ticks. Over the last 50 years, the global incidence of dengue has increased 30 times, largely due to climate change related factors such as rainfall, temperature, and urbanization [15,16]. The incidence of malaria is inversely proportional to a country's per capita gross domestic product, though it remains unclear whether poverty increases the spread of malaria or higher malaria rates inhibit economic growth [17]. The morbitity and mortality of vector-borne diseases are particularly high in children. For example, malaria attributable death rates have been reported to be as high as 25-30% in children under five years old in some regions of Africa [17]. Hence, physicians should be aware of how these dynamic environmental factors are influencing the expansion of vector habitats and risk of disease transmission, as well as the unique health effects of these vector-borne diseases on children.

The psychological toll of climate stressors on child and adolescent mental health is immense. In 2022, one study examined 10,000 young people (aged 16-25) across 10 countries, revealing that 84% were at least moderately worried about climate change, 50% perceived that climate change negatively affected their daily life and functioning, and more than half reported feeling that governmental responses to climate change were inadequate [18]. In addition to their unique physical and emotional vulnerability, children will live longer to feel the effects of climate change, as a child born in 2024 will be just 26 years old in 2050 and 76 years old in 2100. In even the most optimistic greenhouse gas emission scenarios, the planet will be a vastly different place at the turn of the century than it is today [1].

As health professionals, it is our moral responsibility to seek high-quality evidence-based sources on the direct and indirect health impacts of climate change on children's health, which can prepare us for providing optimal clinical care to our patients. For example, UNICEF and the World Health Organization (WHO) developed a free children's environmental health course for healthcare providers, which aims to provide foundational knowledge to make healthcare providers effective communicators and advocates [19]. In our daily clinical practice, it is imperative that we encourage children and families to manage their chronic medical conditions and medications meticulously, which can be exacerbated by climate stressors. We must also incorporate climate change counseling into our clinical practice, by educating families on regional health risks and disaster preparedness strategies. As trusted members of society, we should encourage the adoption of healthy habits, such as using active modes of transportation (e.g. walking, biking) and consuming plant-based diets to increase nutritional intake and reduce carbon emissions[2].

To support urgent action to combat the climate crisis, physicians can lead global discourse, help develop international policies, and share climate and health information with patients, their families, and communities. Across the globe, health systems have prepared and launched action plans to serve as a framework to implement climate mitigation and adaptation measures that meet national and international indicators like the Sustainable Development Goals. Likewise, professional medical associations have taken significant strides to leverage their clinical expertise and offer collective stances. The American Medical Association signed the *U.S. Call to Action on Climate, Health, and Equity: A Policy Action Agenda* in 2019, recognising the need to work across government agencies, sectors, and communities to address the climate and health emergency. The World Medical Association (WMA) adopted the *WMA Resolution on Climate Emergency* in October 2019, highlighting the need to protect the future generation's right to live in a healthy environment, and

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empowering health professionals to act on a broader societal scale [20]. Together, our medical community can contribute to this timely call to action and advocate for policies to stop climate change in the name of children's health on local, national, and international legislative levels. The future needs us.

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Enhancing One Health Communication in the Environmental Sciences

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One Health Day (https://www.onehealthday.com/) is recognised annually on 3 November, and this year marks the ninth global celebration. This day offers a moment to highlight the One Health approach, by reflecting on the direct connections between humans, animals (domestic and wild), plants, and our surrounding environment, as well as understanding that multiple disciplines and sectors can collectively accelerate scientific advancements related to endemic and emerging global risks. Published in October 2022, the *One Health Joint Plan of Action 2022-2026* promotes the importance of the 4C's – communication, collaboration, cooperation, capacity building – that can help align how we can operationalize One Health in practice [1]. As the sixth action track (*integrating the environment into One Health*) prioritizes biodiversity protection and restoration efforts that support the human-animal-environment nexus and sustainable development, health professionals can help galvanize global efforts to better understand the natural and anthropogenic phenomena affecting the delicate ecosystem balance and how to best communicate the health-related impacts with patients and communities.

Illustrating and Communicating Ecosystem Changes

Over the past decades, the effects of climate change have been monitored and acutely observed, including sea level rise, record-breaking temperatures, widespread drought and flooding, and other severe weather events [2]. For example, increased temperatures can cause earlier bloom seasons with greater exposure to pollen and other allergens, changes in soil moisture and nutrient cycling, and expanded vector habitat suitability with risk of disease transmission. The higher frequency and duration of droughts can impact the agricultural sector (including food security and wildfire risk), as well as increase the risk of dust storms affecting air quality, highway safety, and exposure to *Coccidioides* spores. Land-use changes due to agricultural and industrial practices or deforestation can force animals to seek and adapt to new environments that are proximal to humans, just as urban landscape modifications from green space to asphalt can absorb more solar radiation and influence urban heat island effects.

To address these single or concurrent incidents, health systems are challenged by workforce shortages, inadequate infrastructure, and limited resources, which may exacerbate or amplify communicable and non-communicable disease risks. Since the Institute of Medicine published the framework of six domains of healthcare quality (*safe, effective, patient-centered, timely, efficient, equitable*) in 2001, health professionals have observed healthcare trends and emerging gaps in service delivery (including shortcomings during the COVID-19 pandemic) and have suggested revisions, such as weaving "patient-centered" elements in each domain (rather than patient-centered as a separate domain) and incorporating new domains (e.g. ecology, transparency) into the model [3-5]. Similarly, one proposed seventh domain of *patient connectedness* underscored the need to dedicate time to build meaningful provider-patient rapport and genuine connections albeit busy workplace schedules and responsibilities [6]. Renewing trust in healthcare systems, reinforced by effective teamwork and empathetic communication, can ultimately support shared clinical decision-making, improve cultural competence, and promote healthy literacy.

Harnessing new data, tools, and technologies to identify the primary drivers of emerging and reemerging health risks is paramount in capturing a comprehensive understanding of the complex and intricate connections of our changing Earth's systems and public health. This information can help guide health professionals in the development of relevant

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health messages on recommended prevention practices to mitigate exposures to climate-related risks. Collectively, health professionals can empower patients and community members to adopt healthy behaviors, such as seeking protective cover and staying hydrated in extreme temperatures and wearing protective clothing and using repellent to prevent mosquito or tick bites. Their indispensable role in One Health communication on environmental health topics, however, may be met with skepticism amidst the growth of digitalization (including social media technology), which may provoke the diffusion of inaccurate and misleading health messaging for target audiences.

Defining Constructs

As health professionals tailor their health communications, including incorporating audio and visual elements and using diverse communication channels, they should ensure that they simultaneously understand, listen to, and motivate target audiences [7]. Efforts to develop accurate, easy to understand and access, and actionable messages, nonetheless, may be associated with the constructs of misinformation, disinformation, and malinformation. These unexpected outcomes can undermine trust, distort facts, and create barriers to promptly sharing information and adopting recommended health behaviors [8].

Misinformation, defined as the spread of false or inaccurate information without intention to harm, can unintentionally mislead the public about health information. Disinformation is the act of deliberately misleading information, because of specific motives (e.g. economic, political), which can be weaponized to create distrust and block timely health interventions. Malinformation, a relatively newer term, represents the dissemination of correct information used out of context to harm or attack an idea, and simultaneously increases distrust by emphasizing negative aspects without proper framing or context [8]. Addressing these threats requires proactive tactics, including engaging diverse audiences and venues, exiting disciplinary silos to broaden scientific discourse, and building trust and rapport with stakeholders, which can equip health professionals during their direct patient interactions in clinical and community settings.

Identifying and Addressing Gaps in Communication Approaches

Engaging diverse audiences and venues. Communicating within the One Health framework is inherently complex due to its interdisciplinary nature, involving multiple sectors such as public health, medicine, nursing, veterinary science, and environmental sciences. While this connectedness is crucial for addressing One Health challenges, each discipline brings its own terminology and knowledge to the collective discussion. This path, however, can lead to confusing or fragmented communication, which can hinder the ability to craft accurate messages for diverse audiences. Health professionals can tailor messaging when seeking new audiences at community outreach activities, including families (e.g. community family days or public library events), university students (e.g. campus activities), agricultural communities (e.g. local or state fairs, farm stores, zoos), and local policy agencies (e.g. community council meetings) [9]. Aligning messaging with community engagement has been highlighted in the comprehensive reports on prioritized zoonotic diseases through more than 35 U.S. Centers for Disease Control and Prevention (CDC)'s One Health Zoonotic Disease Prioritization (OHZDP) workshops that describe collaborative steps working with One Health partners to mitigate zoonotic disease risk [10]. Also, incorporating environmental principles into One Health messaging has been observed in the National Aeronautics and Space Administration (NASA) *Earth Science Applications Guidebook* (https://appliedsciences.nasa.gov/guidebook/) and the U.S. interagency-supported Earth Information Center (https://earth.gov/), which offer specific examples on using Earth science applications across agricultural, disasters, health, and water sectors.

Exiting disciplinary silos. The impact of disciplinary silos and conflicting stakeholder priorities can create significant barriers to advancing One Health communication. As health professionals engage with different stakeholder groups (e.g. agriculture, industry, policy, trade), shared discourse of cost-effective solutions may result in contradictory perspectives on short- and long-term health and environmental sustainability. Political cycles and frequent leadership changes can bring uncertainty to the sustained investment, commitment, strategic priorities, and communication needed to support the development and implementation of One Health initiatives. Also, with the academic pressure to contribute to scholarly publications ("publish or perish"), researchers may select high-impact journals recognised in their fields, leading to academic or knowledge silos. To promote robust transdisciplinary collaborations among diverse sectors and stakeholders, co-designed projects with equal and meaningful

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participation can offer a valuable platform to leverage expertise, data, and tools, as well as discuss mutual goals that align with optimal human, animal, and environmental health [11]. Bridging gaps and building trust across multiple disciplines will require strategic and transparent communication, commitment to fostering interdisciplinary dialogue, and ethical data sharing and reporting policies [12].

Building trust and rapport. Effective communication among One Health stakeholders requires clear, transparent, and evidence-based information sharing among relevant parties to help build interpersonal connections and trust. Culturally, ethically, and language appropriate strategies should be integrated into community engagement activities, which can help resonate one's lived experiences with support for One Health efforts. For example, visual storytelling or role-playing exercises can capture the audience's attention, presenting scenarios with multiple branches for the discussion of complex health topics. Health professionals have a crucial role in building trust with community leaders and achieving meaningful public engagement across One Health activities [13]. For example, stimulating community interest on One Health partnerships has been observed through artistic creativity and scientific precision in the CDC's One Health in Action stories (https://www.cdc.gov/one-health/php/stories/index.html) as well as through community-driven health fairs and workshops that provide hands-on learning experiences.Also, the Earth Observing Dashboard, a tri-agency collaboration between NASA, the European Space Agency (ESA), and the Japan Aerospace Exploration Agency (JAXA), which provides easy-to-use data portal for the public to explore the interactive dashboard and narratives addressing changes to global ecosystems.

Conclusion

As the world commemorates the ninth annual celebration of One Health Day 2024, global leaders continue to raise awareness of the impacts of natural and anthropogenic phenomena on the delicate balance of our global landscapes. Significant momentum has propelled leaders to build sustainable collaborations and develop novel, nature-based, and cost-effective solutions to mitigate further biodiversity loss and degradation and exposure to harmful pollutants or pathogens. Despite clear scientific evidence of climate-related risks, however, health professionals remain challenged to effectively share creative messaging with tangible actions, as part of their One Health communication strategies [2,14]. Access to broadband internet access, proposed as a social determinant of health, offers essential opportunities to acquire health information and digital health services, employment and virtual learning, and community and social networks [15]. Aside from the multiple advantages of information and communication technologies, the rapid spread of incorrect information on these virtual platforms, coupled with the "digital divide" (gap related to unequal access to digital technologies), can hinder One Health communication efforts to improve health literacy.

As World Medical Association (WMA) members, our moral and ethical responsibilities to care for our patients' physical and mental health and well-being as well as support their healthcare decision-making are based on several landmark policies. First, the WMA Declaration of Geneva, adopted in September 1948 and amended in October 2017, describes the professional and ethical responsibilities of physicians, noting that "*The health and well-being of my patient will be my first consideration*" [16]. Second, the WMA Statement on Healthcare Information for All, adopted in October 2019, emphasizes that health professionals, patients, and the general public must have access to evidence-based, relevant, reliable, and unbiased health information, to help inform decision-making about healthcare services over the lifespan [17]. These policies offer a solid framework, where health professionals can collectively leverage clinical and surgical expertise to develop catchy messaging – accurately describing health risks and illustrating concrete actions to minimize morbidity and mortality rates – to support One Health communication and recommended climate mitigation and adaptation strategies.

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WMA Members Recognise International Doctors' Day

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From the development of modern medicine in ancient Greece to present day, the empirical method emerged as a systematic approach to observe phenomena, collect and analyse data (e.g. hypothesis testing), and conclude findings [1]. These steps underline the unique vantage point of physicians, who endure comprehensive training in evidence-based medical sciences to attain a high level of competency in their clinical, surgical, and public health practice. Their direct interactions and evaluation of patients' underlying physical and mental health concerns, coupled with the close examination of the social and structural determinants of health, reflects the need to build physician-patient rapport and cultivate authenticity in communications [2]. Incorporating robust communication techniques, like the Four Habits Model (invest in the beginning, elicit the patient's perspective, demonstrate empathy, invest in the end) or PEARLS (partnership, empathy, apology or acknowledgment, respect, legitimation, support), into the clinical encounter, reflects the sentiments expressed by Hippocrates, known as the Father of Modern Medicine: *"Cure sometimes, treat often, comfort always."* [3,4]. Physicians, who are cognizant of this moral conduct and accountability and understand the health system as a whole, can leverage their expertise to articulate gaps in healthcare service delivery, advocate for community needs, and contribute to the development of timely interventions and policies with local and national leaders [5].

Since the World Medical Association (WMA) was founded in September 1947, WMA members have adopted two landmark declarations, which serve as guidance to ensure that high-quality ethical standards are prioritised and upheld in daily clinical interactions (including research initiatives) with patients, families, and community members. The WMA Declaration of Geneva (adopted in 1948 and amended in 2017), which emphasises the physicians' professional responsibilities guided by ethical principles, focuses on elements of confidentiality, medical knowledge, physician-patient rapport, professionalism, and respect [6]. Also, the WMA Declaration of Helsinki (adopted in 1964 and amended in 2024) underscores the essential ethical principles needed for medical research involving human participants, for physicians, research teams, and participants [7].

Building upon these declarations, the WMA adopted the WMA Resolution in Support of an International Day of the Medical Profession, October

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30, at the 71st WMA General Assembly (virtual) in Cordoba, Spain, in October 2020 [8]. This resolution was reaffirmed by the 226th Council Session in the Seoul, Republic of Korea, in April 2024. With emerging and reemerging global threats, physicians will be called to lead and contribute to efforts that promote multidisciplinary and multisectoral collaborations, support shared decision-making with patients, and reinforce healthcare service delivery across nations. Their dedicated efforts follow the sentiments of Sir William Osler: *"The good physician treats the disease; the great physician treats the patient who has the disease."*

In this article, physicians from 12 countries – Bulgaria, Côte d'Ivoire, Ecuador, India, Kenya, Malaysia, Myanmar, Nepal, Philippines, Republic of Korea, Trinidad and Tobago, and Türkiye – shared their perspectives on International Doctors' Day, identified existing challenges and described local and national actions to strengthen medical education and practice, and expressed optimism related to the future of medicine. Notably, they shared a symbolic reflection that resembles physicians' leadership, expertise, passion, and compassion across their nations.

Bulgaria

Bulgarian Physician's Day is celebrated annually on 19 October since 1996, paying tribute to St. John of Rila, the revered healer and patron of the Bulgarian people who symbolizes the compassion, dedication, and moral duty that define a doctor's life. The idea for the celebration was suggested by Dr. Totko Naydenov, to acknowledge and praise Bulgarian doctors who perceive medicine as their calling. Each year, the Bulgarian Medical Association marks the occasion by honouring exceptional doctors with awards, including *Physician of the Year* (recognising outstanding achievement), *You are our Future* (highlighting promising young doctors), *Contribution to the Prestige of the Profession* (acknowledging those who elevate the reputation of Bulgarian physicians and medicine), and *Commitment to Innovation* (identifying professionals who drive novel adoption of new techniques and promote growth within the field), and *Dedication and Medical Ethics* (recognising physicians' courage and commitment to patient care and professional values). Complementing Bulgarian Physician's Day, Bulgarian physicians recognise the Day of Salvation on 15 August, paying tribute to all doctors who lost their lives in the line of duty, in remembrance of Dr. Stefan Cherkezov's selfless actions in 1963, who lost his life after saving 47 passengers from a burning bus accident.

Like other countries across the globe, Bulgaria faces a critical shortage of healthcare professionals, as the workforce is aging, and the number of young physicians entering the national healthcare system is dwindling. Combined with the push and pull factors driving professional migration, Bulgaria is experiencing a significant reduction of physicians and nurses, which in turn affects access to quality healthcare services. The newly elected Chairperson of the Bulgarian Medical Association, Dr. Nikolay Branzalov, stated that *"Young physicians seek three things: job opportunities, specialised training, and career advancement. Currently, remuneration is inconsistent with the efforts, but the bigger issues are the complexity of specialisation and career growth. The current specialisation rules are designed as if there were an excess of healthcare professionals, rather than stimulating young physicians to specialise."* For example, the Bulgarian medical community has observed the limited number of health professionals serving in paediatric medicine among other specialties. Recognising these challenges, the Bulgarian Medical Association is committed to supporting the well-being of all physicians, enhancing the profession's prestige, and increasing support for junior doctors and medical students (and hence, recruitment and retention), which can ensure sustainable, quality care for future generations.

The newly elected leadership (2024-2027) of the Bulgarian Medical Association is committed to continuing the Association's work and long-term priorities (including improving working conditions for Bulgarian physicians) in a spirit of continuity and collegiality. First, the Bulgarian Medical Association advocates for a more equitable compensation structure, addressing undervalued physician labour within the current National Health Insurance Fund (NHIF) model. With input from academic experts, a proposed methodology has been submitted to the Bulgaria Ministry of Health and the Council of Ministers, and is currently awaiting review and implementation. Second, the Association seeks legislative amendments to make continuing medical education (CME) and continuing professional development (CPD) mandatory, fostering ongoing improvement and removing barriers that restrict doctors' access to professional growth opportunities. Finally, the Bulgarian Medical Association continues to negotiate with the NHIF, on behalf of various medical specialties, to balance the needs of primary, specialised, and hospital care in service to Bulgarian patients and society. For example,

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the Association successfully advocated for the inclusion of the prohibition of transferred funds from the NHIF budget to other budget lines in the *NHIF Budget Act*.

Bulgaria's healthcare professionals remain dedicated to preserving the future of their field and the well-being of their patients. First, the Bulgarian Medical Association recognises that the next generation of physicians will serve as a vital source of inspiration, reminding the medical community of the higher calling that defines their work. Alexander Sidjimov, a third-year medical student, refers to medicine as *"the key that unlocks the doors of health and hope, transforming knowledge into action for the benefit of humanity."* Second, Bulgaria remains one of the European countries that has the smallest healthcare spending per capita, while providing comparable quality and access for Bulgarian residents. Finally, observing the shortage of health professionals, the Bulgarian Medical Association will continue to advocate for prioritising healthcare services for children in the negotiation process of the National Framework Agreement.

"The Day of Bulgarian Physicians is a time to reflect on our commitment, devotion, and labour, which will remain our lifelong companions in this noble calling." – Zahari Iliev, sixth-year medical student

"There is a moment that has always touched me deeply. If, even for an instant, you feel togetherness, positivity, and energy, that can be the most precious moment… The fate of a doctor is imprinted in the eyes and posture of the older generations… Just one look or a moment is enough to understand how many lives they have saved, how much responsibility they have shouldered." – Dr. Hristina Dimitrova, general practitioner with over 30 years of experience, from Varna, Bulgaria

Côte d'Ivoire

International Doctors' Day, celebrated globally on 30 March, offers a unique opportunity to honour the hard work, dedication, and sacrifices made by physicians around the world. In Côte d'Ivoire, this day holds particular significance for its healthcare professionals, who are the backbone of the nation's health system and play a critical role in ensuring the well-being of Ivorian communities. It serves as a moment for physicians to reflect on their mission to provide high-quality healthcare to residents, especially in a challenging environment marked by economic constraints, disease outbreaks, and limited resources. This day is an acknowledgment of their resilience, leadership, and the sense of responsibility they carry to improve the health outcomes of the population.

In the Ivory Coast, the shortage of trained medical professionals due to the low doctor-to-patient ratio (1.8 physicians per 10,000 people) places immense pressure on existing healthcare providers. Also, limited access to training materials, outdated curricula, and a lack of medical infrastructure in universities makes it difficult for aspiring doctors to receive the quality education they need. To address this challenge, the Université Félix Houphouët-Boigny, the largest public university in the country, has served as a leader in updating medical curricula (clinical and public health education) to align with World Health Organization (WHO) competencies and standards. Ivorian medical institutions have also partnered with international organisations (like the African Medical and Research Foundation, AMREF) to provide training to healthcare professionals and build capacity for medical education across the continent (including in the Ivory Coast).

With restricted access to medicines, diagnostic tools, and specialised treatments, doctors often face difficult decisions about prioritising patient care and maintaining medical ethics (e.g. fairness, compassion, informed consent) in a resource-scarce environment. Ivorian medical associations (like the Syndicat National des Médecins de Côte d'Ivoire, SYNAMCI) have actively promoted ethical training and workshops, emphasised patient-centred care, and supported guideline development to assist doctors in providing equitable healthcare services.

In the coming years, Ivorian doctors can strengthen their impact on local and national health efforts through several key actions. First, doctors can organize and lead community health programs aimed at preventive care (e.g. vaccination, nutrition education, maternal health services) across urban and rural areas. Second, together with their national medical association or participation in medical unions, physicians can amplify their voices and advocate for relevant health policies and reforms, such as improved healthcare funding and working conditions. Third, the current medical community can invest in mentoring junior doctors and medical students, ensuring that they have access to practical experiences and ethical leadership, which may help alleviate the current healthcare workforce shortage. Finally, strengthening public-private partnerships can lead to innovative healthcare service delivery, including telemedicine

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initiatives and advanced clinical services.

"Our role as doctors goes beyond treating disease; we are healers of society. Every day we stand at the intersection of life and death, using our knowledge, compassion, and resilience to restore hope. The challenges are many, but the passion for healing our people will always be greater." – Senior physician working at the Centre Hospitalier Universitaire in Abidjan, Côte d'Ivoire

Ecuador

In Ecuador, International Doctor's Day, celebrated on 21 February, holds a deep significance for the nation's physicians, as it commemorates the birth of Dr. Eugenio Espejo, a pioneering figure in Ecuadorian medicine and public health. Dr. Espejo, born in 1747 in Quito, is revered not only as the father of Ecuadorian medicine, but also as the first medical hygienist, educator, and founder of scientific journalism in the Spanish colonies [9]. His foundational works on smallpox and quinine treatment and his influence on early medical education underscore his legacy. On this day, Ecuadorian doctors honour his contributions and reflect on their own responsibilities toward advancing health in Ecuador, especially by drawing from his spirit of scientific rigor and social advocacy.

Ecuadorian doctors face challenges in healthcare infrastructure and resident physician welfare that affect both clinical practice and patient outcomes. First, Ecuador has a limited number of hospital beds (only 1.4 beds per 1,000 people), compared to the regional average (1.9 beds per 1,000 people), creating bottlenecks in care delivery, especially during public health crises like the COVID-19 pandemic [10]. Furthermore, resident physicians contend with excessive working hours and insufficient remuneration, which restrain both their well-being and professional development [11]. To address these issues, there have been calls to regulate work hours, improve resident compensation, and provide mental health support, drawing from frameworks such as Canada's CanMEDS program to structure professional growth.

Looking forward, Ecuadorian physicians can play a transformative role by advocating for better healthcare infrastructure and a more supportive environment for medical trainees. Actions such as fostering partnerships with international medical bodies for infrastructure support, actively participating in national health policy dialogues, and prioritising fair compensation working conditions and dignified postgraduate training for resident doctors will reinforce their contributions to public health. Additionally, by embracing evidence-based frameworks for professional development and advocating for improved working conditions, Ecuadorian doctors can continue Espejo's legacy of advancing medical education and ethical practice.

"In every challenge we face, we find an opportunity to innovate and better serve our community. Our passion for humanity is the driving force behind positive change in Ecuador's health." – Dr. Pablo Estrella Porter, public health resident in Valencia, Spain

India

International Doctors' Day, celebrated on the first Monday of October each year, holds a special place for physicians worldwide, symbolising the recognition and respect that they have earned for their tireless dedication to public health. This day highlights the extraordinary efforts of doctors who commit their lives to the well-being of others, often facing long work schedules, high levels of stress, and immense clinical responsibilities. In India, Doctors' Day is celebrated annually on 1 July, commemorating the birth and death anniversaries of Dr. Bidhan Chandra Roy, an esteemed physician, politician, statesman, and the former Chief Minister of West Bengal. This day reaffirms doctors' purpose and values that they uphold, provides an opportunity for communities and healthcare organisations to express appreciation and gratitude, and acknowledges the pivotal role doctors play in enhancing healthcare quality and access. Doctors' Day underscores their commitment to advancing medical knowledge and compassionate care, reminding everyone of the profound impact that physicians have on society.

In India, doctors encounter significant challenges affecting medical education and public health practice. First, the limited and uneven distribution of medical training institutions restricts access to well-trained healthcare professionals, especially in rural regions. Despite India having approximately 750 medical colleges and producing around 150,000 medical graduates each year, underserved areas still lack adequate healthcare resources. In response, medical associations and government initiatives are striving to improve infrastructure and implement policies that encourage doctors to serve in these under-resourced areas. Second, increasing violence against healthcare professionals threatens doctors' safety and compromises patient care. Medical organisations are leading

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efforts to address workplace violence, by advocating for stronger legal protections (including policies) and promoting public awareness on the importance of respecting healthcare providers. These proactive measures highlight the medical community's commitment to fostering a safe, equitable, and ethical healthcare environment across the country.

With the increasing commercialisation of healthcare, the medical profession has also continued to face challenges that influence the doctor-patient relationship. Nonetheless, the Sanskrit phrase (*"Vaidyo Narayano Harihi"*) reflects the dedication, expertise, and selflessness of doctors in India, who continue to tirelessly work to uplift the health of their communities. It embodies the spirit of Indian physicians, whose leadership, compassion, and commitment to their patients remain steadfast, even amidst changing times. It underscores the respect and honour traditionally commanded by doctors in Indian society, recognising their vital role as healers and protectors of life.

Looking into the future, doctors in India can take impactful steps to strengthen their contributions to local and national health initiatives, but a significant shift is needed in how healthcare policies are formed. Since medical professionals are not often treated as key stakeholders in policymaking, unfeasible, unscientific, and sometimes unsustainable policies result, which can hinder long-term public health goals. By actively involving doctors in policy discourse, the government can leverage their expertise to address critical issues like healthcare accessibility and resource distribution in underserved areas and serve India's diverse population. Doctors could also drive preventive care efforts through community education programs focused on chronic diseases, maternal health, and hygiene and sanitation, empowering citizens to adopt healthier lifestyle choices. Furthermore, by embracing digital health technologies (such as telemedicine), doctors can extend their healthcare services to rural areas, which can help bridge gaps in healthcare access.

"Vaidyo Narayano Harihi." ("The doctor is to be regarded as next only to God.") – Sanskrit phrase

Kenya

International Doctors' Day, celebrated on 1 July in Kenya, allows doctors to reflect on our important clinical and public health initiatives and our commitment to our patients. This day reminds Kenyan doctors to celebrate one another as colleagues in this esteemed profession, analyse current health system challenges, and identify best practices for sustainable change in our discipline. It also offers an opportunity to reflect on our journeys in the medical profession and recognise our career achievements in advancing science and caring for our patients and society.

In Kenya, the internship period has been marred by challenges, including delayed posting and remuneration, leading to feelings of demoralisation among interns [12]. This sentiment is compounded by the already present shortage of doctors in public facilities, which results in excessive workloads for clinical teams. With a significant number of the population living below the poverty line and corruption within the national health insurance, there are insufficient resources to support health financing for universal health coverage. Hence, Kenyan doctors advocate for health system reforms through professional associations, such as the Kenya Medical Association and the Young Doctors Network [13].

As Kenyan doctors, we must not turn a blind eye to the challenges in the health sector. We must seek leadership positions in our local institutions and communities, where we can leverage our expertise, contribute to national discourse, and help inform relevant and ethical health policies. We should become more active in professional associations, where we can identify community needs, amplify our voices, and network with other health professionals. Using social media and other technologies to help educate the public on health system challenges, we can collectively lead sustainable change that prioritises patient care.

"We are the custodians of healthcare in our country. Politicians come and go by, but we are here to stay. We must be at the forefront of fixing our healthcare system. That is the best way to fulfill our oath as doctors." – Dr. Mutonyi, Convener, Young Doctors Network

Malaysia

In Malaysia, Doctors' Day was first launched by the Federation of Private Medical Practitioners Associations in 2014. Celebrated annually on 10 October, it recognises the unbreakable spirit and commitment of doctors to their patients, as well as the unique bond between doctors and patients. As doctors reflect upon why they chose the medical profession, they understand that they must never lose sight of their passion, amidst

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challenging situations in the clinical workplace and healthcare system. Additionally, Doctors' Day provides a valuable opportunity for the Malaysian Medical Association to advocate for doctors and highlight the challenges that they face within the Malaysian healthcare system. On Doctors' Day 2024, members adopted a Declaration to prevent workplace bullying and harassment reinforcing the belief in their slogan, "Happy Doctors, Happy Patients".

Malaysian doctors face significant challenges, including the ongoing workforce shortage, high levels of burnout, and caring for the aging demographics. First, with limited staffing across public hospitals, doctors often work long hours under intense pressure, leading to physical and emotional exhaustion and impacting the quality of patient care. Second, caring for Malaysia's aging population challenges doctors working with local community members (known as the "Rakyat" in the Malay language), who often cannot afford health insurance and rely on the healthcare system. To address these challenges, policymakers and healthcare institutions can collaborate to ensure a sustainable workforce, improved work-life balance, and supportive mental health resources, which can ultimately benefit doctors and the communities they serve. The Malaysian government has introduced initiatives to promote healthier lifestyles and reduce risk of non-communicable diseases, including encouraging reduced sugar consumption and offering tax incentives for gym memberships and fitness equipment. In collaboration with the Association, the government and Ministry of Health have focused initiatives on the recruitment and retention of healthcare professionals and continued training to support a stronger, more sustainable healthcare workforce and reduce the brain drain.

Doctors in Malaysia can help shape the healthcare system by coming together to support each another and advocate for sustainable solutions to solve urgent healthcare challenges. Through active engagement with the Malaysian Medical Association, they can build trust, collective strength, and momentum for healthcare system reforms that provide the highest quality of care to citizens of all ages and collectively advocate for improved work-life balance and career growth. Malaysian doctors can lead public health campaigns that aim to improve elder care policies and create better public awareness on elderly care. Supervising doctors can provide mentorship to junior doctors in the clinical setting, help expand telemedicine and home healthcare services, and contribute to medical research. These efforts can be further strengthened with the full commitment from the government, healthcare system, and policymakers, acknowledging that healthcare should always be a top priority for any nation. As described in the Malaysian proverb, doctors' selfless actions and commitment to community health will be remembered long after they are gone, honouring their role as compassionate leaders in society. Their expertise, dedication, and care leave behind a meaningful legacy in the lives they touch.

"Harimau mati meninggalkan belang, manusia mati meninggalkan nama." ("A tiger dies leaving its stripes: a person dies leaving their name.") – Malaysian proverb

Myanmar

For Myanmar doctors, International Doctor's Day on 3 October, serves as a reminder of their critical role in providing clinical management amidst adversity and highlights the urgent need for international support and recognition of their efforts. According to the WHO, Myanmar, a country of 54 million population, has an estimated 7.5 doctors per 10,000 population in 2019 (compared to 3.8 doctors per 10,000 population in 2004). Since the military coup in February 2021, Myanmar military attacks have directly targeted healthcare facilities and personnel, violating the principles of medical neutrality [14]. Although many Myanmar doctors are unable to fully celebrate this day, they use this opportunity to demonstrated their ongoing commitment to patient care amidst adversity and advocate for international support, as supported by the WMA declaration [15].

Myanmar doctors continue to face significant challenges in medical education and clinical practice, due to the military coup, with airstrikes and heavy weaponry affecting medical schools and training hospitals. First, damaged and destroyed facilities, limited resources, and overburdened medical teachers, coupled with the transition to online learning, have severely hindered trainees' learning opportunities and essential hands-on clinical training [16]. Second, ethical dilemmas arise as health professionals navigate resource scarcity (including essential medicine and medical equipment), due to power and telecommunication outages and the continued supply chain blockage by Myanmar military and security forces [17,18]. Myanmar doctors often express a strong moral commitment to

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remain in the country, following the Physician Pledge, with an unwavering duty of care to ensure the safety and well-being of patients requiring treatment (albeit risk of arrest, violence or capture) [19].

To support Myanmar doctors, establishing collaborative networks with international health organisations (like WHO and WMA) can help identify best practices for medical care and facilitate resource sharing, including the provision of medical equipment, diagnostic tests, medications, and personal protective equipment. These resources, together with deploying qualified medical personnel to the Myanmar border, can effectively address supply chain disruptions that impact essential medications and equipment as well as ensure continuity of care. Also, Myanmar doctors can partner with the WMA and JDN to identify specific community health needs (including social determinants of health) for the development of educational workshops and targeted interventions. By appointing Myanmar doctors with authorisation to practice in border towns, they can help treat displaced Myanmar civilians without overburdening neighbouring countries' healthcare systems. Finally, international organisations can pursue legal action through the International Criminal Court (ICC) or the International Court of Justice (ICJ), holding Myanmar military and security forces accountable for their actions.

"Myanmar medical students, trainees, fellows, and healthcare professionals are dedicated to saving and healing the injured, often at great personal and familial risk, even as they face opportunities to migrate abroad. Their unwavering commitment to providing care during the darkest times in Myanmar serves as a powerful reminder that hope and resilience can prevail when we strive to do our best for those in need." – Dr. Wunna Tun

Nepal

Since the Nepal Medical Association was established on 4 March 1951, members celebrate Doctor's Day on the Nepali date of Falgun 20 (usually 4 March), as an occasion to recognise doctors' successful leadership and clinical contributions to their patients and the general society each day. This day also reminds policymakers and the public about the need to address challenges experienced by healthcare professionals, such as workplace violence and resource shortages, as well as ensure supportive and safe clinical environments. Doctor's Day also promotes unity among the medical fraternity, including the importance of professional development, ethical practice, and patient-centered care. Moreover, this day provides an opportunity to appreciate Nepali doctors working abroad, who represent Nepal and contribute in global healthcare.

As Nepali doctors help advance the nation's health and access to healthcare services, their commitment aligns with Sustainable Development Goal 3 (*ensure healthy lives and promote well-being for all at all ages*), as well as the *Nepal Health Sector Strategic Plan 2023-2030* that aims to strengthen health equity, promote patient safety, and ensure quality care for all [20]. By combining compassion with integrity, Nepali doctors set inspiring examples of resilience and leadership in healthcare. For example, Dr. Sanduk Ruit is a renowned ophthalmologist, known as "God of Sight," who has transformed lives through thousands of free cataract surgeries for Nepalese patients. Despite this robust infrastructure, Nepali doctors have experienced significant workplace challenges, including multiple incidents of verbal and physical assaults (even damage to hospital property) that have created unsafe environments, and they have responded by participating in widespread community protests and strikes [21]. Also, many doctors are reluctant to work in the rural areas, due to low financial compensation and limited resources across facilities [22].

In response to these challenges, the Nepal Medical Association has led advocacy efforts to improve public awareness of healthcare challenges (e.g. violence against doctors), including partnering with communities and government agencies. The Medical Education Commission has been consistently supporting doctors in their demand for increased pay for resident doctors. However, there is a potential risk of 800 residency seats being allocated elsewhere, raising concerns about future opportunities [23]. Improving healthcare involves implementing strict rules to ensure doctors' safety, increasing postgraduate placements, and offering more government job opportunities. Hence, political commitment is essential to address salary adjustments, secure safe working environments, reduce the clinical workload, properly develop and execute relevant policies, and manage resources [24].

Looking forward into the profession, Nepal Medical Association members believe that improving clinical facilities and adopting telemedicine can help expand access to populations living in remote areas of the country. By establishing sustainable collaborations with federal agencies, leaders can help develop relevant policies that can mitigate workplace violence

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faced by doctors. Finally, building networks with international health organisations can provide valuable knowledge-sharing opportunities, allowing Nepali doctors to incorporate global standards and innovative practices into local healthcare.

"A doctor's mission is to heal with compassion and lead with integrity, a path that Nepali physicians walk every day despite challenges." – Dr. Anil Bikram Karki

Philippines

For the Filipino physician, Physicians' Day signifies the recognition and appreciation for their dedicated service to the health and well-being of the nation. Physicians across the archipelago utilize this day to reflect on their achievements and renew their commitment to patient care and community welfare. It is a moment to honour their relentless efforts, particularly amid challenges such as natural disasters and pandemics, where they have stood as beacons of hope and resilience. The celebration reinforces the noble calling of being a physician in a country where healthcare needs are vast, and resources often limited. Over the past 70 years, the Government of the Philippines and Philippine Medical Association have supported several proclamations related to the medical profession. These proclamations include *Proclamation No. 407* in 1953 (proclaiming Philippine Medicine Day on 15 September, aligned with the 50th Foundation Day of the Philippine Medical Association on 15 September 1903), *Proclamation No. 330* in 1956 (declaring 15-21 September as Medicine Week), *Proclamation No. 439* in 1957 (declaring the fourth week of September as Medicine Week), and *Proclamation No. 1789* in 1978 (declaring 27 September as Physician Day) (https://lawphil.net/). Over time, the focus has shifted from celebrating the medical profession to honoring the Filipino physicians.

Under the Commission on Higher Education (CHED), there are 77 medical schools in the Philippines, of which 24 of the country's state universities and colleges offer a Doctor of Medicine program. As of 2023, the Professional Regulation Commission (PRC) revealed that only 59.7% (or 95,039) of 159,283 registered physicians are active [25]. Following the *Republic Act No. 7722* and the *"Doktor Para Sa Bayan" Act* (RA No. 11509), CHED encourages all eligible state universities and colleges offering medical programs to join the CHED Medical Scholarship and Return Service (MSRS) Program. This program provides opportunities for deserving Filipino medical students who are willing to complete mandatory post-graduate service in low-resource areas without physicians, especially the top 20% of provinces or municipalities identified as geographically isolated and disadvantaged areas by the Philippine Statistics Authority [26]. To address these challenges, physicians are leading efforts to advocate for policy reforms, contribute to updating ethical guidelines and frameworks (guided by the Philippine Medical Association - PRC's adoption of the Code of Ethics of the Medical Profession), and engage in professional development to adapt to modern-day challenges of the medical profession [27].

As physicians grapple with these challenges, the Philippine Medical Association is committed to make its governance participatory, consensus-oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive. Its leadership vows to exercise prudence in policy-setting and decision-making, follow the rule of law, exhibit innovation and responsiveness to change while addressing the present and future needs of the organisation, and ensure that the best interests of all stakeholders, physicians, and patients are considered. Filipino doctors can strengthen their contributions to community health by advocating for policy reforms, improving access to care in underserved areas, and addressing health inequities through preventive care, education, and interdisciplinary collaborations. They can also promote mental health well-being, educate on environmental health risks, and encourage professional development while fostering transparency, research, and public-private partnerships to align with the Philippine Medical Association's commitment to responsive and inclusive governance.

"We are ONE PMA: Empowering the Filipino Physician for Nation Building." – Philippine Medical Association phrase

Republic of Korea

Although "Doctors' Day" is not widely recognised among the Republic of Korea citizens, some local medical associations (such as the Seoul Medical Association) coordinate annual events on 3 June, while some hospitals observe World Doctors' Day on 30 March. By contrast, World Health Day has been observed as a national day since 7 April 1973, consolidating existing health-related commemorative days to enhance public health awareness and honour healthcare professionals. Traditionally, the Ministry of

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Health and Welfare hosts events and campaigns, including awards for exceptional contributions to healthcare. However, this year, no significant events took place, and both Doctors' Day and World Health Day passed with little public acknowledgment.

Republic of Korea physicians, particularly junior doctors, are facing significant challenges rooted in diminishing public trust and recurring disputes with policymakers. First, the government has confirmed a unilateral decision to increase the medical school admissions quota by 66%, starting in 2025. Physicians widely believe that this policy, implemented without addressing the poor training and working conditions of junior doctors, risks harming the national healthcare system in the long run. Second, as junior doctors are increasingly avoiding specialisation, essential medical fields (e.g. paediatrics, surgery) have a shortage of physicians and medical facilities equipped to provide critical care. Contributing factors include inadequate reimbursement rates for essential services and the burden of excessive legal liability on practitioners.

To address these challenges, doctors are striving to uphold their commitment to patient welfare despite adverse conditions and hostile public sentiment. The rapid decline in trust, following the widespread admiration for healthcare professionals as "true heroes" during the COVID-19 pandemic, poses a serious threat to future public health crises. Rebuilding this trust requires societal acknowledgment of physicians' dual roles as caregivers and clinicians, including respect for their right to advocate for improved conditions. The individuals celebrated for their heroism during the pandemic are now leading the fight for sustainable healthcare reforms. Mutual respect and reconciliation between doctors and the public are essential to overcoming these shared challenges and advancing community health.

"True heroes are not those who seek glory but those who persevere in adversity to serve others." – Christopher Reeve

Trinidad and Tobago

Doctors frequently work long hours, and mentally and physically tiring shifts, to provide quality care for their patients. Sometimes, however, their dedicated efforts may go publicly unnoticed. National Doctors' Day is celebrated on 30 March in Trinidad and Tobago, as a reminder of dedicated health professionals who work as a team supporting the health system and their patients. As a Caribbean nation, we have a rich culture and versatile history, especially within the medical fraternity, and we must recognise doctors' contributions to form the best clinical decisions and policies moving forward as well as manage workplace challenges (including dynamic brain-drain and brain-gain). Despite doctors' long arduous hours in the clinical workplace, including efforts leading and navigating the COVID-19 pandemic, doctors nationally serve to protect communities and save lives. Notably, during the COVID-19 pandemic, the Trinidad and Tobago Medical Association collaborated with some organisations (like Starbucks) to acknowledge the hard work of frontline healthcare professionals throughout the country with a small gift [28].

Two major obstacles of the medical profession in Trinidad and Tobago remain the local retention of medical professionals and the provision of specialty training programmes, which have led to a brain drain and need to obtain specialists, even sourcing from other nations (like Cuba) [29-31]. To encourage retention within the health system, one national strategy is that doctors who received academic scholarships must serve their country for five years after their training [32]. Also, the Trinidad and Tobago Medical Association and the University of the West Indies have actively collaborated to develop mentorship programmes for medical students, which can dually help retain physicians after graduating and encourage those who train abroad to return to serve the nation. The *Caribbean Medical Journal*, the official journal of the Trinidad and Tobago Medical Association, has promoted and contributed to the medical academia locally and regionally, by offering a local avenue for physicians to publish their work and hence promote professional identity and pride within the Caribbean region.

Looking ahead, Trinidad and Tobago doctors can promote a more nurturing environment for junior physicians locally and regionally, as they learn from the past, effectively deal with the obstacles they face, and direct future steps to uplift the healthcare fraternity. For example, they can advocate and help strengthen local programmes that encourage physicians to visualize local avenues for professional development without necessarily having to seek international training. Also, incentives for physicians to return to Trinidad and Tobago and serve their communities include the creation of new job placements, mentorship programmes, and teaching posts,

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which foster a sense of identity and pride in the development of Trinidad and Tobago's healthcare system. They can actively promote sustainable community health initiatives, contribute to local and regional research activities, and publish their findings in peer reviewed journals like the *Caribbean Medical Journal* and the *West Indian Medical Journal*.

"In understanding the past, we gain insight into the present and can shape a brighter future." – Dr. Eric Eustace Williams, first Prime Minister of Trinidad and Tobago and a famous Caribbean historian

Türkiye

Medical Day in Türkiye has been celebrated each 14 March since 1919, inspired by the opening of the first medical schools and start to modern medical education on 14 March 1827. Notably, the first celebration was held in 1919, when medical students in Istanbul protested against the British occupation, and this sentiment aligns with the struggle for independence and freedom in present day. Today, 14 March represents a day to celebrate the country's legacy in the medical profession and discuss pressing healthcare issues for patients and health professionals. The Turkish Medical Association, established in 1953, has supported Medical Day (and Medical Week) and organised numerous events each year, such as meetings, seminars, artistic activities, rallies, and demonstrations, to increase awareness of important public health topics and challenges faced by physicians.

Today, doctors in Türkiye face numerous challenges that have reflected the perceived devaluation of the medical profession, including exposure to violence, inadequate educational opportunities, insufficient income, and unsafe working conditions. Since the 1990s, policies in Türkiye have aimed to commercialize healthcare, which appears to devalue doctors' clinical responsibilities across public and private sectors. Public statements from government officials that target doctors and belittle their work have severely damaged the profession's reputation. Likewise, the government has implemented various regulations aimed at reducing the value of medical labour and hindering doctors' professional independence. Each year, 20,000 doctors graduate from 128 medical schools, many of which provide poor education because of inadequate teaching staff and infrastructure. By increasing the number of medical schools, more doctors graduate from medical schools, but it hinders the quality of education, further devalues the profession, and can negatively impact public health.

Since 1953, the Turkish Medical Association has prepared legal initiatives and actions, even filing lawsuits (when appropriate) against legal regulations introduced by the Ministry of Health. The team also conducts meetings with both government and opposition parties to discuss legal arrangements, submits reports, engages in media efforts to inform doctors and the public about the consequences of misguided health policies, and organises various actions (including strikes). For example, doctors and other health professionals at family health centres conducted a three-day strike between 5-7 November 2024, aligning their actions with the "protecting public health and our profession" motto. As Turkish Medical Association members, we will continue to strive for a healthier society in our country and for the rights of physicians and all healthcare professionals.

"Entrust me to Turkish doctors." – Mustafa Kemal Atatürk (1881-1938), founder of the Republic of Turkey

Conclusion

The global celebration of physicians – whether International Day of the Medical Profession or International Doctors' Day – presents a special opportunity to distinguish the dedicated efforts of the medical community, including the deep sense of responsibility and commitment to serve individual patients and protect community health, while navigating challenges within complex health systems [33]. The exponential pace of technological innovation and medical advancements, including the use of artificial intelligence, machine learning models, and genomic sequencing, continue to revolutionize the speed and accuracy of clinical diagnostics and treatment, which can subsequently lead to lower morbidity and mortality rates, improved quality of life, and reduced healthcare expenditure. Hence, physicians hold a pivotal leadership role, where they can leverage their clinical expertise to expand scientific discovery through multidisciplinary and multisectoral collaborations, and ultimately advocate for urgent global collective action to mitigate emerging and reemerging health risks.

Each day, WMA members demonstrate essential leadership skills in the face of adversity, such as improving pandemic preparedness (including reducing risk of antimicrobial resistance), understanding the primary drivers of climate-related health risks and crafting catchy messaging

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for patients and the public, and advocating for timely policies to protect physicians' well-being and reduce risk of burnout [34,35]. They continue to inspire future generations and strengthen the foundation of a more resilient and equitable health system, while upholding the fundamental principle of medical ethics, *"first, do no harm" ("primum non nocere")*. This collective article showcases a regional overview of how physicians have supported high-quality healthcare service delivery, promoted direct interactions and communication techniques to strengthen physician-patient rapport, developed community partnerships that support health messaging and public awareness on pressing concerns, and addressed challenges in medical education and practice. Specifically, it highlights physicians' commitment to improving health outcomes across the African, Americas, Asian, European, and Pacific regions, by illustrating symbolic reflections related to physicians' indispensable role across national health systems.

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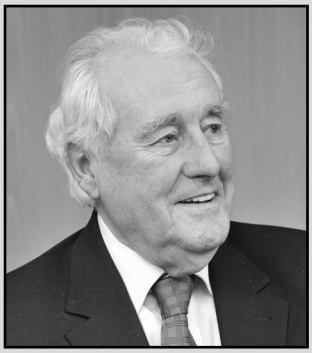

Prof. Dr. Karsten Vilmar

For more than two decades, Professor Dr. Karsten Vilmar stood at the helm of the German medical profession after which he continued to serve the German Medical Association (GMA) and the German Medical Assembly as its honorary president. Sadly, he passed away in October 2024 at the age of 94.

"The German Medical Association is deeply saddened by the news of Karsten Vilmar's death. We remember him as a longtime leader, a patient mentor and a reliable friend. Karsten Vilmar was a man of consistency who tirelessly worked to uphold the independence of the medical profession and the personal nature of the patient-physician relationship as the foundation of a patient-centred healthcare system. With foresight and unwavering perseverance, he placed issues on the political agenda, which are still relevant today. As a person, as a physician, and as an advocate for the medical profession, Karsten Vilmar achieved great things," as expressed by Dr Klaus Reinhardt, the President of the GMA.

Born in Bremen, Germany, on 24 April 1930, Professor Vilmar studied medicine at the Ludwig Maximilian University in Munich from 1950 to 1955, where he subsequently obtained his doctorate. He completed his specialty training in surgery in his hometown. From 1964 to 1995, he was senior consultant at the trauma surgery clinic of the Sankt-Jürgen-Straße municipal hospital in Bremen. His involvement in professional policy began in 1970, when he assumed the role of Chair of the Marburger Bund (MB) physicians' union in Bremen, a position that he held until 1996. At the national level, Professor Vilmar chaired the MB from 1975 to 1979. He was President of the Bremen Chamber of Physicians from 1976 to 1996, and President of the GMA and the German Medical Assembly from 1978 to 1999.

"In his daily interactions, his colleagues remember him as fact-based and steadfast, yet diplomatic in his approach. He upheld agreements and represented them with conviction within and beyond the medical profession," described Reinhardt.

After becoming President of the GMA, Professor Vilmar continued his professional political activities. He was involved in the field of transplant medicine as a member of the Board of Trustees of the German Organ Procurement Organisation. As Chair of the Kaiserin Friedrich Foundation, he was committed to continuing medical education and, as Chair of the Hans Neuffer Foundation, to collegial exchange between German physicians and their colleagues abroad. At the international level, Professor Vilmar assumed leadership roles in the Board of Directors of the European Doctors (CPME) and the Council of the World Medical Association (WMA). Among other things, he served as the CPME President and WMA Treasurer for many years.

"We should remember Karsten Vilmar's tireless efforts to explain that the age distribution of the population and increasing multimorbidity will inevitably increase the need for medical and nursing care, and thus the expenditure on healthcare services. While these correlations were long denied by politicians and cost bearers, no one questions them anymore," said Reinhardt.

A hospital physician by training, Professor Vilmar vehemently championed the interests of physicians in all areas of the healthcare system. He was honoured with the highest award of the German medical profession, the Paracelsus Medal, at the 103rd German Medical Assembly in Cologne, for his extraordinary commitment to the medical profession in Germany and around the world.

"As the medical professional recognises Karsten Vilmar's significant contributions to the medical profession and healthcare, we mourn the loss of a wonderful colleague and great person," expressed Reinhardt.

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Dr. Vincent Lamy

Dr. Vincent Lamy, a Belgian gastroenterologist and active member of the Belgian Association of Medical Unions (ABSyM) for many years, passed away on 10 October 2024. During his relentless, almost two-year battle with myeloblastic leukaemia, he always remained lucid but optimistic. Forced to stop his professional activity when his illness was announced, he devoted all his strength to fighting his illness, and was supported by close family members, including his wife Geneviève, his three daughters, his eight grandchildren, and even his mother at almost 100 years old.

At the end of the 1980s, Dr. Lamy became involved in the ABSyM. At the time, Dr. André Wynen, an emblematic figure of the World Medical Association (WMA), served as President from 1973 to 1976 and General Secretary from 1976 to 1993. Later, Dr. Lamy became Secretary General and was appointed to represent Belgian physicians at the WMA. He was also Vice-President of ABSyM Wallonia, the union of Walloon general practitioners and specialists, and President of Mdeon, a deontological platform comprising 29 medical and paramedical associations.

For Dr. Lamy, medicine was a whole and a matter of sharing! The transmission of knowledge was of paramount importance to him, and he firmly believed in the medicine of tomorrow and the new generation of doctors. For this reason, he was an honorary gastroenterology training supervisor at one of the many hospitals, where he was still working before his illness. As a fervent defender of medical ethics based on trust and patients' interests, professional autonomy and clinical independence were not empty words for our colleague. As he was firmly convinced that medicine was a matter of transferring knowledge and know-how, he was keen to encourage and contribute to regional, national, and international exchanges.

Dr. Lamy's career accomplishments span across the gastroenterology specialty and geographic borders, including:

- Member of the European Board of Gastroenterology and Hepatology at the European Union of Medical Specialists (UEMS) and the European Society of Digestive Endoscopy (ESGE)
- President of the Royal Belgian Society of Gastroenterology (SRBGE)
- Active and long-standing member of the Belgian Group of Specialists (GBS/VBS)
- Member and Treasurer of the Belgian Society of Gastro-Intestinal Endoscopy (BSGIE)
- Representative on the Belgian Medicomut Agreement at the National Institute for Health and Disability Insurance (INAMI/RIZIV)
- Co-founder member and Education Officer of the World Gastroenterology Organisation (WGOE)
- Active member of the Belgian Helicobacter pylori group (BHMSG) of Endofic, an association of endoscopy nurses and numerous national gastroenterology associations (e.g. United States, Italy)
- Co-founder of the African Society of Hepato-Gastro-Enterology (SAHGE)

Notably, Dr. Lamy was born in Burundi in 1950, studied in Africa, and spoke several languages, including Swahili. As he was passionate about the history of the Congo and neighbouring countries, some locals even called him the White Zulu!

Dr. Lamy was also the author of numerous scientific publications, as he was determined to develop his discipline and share his thoughts with the scientific community. Indeed, he always worked with discretion and humility, without boasting of his accomplishments. Right up to his last moments, he kept abreast of the latest medical developments, giving pertinent advice to colleagues, and even organizing events and conferences from his bedside. Until recently, he was also involved in the comprehensive revision of the Declaration of Helsinki.

As the son of a member of the Resistance, he was part of the Group Mémoire, formerly chaired by Dr. Wynen, who was also a survivor of the Nazi camps, and a committed defender of democracy and human rights.

For all his colleagues and friends, Dr. Vincent Lamy's kindness, availability, and devotion to his profession will always be remembered. It is with deep sadness that his colleagues bid him farewell and pay him a vibrant tribute.

Association Belge des Syndicats

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