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WORLD MEDICAL ASSOCIATION OFFICERS, CHAIRPERSONS AND OFFICIALS

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Editorial

Over the past two years, international meetings have highlighted the need to continue initiatives to address the three C's (climate change, conflict, coronavirus disease 2019 pandemic), including driving factors that affect other sectors such as antibiotic resistance, changing demographics, disaster preparedness, food insecurity, and health system resiliency. These public health challenges require One Health solutions and can only be managed through one collective voice of global leaders – a voice that demands urgent joint action and participation across borders, disciplines, and sectors. An example of one important voice is our World Medical Association (WMA) community.

As WMA members represent more than 114 national medical associations (NMAs), their medical and public health expertise can help national leaders develop relevant evidence-based policies and guidelines that can strengthen health system preparedness. During the 226th WMA Council Meeting in April 2024, WMA members contributed to the review and acceptance of five timely resolutions. Specifically, WMA leaders reinforced the call for a bilateral, negotiated, and sustainable ceasefire to protect the health workforce and public safety as well as strongly condemn any violations of international humanitarian law, in response to the ongoing conflict in Gaza and Israel. Notably, WMA members will participate in the upcoming regional expert meeting in Washington, DC in August 2024, and after compiling collective input from previous expert meetings, they will prepare a final draft that will be reviewed and considered for adoption by the Council and General Assembly at the 75th WMA General Assembly in Helsinki, Finland in October 2024.

The 77th World Health Assembly (WHA), held in May 2024, concluded with amendments to the International Health Regulations and a concrete plan to finalise negotiations related to the Pandemic Accord at least by the next WHA. During the proceedings, Member States approved resolutions on diverse global health issues, including antimicrobial resistance, climate change and health, infection prevention and control, and maternal and child health. These high-quality resources – together with the scientific reports from leading agencies like the World Meteorological Organization (WMO)'s *Global Annual Decadal Climate Update (2024-2028)* and *State of the Climate* – can offer valuable insight for scientific debates at international meetings during the latter half of this year.

After the 226th WMA Council Meeting in April 2024, we are enthusiastic to support the 75th WMA General Assembly that will be held in Helsinki, Finland, from 16-19 October 2024. This event will present numerous opportunities to network with other NMAs, contribute to scholarly debates on pressing medical ethics and global health topics, and recognise the important role of NMAs within the WMA community.

In this issue, Ms. Janice Blondeau prepared a detailed summary of the WMA proceedings and included the WMA Code of Conduct and five adopted resolutions. Dr. Roser Domènech Amadó highlighted the European Union's actions to fight antimicrobial resistance using the One Health approach. Dr. Pablo Estrella Porter described the junior doctors' role at the UN Office on Drugs and Crime (UNODC)'s 67th Commission on Narcotic Drugs and shared the Statement by the UNODC Young Doctors Network. Dr. Yassen Tcholakov provided updates related to the Pandemic Accord discussions during the 77th WHA.

Since WMA members are global health leaders who understand the existing knowledge and practice gaps in medical education and training within their countries and geographic regions, we encourage NMAs to openly share these national and regional analyses and research findings at upcoming scientific events and the *World Medical Journal*. First, Dr. Jorge Coronel, Dr. Marcelo Mingo, Dr. César Eduardo Fernandes, Dr. Carlos Serrano, Jr., Dr. Simone Mc Fee, Dr. Damion Basdeo, and Dr. José Minarrieta shared their perspectives on their leadership experiences, ongoing NMA activities, and strengths and existing challenges in medical education in Argentina, Brazil, Trinidad and Tobago, and Uruguay, respectively. Second, Dr. E. Oluwabunmi Olapade-Olaopa, Dr. Marcos Núñez Cuervo, Dr. Ahmed Al Rumayyan and Dr. Harm Peters shared their perspectives on medical education within the African, Americas, Eastern Mediterranean and European regions, respectively. Dr. Nora Schultz presented the history of the German Ethics Council, as an independent body that contributes expertise to bioethical and biomedical questions. Dr. Gayatri Vijapurkar discussed healthcare resource allocation related to smoking and lung cancer within the UK National Health Service. Dr. Shiyi Chen and colleagues described increased public interest in participating in winter sports in China after the 2022 Beijing Winter Olympics. Finally, WMA members representing six countries shared insight on national policies and community activities that support food security and safety measures related to World Food Safety Day 2024.

We are excited to expand our discussions and networking opportunities at the 75th WMA General Assembly in Helsinki!

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WMA Council Report

Seoul, Republic of Korea, 18-20 April 2024

Janice Blondeau

The 226th Council session of the World Medical Association (WMA) convened in the city of Seoul, Republic of Korea, from 18-20 April 2024 (Photo 1).

Wednesday, 17 April

WMA Caucus Environment and Health

In a pre-Council briefing, the WMA Caucus Environment and Health met on 17 April, 2024, with guest speaker Dr. Samantha Pegoraro, of the Air Quality, Energy, and Health Unit at the World Health Organization (WHO), who joined virtually. Dr. Pegoraro gave a presentation entitled, "Air Pollution and Climate Change: An Overview of WHO Activities Targeting Health Professionals," where she outlined ongoing work by the WHO, to empower health professionals and build capacity within the health sector and health workforce.

Thursday, 18 April

Council

The 226th Council session, held in Seoul, Republic of Korea, was attended by 100 delegates from 34 national medical associations (NMAs). The meeting was called to order by the Chair of Council, Dr. Jung Yul Park. He welcomed newly attending Council members – Dr. Carlos Henrique Mascarenhas Silva (Brazilian Medical Association), Dr. Amit Kochhar (British Medical Association), Dr. José Minarrieta (Uruguayan Medical Association), and ASCM (Additional Standing Committee Member) Dr. Thirunavukarasu Rajoo (Malaysian Medical Association) – and read out apologies for absent members.

Chair of Council's Report

Dr. Park welcomed Council members, delegates, and other colleagues to his hometown of Seoul. He highlighted that numerous current global challenges have impacted physicians and how they work, ranging from wars and armed conflicts to climate change and violations of physicians' rights, even in the Republic of Korea. Dr. Park urged broader collaboration, cooperation, and stronger solidarity among WMA members. He expressed his wish for Council members to listen and learn from each other as well as share perspectives on presented issues. He stated that he sees that the WMA has a pivotal role in representing nearly 10 million physicians around the world, while aiming to ensure the highest possible international standards of healthcare.

Dr. Park reported that, both internationally and domestically, he had delivered speeches and lectures, namely the health impacts of climate change. He called for urgent action for the implementation of Climate Medicine in medical school curricula. In closing, he expressed his appreciation to all members of the WMA Secretariat for their support and hard work throughout the year.

President's Interim Report

The WMA President, Dr. Lujain Alqodmani, thanked the Korean Medical Association for hosting this Council Session, and she provided an overview of activities for her first six months in office. She noted that each activity aligned with the advocacy priorities for her term as President, particularly climate change, gender equality, universal health coverage, and intergenerational equity. Dr. Alqodmani declared that she has focused on providing direct support to WMA members, highlighting the importance of safeguarding physicians' rights worldwide and ensuring that they have safe work environments to effectively and ethically provide healthcare services. She reported on the alarming increase in conflicts and attacks on healthcare facilities and personnel across the world, urging WMA members to work together to ensure the safety of all health personnel.

In response to Chinese Medical Association expressing its opposition to the Taiwan's participation in the WHO's activities, the President responded that it is her responsibility to advocate for Taiwan's participation in WHO's health programs. She reminded WMA members that WMA adopted the WMA Resolution in Support of Taiwan's Participation in all WHO Health Programs and Inclusion in the International Health Regulations (IHR) Mechanism at the 72nd WMA General Assembly in October 2021 [1].

In response to Dr. Omar Khorshid (Australian Medical Association), who proposed that the WMA do

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more to address the unprecedented attacks on healthcare facilities and personnel, particularly in the conflict between Hamas and Israel, the President stated that the WMA has released several statements including a letter to the president of the International Committee of the Red Cross (ICRC) to show support and express the need to protect the right to health for all people. Dr. Alqodmani referred to her written report, in which she expressed the need for the WMA to take a stronger stance to ensure that these violations do not continue, drawing attention to the recent attacks in Sudan, Congo, and Haiti. She reminded WMA members of the open letter of the World Health Professions Alliance calling for humanitarian law to be upheld in all regions of the world. She also noted that the previous media statement titled, WMA Takes Stand Against Humanitarian Violations, Calls for Urgent Action in Gaza, had urged a humanitarian pause in the conflict [2]. Dr. Alqodmani added that the Council would be reviewing a new proposed emergency resolution from the British Medical Association.

In closing, Dr. Alqodmani thanked the Secretary General, WMA Secretariat, and Executive Committee for their support.

Secretary General's Report

The WMA Secretary General, Dr. Otmar Kloiber, reported on the Revision of the Declaration of Helsinki, with the phase 1 public comments period conducted in February 2024, to address issues arising from the regional meetings. He advised that the phase 2 public comments period is planned for June 2024, once additional topics have been addressed. Dr. Kloiber stated that the workgroup intends to deliver a final updated draft of the Declaration of Helsinki to the Medical Ethics Committee. This document will be proposed, reviewed, and considered by the Council and the General Assembly in Helsinki, Finland, in October 2024.

He referred to the Consensus Framework for Ethical Collaboration, a consensus-based framework agreement to publicly align on shared ethical values, which was drafted in 2014, as a partnership between the WMA, International Alliance of Patients Organizations, International Council of Nurses, International Pharmaceutical Federation (pharmacists), and International Federation of Pharmaceutical Manufacturers and Associations (IFPMA). Now, 10 years later, he stated that partners will discuss whether the agreement needs to be extended, if new topics should be included, and how to foster its implementation, especially in Africa.
Under the topic of human rights, Dr. Kloiber reported on initiatives to protect patients and doctors, specifically in Israel and Gaza, Iran, Pakistan, Republic of Korea, Russia and Ukraine, Sudan, and Turkey.

On other topics, he mentioned the Health Care in Danger (HCiD) initiative, through which the WMA Secretariat has a close working relationship with the ICRC headquarters. Dr. Kloiber said that the WMA was represented by Past President Dr. José Luiz Gomes do Amaral at the 6th Global Ministerial Summit on Patient Safety in Santiago, Chile, which was occurring at the same time as the Council session. He commented that recent work activities in preparation for the World Health Assembly would be reported in an extra agenda item.
Dr. Kloiber thanked the Taiwan Medical Association for donating to the Junior Doctors Network's travel fund and the Korean Medical Association for providing travel grants for junior doctors to attend this Council meeting in Seoul.

In closing, he reported on developments from the World Federation for Medical Education (WFME), which is now revising its standards for continuing medical education (CME) and continuing professional development (CPD).

Council Resolutions Approved by the 226th Council Session

The following five Council resolutions were approved by the 226th Council session in Seoul, Republic of Korea, in April 2024, as follows:

Treatment of Migrants in the UK

The proposed revision of the WMA Council Resolution on Proposed Legislation in UK on the Treatment of Migrants disregarding the Injunction Interim Measures Rule 39 of ECHR was adopted by the Council.

Bill Lifting the Ban on Female Genital Mutilation in Gambia

The proposed WMA Council Resolution calling for the immediate withdrawal of the bill lifting the ban on female genital mutilation in Gambia was adopted by the Council.

Anti-LGBTQ Legislation in Uganda

The proposed revision of the WMA Council Resolution on Anti-LGBTQ_ Legislation in Uganda was adopted by the Council.

Organ procurement from prisoners

The proposed revision of the WMA Council Resolution on Organ Donation in China, renamed the WMA Council Resolution on Organ Donation in Prisoners, was adopted by the Council.

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Protection of Healthcare in Gaza

The proposed WMA Council Resolution calling for a ceasefire and the protection of healthcare in Gaza was deferred to the Council session on Saturday, 20 April 2024. In the meantime, the British Medical Association and the Israeli Medical Association agreed to review the current draft and endeavour to reach a compromise.

Standing Committees

The Council adjourned for the meetings of the Standing Committees and agreed to reconvene on 20 April to consider the reports of the Standing Committees and one urgent item deferred by the Council session. The Secretary General informed the Council that Dr. Tai-Yuan Chiu (Taiwan Medical Association) had to return to Taiwan, as he had been appointed Minister of Health and Welfare of Taiwan. The Council congratulated him.

As the Medical Ethics Committee and the Socio-Medical Affairs Committee held meetings on 18 April, details of the Council decisions resulting from these two Committees were finalised on Saturday, 20 April.

Friday, 19 April

Finance and Planning Committee

The Finance and Planning Committee received reports from the Chair of the WMA Associate Members, the Junior Doctors Network (JDN), and the *World Medical Journal.*

Chair of WMA Associate Members

Dr. Jacques de Haller, the Chair of the WMA Associate Members, presented his activity report for November 2023 to March 2024. He stated that the WMA Associate Members have a partly renewed Steering Committee, following elections at their Plenary Meeting in Kigali, in October 2023. New members of the Steering Committee are Dr. Julie Bacqué (French Medical Association) in her position of Associate Member Representative to the WMA General Assembly; Dr. Helen Gofwan (Nigerian Medical Association) for the Student Associate members, and Dr. Marie-Claire Wangari (Kenya Medical Association) as the new Chairperson of the JDN.

Dr. de Haller continued that the group has mainly managed the organisation of a webinar entitled, "Misinformation and Disinformation", with the activities of the numerous Associate Members' Workgroups and Taskforces. He said that the webinar, which was held in January 2024, was successful with substantial contributions from several continents, and an audience of almost 60 participants.

He noted that WMA Associate Members are currently involved in the following Workgroups: Associate Members' Workgroup on Aging Physicians, Associate Members' Workgroup on Medical Neutrality, Associate Members' Informal Group to Assist Response on the Declaration of Helsinki revision, WMA Workgroup on Medical Technology, WMA Workgroup on the Declaration of Helsinki, WMA Workgroup on Environment, and WMA Workgroup on Epidemics and Pandemics.

Junior Doctors Network

Dr. Wangari, Chairperson of the JDN, presented her report for October 2023 to March 2024. She introduced the 2023-2024 Management Team:

- Deputy Chairperson: Dr. Balkiss Abdelmoula (Tunisia / Germany)
- Secretary: Dr. Deena Mariyam (India /United Arab Emirates)
- Membership Director: Dr. Pablo Estrella (Ecuador / Spain)
- Medical Education Director: Dr. Merlinda Shazellenne (Malaysia)
- Medical Ethics Officer: Dr. Shiv Joshi (India)
- Socio-Medical Affairs Officer: Dr. Francisco Pego (Portugal)
- Communications Director: Dr. Sazi Nzama (South Africa)
- Publications Director: Dr. Jeazul Ponce Hernandez (Mexico / Spain)
- Immediate Past Chair: Dr. Uchechukwu Arum (Nigeria / United Kingdom)
- Immediate Past Deputy Chair: Dr. Lwando Maki (South Africa)

Dr. Wangari reported that the JDN 2023/24 Management Team strategy focuses on three areas: improving and creating meaningful engagement among members, improving the sustainability of the JDN, and increasing visibility of the JDN in the WMA and wider community. She thanked the Taiwan Medical Association for their continued financial support that enabled JDN members to share their work and key insights in the global health space. In addition, Dr. Wangari thanked the Korean Medical Association for their generous contribution via the travel stipend grant for the 226th WMA Council Session in Seoul. Through this inaugural grant, 27 JDN members from various regions of the world applied for the travel grant, and a total of 13 scholarships were awarded.

In efforts to increase JDN membership, Dr. Wangari said that the JDN has engaged junior doctors interested in joining national JDNs or establishing new networks in Brazil, Cote d'Ivoire, Dominican Republic, France, Indonesia, Republic of Korea, and Uganda. She mentioned that the JDN hosted an ad hoc newcomer's membership session, as a hybrid event, at the Americas region session

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of the 2024 International Federation of Medical Students' Associations (IFMSA) March Meeting, in Quito, Ecuador. She noted that membership has grown 15.47% since August 2023, with 881 registered members.

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Dr. Helena Chapman, Editor of the *World Medical Journal*, presented her activity report for October 2023 to March 2024, highlighting that 2024 marks the 70th anniversary of the journal. She advised that over the last six months, the *World Medical Journal* editorial team has worked with authors to prepare the December 2023 and March 2024 issues. These two journal issues have incorporated collective articles by 22 countries to highlight the emerging threat of antimicrobial resistance (AMR) for World AMR Awareness Week in December 2023, and to promote vaccine adherence across all populations for World Immunization Week in April 2024. She thanked JDN and National Medical Association (NMA) leadership and commitment to promote the One Health concept, coordinate widespread community health activities that increase public awareness, and support the development of relevant policies that strengthen health system resiliency.

Saturday, 20 April

The Council, using a consent calendar for efficiency, considered the Standing Committee reports.

Medical Ethics Committee

The Council considered the report of the Medical Ethics Committee and reached the following decisions:

Declaration of Helsinki

The Council approved that the workgroup for the Declaration of Helsinki revision continue its work and proceed with organising the remaining meetings as well as the second public consultation in June 2024.

Assisted Reproductive Technologies

The Council approved that the proposed revision of recommendation 14 of the WMA Statement on Assisted Reproductive Technologies be circulated to constituent members for comments.

Declaration of Kigali

The proposal to revise the name of the WMA Declaration on the Ethical Use of Medical Technology to the Declaration of Kigali, was approved by the Council and will be forwarded to the General Assembly for adoption.

Finance and Planning Committee

The Council considered and approved the Report of the Finance and Planning Committee and made the following decisions via the consent calendar:

Financial Statement

The pre-audited WMA Financial Statement for 2023 was approved by the Council and will undergo an audit.

Statutory Meetings

- The Council approved that the 238th Council Session be held from 27-29 April 2028.
- The Council approved that the 78th General Assembly be held from 18-21 October 2028, which will be forwarded to the General Assembly
- The Council approved that the proposed theme, "The Impact of Artificial Intelligence on Medical Practice, especially in the Doctor-Patient Relationship", of the Scientific Session of the WMA General Assembly in Porto, Portugal, in October 2025, be forwarded to the General Assembly.
- The Council declined the invitation from the Pakistan Medical Association to host the 235th Council Session in Karachi, Pakistan, in 2026.

Code of Conduct

The Code of Conduct was extracted for individual consideration. The proposed amendments to the WMA Procedures and Operating Policies on Code of Conduct were approved by the Council without further changes.

Socio-Medical Affairs Committee

The Council considered the Report of the Socio-Medical Affairs Committee, with no items extracted for individual consideration. Council decisions reach via the consent calendar are as follows:

Epidemics and Pandemics

The Council approved that the proposed revision of the WMA Statement on Epidemics and Pandemics be circulated within the membership for comments.

Human Papillomavirus Vaccination

The proposed revision of the WMA Statement on Human Papillomavirus Vaccination was approved by the Council and will be forwarded to the General Assembly for adoption.

Mental Health of Physicians

The Council approved that the proposed WMA Statement on Specific Care for the Mental Health

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of Physicians be circulated again within the membership for further comments.

Air Pollution

The Council approved that the proposed WMA Declaration on Prevention and Reduction of Air Pollution to Improve Air Quality be circulated again within the membership for further comments.

Aging Physicians

The Council approved that the proposed WMA Resolution on Aging Physicians be circulated within the membership for comments.

Urgent Item – Healthcare in Gaza

The proposed Council Resolution calling for a ceasefire and the protection of healthcare in Gaza as amended, was adopted by the Council, as the WMA Council Resolution on the Protection of Healthcare in Israel and Gaza.

WMA's Work with the World Health Organization

During this Council session, other presentations made during the Seoul meeting covered WMA's ongoing work with the WHO as well as on the international stage.

International Health Regulations and the Proposed Pandemic Agreement

The Council received a presentation by Dr. Yassen Tcholakov, Past Chair of the JDN, on the amendment of the IHR and International Pandemic Negotiations, in relation to the proposed Pandemic Agreement. He highlighted the WMA's activities, including participation in extensive meetings and ongoing efforts to provide input on the Intergovernmental Negotiating Body (INB) Article 7 on Health and Care Workforce. He outlined the objectives of the WMA, namely to pursue mechanisms of equity in the global response, ensure the protection of health personnel, and advocate for physical and mental health as well as safe working environments and labour conditions. Dr. Tcholakov highlighted that the WMA holds a timely position as a relevant international organisation to continue engaging on these topics.

Health Workforce Advocacy

The Council received a presentation by the WMA Advisor Dr. Caline Mattar on health workforce advocacy. She provided background information on the WHO Global Strategy on Human Resources for Health, a framework to guide policy and investment decisions in health labour markets, with the aim of ensuring a healthy workforce that is capable and equipped to deliver quality health services, and contributing to universal health coverage, health security, and overall health and well-being. The WMA has the opportunity to bring forward national physician perspectives, offer a strong national and international voice on physician-led care, and serve as a champion of decent work, fair wages, and workplace safety through the implementation of the Global Care Compact. Dr. Mattar presented opportunities for WMA members to advocate and amplify physicians' voices, by responding to requests for national input, sending letters, and engaging in national advocacy with ministries in their countries.

Antimicrobial Resistance

The Council received a presentation on AMR by the WMA Advisor Dr. Caline Mattar. She shared that the UN High-level Meeting will be held in September 2024, and that a Zero draft of the UN resolution has been released. Dr. Mattar outlined main advocacy points, such as the timely involvement of NMAs in the National Action Plan development, implementation, and monitoring and evaluation, urging expanded access of new AMR products to areas with the greatest unmet need. WMA members can become engaged at a national level with advocacy around the health workforce message for the High-level Meeting as well as participate in National Action Plan implementation. In addition, WMA members were invited to share information with their national experts who are invited to contribute to these WMA AMR initiatives.

Other Business

Dr. Park introduced the video invitation from the Uruguayan Medical Association, which will host the 229th WMA Council Session in Montevideo, Uruguay, from 24-26 April 2025.

Dr. Kloiber thanked the Korean Medical Association, other staff and volunteers, past and present officers, Council members, observers, advisors, Associate Members and their Chair, World Medical Journal editorial team, legal advisor and facilitator, interpreters, WMA Secretariat, and especially the Chair of Council, Professor Park, and Dr. Alqodmani.
Dr. Park called upon Dr. Alqodmani to speak briefly about the inaugural Women in Medicine lunch. She thanked those who made the event possible and announced that the second Women in Medicine lunch will be planned for October 2024.

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2. World Medical Association. WMA Takes Stand Against Humanitarian Violations, Calls for Urgent Action in Gaza [Internet]. 2024 [cited 2024 Jun 7]. https://www.wma.net/news-post/wma-takes-stand-against-humanitarian-violations-calls-for-urgent-action-in-gaza/

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Photo 1. Group photo at the Geunjeongjeon Hall of the Gyeongbokgung Palace during the 226th Council Session in Seoul. Credit: WMA

WMA Code of Conduct

At the 226th Council session, held in Seoul, Republic of Korea, in April 2024, the Council approved the proposal entitled, "Proposed Amendments on the WMA Procedures and Operating Policies on Code of Conduct," as amended (FPL 226/POPs Code of Conduct REV/ Apr2024), and forwarded it to the General Assembly for information.

Individual Agreement

Following the decision made by the Council during the 226th Council session, the WMA is enforcing the Code of Conduct (Chapter 8, Clause 8.2 of the WMA Procedures and Operating Policies), which reads: "All attendees of WMA hosted meetings, events, and other activities, including social gatherings are expected to exhibit respectful, professional, and collegial behaviour. To this end, every participant is asked to sign a code of conduct when registering for the event."

Each participant must complete their own registration and will be asked to agree to the Code of Conduct individually. Please note that no one else may register on behalf of the participant.

Anti-Harassment Policy (Chapter 8, Clause 8.3 of the WMA Procedures and Operating Policies)

WMA has zero tolerance towards any type of harassment, including sexual misconduct, of any attendee of a WMA-hosted meeting, event, and other activity, including social gatherings. Any form of retaliation against those who report or participate in an investigation of allegations of harassment is not tolerated.

Any persons who believe they have experienced or witnessed an act of harassment, including sexual misconduct, are encouraged to report it to any member of the WMA Secretariat.

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WMA COUNCIL RESOLUTION ON PROPOSED LEGISLATION IN UK ON THE TREATMENT OF MIGRANTS DISREGARDING THE INJUNCTION INTERIM MEASURES RULE 39 OF ECHR

Adopted by the 223rd WMA Council session, Nairobi, Kenya, April 2023 and revised by the 226th WMA Council session, Seoul, Korea, April 2024

The WMA expresses its grave concern about the United Kingdom (UK) government intention to pursue the Safety of Rwanda Bill that legislates the reversal of the Supreme Court's recent unanimous judgement of the risk of harm in Rwanda. The Bill risks leaving people who are vulnerable, fleeing dangerous situations and who have often experienced trauma, subject to an environment where they are potentially re-traumatised and unable to access the medical attention they may urgently need. This will have a detrimental impact on the mental health of those removed.

The WMA is troubled by the proposed provisions in the Bill that would allow ministers to disregard the measures issued by the European Court of Human Rights (ECHR) under Rule 39 of the rules of the court in relation to the treatment of migrants and prohibits courts from having regard to any such measure. The WMA is committed to the principle of respect for international law. If enacted, this legislation would remove an important protection for people seeking asylum, other migrants and those health workers caring for them.

Rule 39 interim measures have prevented the forced removal of asylum seekers from the UK to Rwanda, under a controversial offshoring scheme that the UK medical community has condemned on medical, ethical and humanitarian grounds.

Human Rights are only meaningful and effective if they are applied equally to everyone. Given the key role of the United Kingdom in drafting the European Convention on Human Rights, this creates a dangerous precedent that other nations might seek to follow.

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WMA COUNCIL RESOLUTION CALLING FOR THE IMMEDIATE WITHDRAWAL OF THE BILL LIFTING THE BAN ON FEMALE GENITAL MUTILATION IN GAMBIA

Adopted by the 226th WMA Council session, Seoul, Korea, April 2024

1. The WMA Council meeting in Seoul notes with dismay the bill currently before the Gambian Parliament to lift the ban on female genital mutilation (FGM) in force since 2015. On 18 March 2024, Gambian MPs voted overwhelmingly in favour of the bill which has then been sent to a parliamentary committee for a final review before a final vote in around three months' time.

2. According to UNICEF, 76 per cent of women (15–49 years) and 51 per cent of girls (0–14 years) have experienced FGM [1]. Since FGM was banned in 2015, only two cases have been prosecuted and the first conviction for performing mutilation was not handed down until August 2023 [2].

3. Although Gambia ratified the Maputo Protocol on Women's Rights in Africa, drawn up by the African Union, which condemns and prohibits all forms of female genital mutilation as a violation of the fundamental rights of girls and women, it remains widely practiced across the Country.

4. The Council recalls the WMA Statement on Female Genital Mutilation condemning the practice of genital mutilation or cutting of women and girls, regardless of the level of mutilation, and opposing the participation of physicians in these practices.

5. Reiterating that all forms of FGM constitute a violation of the human rights of girls and women and that its practice can lead to permanent damage to health, including chronic pain, infections, difficulties during childbirth and even death during or after the mutilation, the WMA Council urges the Gambian authorities to:

   - Respect their international human rights obligations, in particular the Maputo Protocol on Women's Rights in Africa, and therefore immediately withdraw the bill lifting the ban on female genital mutilation;

   - Instead, reinforce its legislation for the elimination of FGM with adequate funding and a comprehensive set of policies to empower women and girls to exercise their human rights.

6. The WMA Council calls on WMA constituent members and individual physicians to mobilize and advocate against the bill and for women's rights in Gambia.

[1] https://www.unicef.org/gambia/media/1581/file/UNICEF%20Gambia%20Annual%20Report%202022.pdf

[2] https://www.amnesty.org/en/latest/news/2024/03/gambia-parliament-must-not-lift-the-ban-against-female-genital-mutilation/

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WMA COUNCIL RESOLUTION ON ANTI-LGBTQ LEGISLATION IN UGANDA

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

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. 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, criminalized 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 criminalize 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.

This kind of law challenges 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 and 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 on Transgender People, calls on:

- Ugandan authorities to immediately repeal the Anti-Homosexuality law in its entirety;
- WMA Constituent members to condemn the Ugandan law and advocate against any similar legislation that is proposed or enacted.

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WMA COUNCIL 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

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 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. 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. Their death is from natural causes and this is verifiable.

3. 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

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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] https://www.wma.net/news-post/chinese-medical-association-reaches-agreement-with-world-medical-association-against-transplantation-of-prisoners-organs/

WMA COUNCIL RESOLUTION ON THE PROTECTION OF HEALTHCARE IN ISRAEL AND GAZA

Adopted by the 226th WMA Council session, Seoul, Korea, April 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.

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European Union's Actions to Fight AMR using a One Health Approach

Roser Domènech Amadó

Combatting antimicrobial resistance (AMR) has been a priority for the European Commission for the past two decades. AMR is considered one of the main health threats in the European Union (EU), which will continue to spread if decisive action is not taken. According to the World Health Organization (WHO), 700,000 people worldwide lose their lives each year to drug-resistant bacteria, with more than 35,000 of these deaths occurring in the EU alone [1,2]. This burden could increase to over 10 million annual deaths by 2050 [1]. In addition, AMR significantly impacts the economy and healthcare systems, accounting for an estimated EUR 1.5 billion every year in healthcare costs and productivity losses [3]. These numbers cannot – and importantly *are not* – being ignored by the EU.

In terms of public awareness, the level of general attention paid to AMR is very low – comparable to the level of interest in climate change in the 1980s. AMR is a silent killer, and the general public are still not fully aware of the impending risks. AMR is a disastrous and out-of-control situation with increasing annual mortality rates, and the whole of society needs to understand the urgent need to address it. For this reason, the European Commission is placing a substantial emphasis on raising public awareness around AMR, by providing guidance on specific actions to Member States, healthcare professionals, and citizens in order to mitigate the risk of AMR spreading across their communities.

The EU's fight against AMR is founded on a One Health approach. This is an approach that recognises human, animal, and environmental health as one collective unit within a shared ecosystem [4]. Taking this approach means that our initiatives on AMR – both in terms of science, but also, importantly in terms of our proposals, considers all ecosystems within our shared environment.

In June 2023, the EU proposed the Council Recommendation on accelerating the EU's actions to combat AMR through the application of the One Health approach [5]. As one of the most ambitious EU actions against AMR to date, this recommendation establishes targets to be achieved by 2030, including a 20% reduction in antibiotic consumption in humans. These targets are an important way to drive action against AMR, while respecting national circumstances and maintaining patient health and safety.

The Recommendation also includes increased monitoring and surveillance and enhanced infection prevention and control measures, which gives a boost to research and development efforts and incentives to ensure access to antimicrobials. One example of an incentive would be revenue guarantees for pharmaceutical companies that invest in research and development of novel antibiotics. Further flagship targets include a 50% reduction of the sales of antimicrobials for farmed animals and aquaculture, and statistics have shown that sales decreased by more than 28% between 2018 and 2022 [6,7]. This target is coupled with a ban of routine use to groups of animals for prophylactic purposes, as well as growth promoters in farmed animals.

In parallel, in April 2023, the EU proposed the most comprehensive revision of the EU's pharmaceutical legislation in two decades. The objective is to ensure the supply of safe, effective and innovative medicines to all Europeans, while maintaining a strong and competitive pharmaceutical sector in Europe.

The proposed new legislation includes measures to stimulate the development of novel antibiotics, including 'transferable data exclusivity vouchers' to developers of novel antimicrobials. The voucher, which will be subject to strict conditions, will offer developers an additional year of data protection from competing companies for their novel antimicrobials. This system will consequently generate revenues for businesses that successfully develop innovative medicines against AMR. This legislation also includes measures to improve the use of all antimicrobials and establish an environmental risk assessment for antimicrobials for human use [8].

Like other global health priorities, health financing plays an essential role in mitigating AMR risk. In addition to raising AMR awareness and communication, the European Commission has been supporting Member States as well as Norway, Iceland, and Ukraine, with EUR 50 million of available funding towards reducing the risk of exposure of citizens to antibiotic-resistant bacteria. To support global cooperation on AMR, the EU Global Health Strategy helps support the WHO and their initiatives to identify

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the types of antibacterials needed and initiatives to expedite clinical trials [9].

The EU also actively works with the Quadripartite Organisations (WHO, Food and Agriculture Organization of the United Nations, World Organization of Animal Health, and UN Environmental Programme), with G7 and G20, and in the ongoing negotiations for a Pandemics Agreement. Under the Transatlantic Task Force on AMR (TATFAR), which was established in 2009, the EU frequently exchanges best practices with experts from Canada, Norway, the United Kingdom, and the United States on AMR [10]. On the future global stage, the EU holds great hope for an ambitious outcome from the UN General Assembly High-level Meeting on AMR in September 2024, especially as all international partners will commit to timely, concrete, and evidence-based actions against AMR spread.

In conclusion, when tackling AMR, scientific evidence shows that our global society cannot delay any further in this call to action. Our generation has had the privilege of living in the safe antibiotics era, and we should not be the last generation to do so. From individuals to international partners, we can collectively continue to take urgent and ambitious actions in order to make an impactful difference in reducing AMR risks.

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Pioneering Change: The Junior Doctors Network's Role at the CND67 and Beyond

Pablo Estrella Porter

The United Nations Office on Drugs and Crime (UNODC) supported the organisation of the 67th Commission on Narcotic Drugs (CND67), which was held in Vienna, Austria, from 14-22 March 2024. This global meeting brings together Member States with their government officials, policymakers, health enforcement, and experts from ministries of health, justice, and interior, as well as international organisations such as the International Narcotics Control Board (INCB), World Health Organization, and Civil Society associations. The UNODC aims to enhance global peace, security, sustainable development, and human rights, by addressing issues related to drugs, crime, corruption, and terrorism. Health professionals can play a fundamental role in supporting the UNODC mission and commitment to the 2030 Agenda for Sustainable Development, through striving to enhance access to and availability of controlled medicines for medical and scientific purposes, and hence combat the global drug problem.

During the CND67, the Resolution 63/3 was adopted, which underlines the global commitment to the equitable and effective use of controlled medicines, emphasising the need for comprehensive education and training programs for healthcare professionals and adequate provision of evidence-based guidelines and tools. Specifically, the Resolution 63/3 states: *"Promoting awareness-raising, education and training as part of a comprehensive approach to ensuring access to and the availability of internationally controlled substances for medical and scientific purposes and improving their rational use"* [1]. This commitment recognises that drug use disorders negatively impact health, safety, and well-being, and are exacerbated by stigma and discrimination that hinder access to necessary help.

According to the *World Drug Report 2023*, the number of users of illicit drugs worldwide has increased by 23% over the past decade, from an estimated 240 million people in 2011 to 296 million people in 2021 [2]. Findings demonstrated that the burden of drug use disorders is significantly related to opioid and cannabis use, and that existing disparities in geography (e.g. opioid use in Europe, opioid and methamphetamine use in Asia, cocaine in Latin America), gender (e.g. women may face barriers in accessing treatment due to social stigma or fear of legal sanctions), and socioeconomic status (e.g. individuals living in Africa and Asia have inconsistent access to essential controlled medications for pain relief and palliative care) can hinder the prompt delivery of supporting and life-saving treatment to combat drug use disorders. Implementing regulations that focus on public health can ensure that controlled medicines are accessible and available where necessary, while managing commercial influences and minimising the risks of diversion and non-medical use [2].

For the first time, the Junior Doctors Network (JDN) of the World Medical Association (WMA) contributed significantly to the event proceedings on 18-19 March 2024 (Photo 1). During the CND67 event plenary, the JDN representative (Dr. Pablo Estrella Porter) delivered a compelling statement prepared by the UNODC's newly established Young Doctors Network, framing the challenges in the access to controlled medicines. He emphasised the urgent need to integrate medical education in prescribing controlled medications and pain management strategies, seek sufficient financial resources for training and the implementation of regulatory frameworks, work collaboratively to find a balance between over restrictive and excessively tolerant regulations, and address stigma around the prescription and use of controlled medicines (Photo 2).

This advocacy was key in highlighting the junior doctors' perspective in

Photo 1. Junior Doctors Network representative, Dr. Pablo Estrella, at CND67. Credit: JDN

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Photo 2.Formal presentation by the Junior Doctors Network representative, Dr. Pablo Estrella, on the Statement of the Young Doctors Network at the CND67 plenary. Credit: JDN

the global discourse on drug control and patient care as well as their leadership to create a youth network to collaborate on these pressing issues. Ms. Ghada Waly, Director-General and Executive Director of the United Nations Office at Vienna / UNODC, shared this sentiment at the CND67 on 14 March 2024: *"And to put our words into action, new UNODC programming is building connections in the medical field, recently launching a network of young doctors from around the world to discuss sustainable solutions for stubborn barriers to access"* [3].

During the CND67 side event entitled, *"Taking the Pledge4Action to ensure adequate availability of internationally controlled essential medicines,"* the JDN representative shared real examples of the barriers that junior doctors face when prescribing and accessing key medications in the clinical practice. He specifically highlighted the lack of continuous education for prescribing medications (including controlled medicines), importance of identifying patients who misuse controlled medicines, and limited availability of medications in low- and middle-income countries. This event showcased the global commitment to improving access to essential medicines, with discussions featuring representatives from various countries and organisations, such as Belgium, Brazil, Ghana, INCB, CAPSA Canada, and the International Association for Hospice and Palliative Care (IAHPC). The engagement of junior doctors in this forum has the potential to drive conversations toward practical and innovative solutions for increasing accessibility of prescribed medication as well as strengthening healthcare resiliency.

The CND67 and its side events underscored the political will among Member States to enhance access to controlled medicines, balancing the need for medical use and preventing non-medical use. Although the CND is not primarily centred on health matters, the participation of junior doctor representatives at the plenary and inside events, along with the engagement of diverse stakeholders, demonstrated an increasing willingness to address health-related issues within the context of drug control policies. This indicates a growing recognition of the importance of integrating health perspectives into the broader framework of narcotic drug regulations.

At the CND67 plenary, the Young Doctors Network shared a statement ("Statement by the UNODC Young Doctors Network on Access to Controlled Drugs") that was prepared by the members in collaboration with UNODC and proposed five recommendations:

- To strengthen education and training in rational prescribing of controlled substances
- To foster global partnerships to share best practices and innovations
- To advocate for policy reforms to balance access to controlled medicines and prevent misuse
- To support research and data sharing to inform evidence-based policymaking
- To address stigma around controlled medicines and ensure equitable access to them, particularly in low- and middle-income countries

Additional information about this statement can be reviewed at the end of this article.

Junior doctors hold a key role in advocating for policy reforms, participating in international dialogues, and implementing best practices in clinical settings related to emerging global health challenges, like controlled medicines. The JDN representative demonstrated that their dedicated efforts can advocate for timely policy decision-making on the availability and rational use of controlled medicines, which may help influence clinical and public health practice. Their involvement in UNODC's initiatives, particularly in the accessibility of controlled medicines, sets a precedent for future engagement and policy development. This landmark event specifically highlighted existing challenges and paved the way for actionable solutions, aligning with the UN 2030 Agenda for Sustainable Development and ensuring that no one is left behind in accessing essential healthcare services.

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UN COMMISSION ON NARCOTIC DRUGS STATEMENT BY THE UNODC YOUNG DOCTORS NETWORK ON ACCESS TO CONTROLLED DRUGS

PREAMBLE

Despite the undeniable necessity of some substances controlled under the international drug conventions, especially in pain management and palliative care, numerous barriers prevent equitable access worldwide. These barriers include strict regulatory frameworks, education for health professionals, limited funding, and the stigmatisation of their use, leading to preventable suffering for millions of patients worldwide. As junior doctors, we play a crucial role in improving access to controlled medicines at a local, national, and international level through rational prescribing practices, raising awareness among peers and patients, as well as shaping strategies to tackle this issue. Health professionals must navigate the delicate balance between achieving the desired therapeutic objectives while addressing the risks of dependence, and overcoming overly restrictive or excessively tolerant regulations, diversion, and non-medical use.

CALL FOR ACTION

Given the key role that doctors play in rational prescribing, recognising signs of dependency, contributing to patient monitoring, improving communication, and promoting awareness we call upon action to:

1. Engage in medical education, integrating comprehensive knowledge on drugs under international control and pain management strategies. Junior doctors are in the prime moment to be fully and professionally educated with a long-lasting effect on our medical practice.

2. Provide sufficient resources and establish proper regulations for pain management. A national pain treatment plan should encompass pain prevention, treatment, education, and the management of medicines containing controlled substances.

3. Foster collaboration between drug control regulators and health professionals from their early stages of medical education. Listening to health professionals and ensuring their participation in the development and implementation of national guidelines is crucial for promoting rational prescription practices.

4. Address the stigma associated with controlled medicines and stress the critical need for targeted postgraduate education for healthcare professionals. This education must carefully address the complexities associated with the use of controlled medicines, while preventing diversion and non-medical use.

5. Acknowledge the unique position of junior doctors in navigating the complexities of narcotic drugs, and highlight the need for creating and maintaining platforms, spaces, and funding for exchanging best practices and collaborating in new initiatives inside healthcare networks already existing with support from Member States and other stakeholders.

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Pandemic Negotiations at the World Health Organization: Perspectives from the World Health Assembly in May 2024

Yassen Tcholakov

The World Medical Association (WMA) has been closely monitoring international negotiations on the management of pandemics. The coronavirus disease 2019 (COVID-19) pandemic exposed significant shortcomings in our current international systems, resulting in overworked doctors, unsafe working conditions, and unequal access to preventive and protective resources such as vaccines. In response, various temporary measures were implemented to address these challenges, but they ultimately proved to be insufficient. Recognising the need to tackle the root causes, the World Health Organization (WHO) initiated a process in late 2021, to negotiate a new international legal instrument for pandemic management, with a focus on addressing international inequities, commonly referred to as the Pandemic Accord [1].

Definitions

Pandemic Accord: The international legal instrument currently being negotiated at the WHO aims *"to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade"* [2].

International Health Regulations (IHR): The IHR are an instrument of international law that is legally-binding on 196 countries and which create rights and obligations for countries, including the requirement to report public health events. The Regulations also outline the criteria to determine whether or not a particular event constitutes a *"public health emergency of international concern"* [3].

Process and Progress

This negotiation process began in early 2022, and ran concurrently with efforts to amend the IHR, with the goal of finalising these World Health Assembly (WHA) negotiations in 2024 (Photo 1). Despite significant efforts, the Pandemic Accord negotiations did not result in a consensus on some critical issues [4]. However, the WHA agreed to extend the negotiation timeline by one year, resuming these discussions in July 2024. This extended mandate will build on the successes of numerous accomplishments during the first two years of negotiations, including many parts of the draft text with a predicted consensus, namely the Health and Care Workforce section that was a priority topic of WMA advocacy [5].

Meanwhile, the amendments to the IHR were successfully adopted, marking a significant step forward in global health governance [6]. Key improvements include:

- Equity Focus: The amendments ensure more equitable access to medical products during health emergencies.
- Strengthened Financing: Mechanisms for financing pandemic preparedness and response have been enhanced to ensure that all countries, regardless of income level, can respond effectively to health crises.
- Clearer Criteria for Pandemic Emergencies: A new definition of a "pandemic emergency" provides clearer criteria for triggering international responses.
- States Parties Committee: This committee will facilitate better implementation of the IHR, assess and improve core capacities, finance initiatives, and ensure equitable access to relevant health products [7].

Despite these advancements, some have criticised the lack of compliance mechanisms within the revised IHR and the difficulty in holding countries accountable for their commitments.

Next Steps

The primary objective of improving equity in pandemic responses remains central as negotiations continue in 2024 and 2025. The agreement aims to do so by ensuring that all countries stand to benefit from global surveillance by warranting redistributive equity in resources used to respond to pandemics, technology transfer to continue improving regional and national manufacturing capacity and self-reliance, and financial support from countries with more resources or experience. Reaching an agreement at the next WHA would guarantee better protection for health personnel during future pandemics, optimal allocation of resources to interrupt transmission, and faster, more effective responses

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Photo 1. Dr. Tedros Adhanom Ghebreyesus, WHO Director-General, shared concluding remarks and words of encouragement for the work ahead on the Pandemic Accord negotiations during the closing plenary of the 77th World Health Assembly in Geneva from 22 May–1 June 2024. Credit: Yassen Tcholakov

to future health crises. Furthermore, it can offer a framework for local and national leaders to reinforce prevention measures and surveillance that can help prevent future pandemics by promoting multisectoral collaboration, recognising and addressing environmental, climatic, social, anthropogenic, and economic factors driving pandemic risk, through a One Health approach, and creating systems for pathogen specimen and genetic information sharing between countries.

Given the significant amount of disinformation about the WHO and the WHA negotiations [8], it is crucial for trustworthy actors, including national medical associations and the WMA, to continue advocating for effective international collaboration and investments in health that benefit all people. This ongoing support and advocacy are essential as we strive to improve global health governance and ensure equitable responses to future pandemics. Together, we can make meaningful progress in protecting public health worldwide. By reviewing WMA communications and keeping informed on these WHA negotiations, we can use this information when discussing pressing health topics with ministries of health or national negotiators. Additionally, all WMA members are invited to provide input to the ongoing review and evaluation of the WMA Statement on Epidemics and Pandemics, published in October 2017 [9], which is expected to be discussed at the WMA General Assembly in Helsinki, Finland, in October 2024.

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Interview with National Medical Associations' Leaders of the Latin America and the Caribbean Region

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Dr. Jorge Coronel, Dr. César Eduardo Fernandes, Dr. Simone Mc Fee, and Dr. José Minarrieta, the Presidents of the national medical associations (NMAs) of Argentina, Brazil, Trinidad and Tobago, and Uruguay, as well as Dr. Marcelo Mingo as the Secretary General, Dr. Carlos Serrano, Jr. as the International Relations Director, and Dr. Damion Basdeo as the Immediate Past President of the NMAs of Argentina, Brazil, and Trinidad and Tobago, join this interview with Dr. Helena Chapman, the WMJ Editor in Chief. They share their perspectives on their leadership experiences, ongoing NMA activities, strengths and existing challenges in medical education, and how the World Medical Association (WMA) can support NMA initiatives in the Americas region.

As you reflect upon your journey as NMA president, please describe one memorable experience, one challenge and how you resolved the challenge, and one hope for the future of medicine.

Argentina: During the coronavirus disease 2019 (COVID-19) pandemic, the Confederación Médica de la República Argentina (COMRA) was a leading entity in the dissemination of health policies and proposals that aimed to advocate for improved workplace safety and working conditions for health professionals. They also contributed to the widespread promotion of immunisation adherence and self-care for patients. Currently, members continue to collaborate with national health authorities in the development of protocols and regulations to prioritise high-quality patient care and workplace safety for health

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professionals in Argentina.

As the COMRA represents the national body of physicians across Argentina, we seek recognition by national authorities of our collective healthcare duties to the population, and advocate for a safe workplace and working conditions and remuneration aligned with our professional training and responsibilities. Hence, we believe that we can collectively strengthen primary care across all sectors and help to prevent disease transmission and sequelae. We hope for a more equitable health system, where patients have easy access to treatments and medications for the entire population, and health professionals feel safe, recognised, and valued in their workplace, which will reduce emigration in search of additional opportunities.

Brazil: Since the start of the first term of the Brazilian Medical Association (Associação Médica Brasileira, AMB) leadership (2020-2023), we have had a number of remarkable experiences. As president, I have contributed to intense and constructive debates with our board of directors, focused on tackling the most pressing challenges facing the Brazilian medical and health scene. Although our team celebrates each achievement, one key initiative was the creation of the Extraordinary COVID-19 Monitoring Committee (CEM COVID) (https://amb.org.br/category/cem-covid/), which offered an expert panel to review and discuss research findings with specialists and serve as a reliable source of COVID-19 information for the Brazilian population, health professionals, and mainstream media.

As the AMB aims to improve medical education in Brazil, we have been busy denouncing the indiscriminate opening of medical schools and systematically opposing all proposals to increase the flexibility of the *Revalida* (exam that legitimises medical diplomas issued by international universities). Although this problem is complex and remains far from a satisfactory resolution, the AMB is not standing still. Last year, after we discussed the issue with Dr. Camilo Santana (Brazil Minister of Education) to identify timely solutions, the Ministry of Education set up a working group with the AMB, the Federal Council of Medicine (CFM), and the National Academy of Medicine (ANM). In this context, the work of the Parliamentary Action Center, created to represent the political-institutional channel for Brazil's doctors in 2021, helps articulate consistent responses in defence of medicine and health.

As I look ahead to tomorrow, we just started our second term administration (2024-2026), I firmly believe that technology across the planet will continue to contribute to the evolution of medical practice, enabling more accurate diagnoses. Recognising advances in public policies to promote health, more effective treatments coupled with greater accessibility and access to care has the potential to reduce inequalities. The future of our profession in the Americas region will depend on strengthening associations and unity among health professionals. After all, as technologies evolve, we contribute our unique talents to society. The success of medicine depends on what makes us human, including our capacity to be sociable, empathetic, and caring with our communities.

Trinidad and Tobago: Although my journey as the Trinidad and Tobago Medical Association (T&TMA) president has been short, I fondly remember the celebratory dinner that the association held for the medical and dental sciences graduating classes of 2023. Since mentorship is important to our association, we use the graduation ceremony as an opportunity to meet the new interns and remind them of our continued support throughout their professional journey. As I spoke to the newly minted doctors and repeated the WMA physician's pledge, I was reminded of the nobility of our profession and the fact that it is one of the few esoteric professions. Thus, mentorship and honesty are invaluable to preserving the honour of our profession.

The T&TMA recently had the opportunity to work with the Trinidad and Tobago Ministry of Health in hosting a symposium on non-communicable diseases for the primary care physicians across the nation. The task was monumental, and albeit limited time due to work schedules, teamwork was the key ingredient in overcoming this challenge and organising a successful national event. As we requested assistance from the wider association, members volunteered their time and shared new ideas, and hence we had sufficient staffing to ensure that our team accomplished our goals. Looking toward the future, I hope that T&TMA will continue to be influential in developing timely health policies that strengthen access and availability to healthcare services in the country, the Caribbean, and the Americas region.

Uruguay: In October 2023, I was elected as president of the Sindicato Médico del Uruguay (SMU) (https://www.smu.org.uy/), after having served as Secretary (2022-2023) and working closely with the Immediate Past President, Dr. Zaida Arteta. Over these last few months, we have been evaluating key policy documents that can help Uruguayan physicians improve the quality of health service delivery, especially for those working in the public sector (like

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paediatricians) in Montevideo. We believe that this example represents an opportunity for collective and bipartisan negotiation, where physicians can actively advocate to improve workplace and service delivery conditions through a democratic process.

How would you describe the current opportunities for NMA members to help influence healthcare policy-making activities in your country?

Argentina: As COMRA members, we are currently developing collaborative alliances and agreements with national leaders who contribute to public health policies and health system management. Important political changes have occurred across Argentina, and we hope that health authorities will communicate with the COMRA to collaborate on the design of health policies that can be debated, revised, and consequently adopted into legislation. As we have conducted relevant debates on pressing topics, leaders have prepared policy proposals that support comprehensive health plans for the entire population. For example, as the national constitution proposes that health management be divided by province, we have requested that the Ministry of Health propose basic guidelines and integrative proposals across the nation.

For decades, the COMRA has maintained a Drug Commission that promotes their Rational Use through a National Therapeutic Formulary, as a list of drugs endorsed by the World Health Organization and inspired by other therapeutic formularies (e.g. United Kingdom). In addition, the COMRA aims to develop continuing education courses in management and auditing as well as a training institute that can transition into a medical school over time. Currently, a mutual agreement has been established with the University of Buenos Aires Faculty of Medicine to offer continuing education courses for physicians in Argentina.

Brazil: As the AMB management has encouraged active participation for all members on general or specific debates on health-related issues, we have significantly influenced public policy-making activities (including recent decisions) in Brazil. Today, our association has a significant presence and voice in important official forums, with inclusion in the Commission for Updating the Roll of Procedures and Events in Supplementary Health (Cosaude), contributions to some important health government agencies, and participation in the National Commission for the Incorporation of Technologies in the Unified Health System (Conitec). Overall, we seek to establish active and relevant contributions to dialogue across all levels of government, from the municipalities to the Ministry of Health. The AMB maintains a status separate from any political or ideological involvement in order to contribute to national health discourse that focuses exclusively on best medical practices. Through this inclusive and non-partisan approach, the AMB can ensure that health policies consider evidence-based science and in the interests of the Brazilian population.

Trinidad and Tobago: The T&TMA is recognised as a key stakeholder in the national health system, and members are often invited to actively contribute to policy-making activities. It is important for the association to remain steadfast in its resolve to highlight existing gaps in healthcare service delivery and support relevant policies to fill these gaps.

Uruguay: Since the SMU was founded in August 1920, members have been actively engaged in the discussion and development of robust proposals that complement our political agendas, as well as the vision that Uruguayan physicians have regarding public health policies. We believe that these policies should offer a comprehensive overview for local and national health stakeholders, as well as for other medical associations and global health systems. Although the Uruguayan health system (Sistema Nacional Integrado de Salud: https://www.gub.uy/ministerio-salud-publica/sistema-nacional-integrado-salud) has limitations, the framework was established and has continued to be strengthened by physicians who are indispensable leaders who contribute to pressing health issues in national debates and discussions at national conventions, congresses, journal clubs, and assemblies.

How do perceive the physician-patient relationship and rapport in the clinical setting in your country?

Argentina: In Argentina, the image of the physician is prestigious, and the physician-patient relationship must be developed in a cordial manner, based on the hegemonic medical model. Physicians feel a moral obligation to alleviate suffering and respect patients' beliefs and autonomy, although recognising that the physician-patient relationship can deteriorate due to diverse stressors (e.g. economic and legal aspects) of the medical profession. For example, physicians may need to obtain more than two employment opportunities to achieve a stable income, as observed during the current economic crisis, and their limited attention and time spent with patients may erode the physician-patient relationship.

Brazil: The doctor-patient relationship, which requires mutual respect and open communication, is the basis of good medical practice. Professionals who are attentive to

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people can better understand their needs, concerns, and expectations. In Brazil, it is common for patients to complain about the coldness and indifference of some doctors. This may be due to doctors' excessive work schedules (risk of burnout) or inadequate professional training, noting the proliferation of medical schools of unsatisfactory quality that places poorly trained professionals in clinical practice.

On the other hand, many doctors have developed a more empathetic view during the COVID-19 pandemic, observing how the virus weakened the sick and their families in an unprecedented way. As they were learning about virus transmission each day, without effective treatments available, they were more welcoming and potentially learned from societal pain. As such, we began to rethink the speed of medical consultations, valuing patient interactions without the overhead clocks, returning to the ancestral bonds between doctors (those who care) and patients (those who are cared for). In reality, we live in a country with limited resources, and we use our resources sparingly and responsibly, in order to ensure that everyone – without exception – has the right to receive high-quality healthcare.

Trinidad and Tobago: As physicians are widely respected in Trinidad and Tobago, it can lead to patients being timid to question the opinion of their physicians, especially among senior citizens. Hence, it is important for physicians to encourage patients to ask questions and share in the decision-making process for an appropriate clinical management related to their health and well-being. These actions will inevitably strengthen physician-patient rapport, trust, and treatment adherence.

Uruguay: Our clinical responsibilities have been supported by key relationships within the health system, primarily focusing on interactions between physicians and patients. We believe that patients should be directly involved in their healthcare services, which can be challenging at times due to limited time for evaluating, diagnosing, and managing patients' health concerns in the outpatient setting. As a global medical community, we should consider opportunities to advocate for our patients and identify ways to improve this process within healthcare systems. For instance, the Consejo General de Colegios Oficiales de Médicos (CGCOM) of Spain submitted a proposal to the United Nations Educational, Scientific and Cultural Organization (UNESCO) to declare the doctor-patient relationship as an intangible heritage of humanity, and the SMU supports this initiative.

How would you describe the anticipated challenges in medical education over the next decade in your country?

Argentina: Although traditional academic institutions are recognised with prestige, medical education in Argentina is currently in crisis. Although certain educational policies have been implemented across medical schools in different jurisdictions, we have observed that medical graduates' quality of knowledge is poor. Also, some general trends are apparent in medical residencies, including medical graduates selecting specialties with higher incomes (versus primary care specialties), and more than 50% of most residency placements are obtained by female medical graduates. Hence, we believe that there are three key challenges to achieving high-quality medical education in Argentina. First, most medical schools (albeit some private institutions) have limited financial resources, as they depend on economic support from the government. Second, medical training programs should remain updated with the evidence-based science, supported through agreements that can link institutions with professors to develop high-quality training curricula. Third, physicians should be compensated adequately for their responsibilities, since they work in one or all of the three sub-sectors (namely, medicine or public health) that are financed by unions or private activities (e.g. medical pharmaceutical companies). The COMRA strongly defends the physician union and salary across all subsystems.

Brazil: In Brazil, the main challenge is the unbridled opening of medical schools. In 2023, the AMB and the University of São Paulo School of Medicine (FMUSP) conducted a study, published in the *Medical Demography in Brazil* [1], which noted that the largest expansion of medical education in Brazil's history was recorded between 2013 and 2022. In 2022, Brazilian authorities reported that a total of 389 schools offered 41,805 medical education placements. Of this total, 23,287 new placements were opened after 2013, which was linked to an increase of almost four times greater than data recorded between 2003 and 2012 (e.g. 5,990 authorised placements). At this rate, there will be over one million doctors in the country by 2035.

The rationale of this expansion is based on the reality of doctor shortages across rural communities, and that increased medical education placements can resolve this burden. However, countless doctors return to practise medicine in urban areas due to increased pay and working conditions. Moving forward, we can strengthen medical education and training and incentivise doctors to fulfil primary care leadership roles in rural and low-income populations

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across Brazil. Structural public policies should be adopted to recognise doctors and other health professionals and guarantee that high-quality and safe health services – from northern to southern Brazil – are provided by well-trained health professionals.

Trinidad and Tobago: Presently, Trinidad and Tobago has been experiencing a deficit of post-graduate training options, which is not anticipated to improve over the next decade. Ongoing efforts aim to engage all stakeholders to help find innovative solutions to provide affordable post-graduate medical education and encourage doctors (who have attained their post-graduate qualifications) to work locally. As continued medical education has been at the forefront of local discussions, health leaders support ongoing initiatives to increase access to these educational opportunities over the next decade.

Uruguay: As physicians and representatives of the SMU, it is our obligation to prioritise health literacy, where we can empower, create, and strengthen continuing medical education. Medical recertification can reinforce the inseparable link between clinical practice and education, helping physicians to stay updated on their clinical knowledge and skills, including new technologies, policies, and guidelines that may affect their daily practice. For example, we have started to engage in discussions about the use of artificial intelligence in both academic and clinical settings, particularly its potential applications to enhance medical practice and ethical considerations.

From the medical education perspective, how has your NMA responded to the existing and emerging health challenges within your country?

Argentina: We believe that postgraduate medical education programs can represent the first step to addressing existing and emerging challenges in Argentina. Hence, the COMRA has developed medical education courses in a hybrid format (virtual coupled with in-person attendance), in collaboration with the University of Buenos Aires Faculty of Medicine, and official degrees are awarded by the university.

Brazil: The AMB leads and contributes to various initiatives in medical education and advocacy to address Brazil's health challenges. First, the General Medicine Congress 2023 allowed medical professionals from different specialties to exchange experiences, clarify daily challenges faced by specialists and non-specialists, and promote relevant debates and learning. These discussions helped encourage professionals to search for continuing education courses to acquire new knowledge and improve practice aligned with innovative technology. Second, the AMB has led advocacy efforts to caution authorities about the increased placements across medical schools. In 2023, they met with Dr. Nísia Trindade (Minister of Health in Brazil) to discuss health professionals' training and preparedness to work in underserved areas, evaluations of medical schools, and strengthening the Unified Health System, and they plan to continue this important dialogue.

Trinidad and Tobago: The T&TMA has been at the forefront of promoting continuing medical education for over a decade. Our association has submitted proposals to the Medical Board of Trinidad and Tobago (MBTT), as well as has held discussions with other stakeholders, reflecting our desire that continuous medical education should be mandatory for all practising physicians. In fact, we host at least four continuing medical education activities each month, and we also provide support and co-sponsor activities with other specialist organisations. For example, when Mpox emerged as a challenge within the Americas region, we hosted a webinar on this topic, and physicians from many Caribbean islands participated and contributed to the discussion period. As the T&TMA is well known locally for our educative thrusts, we aim to enhance our ability to provide continuing medical education opportunities throughout the country.

Uruguay: The SMU represents a national voice on a variety of emerging health issues, contributing to public debate, the development of public policies, and the media. For example, during the COVID-19 pandemic, our members provided clinical expertise to the Government of Uruguay for the development of timely health guidelines and public messaging. They have also supported collaborative efforts for mass vaccination campaigns to protect population health. More recently, with the increase in dengue cases across the Americas region, our association is working with national health authorities within the healthcare system to improve and expand the delivery of healthcare services throughout the country.

From your perspective and national experiences, how has the coronavirus disease 2019 (COVID-19) affected medical education in your country?

Argentina: During the COVID-19 pandemic, social restrictions across Argentina impacted medical trainees who were unable to develop fruitful relationships with colleagues, mentors, and patients,

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and simultaneously we observed that they refrained from pursuing certain critical medical specialties like emergencies and intensive care. Also, as academic programs were primarily suspended or delayed, technological advancements allowed professors to modify in-person courses to virtual learning for undergraduate and postgraduate students as well as support telemedicine consults with patients.

Brazil: The COVID-19 pandemic greatly affected medical education and training in Brazil. First, academic institutions were forced to quickly adjust their curricula and methodologies as well as transition from the face-to-face to the virtual model – and now the hybrid model. Without these efforts during this period of social isolation, medical education would have significantly disrupted learning. However, the transition to the virtual world has left gaps. Since medical education requires a holistic and practical approach, the limitations imposed during the pandemic may have affected the quality and depth of training. Hence, continued monitoring and evaluation of medical education programs by authorities will be essential to maintain high-quality education. Second, the pursuit of professional excellence was noted as indispensable, as health professionals were faced with challenges that required additional skills in intensive care medicine, crisis management, and public health. More than ever, organisations must offer professional development opportunities through training programs, continued education courses, and access to relevant educational resources.

Trinidad and Tobago: Overall, the COVID-19 pandemic has made medical education more accessible, as the use of technology has allowed medical students and physicians alike to access tutorials and educative sessions "on the go". We are no longer confined to meeting in a classroom or amphitheatre for academic learning and networking. This improvement has allowed busy physicians to incorporate educational activities into their schedule.

However, in the immediate post-COVID-19 era, we observed a decline in practical skills, since medical students had fewer physical interactions with patients, which resulted in a decline in physical examination skills. Hence, it is important for established physicians to engage these young doctors and help them improve these clinical skills. We recognise that the internship period has become even more important after the COVID-19 pandemic.

Uruguay: Since broadband internet became widely available throughout Uruguay in 2019, distance education has been successfully implemented during the pandemic. While distance education has its advantages, it is important to find a balance between in-person and virtual learning environments. This balance is incredibly important in medical training, which requires human contact to acquire optimal communication skills and foster positive physician-patient relationships.

How does your NMA leadership implement the WMA policies in the organisation?

Argentina: The communications officer of the COMRA regularly shares the *World Medical Journal* issues and WMA declarations, resolutions, and statements, with special emphasis on medical ethics, with COMRA members. We have received valuable positive feedback from COMRA members and colleagues on these high-quality documents.

Brazil: The implementation of WMA policies in the AMB follows an organised and collaborative process. Decisions are made at the WMA General Assembly, after deliberation by the relevant bodies, which take into account the global context and the needs of NMAs around the world. When we receive the WMA guidelines, AMB leaders carefully analyse the proposed policies, assess their applicability in the Brazilian context, and consider the impact that they will have on national medical practice. This process guarantees an approach that is aligned and consistent with international standards and specific needs of our medical community.

Trinidad and Tobago: The T&TMA is actively involved in ensuring access to healthcare to all Trinidad and Tobago citizens. Our leadership has established a committee dedicated to organising healthcare activities in rural areas and supporting efforts to increase accessibility to healthcare services. The association has partnered with the Trinidad and Tobago Ministry of Health to develop timely public health activities and policies, including educating the public on non-communicable disease risks. Recognising that the social determinants of health are fundamental to healthcare, T&TMA members have recently focused on intimate partner violence and child sexual abuse in 2024, by educating physicians and partnering with non-governmental organisations.

The T&TMA has a legacy of leaders who advocate for education and training opportunities, timely changes in healthcare practice, and practical ways of implementing WMA policies. In 2023, Dr. Damion Basdeo (T&TMA President, 2023), who led the charge on climate change and medicine, collaborated with members of other regional medical

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associations to educate doctors throughout the region via the recently formed CARibbean Health Alliance for Climate Action (CARHACA) [2]. Our T&TMA leaders have also helped promote vaccination adherence during the COVID-19 pandemic, in keeping with the WMA Resolution for Providing COVID-19 Vaccines for All, which was adopted by the 73rd WMA General Assembly in Germany in October 2022 [3].

Uruguay: Within the SMU, the International Affairs Commission is comprised of experts representing a broad ideological spectrum. As the commission discusses and debates key issues prioritised by the WMA, they develop an institutional position for formal presentation to the association's Executive Committee. After further discussion within this committee, the association shares the final institutional position with the WMA, as well as any revised policies and documents (e.g. Declaration of Helsinki, Declaration of Geneva, International Code of Medical Ethics) with the wider membership. The association also supports the Medical Journal of Uruguay (https://revista.rmu.org.uy/index.php/rmu), as the official journal for membership. Next year, we have the honour of hosting the WMA Council Meeting in the capital of our country, Montevideo.

How can the WMA support the ongoing NMA activities in your country?

Argentina: As COMRA leaders, we would like to collaborate with national health authorities in the design and development of relevant health policies to improve workplace conditions for physicians and the entire healthcare team as well as maintain continuing medical education as a valuable tool to improve the quality of care. We believe that these activities can help physicians remain updated on rapidly advancing evidence-based medicine and simultaneously feel recognised for their selfless medical service to improving patient care. Hence, the WMA can help support the economic costs for national medical associations to develop and offer innovative physicians' training opportunities on the topics related to health system management and clinical updates, which can offset costs to low- and middle-income nations.

Brazil: The WMA can support the AMB through several key strategies. First, the WMA can use its global platform to advocate for issues important to the AMB, such as the impact on the quality of medical education due to the proliferation of medical schools in Brazil, accreditation of medical education in Brazil, healthcare funding, public health initiatives, and professional autonomy, in order to ensure high standards of education and patient care. Second, the WMA and the AMB can collaborate on offering continuing medical education programs, which can help Brazilian doctors have expanded access to the latest medical knowledge and practices. Third, the WMA can facilitate connections between Brazilian and global researchers, which can help present funding opportunities and foster professional networking toward the development of research collaborations on important medical topics. Fourth, the WMA can establish professional exchange programs that promote knowledge sharing and professional development, where doctors can participate in short-term cross-cultural clinical and surgical training opportunities and directly learn about different healthcare systems. Finally, the WMA can help support the AMB in advancing telemedicine and digital health initiatives, which are crucial for reaching underserved populations in Brazil.

Trinidad and Tobago: The WMA can support the T&TMA by helping to promote local and regional medical research. In developing countries, like Trinidad and Tobago, few regional medical journals exist, and editorial teams may not have the capacity to meet the demands for publication and dissemination of local research. For example, the *Caribbean Medical Journal* (https://www.caribbeanmedicaljournal.org/), albeit limitations in finances, staffing, and specialised skill sets, represents an important scientific resource from the Caribbean region with findings that are applicable to other countries across the Americas, Africa, and Asia.

Like other Caribbean territories, Trinidad and Tobago is affected by several public health issues, including climate change and health, which disproportionally affect developing nations in the Americas region. The implementation of large-scale policies can have a global influence that trickles down to small island developing states (SIDs). The WMA can help T&TMA serve as a voice for other developing countries and help highlight issues that affect SIDs on an international stage.

Uruguay: Physicians worldwide face similar challenges in their daily clinical responsibilities, including improving the quality of healthcare services for citizens and ensuring the occupational safety of healthcare professionals. Therefore, global exchanges between medical professional organisations are essential, and the WMA provides the platform for this respectful shared dialogue of opinions and declarative positions, especially regarding topics related to medical ethics. We believe that the WMA should continue to support open discussion and debate on pressing issues, such as forced

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population displacement caused by conflicts and wars, famine, and climate change, and seek collective contributions from national medical associations for the development of key policy statements. We sincerely appreciate the opportunity to express our professional perspectives from our small country of 3.5 million residents, as we are enthusiastic about representing our SMU in the best interest of the profession and citizens.

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Interview with the President of the Association of Medical Schools in Africa

E. Oluwabunmi Olapade-Olaopa

For this interview, Professor E. Oluwabunmi Olapade-Olaopa, president of the Association of Medical Schools in Africa (AMSA), shares his perspectives on leadership experiences, strengths, and existing challenges in medical education, and how the World Federation of Medical Education (WFME) (https://wfme.org/) and the World Medical Association (WMA) members can foster collaborations, with Dr. Helena Chapman, the WMJ Editor in Chief.

What are the organisational goals, priorities, and current activities of AMSA?

AMSA plays a critical role in advancing medical education and healthcare in Africa. The need to establish this association was proposed during a medical education conference on 15 December 1961 at Ibadan, Nigeria [1]. Five universities attended this event, including the University of Leopoldville (Kinshasa, Democratic Republic of Congo), Diop University (Dakar, Senegal), Makerere University (Kampala, Uganda), University of Khartoum (Khartoum, Sudan), and University of Ibadan (Ibadan, Nigeria). AMSA was formally inaugurated in December 1963, at the Medical Education conference in Kampala, by the unanimous resolution of the five schools who were joined by the University of Lagos Medical School. Representatives from two new medical schools (University of Tanzania, Dar es Salaam and University of Ethiopia, Addis Ababa) were also present as observers. The association went into hibernation in the mid-1980s and was revitalised in 2014, through the efforts of the World Health Organization Regional Office for Africa (WHO-AFRO), supported by the WMA and WFME, taking advantage of the opportunities provided by the sub-Saharan African Medical Schools Survey (SAMSS), and the Medical Education Partnership Initiative (MEPI) projects [2,3].

As the leading medical (and dental) education force in Africa, AMSA's primary goal is to ensure that medical schools in Africa deliver high-quality, socially responsive medical education and conduct impactful community-directed research. It also serves as a forum for medical schools to share ideas and address challenges facing medical education and healthcare delivery in Africa, by enabling the acquisition of globally standardised skills required for clinical practice and research on the continent by graduates of its component schools [1]. AMSA's vision is to drive excellence in medical (and dental) education and propel the continent towards a healthier future, and the mission is to empower medical schools across the continent to equip their graduates with the attitude, knowledge, skills, and cultural sensitivity needed to address critical health challenges facing African communities. This will be achieved by setting and upholding the highest standards for medical schools, thereby ensuring the quality of generations of physicians and dentists who will serve the healthcare needs of Africa.

AMSA's priorities include embracing innovation to foster sustainable development in medical education, thus elevating the quality of medical practice throughout Africa, establishing a strong network of schools and educators across the continent and with the international medical education community, and providing a platform for sharing best practices and innovations in medical education. It also aims to empower African medical schools to continuously improve through capacity building initiatives, stimulating research in medical education and related fields, and advocating for equitable access to medical education across the continent by recognising and addressing demographic and cultural peculiarities.

AMSA's current activities include publishing educational resources [3], leveraging technology to hold hybrid workshops and webcast symposia with international faculty, and promoting collaborative research (e.g. South-South and North-South medical education networks). More recently, AMSA has been collaborating with member institutions and international partners to build on the foundation laid by multinational collaborative medical education strengthening projects (e.g. Sub-Saharan African Medical School Study, SAMSS; Medical Education Partnership Initiative, MEPI; Consortium of New Sub-Saharan African Medical Schools, CONSAMS), during which a community of practice of medical education was established in the sub-region [4-6]. AMSA employs a multifaceted approach to maintain high-quality accreditation standards, ensuring graduates meet the highest benchmarks for patient care.

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Over the past year, what do you consider to be your most important leadership achievements as president (2023-2024)?

AMSA is proud to announce several key achievements that will significantly impact medical education across the continent. First, the AMSA Executive Committee has approved a new Constitution and established the AMSA Secretariat at Ibadan to strengthen governance and provide administrative and financial stability for the association. Second, AMSA is actively planning its upcoming conference, scheduled for the third quarter of 2025 in Ibadan, Nigeria, which will promote scientific and professional exchanges, networking, and social interactions between all stakeholders in medical education in Africa. Third, AMSA has increased contact with medical schools across the continent, thus increasing our membership pool and expanding our network in Africa. Finally, renewed partnerships with the WHO-AFRO will allow the association to leverage expertise and resources to address critical challenges facing Africa's health systems.

How has the coronavirus disease 2019 (COVID-19) affected medical education across your geographic region?

Like other parts of the world, the COVID-19 pandemic had a significant effect on medical education in Africa, limiting the infrastructure and teaching methodologies in the traditional classroom. As these changes were aligned with safety guidelines, there was an urgent acquisition of new equipment to enable the adoption of virtual classrooms (e.g. Zoom meetings, email groups, social media platforms) and the introduction of capacity building programs for faculty to equip them with the skills for virtual instruction. The virtual platforms, however, challenged how educators were able to maintain community-based module training standards. Indeed, the year-long closure created a significant backlog of admissions to medical schools which has been cleared gradually enabling the continued production of much-needed physicians and dentists. Finally, the global post-pandemic economic crisis exacerbated the financial constraints of African medical schools with relatively reduced income (e.g. government funding, lower enrollment, donations) and increased expenditure (e.g. information communications technology systems, staff training), making efficient resource management mandatory.

What are the current strengths and existing challenges in medical education across your geographic region, and how can these challenges be addressed?

AMSA is proud of the current strengths in medical education across the region. First, despite the continuing migration of medical professionals to high-income countries, there remains an appreciable pool of highly qualified and experienced academic and non-academic staff in Africa's medical schools who are committed to medical training and research. This dedicated pool of human capital forms the basis for the continued delivery of high-quality medical education aligned with global standards in these institutions. Second, Africa's strong medical education culture fosters a reputation for excellence, making its medical graduates a much sought after brand globally. Third, most medical schools in Africa are developing a robust network of accomplished alumni who offer valuable connections and potential support for their alma mater, which ultimately helps promote AMSA's vision and mission. Finally, since an increasing number of medical schools in Africa are involved in cutting-edge global research projects, the resultant generation of new knowledge and innovations, coupled with active international collaboration, enables award-winning advancements in medical education and biomedical research.

On the other hand, AMSA understands that there are existing challenges in medical education which require solutions. Regarding financial issues, AMSA can improve organisational and research funding mechanisms by increasing the financial membership, developing sustainable fundraising initiatives, and facilitating a culture of research collaboration between medical schools, national and international funding agencies, and industry partners. Regarding academic issues, AMSA can ensure contemporary curricula by encouraging the regular review of curricula to reflect the local cultures, healthcare needs, and industry demands, whilst maintaining global standards, incorporating new technologies, and developing innovative teaching methods [7]. AMSA can strengthen faculty development by encouraging knowledge exchange and faculty development programs as global partnerships between medical schools as well as identifying opportunities for individual professional development. It can also facilitate further development of graduate tracking mechanisms and networks by medical schools, building on the foundations laid during the SAMMS and MEPI Projects.

Regarding the observed explosion of medical schools, collaborations with postgraduate medical colleges, universities, and medical councils to increase the production of medical specialists and postgraduate

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biomedical science teachers, as well as ensure effective national and regional medical education accreditation and monitoring systems, can collectively help to increase the demand for staff and quality assurance. Also, sharing best practices for student funding including scholarships and low-interest loans can minimise the economic burden associated with medical training.

Aside from the COVID-19 pandemic, how would you describe the anticipated challenges in medical education over the next decade in your geographic region?

First, the increasing migration of skilled ("brain drain") from Africa to high-income countries may reduce the human capital index of the continent and exacerbate the uneven distribution of physicians and other health professionals, which will adversely affect medical education and healthcare delivery on the continent [8]. Second, the population explosion in Africa will result in larger medical school class sizes and less individualised attention for students due to strained resources and worsening of the existing shortage of faculty. Third, socioeconomic barriers (due to widening socioeconomic gaps) may limit access to medical education for talented students from disadvantaged backgrounds, whilst geographic disparity (uneven distribution of medical schools and resources) could further disadvantage certain regions, leaving them with fewer qualified physicians and dentists. Finally, the difficulty in standardisation of medical education due to the explosion of medical schools (especially for-profit institutions) and the increasing costs of training may reverse the gains of previous efforts to increase the retention of graduates across the continent.

What are the key priorities that WFME and WMA members should address in the next five years?

Over the next five years, there are four specific priorities where AMSA, WFME, and WMA members can foster robust collaborations. First, the rapid increase in medical schools, particularly in countries with inadequate accreditation and monitoring systems, may lead to a decline in the overall standard of medical education and will therefore need to be addressed by all stakeholders. Second, the pressure to standardise medical education across diversely located institutions may stifle innovation and hinder efforts to develop curricula that are adapted to local healthcare needs. Third, with the increasing globalisation of medical and other health professionals training, extra effort is required to ensure medical schools in Africa preserve the cultural sensitivity that is necessary to maintain social responsiveness. This is particularly important as most schools have community-based training programs that focus on increasing retention by producing culturally adapted graduates. Finally, with the importance of standardisation throughout the continuum of medical education being increasingly recognised, AMSA must work with the WMA, WFME, and African Medical Councils and Postgraduate Medical Colleges on global initiatives that standardising postgraduate medical education.

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Interview with the President of the Pan-American Federation of Associations of Medical Schools

Marcos Núñez Cuervo

For this interview, Professor Marcos Núñez Cuervo, President of the Pan-American Federation of Associations of Medical Schools (PAFAMS) (Federación Panamericana de Facultades de Medicina, FEPAFEM) (https://www.fepafempafams.org/index.php/en/fepafem-pafams-en/definition), shares his perspectives on leadership experiences, strengths and existing challenges in medical education, and how the World Federation of Medical Education (WFME) (https://wfme.org/) and the World Medical Association (WMA) members can foster collaborations, with Dr. Helena Chapman, the WMJ Editor in Chief.

What are the organisational goals, priorities, and current activities of PAFAMS?

Founded in 1962, PAFAMS is the leading non-governmental organisation consisting of more than 650 affiliated medical schools in 13 countries (Argentina, Bolivia, Canada, Chile, Colombia, Dominican Republic, Ecuador, Guatemala, Mexico, Panama, Peru, United States, Venezuela), that aims to link medical education programs with healthcare institutions across the Americas region. The organisational mission is to *"promote quality in medical education in the manner that it impacts health, through academic, research and extension activities"*.

For the upcoming year, PAFAMS leaders recognize three main priorities across the Americas region, including supporting professional networks, offering capacity building opportunities, and incorporating primary healthcare and One Health topics in training. First, the Pan-American Mobility (Exchange) program plans to support scientific and cultural exchanges that help expand networks between students and faculty members across the region. Second, the development of a diploma course that incorporates leadership training for medical school deans, directors, and administrators will help build capacity on strengthening academic programs in the region. Third, guided by the Pan American Health Organization (PAHO)'s published guidelines, innovative measures to introduce primary healthcare and One Health topics into medical education and training will be crucial to foster a holistic view of the determinants of health that influence physical and mental health and well-being. Together, these priorities can help bridge existing gaps with innovative solutions that reinforce high-quality medical education programs that serve local communities.

Over the past year, what do you consider to be your most important leadership achievements as president (2023-2024)?

Over the past year, I have been honoured to serve as the PAFAMS president and lead our collective activities that aim to strengthen medical education and training. First, we have successfully strengthened regional networks, by encouraging inactive members to participate in ongoing activities as well as incorporating new partnerships with associations like the Latin American Association of Medical Schools (Asociación Latinoamericana y del Caribe de Facultades y Escuelas de Medicina, ALAFEM) with our federation. Second, we have established a sustainable community system that helps streamline PAFAMS communications through the website (https://www.webfepafem-pafams.org/), monthly newsletter, and three social media tools (Instagram, LinkedIn, Twitter/X). Third, together with WFME, we have supported the development of the first known Pan-American Diploma on Senior Management and Leadership, directed to regional leaders and academic professors. Finally, I have served as an invited panellist and speaker at more than 10 scientific events across North and South America, the Caribbean, and Europe, highlighting topics of medical education, international accreditation, and challenges in global medical education.

How has the coronavirus disease 2019 (COVID-19) affected medical education across your geographic region?

The COVID-19 pandemic had an unprecedented impact on medical education, especially among low- and middle-income countries (LMICs) which were less prepared to initiate virtual learning in their academic programs. The influence of the social determinants of health has demonstrated the significant inequities and disparities between

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countries in the Americas, including large gaps in information technology, educational resources, and internet availability for distance learning. Furthermore, health professionals have observed the unequal access to recommended immunizations (including COVID-19 vaccines and boosters) between high-income countries and LMICs, noting that vaccine hesitancy has led to increased risk of infectious disease outbreaks like measles to date. Finally, mental health concerns like depression and suicidal thoughts were exacerbated, due to the short- or long-term effects of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), solitary conditions due to recommended social restrictions, and overwhelmed academic responsibilities in the virtual, university or clinical workplace.

What are the current strengths and existing challenges in medical education across your geographic region, and how can these challenges be addressed?

Health leaders have witnessed strengths that can help continue to support medical education and training in the Americas region. First, as local, regional, and national differences exist between medical schools in the Americas region, robust collaborations that identify synergies, leverage expertise, and promote best practices within medical associations, government and non-government organisations, and society will be crucial to prepare physicians to address challenges of the 21st century. With health surveillance systems, physicians should have a comprehensive understanding of the common communicable and non-communicable diseases affecting communities. Also, PAFAMS leaders have been able to incorporate diverse communication strategies (e.g. WhatsApp, email, newsletters, social media, websites) to share news, analyse scenarios, and explore novel solutions with associations and members. Finally, PAFAMS colleagues, representing countries from Canada to Chile, have shared insight and valuable recommendations based on their expertise and best practices in clinical medicine, medical education, and research.

Health leaders have also noted challenges related to promoting high-quality medical education with a set of competencies (e.g. knowledge, skills, abilities) for their clinical responsibilities. First, with limited training in digital technologies, leaders should consider including academic training on telemedicine, software programs, and other technological applications that can alleviate the fast-paced clinical environment. Second, with limited health financing for primary care, leaders can lead didactic theory and practice (e.g. case studies) that incorporate the framework for person- and community-centred care to manage acute and chronic illnesses. Third, with a visible digital gap between countries and regions, shared knowledge exchanges on clinical and surgical medicine, medical ethics, and research topics can help bridge connections and expand professional networks. Although complicated challenges, we can collectively aim to identify synergies, collaborate on pressing global health needs, and identify opportunities to replicate best practices in clinical and community settings.

Aside from the COVID-19 pandemic, how would you describe the anticipated challenges in medical education over the next decade in your geographic region?

WFME and PAFAMS leaders as well as the wider medical community have openly discussed anticipated challenges in medical education across the Americas region. First, weak healthcare infrastructure coupled with unstable political and community leadership across countries can hinder the rapid identification of community needs and the development of relevant policies to protect population health. Second, as the health impacts of climate change, ranging from natural disasters to potential zoonotic spillover, will be unveiled over time, satellite data can be particularly useful toward monitoring these landscape changes for subsequent action (e.g. air quality management, disease early warning systems, heat risk maps). Special considerations should be applied to ensuring that vulnerable populations, such as rural, indigenous, and LGBTQIA+ communities, have equitable access to primary healthcare services. Third, in addition to the reported global health workforce shortage, the migration of health professionals from LMICs to high-income countries ("brain drain") widens the gaps between the Global North and South. Finally, since medical education programs across the geographic region remain diverse in coursework, training opportunities, and timeline, regional conferences that permit academic debates and information sharing can offer valuable resources for health leaders.

What are the three key priorities that WFME and WMA members should address in the next five years?

Over the next five years, I believe that WFME and WMA members can focus their efforts on three key priorities that ultimately strengthen global medical education and training. First, WMA members can establish a memorandum of understanding with the International Federation of Medical Students' Associations (IFMSA) and Junior Doctors Network (JDN) to ensure high-quality curriculum

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development for medical education, by promoting shared governance and incorporating medical students' and junior physicians' feedback. Second, they can incorporate the established IFMSA networks with the Pan-American Mobility (Exchange) program and support shared learning of clinical and research knowledge and skills among professors and students across continents. Third, WFME and WMA leaders can invite IFMSA and JDN members to participate in the event proceedings of the XXIII Pan American Medical Education Conference (Conferencia Panamericana de Educación Médica, COPAEM), which will be held in Quito, Ecuador, in 2025.

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Interview with the President of the Association for Medical Education in the Eastern Mediterranean Region

Ahmed Al Rumayyan

For this interview, Professor Ahmed Al Rumayyan, president of the Association for Medical Education in the Eastern Mediterranean Region (AMEEMR), shares his perspectives on leadership experiences, strengths and existing challenges in medical education, and how the World Federation of Medical Education (WFME) (https://wfme.org/) and the World Medical Association (WMA) members can foster collaborations, with Dr. Helena Chapman, the WMJ Editor in Chief.

What are the organisational goals, priorities, and current activities of AMEEMR?

AMEEMR is dedicated to advancing medical education across the Eastern Mediterranean region. Central to our mission is promoting excellence in medical education, fostering a culture of quality and accreditation, and nurturing faculty members in health professions education. Our primary goal is to promote a comprehensive spectrum of medical education, from undergraduate to postgraduate studies and continuous professional development, through a diverse range of activities. These efforts include facilitating the exchange of teaching, research, and evaluation materials among educators and institutions, organising exchange visits for medical educators and students between member countries, and actively supporting and promoting faculty development programs and scholarly activities.

Furthermore, AMEEMR advocates for WFME accreditation standards, policies, and procedures in medical education and collaborates closely with relevant accreditation bodies and member states, in order to uphold high-quality educational practices and ensure recognition. We prioritise collaborations with partner associations within WFME and affiliated international organisations (like WMA) to further our collective goals in advancing medical education. Overall, AMEEMR's organisational goals, priorities, and current activities reflect our commitment to enhancing medical education standards and fostering excellence in the Eastern Mediterranean region.

Over the past year, what do you consider to be your most important leadership achievements as president (2023-2024)?

As president, I am enthusiastic to highlight a few leadership achievements from the past year. First, since AMEEMR is a non-profit organisation, securing support from King Saud bin Abdulaziz University for Health Sciences (KSAU-HS) and allocating resources for the execution of AMEEMR initiatives have enabled the association to advance medical education in the Eastern Mediterranean region. Notably, KSAU-HS's support led to the creation of the AMEEMR website (http://rupipspsrv01:700/Pages/Home.aspx) in 2022. Second, establishing strategic collaborations with like-minded entities, such as the World Health Organization and the Education and Training Evaluation Commission (ETEC) (as the National Commission for Assessment and Accreditation), has expanded discourse between health professionals in medical and health sciences education and healthcare systems.

Third, on a practical level, the successful adoption of WFME standards by accrediting agencies in the region has enhanced medical training and improved the quality of medical education. The incorporation of infectious disease and pandemic topics as well as interprofessional education and collaborative practices into medical curricula provided additional knowledge and skills in teamwork, communication, and patient care. Fourth, as a regional faculty enhancement initiative initiated in 2022, AMEEMR has invited leading health professions education speakers to present AMEEMR monthly webinars. Due to these successful webinars, the AMEEMR Virtual Symposium entitled, *Medical Education in the Context of the Eastern Mediterranean Region*, was held on 21-22 May 2022. For this academic year, six monthly webinars have been scheduled for December 2023 to June 2024. AMEEMR also plans to work towards creating annual Health Professions Education Conferences.

Finally, I am most proud of the establishment of the *Health Professions Education* journal (ISSN:2452-3011) (https://hpe.researchcommons.org/journal/) in 2015, an international, peer-reviewed, open-access journal that publishes empirical and theoretical contributions from all health professions disciplines. In recent years, the journal has

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increased popularity among the medical education community, based on citations (15 out of 45), notable impact for a new journal with five years, and formal indexation in Scopus and Google Scholar (CiteScore of 4.1) (while exploring indexation in MEDLINE).

How has the coronavirus disease 2019 (COVID-19) pandemic affected medical education across your geographic region?

The impact of the COVID-19 pandemic on educational strategies and healthcare management varied across regions and countries, prompting tailored responses based on population demographics and available resources. First, the COVID-19 pandemic necessitated the adoption of e-learning and blended learning methodologies across the delivery of theoretical and practical educational content and assessment measures in health professions education. There was also a significant shift towards utilising technology for governance, administration, and faculty development initiatives. Second, the need to implement proactive measures, such as the integration of infectious disease and pandemic topics into existing medical curricula, helped prepare health professionals with the necessary knowledge and skills to manage future pandemics.

What are the current strengths and existing challenges in medical education across your geographic region, and how can these challenges be addressed?

The Eastern Mediterranean region offers diverse clinical environments and patient populations, providing medical students with rich learning experiences in clinical and health professions education research. The region's cultural diversity enriches medical education by exposing students to various healthcare beliefs, practices, and perspectives. Recently, there has been an increased number of recognised accreditation agencies by the WFME, with notable support from health professions education leaders within the region towards AMEEMR initiatives. Many medical institutions are investing in faculty trainings for health professional educators within the region.

Albeit these strengths, diverse challenges inevitably exist when dealing with two dynamic fields of health and education. First, institutions are facing resource constraints in terms of funding, infrastructure, and technology access, which can hinder the delivery of high-quality medical education. Second, political situations in some countries within the AMEEMR region can lead to disparities in healthcare access, which can affect the educational experiences of medical students as well as population health outcomes. Third, graduates may be unable to meet the minimum competency requirements if WFME standards or guidelines are incohesive, including limited uniformity in curricula, assessment methods, and educational outcomes. Fourth, the fragmentation of health professions education activities in the region is leading to resource duplication and limited collaborations, which can hinder the ability to address systemic issues and advocate for necessary reforms or improvements in health professions education.

To address these challenges and adhere to the WFME standards, health professional educators should invest in medical education infrastructure, prioritise investment in facilities, technology, and resources, and establish roadmaps to ensure consistency and quality in medical education across the region. Regional collaborations among medical institutions can facilitate the sharing of resources, expertise, and best practices. Engaging with local communities and healthcare stakeholders can help medical schools address disparities and tailor educational programs to meet the needs of diverse populations. Finally, relevant institution and universities can emphasise the need for sustainable funding, multidisciplinary collaborations, and robust infrastructure development to advance knowledge, improve healthcare outcomes, and support medical research initiatives in the region.

Aside from the COVID-19 pandemic, how would you describe the anticipated challenges in medical education over the next decade in your geographic region?

Over the next decade, AMEEMR anticipates six specific challenges affecting medical education in the Eastern Mediterranean region. First, with rapid advancements in medical technology, including artificial intelligence, integrating these applications effectively into medical curricula while ensuring equitable access and training for all students will offer novel insight into combatting complex challenges like climate change. Second, incorporating timely health topics (e.g. aging population, increase in non-communicable diseases) into medical education can help ensure that curricula are relevant to evolving healthcare needs. Third, interdisciplinary education and training will be fundamental to prepare future healthcare professionals to respond to emerging infectious diseases, antimicrobial resistance, health impacts of climate change, and other global health threats.

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Fourth, the mental health and well-being of medical students and faculty should be monitored, in order to provide adequate support systems that can help reduce stigma and promote self-care. Fifth, fostering interprofessional education and collaborations among healthcare professionals can improve patient outcomes, enhance teamwork, and address multifaceted healthcare challenges. Finally, by navigating ethical dilemmas, such as emerging technologies, end-of-life care, and patient autonomy, medical leaders can ensure that medical students are equipped with appropriate knowledge and skills to uphold ethical standards in clinical practice.

What are the three key priorities that WFME and WMA members should address in the next five years?

Over the next five years, the WFME and the WMA can focus on three key priorities to ensure high-quality medical education and training in the Eastern Mediterranean region and world. First, the continuum of WFME standards to include postgraduate training program as well as continuous professional development initiatives will be fundamental to demand high-quality curricula that prepare physicians to address emerging global threats. By establishing informative roadmaps, medical education leaders can feel confident in leading academic efforts that ensure consistency and quality in medical education that follows WFME standards and WMA ethical values.

Second, reinforcing standards and guidelines will be necessary to address the use of artificial intelligence and diverse medical technology in available curricula. Medical educators and physicians can lead efforts to formulate the code of ethics that can help their teams navigate anticipated ethical dilemma relevant to technology-based medical education and patient care. Finally, yet importantly, I believe that the WFME and the WMA should prioritise addressing the mental health of medical students, faculty, and physicians in their policies and initiatives. With rapid changes of clinical roles and responsibilities in their professional development as well as rapport with patients and communities, maintaining optimal physical and mental health and well-being cannot be overlooked to avoid burnout and other complications.

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Interview with the President of the Association of Medical Schools in Europe

Harm Peters

For this interview, Professor Harm Peters, president of the Association of Medical Schools in Europe (AMSE), shares his perspectives on leadership experiences, strengths and existing challenges in medical education, and how the World Federation of Medical Education (WFME) (https://wfme.org/) and the World Medical Association (WMA) members can foster collaborations, with Dr. Helena Chapman, the WMJ Editor in Chief.

What are the organisational goals, priorities, and current activities of AMSE?

The primary goals of AMSE are to promote the highest quality, standards, value, and relevance of management, medical education, research, and patient care in medical schools throughout Europe. AMSE´s current activities focus on quality assurance and accreditation processes to ensure that the quality of medical education programs is aligned with the WFME scheme for recognising accrediting agencies. This process includes collaborating with national and international stakeholders and organising conferences to increase access to best practices and resources, as well as advocating for policies that support medical education.

Like other stakeholders in medical education research, AMSE is concerned about the so-called "reproducibility crisis", a term referring to the widespread concern that scientific studies (e.g. biomedicine) cannot be replicated or reproduced by other researchers. The reliability and credibility of scientific findings are compromised, not only by a lack of replication studies, but also by a lack of transparency, small sample sizes, selective reporting, and publication bias. AMSE, therefore, supports efforts to address the "reproducibility crisis" in medical research, which is reinforced by the European University Association (EUA)'s agreement to reform research assessments and the Coalition for Advancing Research Assessment (CoARA) initiative (https://coara.eu/).

Over the past year, what do you consider to be your most important leadership achievements as president (2023-2024)?

Over the past year, there have been several noteworthy achievements within AMSE. First, AMSE was selected as the new regional member representing Europe on the WFME Executive Council, with formal recognition at the WFME Executive Council meeting in Quebec, Canada, on 11-12 April 2023 (https://amse-med.eu/amse-newsletter-2023-no-6/). This acknowledgment has substantially increased the reach and importance of AMSE within Europe.

Second, the AMSE Annual Conference was held at the Grigore T. Popa University of Medicine and Pharmacy of Iasi in Iasi, Romania, from 5-7 October 2023. Using the conference theme, "Digital Transformation for Healthcare Professions: Patient Care, Education, and Research", attracted more than 531 participants (426 in-person, 103 online) from over 19 countries (Bosnia and Herzegovina, Czech Republic, Georgia, Germany, Greece, Hungary, Italy, Lithuania, Malta, Oman Poland, Republic of Moldova, Romania, Serbia, Slovenia, Spain, United Arab Emirates, United Kingdom, United States). In addition to insightful keynote talks, workshops, presentations, and posters, the inaugural Peter Dieter Leadership Award was formally presented to Professor Ronald Harden, Editor of *Medical Teacher* and former long-standing Secretary General of the Association for Medical Education in Europe.

How has the coronavirus disease 2019 (COVID-19) pandemic affected medical education across your geographic region?

The COVID-19 pandemic had a significant impact on medical education in the World Health Organization (WHO) European Region. This period was marked by an abrupt shift to online learning and social distancing measures to reduce the risk of virus transmission. To meet these challenges, the adaptation of medical curricula included integrating more virtual patient encounters, simulations, and telemedicine experiences into curricula to ensure that students continued to receive comprehensive training despite restrictions on in-person clinical activities. The stress and anxiety associated with the pandemic, combined with the challenges of adapting to new learning formats and uncertainties about the future, took a toll on the mental well-being of medical students, faculty, and healthcare professionals. Beyond

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medical education, the pandemic significantly affected medical schools and universities in Europe in the areas of patient care and research.

What are the current strengths and existing challenges in medical education across your geographic region, and how can these challenges be addressed?

There are several strengths in medical education across the WHO European Region. First, many medical schools offer high-quality training with well-established curricula, experienced faculty, and state-of-the-art facilities. Second, clinical training in the European region is extensive, and students learn from hands-on experiences in a variety of clinical settings. Third, medical students generally can participate in cutting-edge research that reinforces health guidelines and protocols. Fourth, many medical schools have established international partnerships that facilitate knowledge exchange, research collaborations, and cultural understanding.

One main challenge in medical education in the European Region is the shortage of qualified faculty, which can directly affect the quality of patient care and academic education available to medical students. Second, medical education leaders should respond to the accelerating speed at which new approaches and technologies are being incorporated into almost all areas of medical practice. These developments have implications for what needs to be taught, how it is taught, and how faculty are trained to teach in these new areas. Third, with the demanding nature of medical education and training, combined with the stressors of the healthcare environment, there is a need to promote coping mechanisms to manage mental health and well-being of medical students and faculty. Addressing these significant challenges will require investment in faculty development, efforts to ensure equitable access to resources among medical schools, provision of training and support for faculty to effectively integrate technology into curricula and teaching methods, and efforts to promote the well-being of students and faculty. By building on existing strengths, medical education in the WHO European Region can continue to prepare future generations of healthcare professionals to meet the evolving needs of patients and communities.

Aside from the COVID-19 pandemic, how would you describe the anticipated challenges in medical education over the next decade in your geographic region?

Several challenges in medical education are likely to shape the landscape in the WHO European Region over the next decade. First, the changing landscape of healthcare in Europe is characterised by changing demographics of the population, increasing prevalence of non-communicable diseases, and emerging global health threats. Second, noting the global shortage of the health workforce, a substantial increase of the number of healthcare professionals is required to maintain diversity and inclusion, address healthcare disparities, and provide culturally competent care. Third, rapid advances in technology, such as artificial intelligence, virtual reality, and telemedicine, will continue to impact medical education with the need to effectively integrate these technologies into curricula effectively while ensuring equitable access and addressing digital literacy among faculty and students. Meeting these anticipated challenges will require collaboration among medical educators, healthcare institutions, policy-makers, and other stakeholders to innovate and adapt medical education programs to meet the needs of patients and society in the WHO European Region.

What are the three key priorities that WFME and WMA members should address in the next five years?

Both the WFME and the WMA play a vital role in setting standards and guidelines for medical education and practice throughout the world. Together with AMSE, WFME and WMA members should address the following three priorities over the next five years. First, they can enhance quality assurance in medical education, which can help further develop and strengthen the mechanisms for quality assurance in medical education, accreditation processes, and continuing professional development. Second, they can adapt medical education curricula to rapid advances in technology, such as telemedicine, digital health solutions, artificial intelligence, and the emerging field of genomic and personalised medicine, which can ensure that future healthcare professionals are equipped with the necessary skills and knowledge. Finally, they can promote diversity and inclusivity in medical education and advocate for policies that address global health disparities in access to and outcomes of healthcare for underserved populations in different regions of the world.

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AMSE
THE ASSOCIATION OF MEDICAL SCHOOLS IN EUROPE

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A Forum for Significant Ethical Questions

Nora Schultz

Since 2008, the German Ethics Council has been serving as an advisory body to German politics and society on bioethical, biomedical, and wider-ranging ethical questions. The real beginning of its story, however, goes back to 2001. At this time, Germany was torn over the question of whether to permit the import of human embryonic stem cell lines from abroad, which hold potential for medical innovation. To generate such cell lines, human embryos must be destroyed, which is strictly forbidden by the *German Embryo Protection Act (Embryonenschutzgesetz).* German scientists wished to import and use existing human embryonic stem cell lines and argued that as the embryos used to generate the stem cell lines had been destroyed long ago, using the regenerating cell lines without creating new ones should be permissible. Faced with complex ethical questions around this issue, German politicians wished to obtain interdisciplinary expert advice and created two advisory groups.

The first group, the parliamentary Commission of Inquiry (Enquête-Kommission) on *Law and Ethics in Modern Medicine,* composed of 13 parliamentarians and 13 external experts, was set up by the federal parliament in the year 2000 [1]. The second group, the National Ethics Council (Nationaler Ethikrat), was installed by the federal government in May 2001, and explicitly ruled out participation by active politicians [2]. For five years, these two remarkably similar advisory bodies worked in sometimes fierce rivalry. They often covered the same topics, starting with their recommendations on the aforementioned issue of human embryonic stem cell imports, published in late 2001. Both groups were divided in their opinions, with a majority of the Commission of Inquiry being opposed to imports, whereas a majority of the National Ethics Council voted in favour [3,4].

Establishment of the German Ethics Council Act of 2007

Soon, there was growing recognition that a unified advisory body that would serve both the parliament's and the government's needs might be preferable to having two committees ploughing the same field. As a result, the *German Ethics Council Act (Gesetz zur Einrichtung des Deutschen Ethikrats)* was adopted in July 2007, as a federal law that establishes the terms for the Council's work. According to the Act, the *"German Ethics Council shall pursue the questions of ethics, society, science, medicine and law that arise and the probable consequences for the individual and society that result in connection with research and development, in particular in the field of the life sciences and their application to humanity"* [5].

The German Ethics Council and the National Ethics Council have similar frameworks. The 26 members of the German Ethics Council should represent *"scientific, medical, theological, philosophical, ethical, social, economic and legal concerns, […] contain representatives of a variety of ethical approaches and a pluralist spectrum of opinion"* and may not hold an active political mandate [6]. Like its predecessor, the German Ethics Council is also supported in conducting its duties by an administrative office located in Berlin. An important difference, however, is that half of the German Ethics Council's members are nominated by the government and half by the federal parliament, thus ensuring that both political bodies have a recognised voice within the Council's composition, including opposition parties. Members are asked to serve for four years and can return for a second term, after which they cannot be renominated. The German Ethics Council began its work in April 2008, with many of its inaugural members previously having served on either the parliamentary Commission of Inquiry or on the National Ethics Council, thus providing continuity to both committees' previous work.

Duties of the German Ethics Council

The three core duties stipulated by the German Ethics Council Act include "informing the public and encouraging discussion in society", "preparing Opinions and recommendations for political and legislative action", and international "cooperation with national ethics councils and comparable institutions".

Fostering Public Discourse. The German Ethics Council is requested to inform the public and encourage open discussion within society. It holds several free-to-attend public events each year, ranging from all-day conferences to evening symposiums, external expert hearings, and short online-only events. Here, Council members usually discuss the topic

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of the day with external experts and members of the public who can submit their own questions and comments. The Council provides extensive documentation of these events, with video recordings, transcripts and speakers' presentations usually made available for downloading. In recent years, the Council has also developed an active social media presence to explore further channels for interaction with the public. Many Council publications, as well as press releases and information about events are translated from German to English and available on the website (www.ethikrat.org).

Preparing Opinions and Recommendations. Although this task is second on the Act's list, this is what many Council members spend most of their time on. Preparing scholarly documents that offer academic perspectives on diverse (bio)ethical and biomedical topics requires in-depth research, deliberation, drafting and revising. This work is usually split between a smaller working group and plenary discussions with all Council members. Consensus is not required. In fact, the Act explicitly states that members may express dissenting views in the Council's publications – and they often do. Whilst unanimous recommendations may have greater impact and convey more clarity, the controversies of complex ethical issues cannot always be resolved. Many Council publications thus include split votes or alternative recommendations and aim to support decision makers in forming their own opinions by elucidating the arguments behind each position.

From the beginning, the scope of the Act's focus on questions "*in connection with research and development, in particular in the field of the life sciences and their application to humanity*" has been debated. The Council's first Opinion was published in 2009, discussing the anonymous relinquishment of infants in baby drops or anonymous birthing facilities. Many subsequent projects have focused more closely on ethical questions in life science research and development, including reports on human biobanks, human-animal mixtures, pre-implantation and other types of genetic diagnostics, brain death, biosecurity, embryo donation, and human germline editing. Other projects have tackled broader societal or predominantly legal issues, such as the costs and benefits in healthcare systems, patient welfare in hospitals, intersexuality, prohibition of incest, dementia, benevolent coercion, and animal welfare. In recognition of the increasing interconnectedness of many developments and areas within society, the Council has recently expanded its scope, or example with projects on artificial intelligence and climate justice.

Networking with National and International Councils and Institutions. The German Ethics Council meets regularly with select partner councils, including those from France and the United Kingdom, for a yearly trilateral meeting, and those from Austria and Switzerland. The second trilateral meeting is held in German. Council representatives also attend biannual European National Ethics Councils' fora, which are based on the rotating presidencies of the European Union's Council and the Global Summit of National Ethics Committees, held every two years.

Achievements

Over the past 16 years since its foundation, 76 members have served on the German Ethics Council, and collectively, they have published a total of 24 Opinions and 14 Ad Hoc Recommendations, as well as organised more than 55 public events. The arrival of coronavirus disease 2019 (COVID-19) forced some drastic changes upon the way the Council worked. As the virus appeared in Germany in early 2020, the German Ethics Council was approaching a changeover, with around half of its members (including the Chair) finalising their second term and thus leaving the Council. With Germany entering its first lockdown in March 2020, Council members connected online in a series of late-night sessions to draft the first pandemic-related publication. Published on 27 March 2020, the Ad Hoc Recommendation titled, *Solidarity and Responsibility during the Coronavirus Crisis*, was the first of nine publications and four public events dedicated exclusively to the pandemic, covering, for example, immunity certificates, access to vaccines and social contacts, triage, mandatory vaccinations, and mental health of young people [6].

Like many organisations, the German Ethics Council aimed to find ways to effectively communicate and collaborate throughout the pandemic, despite social restrictions. Although virtual meetings were successful, Council members soon noticed limitations compared to in-person meetings as there were fewer opportunities to build trust and rapport. Nowadays, the Council aims to combine the best of both worlds by offering a hybrid platform with a mix of in-person attendance and video-conference participation. Public events are livestreamed for those who cannot participate at the venue and offer virtual audience interaction.

The external perception of the German Ethics Council also changed during the pandemic. With substantial political and public interest in ethics advice on pandemic-related topics, Council members frequently appeared on camera (e.g. news and talk shows), observing new opportunities to

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engage with the public in multi-faceted ways. However, as restrictions of public freedoms continued and controversies surrounded vaccinations, some Council members found themselves the target of abusive remarks, misinformation campaigns, and even threats. Undoubtedly, there are still lessons to be learned from the pandemic on how to address and communicate complex ethical issues under pressure, and the German Ethics Council continues to reflect on these questions internally, publicly and in exchange with its international partner committees.

As the German Ethics Council begins its fifth term in mid-2024, about half of its members will leave their positions, and new members will join and contribute to the scope of the new work programme for the rest of the year and beyond. As recent work has highlighted that diverse challenges are propelling the need to find ethically acceptable solutions for a culturally diverse and increasingly interconnected world, the Council will continue to contribute to these important endeavours in preparing recommendations, fostering public discourse, and networking with relevant councils and institutions around the world.

Note: The author has been a research officer in the German Ethics Council's administrative office since November 2008.

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Healthcare Resource Allocation: Smoking, Lung Cancer, and the National Health Service

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The National Health Service (NHS) is the United Kingdom's health service, which uses a tax-funded model that allows healthcare to be accessed free at the point of service. Healthcare wait lists are currently sorted by the urgency of procedures, averaging around 18 weeks for elective procedures and two weeks for cancer referrals, and the proportion of patients exceeding those wait times has drastically increased. The coronavirus disease 2019 (COVID-19) pandemic has resulted in a tremendous backlog of persons seeking non-COVID-19-related care, with wait list numbers at 7.54 million cases as of March 2024 [1]. This means that there are longer wait lists for treatments and clinical procedures for diseases unrelated to COVID-19, which should be managed in an efficient, cost-effective, and fair manner.

The scarcity of healthcare resources brings forth dilemmas of fairness and distributive justice. Within these dilemmas, one must ask if it is fair for personal responsibility for health to be a factor when making decisions about resource allocation, which adds additional layers of complexity to the debates of distributive justice. In the ideal world, healthcare is a right, and known harmful substances such as cigarettes would be banned. However, this is easier said than done. In today's world, some challenges to consider include the rights and liberties of individuals to make their own healthcare decisions, the powerful tobacco company lobbies, the struggles of enforcing laws and prohibiting back door trade, and the effectiveness of bans. In the meantime, is there another way to navigate healthcare shortages by de-prioritising patients using personal responsibility?

This article aims to describe some of these complexities and stimulate discussion that can explore the ethics of personal responsibility and distributive justice, specifically in relation to smoking, lung cancer, and treatment wait lists. It will be structured into three segments – defining personal responsibility for health, presenting luck egalitarianism (LE) as an ethical theory that may be applied to resource allocation, and exploring two critiques of LE.

Defining Personal Responsibility for Health

I would like to define personal responsibility for health (PR) as being a notion that holds individuals to account for choices they make regarding their health. The NHS acknowledges the importance of PR – a section within the NHS Constitution is dedicated to outlining these responsibilities. The first point stated is: *"please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it"* [2]. This is clearly noted in the Constitution, but it is unclear how the NHS will hold patients accountable to their responsibilities. The United Kingdom's Department of Health and Social Care does not detail the extent to which individuals take responsibility for their health. One way to hold patients accountable is to de-prioritize them on treatment wait lists – it is safe to say PR is controversial for a plethora of reasons. Let's explore this specifically in relation to smoking and lung cancer.

I would dissect the key aspects of patient *choice* to engage in behaviours linked with health or illness to involve two main concepts – firstly, whether patients are able to make informed decisions (e.g. whether they were provided with enough information of risks and benefits of behaviours), and secondly, whether they are able to have free will (free from coercion or compulsion). To address the first aspect: tobacco smoking has been a part of human history for many centuries, and the link between smoking and lung cancer has been long established since the mid-1900s, with cigarette smoking being identified as the cause of a global lung cancer epidemic in the 1940-1950 [3]. In the United Kingdom, cigarette packets are printed with grotesque images of health risks associated with smoking, with the clear message that *Smoking Kills.* It can be said the harms of smoking are well circulated to increase patient awareness. This means the second aspect of choice, making decisions with free will, free of coercion and compulsion, is the main point of contention.

Addiction is the reason for the continuation of smoking and is supposedly a state in which behavioural control has been extinguished, rendering the smoker unable to do otherwise. When the smoker is under such compulsion to continue smoking, it seems unfair to

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use the term *patient choice* when no such choice exists. However, Hanna Pickard, professor of Philosophy and Bioethics at Johns Hopkins University, reasons that although smoking and subsequent addiction may impair the ability to exert behavioural control upon oneself, the impairment does not mean the ability to do otherwise has been extinguished [4]. In other words, Pickard endorses the view that addiction does not mean compulsion. The NHS Smoking Cessation Services (SCS) rely on a mixture of Cognitive Behavioural Therapy (CBT) and pharmacological therapy to help counsel smokers wishing to stop, as well as support them through the nicotine withdrawal effects. CBT especially would not be successful if the ability to do otherwise had been extinguished, as it relies on educating patients to question their thoughts and behaviours, which then supports them to make decisions that may be better for them.

However, there are more nuanced complexities that must be considered. Studies have shown that individuals who smoke usually start smoking in adolescence. In the United Kingdom, eight out of ten adult smokers start smoking before they turn 19 years of age [5]. Furthermore, smoking habits are intertwined with lower socioeconomic groups, and already marginalised communities such as travelling communities. When such pivotal factors play a role in an individual developing smoking habits, is it truly fair to say that these individuals are making a *choice* to smoke? Do they actually have free will when under the influence of families and social groups? These questions must be asked to ensure ethical theories can be applied in the real world. To counter these questions, holding patients accountable for their choices is only fair when there is a level playing field. However, can this ever be reality, and does anyone ever truly have free will? Such debates are controversial, but in my opinion, a topic being controversial should be changed to the topic being conversational. By this, I mean to say that generating respectful and productive conversations around such controversial topics can lead to policies being developed that are fair and avoid exacerbating inequalities already present in healthcare.

LE as an Ethical Theory for Resource Allocation

I will illustrate LE and how it incorporates the concept of *choice*. Generally, LE is intended as an account of justice/fairness and emphasises the role of responsibility directly in matters of distributive equity. It holds that moral equality between people is dependent on the idea that individuals take responsibility for their choices and face any later consequences (p.665) [6]. When applied to healthcare, LE holds that patients should be held accountable for their choices, which may lead to disease development. It incorporates the role of responsibility by distinguishing between *option luck* versus *brute luck*.

I will illustrate the difference between these two types of luck by using a scenario with two patients, X and Y, who have been diagnosed with lung cancer (scenario adapted from p.129) [7]. Patient X follows an unhealthy lifestyle and smokes heavily, whereas Patient Y follows a healthy lifestyle, keeping active and fit. Both patients are unlucky – not all heavy smokers develop lung cancer, thus Patient X has "bad luck" in that aspect. It is even more unfortunate for individuals with healthy lifestyles to develop lung cancer, and it is evident that Patient Y has "bad luck". LE holds that the "bad luck" of the two patients is morally very different (p.129) [7]. Patient X could have reduced their chances of developing lung cancer by choosing not to smoke and choosing to maintain a healthy lifestyle, whereas Patient Y did not have any control over developing lung cancer. By differentiating this, LE attributes Patient X's bad luck to bad *option luck*, whereas Patient Y's bad luck is attributed to bad *brute luck*.

LE holds inequalities caused by bad *brute luck* must be compensated as a matter of justice. These individuals must not be held responsible for their bad health – they should receive priority when distributing scarce and expensive treatment (e.g. for lung cancer). Patients who have ill-health because of bad *option luck* are deemed to be responsible for their poor health, thus should not be given priority over patients with poor brute luck, like Patient Y. LE's concept of luck suggests health and disease are essentially lotteries. LE does not argue treatment should be withheld from patients with bad option luck, nor wishes bad health upon patients who have made poor health choices. It simply provides a way to determine how to distribute resources when they are scarce, thus providing a way to organise waiting lists.

Exploring Two Critiques of LE

Perhaps the strongest critique of LE is against the concept of option luck because whether smokers have an *option* is heavily debated. The word *option* suggests smokers have the freedom to make the choice of picking up a cigarette and lighting it, and then repeatedly doing so. This paints a very black and white picture of a topic that has many grey areas. As health professionals, we must strive to empower individuals who already face inequalities. If patients are to be held accountable for their choices, they must also be provided with the appropriate support should they wish to alter their choices. This

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means if individuals who smoke are to be held accountable for their choice if they develop lung cancer, they must also have been given plenty of opportunities to engage with SCS. Such SCS are available on the NHS, established to primarily target disadvantaged smokers, and have been successful in reducing smoking rates among these target groups [8].

Another argument against LE is that diseases such as cancer are often multifactorial and defining the extent to which smoking is a cause of disease is difficult, which is why personal choice should not factor into healthcare decisions. The multifactorial model of disease provides a holistic outlook on disease causation, but it may be used as a scapegoat to avoid taking responsibility for one's actions. Alex Broadbent, a philosopher of epidemiology, acknowledges that diseases can have multiple causes, but also presents that diseases can also share some common aetiology in his *contrastive model of disease* (p.145) [9]. Despite lung cancer having a combination of environmental and genetic causes, smoking causes significant increases in disease risk. Tables produced by the International Agency for Research on Cancer and the World Cancer Research Fund classify lung cancer risk factors as either increasing risk or decreasing risk with either sufficient or convincing evidence or limited or probable evidence [10]. This categorisation indicates it is possible to isolate causal factors despite diseases being multifactorial. Smoking is categorised as increasing risk, with sufficient or convincing evidence. This shows that in many cases when smokers develop lung cancer, smoking cessation would have avoided the development of lung cancer [10].

Conclusion

This article illustrates some nuances and complexities associated with incorporating personal responsibility in matters of distributive justice. Although it aims to stimulate conversations around such controversial topics, many arguments and counterarguments remain for debates when it comes to discussing personal responsibility in healthcare. My utmost hope is that harmful substances will be completely banned, and that healthcare services will strive to avoid further exacerbating pre-existing healthcare inequalities, especially if personal responsibility is incorporated into resource allocation (such as through de-prioritisation).

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Sports Medicine in China after the 2022 Beijing Winter Olympics

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In February 2022, the Olympic flame from the Temple of Hera in Greece was lit again in Beijing, China. As the International Olympic Committee (IOC) had officially elected Beijing to host both the Summer 2008 and Winter 2022 Olympic Games, Beijing became the only double-Olympic city in the world. Over the past seven years, tremendous changes have occurred in China and around the world, and the development and pattern of China's winter sports have undergone a complete transformation.

The success of the 2022 Beijing Winter Olympics attracted global attention, with over two billion people watching the 6,000-hour broadcast. The Winter Olympics sportsmanship showcased athletes' tenacity and perseverance, and audiences were inspired people to strive forward. Notably, the IOC President Thomas Bach praised Beijing for its frugality of the 2022 Beijing Winter Olympics. Total revenue from advertising sponsorship, event broadcasting fees, and brand authorisation reached US $2.8 billion, setting a new "miracle" for the Winter Olympics. In this article, the authors aim to explore the underlying reasons for the success of the 2022 Beijing Winter Olympics, which can provide profound insights into China's future in sports, culture, economy, and public health.

Winter Sports to Help Build a Healthy China

Achieving a healthy life for all is the next step after the successful hosting of the 2022 Beijing Winter Olympics. The *Healthy China 2030 Plan* outlines that the number of people who regularly participate in physical exercise will reach 530 million by 2030. The national call – *"To encourage 300 million people to practise winter sports"* – has encouraged all Chinese citizens to participate in winter sports, such as skiing, skating, ice hockey, and curling. Over the past few years, various ice and snow clubs and cultural events have become popular, expanding across the Shanghai Pass and China. In southern regions, where residents are less familiar with winter sports due to different climatic and topographic regimes, 12 provinces (30%) are currently participating in winter sports. Hence, these trends demonstrate that the presence the Winter Olympics in Beijing has led to an increased number of citizens participating in winter sports across the city and country.

Continuously expanding the social effects of winter sports as well as the general sports industry will be a major driving force for the future construction of a Chinese population. It can help ensure the broad and sustainable development of the national fitness campaign as well as support efforts to achieve the national health system goals. It can also move the focus of medical care from disease treatment to health promotion and disease prevention, which can greatly reduce medical expenses and improve the overall physical fitness and quality of life of citizens.

Strengthening the National Health System

According to the *Healthy China 2030 Plan*, the total scale of China's health service industry will exceed 8 trillion yuan by 2020 and will reach 16 trillion yuan by 2030. The sports health industry is expanding in scale, coverage, and industry chains, and has incorporated winter sports and cultural tourism, which is crucial for the *Healthy China 2030 Plan* and national economic growth. During the preparation and hosting of the 2022 Beijing Winter Olympics, the medical and safety service stations, including sports venues, fitness centres, and sports health management platforms, were significantly improved to meet the safety and health protection of sports participants. Hebei Province, the main host of the Beijing Winter Olympics, led the construction of a coordinated health security pattern across multiple fields and departments. Based on this successful experience, future large-scale sports events, sports activities, fitness, and recreation are recognised as inseparable from the solid medical security software and hardware infrastructure and system construction. Achieving a sports-driven, health-promoting system that leads in sports fitness, injury prevention, and recovery, which fits the concept of healthy cities and sports cities, can enhance the practical application of the *Healthy China 2030 Plan* across the nation.

Promoting China's Sports Medicine Industry

During the 2022 Beijing Winter Olympics, one joke alluding to skiing injuries was circulated on social media: *"As 300 million people play on the ice and snow, the end of the ski slope is the orthopaedic department."*

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However, Li Guoping, who serves as a core member of the IOC's Medical and Scientific Committee, head of the medical core expert group of the 2022 Beijing Winter Olympics, and the founding chairman of the Chinese Society of Sports Medicine, disagreed. He said: *"Along the ski slopes and ice rinks, the core is the precise protection, prevention, treatment, and rehabilitation provided by sports medicine from start to finish, including the construction of rescue teams with ski doctors and the application of minimally invasive reconstruction and sports rehabilitation technologies."* Therefore, he believes that *"the end of the ski slope should be happiness and health, and the higher goal is to return to sports after injury."*

Sports medicine was once defined as "Special Medicine", and now it is rapidly developing as a national secondary discipline of clinical medicine. Since the establishment of the Chinese Society of Sports Medicine in 2007, the connotation of sports medicine in China has been continuously expanded and enriched. Although sports medicine was previously exclusively dedicated to serving elite athletes, it now combines theories, methods, and technologies from internal medicine, surgery, traditional medicine, rehabilitation medicine, and diagnostic imaging to achieve sports injuries prevention, treatment, and rehabilitation for the general public.

Furthermore, the continued large-scale development of winter sports will provide important insights and opportunities for the Chinese sports medicine community in seven areas. These topics include health promotion by exercise, medical services and protection for winter sports events, precise treatment and management of winter sports injuries, international exchanges in winter sports medicine, and innovation and translation in sports medicine.

Health Promotion by Exercise

Exercise is beneficial for fitness and disease prevention and can enhance physical fitness and immune function. However, chronic diseases such as hypertension are more prevalent during winter months, due to the increased blood viscosity, reduced blood circulation, and winter haze events (e.g. increased $PM_{2.5}$), which can negatively influence respiratory health. Examining the impact of winter sports on health outcomes can open new directions for sports medicine. In order to implement the *Healthy China 2030 Plan*, health leaders should be committed to ensuring the widespread promotion of fitness to prevent chronic diseases and strengthen health service management.

Medical Services and Protection for Sports Events

Providing medical care and support for major domestic and international athletic events has always been a core mission and key research area. Higher demands may be placed on the rescue system, medical treatment level, and facility conditions for sports team services and event support. Sports medicine experts should lead next steps to establish a fully equipped medical centre to monitor and treat sports injuries and strengthen the treatment model observed during the 2022 Beijing Winter Olympics.

Compared with summer sports, winter sports have higher requirements in terms of technology, venues, safety protection, and emergency equipment. For example, winter sports require high-speed skating and sharp turns, which place high demands on physical qualities such as strength, core stability, explosiveness, endurance, coordination, balance, and joint mobility. To minimise potential sports injuries, it will be crucial to promote the value of winter sports across China and the world, especially better understanding the injury risks, taking precautions to protect health, and familiarising oneself with emergency treatments.

Precision Treatment and Management of Winter Sports Injuries

At the 2022 Beijing Winter Olympics, many athletes returned to the field after receiving medical treatment for injuries (e.g. knee ligament injuries), continuing to bring honour to their countries. Arthroscopic minimally invasive surgery, as the preferred surgical treatment for tendon and ligament injuries and ruptures, can be performed quickly with subsequent sports rehabilitation, for prompt recovery and return to competitive sports. As diverse winter sports are promoted across China, health leaders should explore other surgical and non-surgical treatment options, as part of precision (or personalised) medicine.

As sports injuries like knee ligament injuries may require surgical interventions, soft tissue sprains can imply conservative management without surgery. However, sports medicine requires careful evaluation and treatment, to reduce risk of chronic impairment with sequelae. In 2005, the new concept of sports rehabilitation was first proposed in China, shifting from traditional rehabilitation to the integration of sports and medicine and emphasising personalised patient guidance. As the authors have estimated that the total scale of China's sports medicine market will reach 200 billion yuan in the future, where half of revenue accounts for non-surgical management, health leaders should explore ways to promote the value of the sports rehabilitation industry.

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International Exchanges in Winter Sports Medicine

The *13th Five-Year Plan for Sports Development* proposes to strengthen and expand international cooperation and exchange in sports and engage in mutually beneficial collaborations. By learning from international winter sports training programs, Chinese health leaders can identify knowledge and practice gaps and develop strategies to improve training programs for the Chinese athletes' safety as they prepare for competitions.

Innovation and Translation in Sports Medicine

The history of the Summer and Winter Olympics has been closely linked to research and innovation in sports medicine. The 2022 Beijing Winter Olympics were held during the coronavirus disease 2019 (COVID-19) pandemic. Notably, behind the Bird's Nest Stadium, where the opening and closing ceremonies were held, scientists contributed to technological innovations and applications in various fields, including closed-loop health monitoring for competition, 5G technology, cloud computing, big data and artificial intelligence, winter sports rescue, air transportation, and remote medical consultations.

Summary

The *Healthy China 2030 Plan* has established a set of priorities for the populace, including *"To encourage 300 million people to practise winter sports"*, that physical exercise can reduce risks of chronic diseases. Significant movement to participate in winter sports was observed after the 2022 Beijing Winter Olympics. As an emerging discipline, sports medicine represents a multidisciplinary system that focuses on the sports injury treatment, rehabilitation, and prevention. Specifically, two main goals of sports medicine in China include *"promotion by exercise"* and *"function priority, early rehabilitation, and return to sports"*. Moving forward, sports medicine can identify lessons learned during the 2022 Beijing Winter Olympics and continue to promote integrated scientific research that explores how technology can help advance treatment, rehabilitation, and prevention approaches for the global population.

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WMA Members Discuss National Initiatives to Enhance Food Security and Safety

Credit: Riccardo Mayer / shutterstock.com

As food. security and safety are directly related to nutritional health outcomes, limited access to adequate food intake can lead to underweight (e.g. wasting, stunting) or overweight conditions and negative health impacts. As a result of the 1996 World Food Summit, food security is defined *"when all people, at all times, have physical, [social] and economic access to sufficient, safe and nutritious food which meets their dietary needs and food preferences for an active and healthy life"* [1]. This definition describes the four elements of food security as food availability (sufficient production and supply of high-quality food), food access (adequate food supply at the household level), utilisation (biological process of food ingestion that influences nutritional health outcomes), and stability (consistent state of food availability, access, and utilisation) [1].

According to the United Nations (UN), an estimated 735 million people (9.2% of the global population) conveyed facing chronic hunger (when compared to 613 million in 2019), and 2.4 billion people expressed living with moderate to severe food insecurity (when compared to 391 million in 2019) in 2022 [2]. Also, the World Health Organization (WHO) reported that approximately 420,000 deaths and 600 million cases (1 in 10 persons) of food-borne illnesses each year result from ingesting contaminated foods [3]. This global burden is especially challenging for low- and middle-income countries (LMICs), with more than US $110 billion annual estimated losses from economic and health expenditure due to unsafe food [3]. Noting the multidimensional nature of food security, it is essential to understand the emerging risks to food systems, such as limited political commitment, climate or weather variability, urbanisation (e.g. loss of lands), health status (e.g. immune function to combat infectious diseases), consumer choices of convenient and pre-packaged foods (including fast foods), and economic access to food supplies [1].

The UN Sustainable Development Goals (SDGs) present the close connections of food security and safety to at least 12 of the 17 goals, namely reducing poverty (SDG 1), reducing hunger (SDG 2), optimal health and well-being (SDG 3), work productivity and economic prosperity (SDG 8), responsible production and consumption (SDG 12), and collective action and partnerships (SDG 17) [4,5]. To achieve these ambitious goals, food systems should apply the One Health concept (interconnectedness of humans, animals, and surrounding

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environments) and enhance multi sectoral coordination across scientific disciplines and sectors, which can ultimately incorporate evidence-based scientific findings into management and policy decisions, strengthen stakeholder communication and engagement, support safe domestic and international trade, and promote proactive systems to identify and respond to emerging risks [5].

Over the past decade, the road to ensure high-level commitments for endorsing global food safety led to the UN General Assembly's adoption of *Resolution 73/250* in 2018 and the World Health Assembly (WHA)'s approval of the *Resolution WHA73.5* in 2020, declaring World Food Safety Day on 7 June (https://www.who.int/campaigns/world-food-safety-day/2024) [6,7]. This annual celebration, led by the WHO and the Food and Agriculture Organization (FAO) of the UN, offer a renewed focus on supporting high-quality food sources for health and well-being, sustainable development, agriculture productivity, and economic prosperity. The 2024 theme, "Food Safety: Prepare for the Unexpected", presents an opportunity for community citizens (from consumers to producers) to reflect upon the collective responsibility of strengthening food systems as well as recognize existing challenges (e.g. extreme weather events like droughts and floods, reduced crop yield) that impact food access and availability across global communities.

To advocate for equitable and sustainable nutrition actions, global health leaders should first examine food and nutrition security across nations, such as the *Global Nutrition Report* (https://globalnutritionreport.org/) and Global Alliance for Food Security (https://www.gafs.info/home/), and analyse epidemiological trends and existing challenges of food systems facing communities. This valuable information can help leaders design relevant local and national initiatives that foster multi sectoral collaborations with community stakeholders and meet community needs. In this article, physicians from six countries – Argentina, Myanmar, Philippines, South Africa, Trinidad and Tobago, and Uruguay – provided a holistic view of local, national, and regional efforts to promote food safety through timely policy development, community outreach, and capacity building across their national health systems.

Argentina

Foodborne illnesses pose a significant public health challenge to health and well-being in Argentina, and the World Food Safety Day offers a call to act as guardians of life, committed to unravelling and eradicating the invisible threats that lurk in our food. Argentina, a country of 44 million residents, has a diverse geography and climatology regimes, serving as a major food producer and exporter for soybean and beef, but also other staple products (e.g. barley, cotton, maize, mate, rice, sorghum, sugar, tobacco wheat) [8]. The Government of Argentina has made strides in improving food safety, albeit economic crises over the past two decades, but existing challenges highlight the need for continued vigilance and action.

Over the past few years, the Government of Argentina has implemented various policies and programs to enhance food safety. In 2019, the Government of Argentina adopted the *Food Emergency Law (Ley 27519 de Emergencia Alimentaria),* valid until December 2022, which will permit a 50% increase (8,000 million Argentine pesos or US $135 million) in food assistance to the nation [9]. Also, in 2019, the *National Food Security Plan* (*Plan Nacional de Seguridad Alimentaria*, PNAS) was launched, with the aim of enabling access to complementary food resources for populations experiencing social and nutritional vulnerabilities, including children (less than 14 years of age), elderly, pregnant women, and persons with disabilities [10]. In 2021, the *Promotion of Healthy Eating Law (Ley 27642 de Promoción de la Alimentación Saludable)* was approved, which established the addition of health advisory labels (e.g. calories, saturated and total fats, sodium, sugars) on the front of food packages as well as the implementation of food and nutrition education in primary and secondary schools [11,12]. Also, in 2021, the *"Argentina against Hunger" National Plan (Plan Nacional "Argentina contra el Hambre")* was adopted, which promoted wider access to the basic food basket distributions [13]. Finally, social leaders and municipalities have regularly supported community initiatives, such as the "Safe Foods" ("Alimentos Seguros") campaigns, which help increase public awareness about proper food handling and preparation practices.

Furthermore, notable efforts have been made across the Americas region to support food and nutritional security. The Food Code (Codex Alimentarius) is a collection of food standards, guidelines, and codes, which is an essential element of the FAO and WHO Food Standards Program to safeguard consumer health and fair practices in food trade [14]. The Pan American Alliance for Nutrition and Development has fostered regional cooperations to address food safety and nutrition challenges [15]. Although these robust efforts are widely recognised, more work is needed to strengthen food safety regulations, improve health surveillance systems, and promote collaboration among stakeholders across the food supply chain.

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On this international health day, physicians can continue to lead this global movement that advocates for elevated food safety standards across the Americas region and globe. Only when we conquer the dangers that exist on our plates can we fully celebrate the culinary arts as a true expression of health, well-being, and the joy of living. Together, we can promote a world where resilient systems ensure the integrity of every ingredient that reaches our tables, and every bite represents a celebration of nutrition, not a risk to our well-being.

Myanmar

In Myanmar, a country of 53 million residents and 135 ethnic groups, the agricultural sector represents the core of the national economy, including 32% of the gross domestic product, 56% of the labour force, and 21% of exports [16]. However, according to the World Food Programme, an estimated 2.8 million Myanmar citizens are recognised as food insecure in 2021 [17]. Since the start of the Myanmar coup on 1 February 2021, food insecurity and hunger have become even more widespread, further exacerbating conditions resulting from climate change and the coronavirus disease 2019 (COVID-19) pandemic, with potential risks for food insecurity to up to 3.4 million additional residents [17]. By obstructing assistance delivery and arresting humanitarian personnel, the military has denied food, water, and essential medications to the displaced population [18]. The combined rise in food products (e.g. rice, cooking oil) and fall in agricultural output has posed a danger to food availability for one-fifth of the 54 million residents [19]. Furthermore, Myanmar military and security use massive quantities of fossil fuels in their bombard aircraft and tanks, resulting in environmental disturbances like forest destruction, emissions of greenhouse and other poisonous gases, and damage to water infrastructure, as well as population exposures to harmful air, water, and soil quality.

The National League for Democracy (NLD), an influential pro-democracy party established in 1988, had supported a food sector reform in 2016. The strategic plan aimed to provide food and nourishment to food-insecure regions, with the vision that Myanmar's under-five children would have improved their nutritional status aligned with government goals by 2022 [20]. However, as part of this political crisis, the NLD's food sector reform plan was halted, and hence there was a drastic reduction in agricultural production. Food security across the country is now jeopardised, and farmers are unable to return home to work their land due to the military-installed land mines on the premises [21]. Through military operations (e.g. using fighter planes to attack agricultural fields, setting entire communities on fire), farmers' homes, possessions, and crops (e.g. rice, paddy, bean, pulse seeds) have been set ablaze and destroyed by the junta's soldiers.

To date, Myanmar's people continue to be targeted by Myanmar's military and security forces, and humanitarian aid is needed through financial transfers, food distribution and nutrition programs, and livestock and fisheries restocking in regions damaged by Myanmar's military and security forces [22]. As next steps, we put forward a plea to international organisations (including the WMA and Junior Doctors Network) and the wider community, to advocate for urgent localised action to strengthen food security and support for the Myanmar population.

Philippines

The Philippines, an island nation with a complex geography of the archipelago with more than 7,000 islands, alongside socio-economic disparities, has observed unique obstacles to food availability, access, utilisation, and stability for citizens. However, since 2020, the nation is taking strides through a variety of measures to ensure that every Filipino has access to adequate, nutritious, and sustainable food sources. To support this commitment, an inter-agency task force was established under *Executive Order No. 101,* dubbed the Zero Hunger Task Force (National Food Policy) on 10 January 2020, which focuses on ensuring the availability and accessibility of food for all Filipinos, as to eradicate hunger and achieve food security by 2030 [23].

Over the past decade, the Department of Agriculture (DA) has implemented several programs and projects to support food productivity and accessibility for the nation. First, the *Comprehensive National Fisheries Industry Development Plan 2021-2035* was developed in 2016, to ensure the sustainability of marine resources and improve the livelihood of coastal communities [24]. Second, the *Kadiwa ni Ani at Kita* was launched in September 2019, as a market linkage between food producers and consumers that provided high-quality produce to consumers and ensured fair prices for farmers and fisherfolk [25]. Third, the *"Plant, Plant, Plant Program" ("Ahon Lahat, Pagkaing Sapat, ALPAS, Laban sa COVID-19")* program was established in 2020, to promote the national agri-fishery industry through innovative technologies and farming and fishery practices, to support farmers, fishers, and consumers [26]. Fourth, the Philippine Integrated Rice Program was developed in 2020, to improve

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rice productivity and achieve rice self-sufficiency through the use of hybrid seeds, modern farming techniques, and adequate irrigation [27]. Finally, the Urban Agriculture Program was developed in 2020, to encourage city dwellers to start gardening in their backyards, empty lots, and even containers [28].

As the Government of the Philippines recognised early on that food safety, nutrition, and food security are inextricably linked, leaders enacted the inaugural *Code on Sanitation of the Philippines* (PD. 856) in 1975, to serve as a reference and guide for enforcing sanitation standards (including food establishments). More recently, the *Food Safety Act of 2013* (RA 10611) established the foundation for implementing a farm-to-fork food safety regulatory system, which aimed to safeguard consumer health, promote fair trade practices, and enhance the global competitiveness of Philippine food products. It has achieved these goals by managing hazards in the food chain, implementing precautionary measures informed by scientific risk analysis, and aligning with international standards [29]. To support these food safety standards, a National Codex Technical Committee was established in 2005, and *Presidential Proclamation No. 160* was adopted in 1999, to commemorate Food Safety Awareness Week each October [30]. Future directions include reassessing policy frameworks, establishing and strengthening partnerships to incorporate food safety into mainstream practices, ensuring protection against cross-contamination and foodborne illnesses, improving public education through comprehensive information dissemination, and acknowledging the pivotal role of food safety in achieving food security [31].

Indeed, the journey towards achieving food security in the Philippines is multifaceted, requiring concerted efforts from the government, private sector, civil society, and communities. By addressing the challenges in agricultural productivity, empowering local producers, adopting nutrition-sensitive approaches, and strengthening food supply chains, the Philippines is making significant progress toward the realisation of the SDG of Zero Hunger. As these efforts continue to evolve and expand, the nation moves closer to ensuring that every Filipino has access to safe, nutritious, and sustainable food, not just today, but for generations to come.

South Africa

Although South Africa, a country of 57 million residents, is recognised as Africa's economic powerhouse, the Global Hunger Index was estimated at 13.0 (moderate) in 2023, on a scale of 0 (no hunger) to 100 (alarming hunger) (https://www.globalhungerindex.org/south-africa.html) [32]. Based on the General Household Survey in 2021, the Statistics South Africa reported that an estimated 2.1 million households experienced hunger, 2.6 million had inadequate food access, and 1.1 million reported severe inadequate food access in South Africa [33]. As food insecurity is driven by socioeconomic inequalities, cheaper counterfeit foods (foods produced without safety standards) lack nutritional value and may contain harmful substances, as observed with documented reports of hospital admissions and child deaths [34,35].

The Government of South Africa has adopted two key policies and community actions to address the challenge of food security. First, the *Foodstuffs, Cosmetics and Disinfectant Act 54 of 1972* established guidelines for manufacture, sale, and importation of food items, cosmetics, and disinfectants in South Africa. The government employs environmental health officers across each district, with primary responsibilities to inspect food products that are sold in formal and informal establishments. Second, the *National Policy on Food and Nutrition Security for South Africa (2018-2023)* was launched in 2017, to present a situation analysis, identify quantitative metrics to measure trends over time, and promote best practices to establish clearly [36]. Finally, the Government of South Africa has clamped down on syndicates that manufacture counterfeit food by investigating and prosecuting cases of unregulated food production and sales. As clandestine factories continue to exist, coupled with the increased number of migrants who ship foods to their home countries, further actions are urgent to hault the production and sale of counterfeit foods from continuing to spread throughout the region.

Stronger food security in South Africa and the African continent is essential to ensure economic growth and promote food safety to all Africans. Without strong policies and law enforcement efforts to stomp out counterfeit foods, the African region can anticipate growing healthcare expenditure, especially related to non-communicable diseases (like cancers) management. Economic transformation policies have the potential to reduce inequalities and eradicate poverty.

Notably, doctors working in the public sector and non-governmental organisations have a fundamental role in identifying community members who experience hunger or malnutrition and referring them to relevant social programs. For example, doctors can partner with charitable organisations with missions relevant

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for distributions of food resources to community members experiencing food insecurity and help alleviate need for themselves and their families.

Trinidad and Tobago

The Caribbean Public Health Agency (CARPHA) estimates that 1 in 49 persons in the Caribbean (or 142,000 persons) would be exposed and ill with foodborne pathogens each year. Notably, infants of ages 1-4 years account for 40% of these cases [37]. Globalisation increases the risk and spread of foodborne illnesses in Trinidad and Tobago, as it entails the spatial and temporal distribution of mass movement of persons and food products, ingredients, equipment, and supplies. Since the consumption of contaminated food products distributed throughout a region can have detrimental economic impacts on food corporations, such as massive recall programs, the economic and reputational impacts of foodborne illnesses are of significant national concern to Caribbean nations that depend on tourism.

As climate change is inextricably linked to food safety, Caribbean nations will need to implement adaptations that will strengthen food production and distribution systems and reduce risk of exposure to emerging foodborne pathogens, in order to mitigate microbial adaptation and antimicrobial resistance. This is further compounded by inadequate public health resources, including infrastructure and limited support for policy, legislation, and funding of public health initiatives to improve food safety. To prioritise food safety, the Republic of Trinidad and Tobago in collaboration with CARPHA and the Pan American Health Organization (PAHO) hosted two workshops in Trinidad and Tobago and Barbados in January 2024, in order to strengthen the *Climate Resilient Food and Water Safety Plans for Trinidad and Tobago* [38]. Also, Trinidad and Tobago leaders support the ongoing evaluation of the *National Food Safety Policy of Trinidad and Tobago (2018-2023)*, as a policy that provides a harmonised approach amongst governmental agencies and key stakeholders, to achieve food safety and consumer health protection [39].

Across the Caribbean, physicians play an important role in reducing the spread of foodborne illnesses as individuals afflicted with the illness would first seek medical attention. Early warning signs can prompt physicians to alert other members of the health team to initiate an outbreak response and identify sporadic cases and clusters for prevention and control efforts. However, as laboratory capacity across LMICs may be limited to identify all microbiological (e.g. viruses, mycotoxins) and chemical agents (e.g. pesticide residues), physicians may be unable to properly treat the foodborne illness without understanding the microbiological and chemical aetiology. Furthermore, physicians also serve a secondary role as food safety educator, and their direct interactions educating patients on these potential risks is crucial.

As future steps, national authorities can advocate to strengthen regulatory compliance, food safety systems along the food continuum from farm to table, and educational food safety campaigns for consumers. They can also promote collaborative teamwork amongst all stakeholders including regulatory agencies, public health institutions, producers, processors, distributors, wholesalers, retailers, and consumers. Finally, medical training programs should consider incorporating food safety in the curricula or adding continuing education programs to emphasise food safety, to prepare physicians to manage outbreak scenarios and patient education in the clinical and community setting.

Uruguay

In Uruguay, a population with 3.5 million residents, food and nutritional insecurity represents a significant challenge. Findings from the National Household Income and Expenditure Survey reported that 14.6% of Uruguayan households (and 16.3% of the population) face a moderate or severe degree of food and nutritional insecurity [40]. There are higher documented rates of food security (15.6% moderate and 3% severe levels) in the capital city of Montevideo (departments of Artigas, Tacuarembó, Rivera, Cerro Largo, Treinta y Tres), and lower documented rates in the central and eastern regions (departments of Flores, Florida, Durazno, Lavalleja, Maldonado, Rocha) [40]. As data clearly reveal stark differences in food insecurity across Uruguay, further exploration of driving factors affecting this variation can lead to timely policies that can be developed and implemented to address these regional discrepancies.

Over the past decade, the Government of Uruguay has supported several national policies and plans to support access and availability of food resources for the population. In 2006, the Uruguay Social Card (Tarjeta Uruguay Social) (formerly, the Food Card) was approved, where home visits to populations experiencing socioeconomic vulnerability offered monetary benefits to help improve accessibility to food and other basic necessities [41]. In April 2023, the Uruguay's Ministry of Social Development (Ministerio de Desarrollo Social) adopted the *Territorial Food Plan* (*Plan de Alimentación Territorial*, PAT), which aims to expand the number

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of dining facilities of the National Dining System (Sistema Nacional de Comedores) and deliver meals to low-income and marginalised communities. To support these initiatives, the Ministry of Social Development also educates residents on food safety and storage, to help extend the quality of food sources. As the program is operational six days a week (closed on Sundays), double portions are provided on Saturdays [42].

To reflect the Government of Uruguay's commitment to reducing nutritional and food insecurity among its population, additional efforts have promoted the search for self-sustaining and sustainable solutions to ensure that all citizens enjoy the full right to adequate nutrition. Within state policies, national leaders recognize the role of family farming to achieve Food Sovereignty in rural communities. This policy promotes the access to organic foods, nutritionally adequate to the requirements of the population, which can help reverse food and nutritional insecurity across the country. Leaders have met with farmers (including those with small and family farms) and collaborated on the implementation of specific trainings in economic financing and other forms of professional assistance, which not only increase food production, but also improve their quality of life. These resources benefit farmers and their families, as well as contributes to the strengthening of local economies and reducing dependence on food imports [43].

As physicians contribute to leading clinical care across health institutions, it is important to highlight the crucial role that nutrition professionals play in multidisciplinary teams dedicated to tackling food insecurity. Consequently, they collaborate with health teams to ensure that patients have access to safe and secure nutritional sources, balanced by sufficient quantity and high-quality nutritional value. Their expertise is an essential component of the healthcare team, where they help strengthen each individual's ability to maintain a healthy lifestyle through optimal nutritional intake and support the related targets of the 2030 UN Agenda for Sustainable Development.

Conclusion

The World Food Safety Day offers a timely opportunity for global leaders to identify existing barriers that hinder the access and availability of high-quality and safe food sources across communities. Food systems are complex and involve diverse stakeholders, ranging from consumers to producers, requiring a holistic view to better understand the food chain (e.g. distribution, processing, retail, service), farming practices and post-harvest activities, and consumer behaviours (including food waste) [5]. Since food security and safety topics overlap with at least 12 of the 17 SDGs, leaders can collectively discuss emerging risks to food systems (e.g. impact of climate change on crop yield or pathogen transmission), brainstorm on sustainable solutions to promote equitable food systems (e.g. farm-to-table initiatives enhanced food systems monitoring), and develop relevant policies, partnerships, and community activities that prioritise nutritional health outcomes.

WMA members regularly contribute their clinical expertise to scientific discourse on diverse health topics that directly impact population health outcomes across their nations and geographic regions. In their clinical role, physicians can help identify patients experiencing food or nutritional insecurity, collaborate with the healthcare team, and connect patients with available community and state resources. For example, three specific clinical questions – *Within the past 12 months, have you felt anxious about running out of food before you were able to buy more food? Have you run out of food and were unable to buy more food? Have you obtained resources from a food bank?* – can help physicians maintain an open dialogue with patients, examine nutrition risks associated with social determinants of health, and create a safe environment by reducing shame or stigma [44]. Furthermore, in their academic role, they can encourage medical school administrators to incorporate food systems courses in existing curricula or continuing education courses and hence prepare future physicians to address emerging global health topics.

This collective article provides a comprehensive review of local and national policies, stakeholder engagement and risk communication, and public activities that increase awareness of foodborne risks (including antimicrobial resistance and zoonotic diseases) and drive community action to ensure proactive food systems for all ages. These collaborations exemplify the robust leadership across African, Americas, South-East Asian, and Western Pacific regions, highlighting novel policies and events that underscore the fundamental role of sustainable agriculture to ensure food security and safety and safeguard population health.

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