

JUNIOR DOCTORS NETWORK

Newsletter

The World Medical Association, Inc.
L'association Médicale Mondiale, Inc.
Asociación Médica Mundial, Inc.

Next meeting

Junior Doctors Network,

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Trade+Health: A Call to Action

Centre International de Bureaux
Immeuble A "Keynes"
13, chemin du Levant
01210 FERNEY - France

JDN

Website : www.wma.net
Telephone : (33) 4 50 40 75 75
Fax : (33) 4 50 40 59 37
E-mail address : wma@wma.net

Postal Address :
Boîte Postale 63
01210 FERNEY-VOLTAIRE Cede
France

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Editorial



Dr. Wunna Tun
Communication
Director
JDN, WMA
Editor in Chief,
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The WMA-JDN had elections in Durban in October, 2014. We welcome Dr Ahmet Murt from, Istanbul, Turkey as the new JDN chair. The new team comes from different regions including Africa, Asia-Pacific, Eastern Mediterranean, Europe, North-America and Latin America. **This issue includes:**

- Ahmet Murt, MD makes his first chair address for the new term.
- Ayako Shibata, MD highlights community medicine for super elderly population in 2025.
- Ricardo Correa reports on his journey on medical editor.
- Arthur H. Danila discuss about Social Media Summit

at the International Conference on Residency Education in 2014.

- Elizabeth Wiley, MD share about the IFMSA meeting in Taiwan and Trade and Health working group
- Pasqualina Coffey and James Churchill presents CDT guideline on clinical images.
- Zeinab Osman share the plight of an African Mother suffering from Female Genital Mutilation. **I am sure you will enjoy the stories in this new year issue .**



Written by Dr.
Ahmet Murt
Chair , WMA
JDN

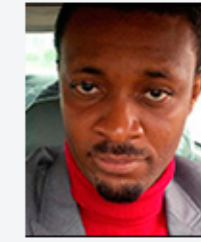
JDN has started the year with a visionary governing team that has a wide geographic representation. Preparing to celebrate the 5th year after its foundation, JDN is well aware of the needs of junior doctors as well as of the medical profession. These will be guiding the JDN to meet the requirements of the junior doctors and of the medical profession. While JDN is composed of personal members who are associate members of WMA, many of them are already representatives of their local, national and/or regional junior doctor organizations. JDN now concentrates on aligning the personal membership with these organizational representations. That is why we call the year as a reforming year.

This journey is planned to be an ongoing communicative process between many stakeholders. We kindly ask all medical associations across the world to be supportive towards juniors' efforts while they are working hard to institutionalize the representation of junior doctors in their regions or countries. Another key factor to be successful in the journey is cooperation. This is between the junior and the senior organizations as well as between the organizations from different countries. This cooperation will help junior doctors worldwide to recognize the skills of 21st century doctors that generally can not be gained by just their own. When planned carefully, an effective cooperative framework will help not only for learning from each

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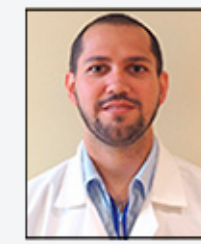
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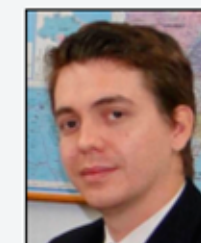
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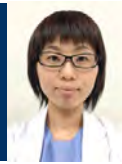


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Dr. Caline MATTAR
Immediate Past Deputy Chair
(Lebanon/United States)

Written by: Ayako Shibata,MD :
OBGYN senior resident:Osaka Japan



JDN is respectful towards the diversities of junior doctors from different regions of the world and encourages them to share their cultures while trying to formulate a global approach to health. Although not old in age, the dense experience of the network showed us that, the greater the diversity among members, the higher is the new knowledge generation. The JDN will work harder not only for scientific and professional interactions but also for social and cultural interactions among junior doctors. There have sometimes been observed differences among different regions. This situation directs us to initiate regional meetings and also to build close relations with already founded regional representative organizations. To give some examples; there have been two meetings organized in Eastern Mediterranean, along with meetings in Latin American, Africa and the Asian region in the previous two years. The JDN also tries to keep the close partnership with Permanent Working Group of European Junior Doctors in European Region. The journey will not always go on a smooth path, the changing patterns of learning and working environment of junior doctors in different parts of the world will need a dynamic strategy which can be adaptable to different situations. JDN will be in the service of junior doctors worldwide, with sometimes shallow but generally deep policies and with sometimes narrow but generally broad horizons. Looking forward to a more successful era, with reforms while protecting the tradition.

Editors:

Dr. Wunna Tun
(Communication Director)
Dr. Ricardo Correa
(Publication Director)

oficers
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(Lista)



Join the group of
Junior Doctor Network of
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Contact: jdn@wma.net

White Paper

Social media and medical professionalism

Relevant Junior Doctor Policy

Ethical Implications of Collective Action by Physicians

Current projects

Doctors' health and wellbeing
Global health training and its ethical implications
Quality in postgraduate medical education and training

Diagramação

Logo - Suport

AMB - Associação Médica Brasileira

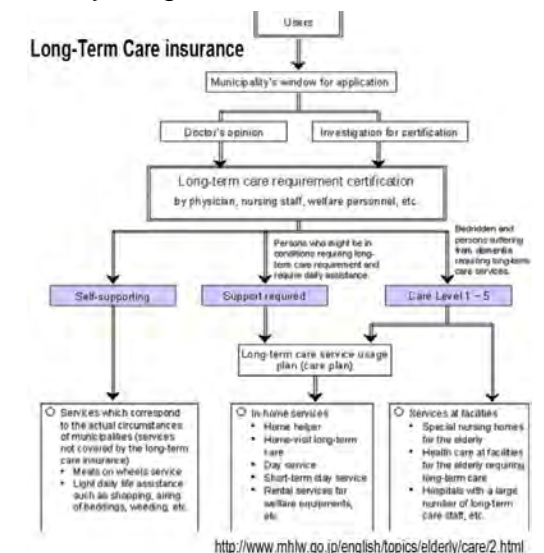
* The JDN is an initiative of individual Associate Members of the WMA. The information and opinions expressed in this newsletter represent the opinions of the authors and do not necessarily reflect those of the WMA. WMA and WMAJDN assumes no legal liability or responsibility for the accuracy, completeness, or usefulness of any information present

Planning future community health care system for the super-elderly society

Japan is getting into the super-elderly society for the first time in the world. In 2012, 24.1% of the Japanese population was over the age of 65. By 2050, 39% of the Japanese population will be over the age of 65 (OECD Historical Population Data and Projections Database, 2013). As limitations of the current system has appeared here and there, the need to think about the "new form of medical care, welfare, and care" has been increasing. We organized a workshop to think about "Community medicine for the year 2025", by inviting Dr. Yoshihiro Takayama, a physician from the Ministry of Health, Labour and Welfare.

In 2000, Japan has introduced a Long-Term Care Insurance (LTCI) programme, with 45% of the funding comes from taxes, 45% from social contributions, and 10% from service users. One of the characteristics of LTC is a "single-entry system", where case managers have the responsibility for creating care plans and monitoring conditions of the users from assessment to referral and end of care. The percentage of home care is high compared with institutions (12.6% vs 2.8%) in Japan (OECD average 7.9%). At the workshop, 40 participants were multi-disciplinary from the medical students to the pharmacists as well as young doctors.

Long Term Care(LTC) Insurance in Japan





JDN @ IFMSA August Meeting 2014, Taipei, Taiwan



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**JDN @ IFMSA
August Meeting 2014,
Taipei, Taiwan**



**Written by
Elizabeth Wiley, Social Medical
Affair Of
ficer, WMAJDN**



**Written by
Ricardo Correa MD, Es.D
, Clinical Fellow, Endocrinology
NICHD/NIH, USA, Publication
officer JDN**

After Dr. Takayama showed us the real case scenarios, the participants discussed the plan to support patients' end of life time and their wishes. Japanese JDN will continue to make learning opportunities concerning public health and health policy for young doctors.

R e f e r e n c e
Social Security in Japan 2014 National Institute of Population and Social Security Research <http://www.ipss.go.jp/s-info/e/ssj2014/005.html>
OECD A Good Life in Old Age- Japan 2013 <http://www.oecd.org/els/health-systems/Japan-OECD-EC-Good-Time-in-Old-Age.pdf>
Long-term Care Insurance in Japan Ministry of Health, Labour and Welfare 2002 <http://www.mhlw.go.jp/english/topics/elderly/care/index.html>

August 5-11, 2014. The AM2014 theme was "Sustainable De-velopment for the New Era." Plenary sessions at AM2014 focused on "IFMSA reform" with more than 200 proposed bylaws changes. The effort to reform IFMSA was a result of a campaign to identify ways to achieve the "IFMSA We Want." Among the reforms adopted at AM2014 were a significant change to IFMSA's alumni strategy including a phased-in elimination of the Alumni-Director (Alumni-D) position on the Team of Officials. In 2015, the IFMSA will assume primary responsibility for maintaining contact with alumni.

Alex Papadopoulos, 2013-2014 JDN Membership Officer, served on the AM2014 plenary team as Vice Chair. Elizabeth Wiley, 2013-2015 JDN Socio-Medical Affairs Officer and IFMSA Supervising Council Member, attended the AM2014 Team of Officials Meeting.

The next IFMSA General Assembly will be held in Turkey, March 3-9, 2015 with an IFMSA Alumni Meeting tentatively planned for March 5-8, 2015.

In this occasion, I will tell you my experience as a junior doctor involve in the medical editing area. I hope that you will consider getting more involved in the area of medical editing once you learn a little from my experiences thus far. As a new physician, this has been a fun and intellectually challenging experience for me. Six years ago, I was invited by LATINDEX to participate in a course titled "How to be an Editor". At first, I was reluctant to participate because I was really busy working as a recently graduated clinician and was also doing a research fellowship focus on public health. My mentor, however, told me that if I wanted to improve my country scientific publication besides doing papers I should get involved in editorial process. This recommendation led me to participate in the fellowship/course. The course had a lot of group and individual homework, presentations, and finally a personal meeting with an editorial board to discuss everything about editorial process and appraise/analyze/edit an article. After several months, I accomplished my goal and finished this intense but valuable course.

THE COURSE ENDED UP BEING A LIFE CHANGE EVENT.

The perspective how I see the entire scientific process is different. Prior to the course, every time that one of my articles was rejected, I usually criticized the editors. I thought that because I was not an important scientist, they did not read my work. After this experience, I realize that the editorial board is made up of people who work because they have passion for science and want to contribute to it. It was at this point I decided to start my career as a Medical Editor, I can personally tell you that this pathway has been very difficult.

At the beginning, nobody was paying attention to me, probably because I was a young with some training but not a lot of real publications. However, I kept at it. My first experience was in a Spanish journal entitled: "Archivos de Medicina". This journal gave me the opportunity to start applying what I had learned in initial course I took. I started as a junior editor, which was little frustrating because I felt I was doing basically secretarial work. Then after a couple of months, I was promoted to full editor and the real work started. I worked at least 3 hours per night. Given my other responsibilities, there were some points that for my love of publications I would have quit due to exhaustion, however, this did not happen. During my tenure with Archivos de Medicina, I learned a lot from

my mentor and decided to continue the journey and get involved in International Journals.

Meanwhile, in Panama, the medical journals quality was decreasing so I decided to make a change. I had a meeting with all the Senior Editors of the Panamanian Journals and presented a project to make there journals more effective. That was one of the most frightening moments of my life.

Can you imagine been in front of all your professor and telling them what they need to do? At the end of that meeting, they agreed with all my recommendations and decided to implement them. As a result, we founded the Panamanian Association of Medical Editors (PAME), an organization to this day has saved seven journals in the region VAs a result of PAME, I was invited to work on a project to create the Central American Association of Medical Editors (CAME). Finally in 2009, the CAME project became a reality and we had our first meeting in Honduras. Being the youngest and most energetic in the group gave me the opportunity to assume a lot of responsibilities and to quickly learn about the participating organizations and further about ethics in publication.



"I AM SO PROUD OF MY INVOLVEMENT IN CAME"



I am so proud of my involvement in CAME. CAME is now helping a lot of regional journals and every day more of them are been indexed to MEDLINE, ISI, EMBASE and others. In 2010, the World Association of Medical Editors (WAME) and the Cooperation for Ethics in Publication (COPE) invited me to become part of their organization. Being part of them, has increase my knowledge and my loved for medical editing. Due to my experiences and the relationships formed from them, I have found a couple of mentors that like my enthusiasm and have offered me training positions on their editorial boards. The Journal of Infectious Disease in Developing Countries and International Archives of Medicine, were the two journals where I had my first non-Spanish editorial experience. From these experiences, I

learned the methodology of approaching different papers, how to evaluate double publication, how to use certain editorial computer programs and how to analyze and integrate the peer reviewers commentaries and recommendations. learn a lot and you will make a contribution to the scientific world.

Another project that I started during that time, with the knowledge that I gained editing was to write a book for medical students. Finally in 2010, my first book titled "Casos Clinicos: Semiologia y Publicacion" was published. I believe that science should be available to everyone and the Open Journal System (OJS) is one of the ways to obtain that objective. Believing this, in 2011 I decided to train on OJS. With this new training and knowledge, I have the idea of creating the first open access junior doctor journal. The main objective will be to stimulate publication among our peers. Every day I am learning more about this fascinating area, medical editing. I can tell all of you that even though this journey had its difficult and busy periods, I don't regret it. Being a junior medical editor has allowed me behind the scenes in scientific publication and forwarded my knowledge base as to how articles get published and why some do not.

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Written by
Socio Medical Affairs Officer, Eliza-
beth Wiley

Trade+Health: A Call to Action

Over the last five years, a new generation of “mega” trade agreement negotiations have emerged globally. The size, scope and lack of transparency of these negotiations is unparalleled. Launched in 2010, Trans Pacific Partnership (TPP) include twelve negotiating parties: Australia, Brunei, Canada, Chile, Japan, Malaysia, Mexico, New Zealand, Peru, Singapore, United States and Vietnam. The Transatlantic Trade & Investment Partnership (TTIP) negotiations include the European Union and United States. The Comprehensive Economic and Trade Agreement (CETA) is being negotiated between the European Union and Canada. Between the TPP, TTIP and CETA, forty countries representing more than 60% of the global gross domestic product (GDP) are involved in these negotiations. Moreover, these agreements seek to establish a new global framework for trade governance and are designed to serve as a model for all future trade agreements. **But why do these trade agreement negotiations matter to junior doctors?**

If successful, these agreements could significantly reshape the environment in which we serve patients and practice medicine. On a truly global scale, these agreements may affect:

- health care services;
 - access to medicines for patients;
 - drug safety and research including clinical trial data transparency;
 - prevention and control of non-communicable diseases including regulation of tobacco and alcohol;
 - treatment of communicable diseases;
 - environmental protection;
 - food safety and supply;
 - environmental and occupational health; and
 - medical education and the supply of health professionals.
- Unfortunately, these trade agreement negotiations are conducted largely in secret with disparate access to draft texts and negotiators afforded to industry. Of particular concern is the possible inclusion of a broad investor-state dispute settlement (ISDS)

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mechanism in these agreements. ISDS provides a way for investors to bring claims against governments and seek compensation. ISDS cases are generally adjudicated by panels of private corporate attorneys with little transparency. When incorporated into smaller scale trade agreements, these provisions have been used to challenge successful, evidence-based public health initiatives such as cigarette plain-packaging. More than half of ISDS cases are either settled or decided in favor of the investor. Moreover, there is concern that the mere availability of ISDS may deter governments from adopting policies to protect health, a phenomenon called “regulatory chill.” In accordance with the WMA Statement on Patient Advocacy and Confidentiality, physicians have an ethical duty to advocate “... for patients, both as a group (such as advocating on public health issues) and as individuals.” Given the potential implications of

these trade agreements on health and health care services, it is critical that we, as physicians, advocate to ensure that these agreements advance rather than undermine health

The JDN has established an informal working group on trade and health and is currently working to draft a policy statement. Please contact JDN Socio Medical Affairs Officer, Elizabeth Wiley, at elizabeth.wiley.md@gmail.com if you are interested in working on these issues.

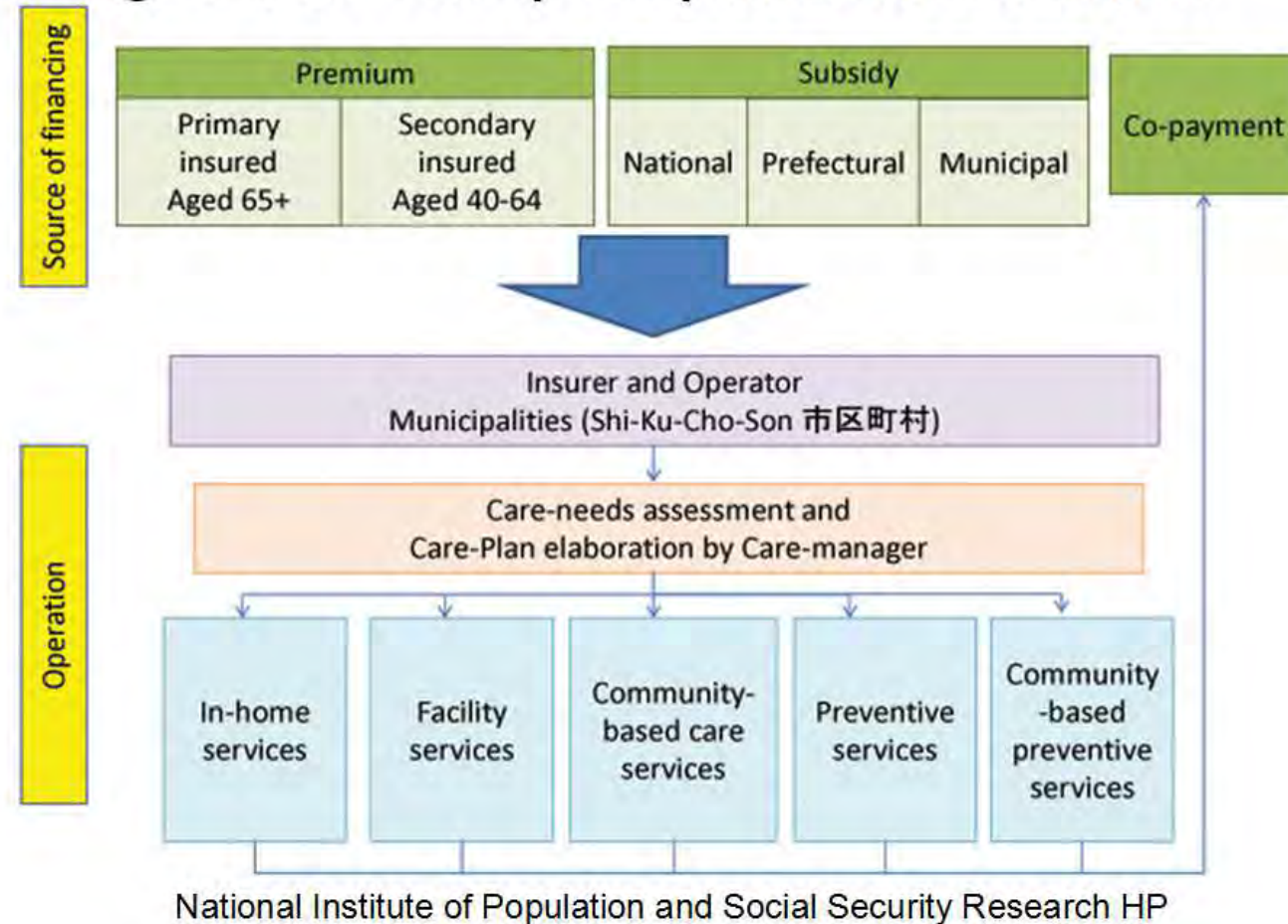
THERE IS A LOT MORE TO LEARN. HOWEVER, I HOPE THAT ONE DAY I REACH MY GOAL OF BEING A SENIOR



The role and make up of medical editors is changing. In the past, you became an editor only if you published many articles. Nowadays, beside publication you need training in editorial process. I remembered that the editor in Chief of JAMA in a meeting told me “if I knew that I would become the senior editor of JAMA, I would start my training since I was a resident 30 years ago.”

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Long Term Care(LTC) Insurance in Japan



Guidelines for junior doctors on the use of mobile devices for taking clinical images

Written by
 Dr. Pasqualina Coffey, Northern Territory Representative, CDT.
 Dr. James Churchill, Chair Council of Doctors in Training.



With the ubiquitous smart phone poking out of nearly every junior doctor's pocket, it is not surprising that using our little electronic friends for taking photos or videos during our work has become more and more common. Images are frequently taken for documenting and monitoring key clinical signs, injuries or lesions, can help assist with



referrals and offsite specialist advice, and are often used for teaching, training or research.

However, the ease and utility of using personal mobile devices to capture clinical images needs to be tempered by important legal, professional and ethical boundaries. The Council of Doctors in Training (CDT) in Australia has realised that many junior doctors and

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medical students do not fully appreciate their obligations. Furthermore, local policies are often not clear or are non-existent. Also, numbers of complaints received by regulatory agencies regarding the improper capture and use of clinical images are increasing. Remain up to date with commonly used devices, storage and messaging software and applications. CDT will also advocate to improve image upload and printing services in hospitals and hope that the guidelines will prompt individual health services to consider their own policies and staff awareness in this valuable but potentially risky practice. The guidelines will be published shortly and will be available from the CDT section of the Australian Medical Association's website www.ama.com.

look forward to sharing them with the Junior Doctor Network. Over 2014 the Council has developed easy to use guidelines aimed at junior doctors and medical students to help them make full use of this helpful tool, while protecting patient safety, privacy and autonomy. The guidelines cover common pitfalls for junior doctors and medical students including inadequate consent and documentation; image quality

guidelines for doctors and medical students working in the Australian healthcare system. The guidelines have been made into an easy to use brochure, which clearly outline the key points doctors and medical students should follow whenever they take a clinical image. In composing these guidelines, CDT was very aware of the fast pace of technology. As such, we will be reviewing the guidelines in one year to ensure they are relevant and remain up to date with commonly used devices, storage and messaging software and applications. CDT will also advocate to improve image upload and printing services in hospitals and hope that the guidelines



ity; de-identification; insecure storage; and inadvertent or deliberate unloading to cloud storage or social media. For example, one study at an Australian hospital revealed that 65% of respondents had taken clinical images, but only 25% obtained consent. Many kept the images for later use and only 40% were aware of a hospital policy. 60% believed they owned the image. The CDT guidelines for clinical images and the use of personal mobile devices will be the first relevant national professional

w i l l prompt individual health services to consider their own policies and staff awareness in this valuable but potentially risky practice. The guidelines will be published shortly and will be available from the CDT section of the Australian Medical Association's website www.ama.com.au/dit. We look forward to sharing them with the Junior Doctor Network.



Social Media Summit at the 2014 International Conference on Residency Education

Save the date! Upcoming meetings in 2015

- April 15th, 2015: WMA Junior Doctors Network Meeting Oslo, Norway
- May 8th – 9th, 2015: EJD Spring Meeting 2015, Vienna, Austria
- May 16th – 17th, 2015 : JDN Working Meeting in WMA, France
- September 22nd – 24th, 2015 (tentative): CMAAO meeting, Yangon, Myanmar
- October 12th - 13th, 2015: WMA JDN Meeting, Moscow, Russia

On October 22nd, Toronto was home to the world's first Social Media Summit for Health Professional Education held prior to the Royal College of Physician and Surgeons of Canada's 2014 International Conference on Residency Education. This one-day summit brought together over 100 participants from countries around the world to develop consensus on the best use for social media in medical education. WMA JDN members included Dr. Ian Pereira (@IanJohnPereira, Queen's University, Canada) who helped organize the sessions. The Summit was chaired by Dr. Jonathan Sherbino (@Sherbino, McMaster University, Canada) and Dr. Ali Jalali (@ARJalali, University of Ottawa, Canada), both enthusiasts of appropriate and innovative uses of technology in medicine. Dr. Sherbino's initial remarks emphasized the breakthrough of this meet-

ing as one of the first to engage an international audience both within the Allstream Centre and online through twitter and blogs.

The Opening Plenary featured world-renowned Dr. Anne Marie Cunningham (@amcunningham, Cardiff University, UK) from the "Wishful thinking in medical education" blog on "How social media can change health professional education". She highlighted the importance of an online identity, appropriate behavior, and a set of values relevant to the digital age. She also encouraged those interested in health professional education to consider the potential for social media for good, such as its ability to create a truly collaborative and supportive environment. She also warned us against stressing widespread

fears of social media in isolation within considering its benefits, drawing on Dr. Jacalyn Duffin's concept of "vanilla physicians" – doctors whose attitudes and core values become softened and withdrawn because of fear for exposure. Participants then attended two of four possible sessions intended to develop consensus guidelines on each topic. I had the opportunity to participate in one on the "Professional use of Social Media for Health Professional Education" facilitated by Drs. Jalali, Cunningham, and Pereira. Using the positive lens of an appreciative inquiry framework, we identified

what works well in the professional use of social media today, what may work better in the future, and what we need to do to design and implement changes to make these improvements a reality. The second session was on "Best practices for Social Media platforms" led by Dr. Michelle Lin, an Emergency Physician and founder of the "Academic Life in Emergency Medicine (ALiEM)" blog (@M_Lin, University of California). This session used interactive polling to reach consensus on best practices and develop quality indicators that could be used to evaluate the impact of this technology. Other concurrent sessions were on "How education theory should inform Social Media" by Dr. Jalali

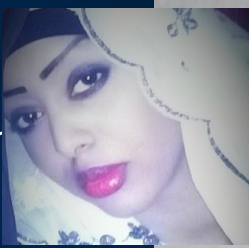
and Dr. Leslie Flynn (@flynnlv, Queen's University, Canada) and on "Defining and evaluating Social Media education scholarship" by Dr. Sherbino. The second plenary was "How health professions educators should use Social Media" and presented by Dr. Lin, whose motto was "there is no greater job than being an educator." She stressed that we want to make a difference where the learners are as a part of a global community and delivered a thorough review of how social media can shift the academic value for the traditional role of the clinician-educator to the digital-innovator-educator. The plenary concluded with suggestions on how each one of us could develop our own digi-

tal identity as a medical educator. It was a consensus from the attendees that this meeting empowered participants to participate in good discussions and take home practical advice on the use of social media in medical education. It also engaged a wider audience through social media (including Facebook, Twitter, and the conference blog). What now challenges us is to encourage our institutions to join these discussions on the use of social media and consider its use where appropriate for better health professional education. To help, next steps from the conference organizers will be to build on this day to develop consensus guidelines on the use of social media for health professional education. I look forward to these publications, and the role they may

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Written by Dr
Zeinab Osman
Medical Officer
from Somalia



At some point of her life
she asked her self why?
All the eyes are on her
it makes her want to cry
* * * * *

They want her to be tough
Pass this habit to her kids
Teach them to be rough
let them feel what she felt
* * * * *

But what if it's wrong?
And it has be wrong!
It doesn't make her feel strong
* * * * *

This is a story
that no one wants to hear
it's only her destiny
to end this life with fear
* * * * *

she was only five years old
when she started to realize
those girls are born to be cold
just like a useless device
* * * * *

It's not their right to complain
As a matter of fact,
they should withstand all emotions

including physical pain
* * * * *

She heard one of her friends
became a hero
because she went un-
der a procedure
that makes her so
* * * * *

She knew her day
will come in any way
because she had no options
it was compulsory
* * * * *

She had to bite her lips
Hold the tears in her eyes
Because if she cries
they will inform other kids
that she was a coward
and will never move
one step forward



Now she takes one second
and wonder why people
always put her second?
Why not first?
Why it's always about
what they want out of her?
No one is considering
No one even bother to care
* * * * *

She struggle hard not to cry
while remembering the
worst scenario of her life
that brought tears to her eyes
And unfolded the hid-
den memories in her mind
* * * * *

When she had urine retention
and needed a medical attention
but first they want-
ed a permission
from those who nev-
er changed their vision
* * * * *

To cut her up
to leave her with no choice
but to give up
* * * * *

I guess, they nev-
er cared about
her deep emotion
or they would em-
pathize know-
ing the sensation
inside her was a tre-
mendous commotion
she was lost in an in-
visible and painful ocean
* * * * *

The pain and she
had already grown up
Together they nev-
er attempted to stop
Looking forward
Seeking for some to the golden age
thing to separate them
Where it all will vanish
they never gave up
Can't wait the golden age
* * * * *
To come and end
this punishment