Trade+Health: A Call to Action
Editorial

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.
- Pasqualla 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.

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
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.

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Join the group of
Junior Doctor Network of
World Medical Association
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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

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.

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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.

Reference:

In this occasion, I will tell you my experience as a junior doctor involved 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's scientific publication besides doing papers I should get involved in the 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/edit an article. After several months, I accomplished my goal and finished this intense but valuable course.
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 their journals more effective. That was one of the most frightening moments of my life. Can you imagine been in front of all your professors 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. As 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. As 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. 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 has 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 to how articles get published and why some do not.
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) 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, Eliza-beth Wiley, at elizabeth wiley.md@gmail.com if you are interested in working on these issues.
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 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. Remains 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.au. We look forward to sharing them with the Junior Doctor Network.

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 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. Remains 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.au. We look forward to sharing them with the Junior Doctor Network.
Social Media Summit at the 2014 International Conference on Residency Education

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 meeting 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, Cunninghame, 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 of 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 digital 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...
The pain and she
had already grown
Together they nev-
ever attempted to stop
Seeking for some-
ting to separate them
they never gave up
************
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 his 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

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 hidden
memories in her mind
When she had urine retention
and needed a medical attention
but first they wanted
ed a permission
from those who nev-
ever changed their vision
To cut her up
leaving her with no choice
but to give up
I guess, they never
cared about
her deep emotion
or they would empathize
knowing the sensation
inside her was a tremendous commotion
she was lost in an invisible and painful ocean

She heard one of her friends
became a hero
because she went under 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

The pain and she
had already grown
Like any other Somali girl
they knew FGM is the only night mare
Looking forward
for some to the golden age
where it all will vanish

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Written by Dr
Zeinab Osman
Medical Officer
from Somalia

FGM is the only night mare
Looking forward
to the golden age
Where it all will vanish
Can’t wait the golden age
To come and end
this punishment