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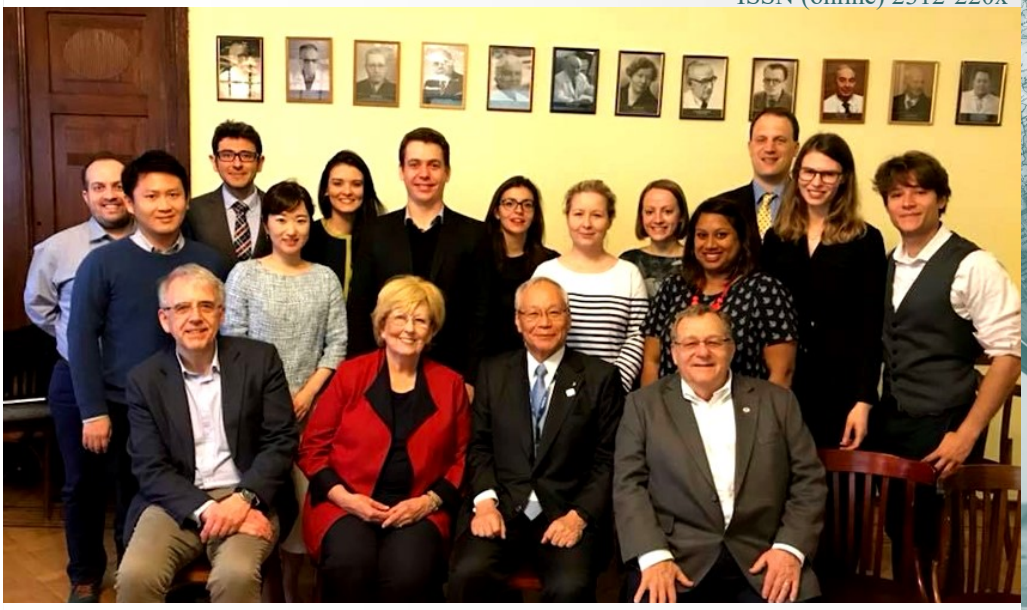


Picture 1. Participants at the JDN Riga Meeting 2018 with the WMA leadership.

Junior Doctors Network Newsletter

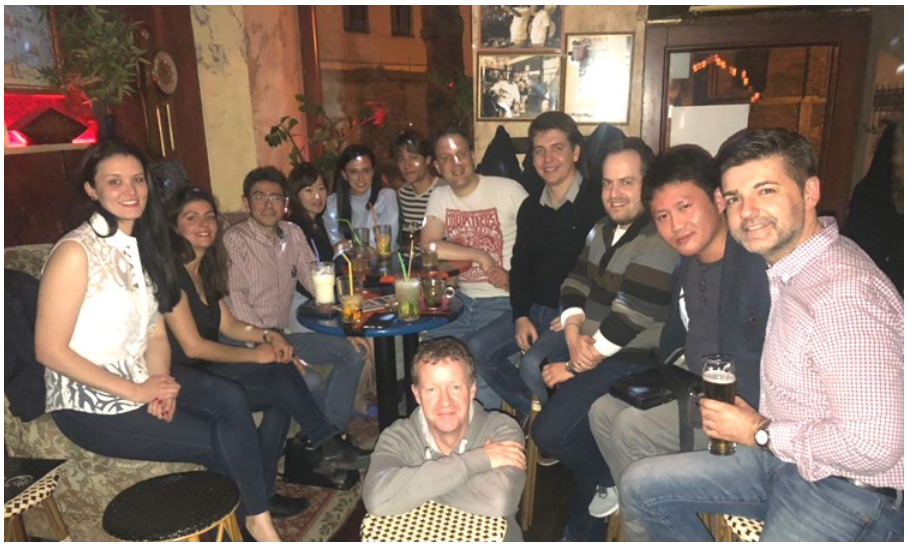
Working conditions and leadership education: the topics of JDN Meeting in Riga

Konstantinos Roditis, MD, MSc*

Members of the Junior Doctors Network (JDN) of the World Medical Association (WMA) gathered for their April 2018 Meeting in Riga, Latvia, hosted by the Latvian Medical Association (LMA). The meeting took place on April 25, 2018, at the LMA premises in Riga, prior to the 209th Session of the WMA Council also attended by JDN representatives. Around 15 junior doctors coming from Turkey, France, Germany, the United States of America, Lebanon, Kuwait, Italy, Brazil, Nigeria, Japan, Canada, Greece, Latvia, and the United Kingdom (European Junior Doctors Association - EJD representative), attended the meeting and discussed current topics of interest to junior doctors globally, as well as relevant WMA policies to be addressed at the Council Session and forwarded for adoption at the next WMA General Assembly (GA) in Reykjavik, later this year.

The meeting started with a welcome speech by the JDN Chair, Dr. Caline Mattar, who welcomed everybody to the Riga meeting and briefly presented the meeting agenda, offering background information especially to newcomers. Each participant then took the floor and introduced themselves, presenting their role

Index



Picture 2. JDN participants socializing at a Riga pub.

within JDN and/or the junior doctors' organization in their respective countries, as well as their expectations from the meeting.

Interestingly, as both the WMA Council Session and GA are organized in Europe for the year 2018, special attention was given by the participants to certain junior doctors' issues in Europe. The discussion was further enriched by the introduction given by Dr. Kitty Mohan, President of the European Junior Doctors Association (EJD) who was also present as a guest at the meeting, followed by the representatives of the Latvian Junior Doctors Association, who presented the challenges they are facing both in their post-graduate medical education and training, along with exhausting working hours and unsatisfactory working conditions.

The meeting was honored by the presence of WMA leadership, namely Prof. Yoshitake Yokokura, WMA President, Dr. Ardis Hoven, WMA Council Chair, and Dr. Otmar Kloiber, WMA Secretary General, who all greeted the participants, wishing them a fruitful meeting and great outcomes, and at the same time welcomed JDN at the 209th WMA Council Session. All participants were then split into three small working groups and addressed the following topics, under the WMA leadership:

1. Building regional collaborations (Dr. Yokokura) - The CMAAO example and Japan leadership role in its development were mentioned, with emphasis in the historical background and current progress. Dr. Yokokura also presented on the Chinese-Japanese medical association and its evolvement throughout the years, as an example of regional partnership between neighboring countries. He then received questions by the participants, specifically on how he envisions the role of smaller, underdeveloped nations in the proceedings of such regional collaborative initiatives.
2. Healthcare systems reforms - Primary healthcare (PHC) and the role of other health professionals (Dr. Kloiber) - A presentation was given on challenges arising from introducing nurse practitioners and pharmacists into PHC structures, followed by discussions on the alienation between doctors and patients due to super-specialization in medicine, certain PHC reforms and decapitation of physician care (being paid per capita), the introduction of pharmacies in super markets and shopping malls, as well as the prescription of medications and diagnostics by non-physicians and on the related WMA position.
3. How to engage people to work in a certain field (Dr. Hoven) - Emphasis was given on the example of the WMA Associate Members targeting public health physicians and medical ethics experts and the role of emotional influence in increasing individual commitment to collaborative work by Dr. Hoven.

The next point in the agenda was a brainstorming session (splitting into smaller groups) tackling:

-Structure of JDN meetings (facilitators: K. Roditis and A. Fontaine)
-JDN membership (facilitator: C. Mishima)

A workshop led by Dr. Yassen

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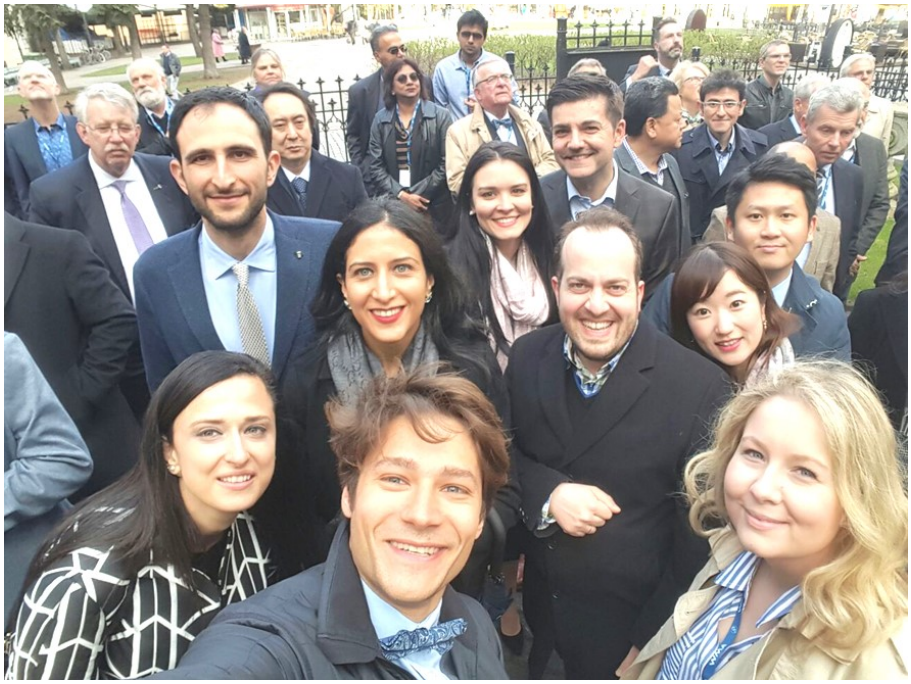
Cholakov on Climate Change followed. First, he offered a brief presentation on United Nations Framework Convention on Climate Change (UNFCCC) history of climate change, mentioning health in negotiations, working towards the Paris Agreement and the role of WMA in climate change policy / JDN's contribution (revision of the Delhi Declaration). Participants then were once again split into smaller groups and went through the National Determined Contributions (NDC) interim reports of all different signatory countries, as listed on http://www4.unfccc.int/ndcregistry/Pages/All.aspx. Then, there was a discussion about health, air pollution, healthcare resilience, and nutrition in the reports, addressing various reasons why these topics were not mentioned. Further ways of engaging WMA's National Medical Associations (NMAs) into contributing more resources to Climate Change talks were also explored at the end of the workshop.



Picture 3. JDN participants at the Opening Reception of the 209th WMA Council Session.

As the JDN meeting had no central theme this time, the participants focused on several issues the JDN is currently working on, mainly the work being done within JDN's working groups (WG).

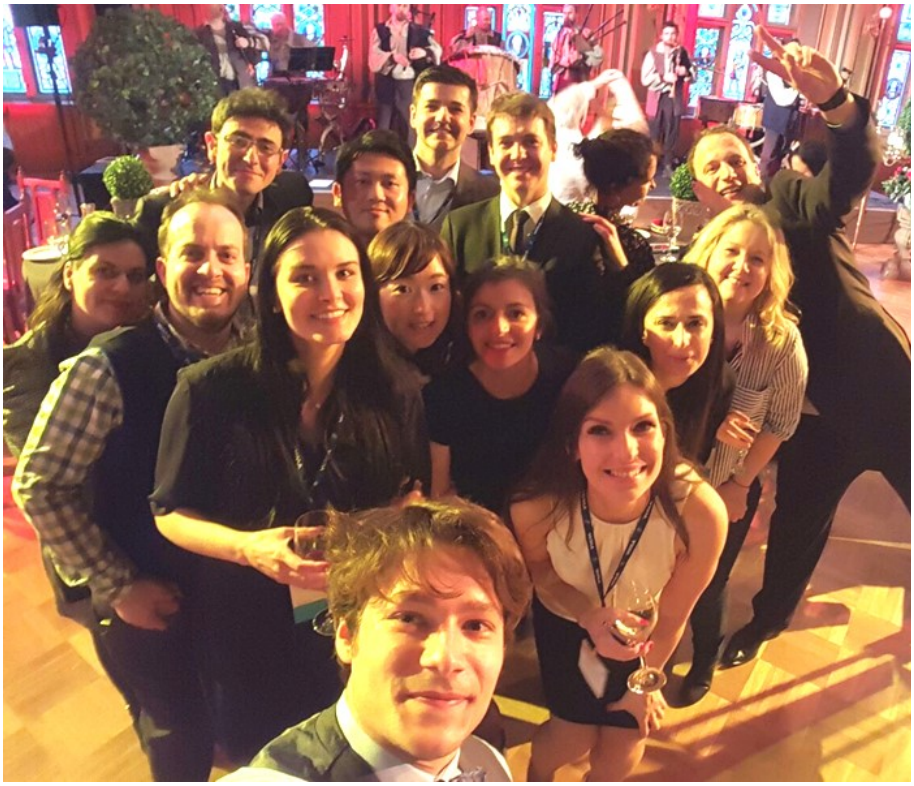
The future of JDN's WG on Working Conditions monopolized the discussion, starting with a brief introduction given by Dr. Caline Mattar on the work completed so far by the WG. All participants were engaged in suggesting ways of moving forward with the WG, in terms of producing actual results and achieving specific goals. Approaching possible partners from the Academia, conducting a well-designed survey on working conditions among JDN members in different world regions, creating an online platform for the referral of violations of working conditions by JDN members, writing an introductory article on existing working conditions regulatory systems around the globe to be published in the World Medical Journal, organizing solidarity campaigns to support our colleagues in countries with challenging working conditions, were among the ideas mentioned by the participants.

The meeting concluded with a Leadership in Healthcare

Picture 4. JDN participants in front of the Livonian medieval Castle, joining the post-meeting tour in the Latvian countryside town of Cecis.

workshop, offered by Drs. Greg Radu and Paul Kneath Jones, both experts in running leadership workshops in international conferences worldwide. The participants received a comprehensive presentation on different leadership theories and ways and tools to build a strong leadership profile in healthcare settings.

All in all, the meeting was a success for JDN, as the participants had the chance to meet again with colleagues from all over the world, exchange ideas, build strong connections, and enjoy the Latvian culture, cuisine, and nightlife! At this point, we would all like to thank our Latvian hosts for their hospitality, with our special thanks going out to Ms. Maira Sudraba, who was always there to accommodate us. The next rendez-vous for the JDN members will be the JDN Annual Meeting, taking place in Reykjavik, Iceland in October 2018. Until then…



Picture 5. JDN folks having a great time at the 209th WMA Council Session Reception.

Report from WMA European Region Meeting on End-of-Life Questions

Maki Okamoto, MD*

The World Medical Association (WMA) European Region Meeting on End-of-Life Questions was held in the Vatican on November 16-17, 2017, which was hosted by the German Medical Association in collaboration with the WMA and the Pontifical Academy for Life in the Vatican. This event included a series of regional workshops that focused on dynamic discussions on euthanasia and physician-assisted dying and its ethical dilemmas relating to end-of-life issues. The discussion was first started in Oslo, Norway, in April 2015, in the 200th WMA Council Session, where WMA reaffirmed the "WMA Declaration on Euthanasia". It was then followed by the regional meetings in Tokyo, Japan in September 2017, the Vatican in November 2017, and Abuja, Nigeria in February 2018.

The End-of-Life discussions seemed particularly important in the European region, because a variety of standpoints and legal settings towards euthanasia or physician-assisted suicide (PAS) were observed among the European countries.

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Referring to the result of questionnaires from 19 Asian countries at the End-of-Life symposium in Tokyo, Japan, in September 2017, the majority of Asian countries showed negative attitudes toward "active euthanasia". Furthermore, it was implied that the way of religion or the view of life are involved in thinking and decision-making processes for end-of-life care

in Asia. In contrast with this trend in Asian countries, the European region had different religious backgrounds, and each country had its own perspectives about euthanasia or PAS. This emphasized the fundamental significance of having a regional conference in Europe and attracted attention from all participants in the Vatican. For this two-day conference, European medical professionals, legal authorities, experts in palliative care and medical ethics, theological scholars and philosophers were all gathered in the Vatican, debating end-of-life questions from different perspectives.

The discussion first began with providing the setting and perspectives from the WMA as well as the country where the euthanasia or PAS is allowed. Professor Dr. Montgomery, the president of the German Medical Association, spoke about the perspectives from the WMA. Despite the fact that the practice of active euthanasia with physician assistance has been legalised in some countries, the WMA strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if the national law allows or decriminalizes it. On the other hand, Dr. René Héman took part in showing the viewpoint from the Netherlands, where euthanasia is authorized under certain conditions. The six due care requirements for euthanasia are as follows; 1) There is a voluntary and well-considered request; 2) There is an unbearable suffering and no prospect of improvement; 3) The patient is informed about the situation and future prospects; 4) There is conviction that no other reasonable solution for the patient's situation is available; 5) One other independent physician is consulted; and 6) Termination of life or assisted suicide is performed with due care. In addition to these requirements, there is no obligation for physicians to perform euthanasia, and it relies on the physician's compassion. However, it is still not a simple pathway, and physicians who perform euthanasia also experience intense psychological suffering. Dr. Yvonne Gilli, from the Swiss Medical Association, presented the current situation of assisted suicide in Switzerland. She indicated that the number of assisted suicides in Switzerland has increased from 2% to10% over the past 15 years (2000-2014). She also stated that the use of continuous deep sedation as a treatment method in end-of-life-care has also increased substantially in recent years. Additionally, she mentioned the importance of organizing the end-of-life-care guidelines especially for the palliative sedations, as well as reconsidering the importance of physicians conversing with patients about this delicate decision.

The second part of the conference was based on theological views. Ethical specialists interpreted the Catholic, Jewish, and Islamic perspectives by providing different interpretation of death. Dr. Daniela Mosoiu, an experienced palliative care physician from Romania who has dedicated her work in hospice, presented real clinical cases from her practice. Most of the patients were suffering from the anxiety of not knowing what to do. In addition, patients, families, and health professionals collectively suffer. However, the important element is to provide "curing" and "healing" for patients, where "curing" refers to the physiological reconstruction of the physical body, and "healing" refers to mainly mental meanings, such as inner peace, forgiveness, removal of stigma, and elimination of social barriers. Transformation of suffering, acquaintance with one's death, and gratitude and worship are essential keys to achieve "healing".

"I will stand in front of him, behind him and next to him, when he needed my care."

The third part of the conference was related to laws or delineating euthanasia and PAS, which was presented by Professor John Keown, Professor Dr. Volker Lipp, and Dr. Laurence Lwoff. Euthanasia, defined as intentionally killing another person in order to relieve this person's suffering, is divided into three sub-groups: 1) voluntary, or a person who follows the person's will; 2) non-voluntary, or a person incapable of making decisions (such as coma, mentally retarded or dementia); 3) involuntary, or a person who

wants to live but was killed. While PAS is defined as suicide with assistance of a physician, there is also another context that has become widely accepted in principle, such as “letting die”, defined as limiting, terminating, or withholding life-sustaining treatment because it is futile or according to the patient’s will. In terms of criminal law, most European countries, except the Netherlands, Belgium, and Luxembourg, ban all forms of euthanasia. The Netherlands allows non-voluntary euthanasia of terminally ill newborn babies. In countries such as Switzerland or Germany, PAS is legal under certain conditions, while euthanasia is banned in those countries. However, these definitions of each term overlap in many ways, and we have a variety of conditions in laws, religions, histories, cultural backgrounds or patients’ conditions, which make the discussion over euthanasia and PAS more challenging. Some highlighted that the discussions regarding the decision-making processes are as follows: How can we define the patient as incapable to decide or who is to decide for them? How can we deal with the will of patients with dementia or senility? How can we decide whether or not to withdraw fundamental life support (such as hydration or nutrition) compared to medical life-prolonging treatments?

In the latter half of the conference, the discussions moved to the theme regarding compassionate use and conscientious objections, the right to determine one’s own death, and choice of treatment limitations as an alternative to euthanasia. Many specialists from all backgrounds were gathered to openly discuss these topics. Roughly estimated, the number of people euthanized each year in the Netherlands is set to exceed 7,000, and it rose 67% from five years ago. The number of persons receiving euthanasia in Belgium is estimated to be as high as 4,000 each year. However, it means that approximately half of all requests were granted, and the other half of all requests were denied. This fact implies that more alternatives are available before selecting the ultimate choice such as euthanasia or PAS. Professor Dr. Leonid Eidelman, from the Israeli Medical Association, presented the clinical case of a patient who was suffering from intensive back pain and shouted for someone to kill him. However, after he was treated with continuous infusion of anesthesia to his spine, his pain was relatively cured, which produced a smile and allowed him to travel around the world before he died. This case suggests the importance of reconsidering this possible treatment as an end-of-life-care measure. Dr. Anne de la Tour, a palliative care physician from France, explained the possibility of deep and continuous sedations. Patients who live in countries that do not allow euthanasia or PAS, can also be free from unbearable pain through deep and prolonged sedation continued until death. However, this measure must be conducted within the legal authorization, when a patient is in the terminal phase and suffers from a serious and incurable life-threatening condition.

The discussion over euthanasia and PAS will never end. As more people, especially from western Europe, are in favor of PAS, it is important to provide patients with many different choices and let them choose what they are willing to receive. At the same time, it is more important to discuss end-of-life care, build up the system, and provide correct information about all treatment options to the public. As physicians, we must think about how we can dedicate ourselves to people who are suffering from terminal illnesses. As such, the conference was concluded with this symbolic phrase: “I will stand in front of him, behind him and next to him, when he needed my care”.

A report of the WMA African region meeting on End-of-Life Questions hosted by the Nigerian Medical Association in Abuja, Nigeria from February 1-2, 2018

Ndiokwelu Chibuzo, MD, MWACP*

As part of the efforts of the World Medical Association (WMA) to generate open regional discussions on the dilemmas related to End-of-Life issues, particularly with respect to palliative care, euthanasia, and physician-assisted suicide, the WMA Council meeting held in Livingstone, Zambia, in April 2017, encouraged the African region of the WMA to organize an African Regional meeting on End-of-Life issues.

As such, the Coalition of African Medical Associations authorized the Nigerian Medical Association to host the WMA African Region Meeting on End-of-Life issues. This WMA African Region meeting on End-of-Life issues (palliative care, euthanasia, and physician-assisted suicide) was hosted by the Nigerian Medical Association in Abuja, Nigeria, from February 1-2, 2018.

This meeting was born out of the need for the WMA to generate discussions and assess the scope of the dilemma facing doctors in different cultural domains. The WMA aimed to better understand the problem in order to adequately address related policies in the future. This was one of the four WMA End-of-Life meetings organized in the Asia-Pacific, Europe, Latin America, and Africa regions.

The End-of-Life meeting, which held at the Transcorp Hilton Hotel and Towers, Abuja, promoted the theme, ”An Excursion into the End-of-Life Spectrum: Defining the boundaries between Palliative care, Euthanasia, and Physician assisted suicide”. The Secretary General of the WMA, Dr. Otmar Kloiber, attended and presented the WMA policy on End-of-Life issues. Other dignitaries in attendance were the presidents and delegates of the National Medical Associations from Nigeria, Zambia, Kenya, South Africa, Cote D’Ivoire, and Botswana.

Picture 1. Dr. Enabulele Osahon, past president Nigerian Medical Association; Dr. Othmer Kloiber, WMA Secretary General; and Prof. Ogirima Mike, Nigeria Medical Association.

Activities conducted during the meeting included the welcome cocktail, formal opening ceremony, scientific sessions with presentations by various guest speakers on End-of-Life issues, breakout technical sessions, local tourism activities, and closing dinner.

The formal opening ceremony was chaired by the Senate President of the Federal Republic of Nigeria, Senator Dr. Bukola Saraki, who was represented by Senator Dr. Lanre Tejuosho, while the Honourable Minister of Health, Professor I.F. Adewole, represented the President of the Federal Republic of Nigeria, Muhammadu Buhari GCFR.

During the meeting, numerous discussions focused on palliative care, euthanasia, and physician-assisted suicide with several observations:

1) There is no specific policy or legislation on euthanasia and

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Picture 2. A cross section of delegates at the meeting.

physician-assisted suicide in Africa.

2) Few countries, like Nigeria, Zambia, Kenya, Uganda, South Africa, and Botswana, have policies, guidelines, and practices on palliative care.

3) In the African culture, tradition and religion, life is held sacred, and families never abandon their loved ones at the End-of-Life period.

4) Palliative care as a concept is generally accepted in the African culture, tradition, and religion.

5) Involvement of physicians in euthanasia and physician-assisted suicide is frowned on as it is viewed as contradictory to medical ethics and the physicians' pledge.

6) There is a low level of awareness on End-of-Life issues among African populations and health professionals.

7) There is a dearth of standard health care systems and medical personnel equipped to deliver palliative care.

8) There is a high poverty rate, poor access to affordable, equitable and quality health care, and poor access to palliative care in most African countries.

Finally, the meeting ended with some resolutions to guide the WMA in further discussions as they relate to the African region.

1) African National Medical Associations (NMAs) are unanimously opposed to euthanasia and physician-assisted suicide in any form.

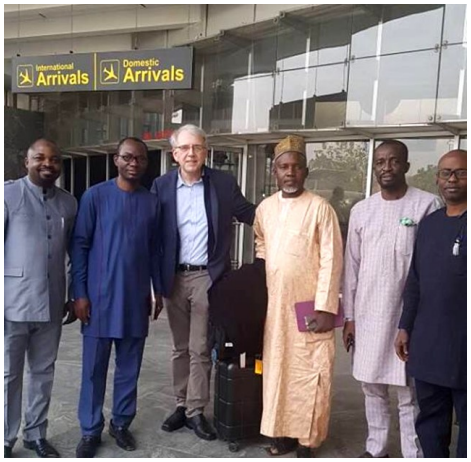
2) African NMAs support policies and legislations permitting and strengthening palliative care.

3) African NMAs, non-governmental organizations (NGOs), and other agencies or institutions need to embark on enlightenment and advocacy campaigns to government, policy makers, and the general public on the importance and availability of palliative care.

4) There is great need to strengthen African health systems, promote universal health coverage, improve budgetary allocation to health services, and integrate palliative care and other chronic medical conditions into the health financing and insurance schemes of African countries.

Acknowledgements
Nigeria Medical Association, Report of the WMA African region meeting on End-of-Life Questions in Nigeria, January 2018

Picture 3. WMA Secretary General on a sight-seeing trip to see the Zuma Rock.



Picture 4. Arrival at the airport.

Picture 5. Smiles at the closing dinner.

Picture 6. Dr. Othmer Kloiber, Secretary General WMA; and Dr. Tanko Sununu, Secretary General, Nigerian Medical Association wearing local traditional attire.

Report from the WMA JDN preWHA 2018

Yassen Tcholakov, MD, MSc*

The Junior Doctors Network (JDN) organized its annual pre-World Health Association (WHA) meeting on May 19-20, 2018, at the World Medical Association (WMA) offices in Ferney-Voltaire, France.

At WHA71, delegates engaged in deep conversations with Dr. Maria Neira, WHO Director of the Department of Public Health, Environmental and Social Determinants of Health, on issues related to environmental health and climate change. Many highlighted the potential leadership role that the WHO could take in front of other United Nations' (UN) agencies and organizations on issues of climate change and air pollution. The conversation even boldly suggested that the WHO should use its treaty-making powers to create a Framework Convention on (un)Clean Air in the near future.

Picture 1. Briefing session for delegates at the Geneva Graduate Institute.

Thereafter, delegates worked on issues related to nutrition and noncommunicable diseases (NCDs) and had the chance to interact with an expert panel, including Ms. Jess Beagley, Policy Research Manager at the NCD Alliance, Mr. Jack Fisher, past Executive Director of NCD Free, and Dr. Francesco Branca, WHO Director of the Department Nutrition for Health and Development. Delegates discussed the third High-level Meeting of the General Assembly on the Prevention and Control of NCDs, how food policy is different than policy on other NCD risk factors, and how to examine conflicts of interest when engaging with the private sector in health interventions.

Lastly, Ms. Diah Satyani Saminarsih, WHO Advisor on Gender and Youth, presented the new WHO vision to be adopted through the 13th General Programme of Work (GPW13), under the leadership of Dr. Tedros Adhanom, WHO Director-General.

Additionally, the WHO organized the first-time event, "Walk the Talk", as a walk/run activity around Geneva to promote healthy lifestyles and physical activity. PreWHA delegates participated in the event, by walking or running the 8.6km distance, while some finished the race hand in hand with Haile Gebrselassie, multiple Olympic and World Champion long distance runner and world record holder.

Lastly, all delegates attended the briefing for delegates to the WHA organized by the Geneva Graduate Institute. After

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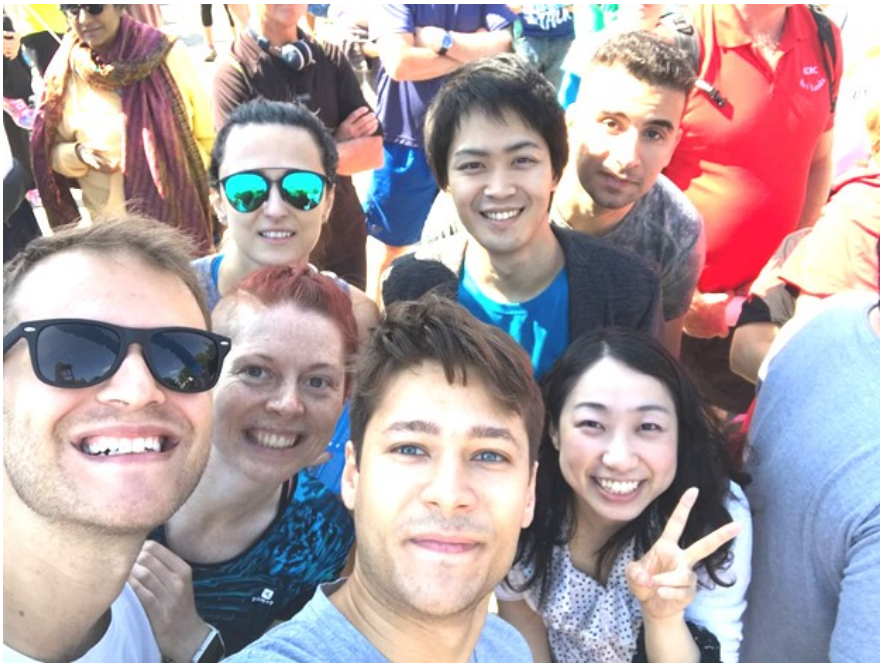
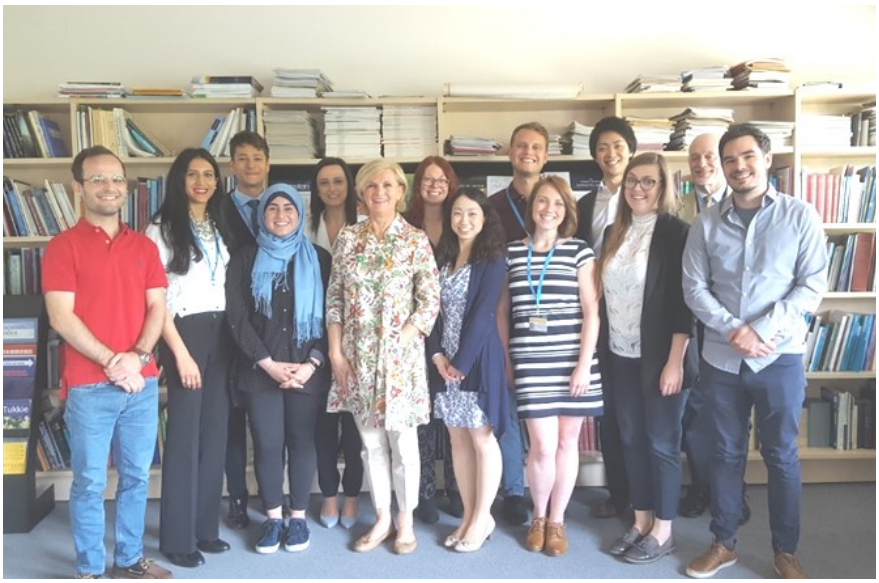
learning about the GPW13 and WHA procedural rules, they gained insight on four important WHO topics, such as the polio transition, health emergencies, pandemic influenza preparedness plan, and nutrition.

While the preWHA agenda has varied from those of previous years, the JDN's participation in external events organized by the WHO has helped foster engagement and communication with other groups with similar interests.



Picture 2. JDN delegation ready to participate in the "Walk the Talk: The Health for All Challenge".

Picture 3. Alice McGushin, JDN delegate to WHA, crossed the 8.6km run finish line with Haile Gebrselassie, multiple Olympic and World Champion long distance runner and world record holder.



Picture 4. JDN session on Environmental Health with Dr. Maria Neira at WMA Offices.

JDN at the 2018 Spring Meeting of the European Junior Doctors Permanent Working Group

Chukwuma Oraegbunam, MBBS, MWACP*

The Junior Doctors Network (JDN) was invited to the 2018 Spring meeting of the European Junior Doctors Permanent Working Group (EJD), which was held at the "Andrija Štampar" School of Public Health at the University of Zagreb in Zagreb, Croatia, from May 4-5, 2018. I attended this meeting on behalf of the JDN membership.

All meeting hosts, including Dr. Kitty Mohan, the EJD President, and the Management team, developed a high-quality program agenda and positive networking environment for conference participants. Participants included members of the European Junior Doctors Associations and other invited guests. The opening ceremony addressed "Employment and Free Mobility", and was attended by top Croatian government officials and the Croatian Medical Association leadership. Interactive panel discussions and meeting sessions provided opportunities for participants to elaborate on this topic. Coordinated social events incorporated formal and informal networking dinners as well as a collective walk around the ancient City of Zagreb that we experienced with a rain shower.

In addition to my participation and contribution to different panels and sessions, I had the opportunity to introduce the objectives and mission of the JDN, describe our structure within the World Medical Association (WMA), and mention our past and current professional activities. In fostering our existing collaborations, I stressed the commitment of the JDN in partnering with the EJD in areas of mutual interest. For example, as one mutual interest is the Working Group on Junior Doctors' working conditions, Dr. Kitty Mohan joined the JDN Working Group on Working Conditions.

As JDN members, we believe that the collaboration with the EJD is one that should be nurtured and encourage future relationships with other regional Junior Doctors Organizations.

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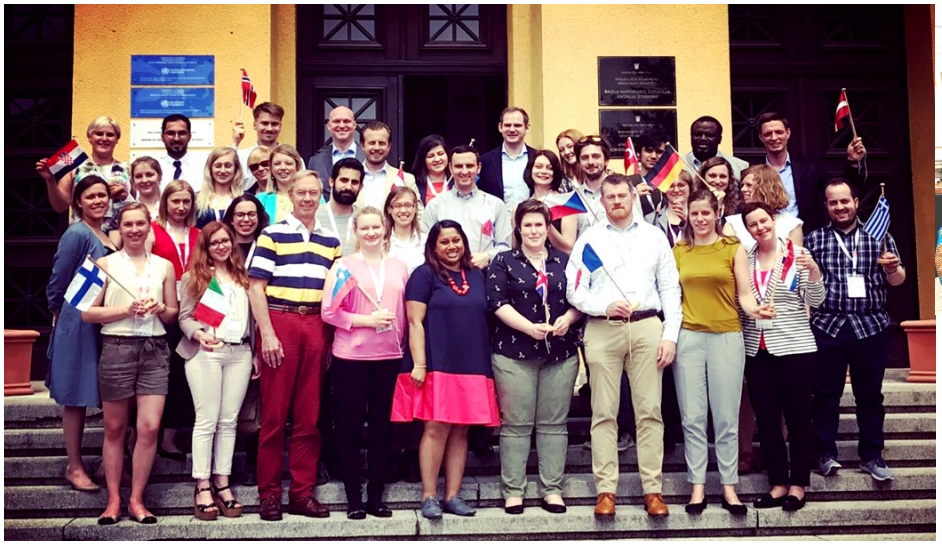
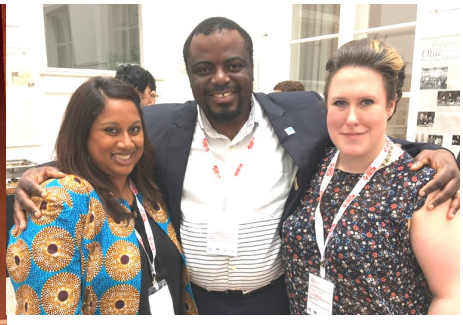


Picture 1. Cross section of delegates to the 2018 EJD Spring Meeting.



Picture 2. (Left to Right) Dr. Kitty Mohan, EJD President; Dr. Chukwuma Oraegbunam, JDN Deputy Chair; Dr. Ellen McCourt, former UK Junior Doctors Committee Chair.

Global surgery: a new and emerging field in global health?

Manon Pigeolet, MD, MA(candidate)*1, Sara A.M. Alam Eldeen, MD*2, Antonio R. Reyes Monasterio, MD*3, Godfrey Sama Philipo, MD, MPH*4, Irene Schirripa, MD(candidate)*5, Jef Van den Eynde, MD (candidate)*6

"Global Surgery", what's in a name

Global Surgery was described by The Lancet Commission on Global Surgery (LCoGS) in 2015 as "a field that aims to improve health and health equity for all who are affected by surgical conditions or have a need for surgical care."(1) In 1980, Dr. Halfdan Mahler, then the acting director-general of the World Health Organization (WHO), described adequate surgical care as a key factor in achieving health care for all.(2) However, outbreaks of communicable diseases like the human immunodeficiency virus (HIV) and tuberculosis (TB) overshadowed the need for affordable surgical care, and consequently, global surgery had been neglected until the start of the 21st century.(3)

Currently, an estimated 5 billion people have no access to timely and adequate surgical care, and this is responsible for the deaths of 17 million people annually predominantly in low- and middle-income countries (LMICs) and the poorer wealth quintiles in all countries.(1) Each year, 401 million Disease Adjusted Life Years (DALYs) are lost due to inadequate surgical care, compared to 214 million DALYs lost in the same time period for HIV, TB, and malaria combined.(4) DALY is a measure of population health, and it calculates the relative impact of a certain disease category on the overall burden of disease for a population. It combines the Years of Life Lost (fatal burden of disease) with the Years Lost to Disability (non-fatal burden of disease), and is the preferred metric to analyse and compare the burden of diseases.(4) The global health community is starting to realise that we need to address this alarming situation.(1,4) Traditionally, week-long surgical missions and provision of money used to be the answer, but now there is an appreciation that a broader focus and a need for a different approach are necessary.(3) Currently, five key players are shaping this changed approach: the LCoGS, the World Bank, the WHO, Harvard Medical School (HMS) and the G4 Alliance, which is the Global Alliance for Surgical, Obstetric, Trauma, and Anaesthesia Care.(1,5–8)

The World Bank challenged the LCoGS in 2014 to produce consensus-based indicators to evaluate progress in surgical care delivery in LMIC.(9) The LCoGS responded in 2015 by producing a report, *Global Surgery 2030*, in which they outlined an approach through investigation, innovation, and implementation.(1) To monitor the universal access to safe, affordable surgical, anaesthesia, and obstetric care (SAO) care, the LCoGS used six core-indicators: access to timely essential surgery; specialist surgical workforce density; surgical volume; perioperative mortality rate; protection against impoverishing expenditure; and protection against catastrophic expenditure.(1)

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However, to implement this new approach, the LCoGS was in dire need of other partners. The World Bank started collaborating with the global surgery systems and included the six indicators in their new World Development Indicators dataset in 2016.(6,9) Additionally, they included global surgery in their latest Disease Control Priorities publication in 2015, attributing a whole volume to the topic.(4) Around the same time, HMS started an initiative, the Program in Global Surgery and Social Change, to strengthen global surgical systems through advocacy, research, and implementation science based on the LCoGS' six indicators.(5) The WHO has been involved in the field of global surgery since

2005, through their Global Initiative for Emergency and Essential Surgical Care (GIEESC).(7) One of their main achievements is the development of the Surgical Safety Checklist, which aims to decrease errors and adverse events, and increase teamwork and communication in surgery.(4,7) In light of the negotiations of the new set of Sustainable Development Goals, in May 2015, the WHO underscored the idea that universal health coverage must include SAO care, and reemphasized this view in their 13th general program of work 2019-2023, adopted at the 71st World Health Assembly in May 2018.(7,10) And last but not least, to advocate for the neglected surgical patient, a fifth party, the G4 Alliance was formed in 2014: a coalition of more than 85 of the world's leading SAO care organisations. They aim to provide a united call for access to safe, essential, and timely SAO care.(8) However, even if the problem has been clearly outlined by the LCoGS, important strategic challenges have emerged in setting global surgery as a political priority both at the local and international levels. The global surgery community is a very fragmented one, with its first challenge being governance.(11) There is still no consensus about how guiding institutions can facilitate collective actions, and more importantly which institutions should take on this leading role.(11) This lack of guidance has led to a lack of process on defining shared solutions on agreed problems; that is, agreement on the fact that surgical care is neglected but there is disagreement on what level of essential surgical care should be provided.(11) Lastly, one of the biggest challenges is that public opinion tends to misinterpret the cost-effectiveness of surgery, with many thinking it is a luxury when, instead, it is a very cost-effective tool to fight non-communicable diseases, maternal and child health issues, and injuries among others.(11–13)

We need to overcome these challenges to ensure collective action for equal access to surgical care around the world.

Picture 1. Surgical Interns at AIC Kijabe Hospital in Kenya.

As indicated above, global surgery is an evolving discipline acting on the frontier between clinical surgery, public health, and global politics. Many of the challenges ahead can only be tackled if representatives from these different fields unite and work together in an interdisciplinary manner on the local, national, regional, and international levels.

InciSioN: uniting the future global surgeons, anaesthesiologists and obstetricians of the world

With growing attention for global surgical and anaesthesia care, and with many medical curricula lacking attention for global surgery and anaesthesia care, the need for an association where global surgery enthusiasts could discuss and take action together became a pressing issue. Out of this need, and under the wings of the International Federation of Medical Students' Associations, the International Student Surgical Network (InciSioN) was born as an informal group in 2014 and became a fully established independent organization in 2016. InciSioN is an international non-profit organisation, comprised of medical students, residents, and young doctors from around the world, who work together to educate on, advocate for, and perform research in global surgery. InciSioN consists of an international core team charged with overseeing the projects and activities done under the InciSioN flag globally, and an international Board of Trustees, guiding the

work of the core team. The actual work on the ground is done by 2,800 members globally, working in over 20 national working groups spread all over the world. For their advocacy efforts, they have often collaborated with the G4 Alliance, and for their research efforts, previous collaborations included the GlobalSurg 1 and 2 (14–21) research initiatives, and reporting about basic surgical indicators worldwide.(22) A multitude of events have been organised by InciSioN, including trainings and conferences, with their latest event being the International Global Surgery Symposium (IGSS2018) this May in Leuven, Belgium.(23)

IGSS2018 at a glance

IGSS2018 brought together over 200 global surgery enthusiasts from over 45 different countries representing all different continents.(24) Another impressive achievement, and unfortunately still a rarity at global surgery conferences, was the creation of travel scholarships by IGSS through which they were able to welcome 11 international scholars coming from various LMICs. Each and every one of those 11 scholars are true leaders in the field of global surgery and made IGSS2018 truly global, creating opportunities to discuss, exchange, and interact between the attendees. The conference programme had a wide range of speakers, including Dr. Walt Johnson (Director of GIEESC at the WHO), Dr. Kathleen Casey (from the G4 Alliance), and a number of practicing SOA specialists from around the world. The conference was energetic and motivated the attendees to work towards improving surgical and anaesthesia care globally. Below is a short overview of the topics discussed.

- Trauma is making its way up in the burden of disease statistics, with a projection of 7 million deaths worldwide due to injuries by 2030.(25) This will be a clear challenge to come for LMICs and its SAO providers. The lack of human resources for health to address this issue was emphasized by Dr. Basem Higazy from the WHO, who stressed the dire need of trained health personnel, in particular SAO providers in LMICs.

- Various speakers touched upon the need for adequate surgical training in LMICs. The newly established surgical training programme by the College of Surgeons of East, Central and Southern Africa in 15 African countries remains one of the most important achievements in this field.

- Technology is also finding its way into surgery in LMICs. For example, Lifebox has developed a super-resistant pulse-oximeter that is usable for both adult and pediatric patients in low-resource settings. It has been developed in collaboration with WHO and adapted to local needs in LMIC. It is resistant to power outages up to 14 hours and unstable electric current, water-resistant and thanks to its protective case also resistant to falls from heights.(26) Peer-support programmes where interventions can be followed and discussed live via social media are finding their way into the operating room. Inexpensive virtual reality headsets, like Google Cardboard or open source programs such as Touch Surgery, create local possibilities to improve the surgical skills of residents in LMICs.

- However, there is no safe surgery without safe anaesthesia. The World Federation of Societies of Anesthesiologists and Lifebox talked about the critical need for anaesthesia providers worldwide. LMICs have a low anaesthesia provider rate (this includes general physicians providing anaesthesia) ranging between 0.19 and 6.89 per 100,000 population, compared to an average of 17.96 for the high-income countries.(27) Or when put in a more general context of SAO-provider rate, low-income countries achieve an average of 0.7 and lower-middle-income countries an average of 5.5 both per 100.000 population.(28) These numbers remain far below the LCoGS Global Surgery 2030 objective of 20 SAO-prividers per 100.000, which aims to strengthen the specialist surgical workforce density. The essential role of anaesthesia in the provision of surgical care is not always well understood by decision makers, and as a consequence, development of anaesthesia care has often been given a lower priority than the development of surgery per se.(29) Lack of

infrastructure and equipment for anaesthesia provision in LMICs worsens this situation.

- The conference concluded by briefly touching upon the topic of women in global surgery. Gender is increasingly being discussed during conversations about human resources for health. Female health workers tend to compensate for the shortcomings of many healthcare systems around the world, at times at the expense of their own health and well-being.(30) Many of these female health care providers do this in an informal setting, where they are poorly supported and poorly paid or not paid at all.(31) When looking specifically at women in surgery, the LCoGS, estimates there are only around three females surgeons for every one million people in low income countries. (32)

IGSS2018 a formula for success?

Congresses such as IGSS2018 have great potential to be a driving force for global surgery. As with any movement, having some organisations and activities at the basis is essential to foster action and to provide a means for the diffusion of ideas.

IGSS2018 emphasised the inclusion of participants regardless of gender, ethnicity, professional titles, or country of work. A diverse range of speakers represented the diverse range of countries and realities that the topic covers. The atmosphere in which IGSS2018 took place was one of equity regardless of gender, race, or professional titles. A funding program was even arranged to cover the traveling costs of the 11 international scholars. Speakers came from all over the world, so that the countries and realities that we were talking about were actually represented in the symposium itself. IGSS2018 was a home for alike thinking people to share their experiences, learn from each other's stories, and to motivate each other to take on new endeavours. Specialists, residents, and students all had the opportunity to build new contacts, drawing the blueprints for future collaborations. With confidence, we can say that IGSS has given rise to new projects: some participants have created new InciSioN National Working Groups after returning back to their home country, others have been inspired to do research in the field of global surgery, and people already involved in the field saw the influence of their work confirmed.

We believe that IGSS2018 provided an excellent example for many more symposia to come: the combination of an international audience, diverse and enthusiastic speakers, and a shared passion. The general thought permeating the whole congress was that global surgery is an important, recently revived, rapidly-evolving, and exciting field that more than deserves greater attention, a thought to which we certainly subscribe to.

Conclusion

Global surgical debt and access to safe surgery is an aspect that not only concerns the doctors of LMICs, but also surgeons and doctors in high-income countries and doctors advising health policies around the world. We are hopeful for a time when the geographical, political, or socio-economic circumstance of a person will not affect access to safe, essential, and timely surgical care. We are a generation that has the responsibility to do what others could not do in past decades. We live in a time where the platform for global surgery has been established in the global health arena, and we have an abundance of opportunities at hand to create a world where surgical care will be truly accessible for all.

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A Word from the Chair

Caline S. Mattar, MD

Chair, Junior Doctors Network,
World Medical Association

Dear colleagues from around the world,

More than half way through this term, it is time for us to reflect once more on the achievements our Network has accomplished, and to set sight on the future.

We have continued to grow, and now the JDN comprises members from over 70 countries and counting. Standardization of our processes, reporting and terms of reference has been completed. We have a newly revamped newsletter, whose quality reflects the enthusiasm, professionalism and hard work of a dedicated publications and management teams. Our Strategic Plan, through a lengthy and comprehensive consultative process, is now complete and ready for approval. We have worked to strengthen our collaboration with Regional Platforms. We are proud of our engagement with the European Junior Doctors Permanent Working Group, and are looking forward towards building bridges with other regions around the world.

On the external front, we have continued our engagement on Climate Change, and Antimicrobial Resistance, among others, and we have strengthened our position as a Global Actor advocating for Human Resources for Health, as well as the role of physicians and Junior Doctors in the provision of Primary Care services. We are now a full member of the World Federation for Medical Education's Council, and we look forward to further contributions to various Global advocacy issues.

The Junior Doctors Network this year celebrated its 7th anniversary. This adventure started in 2010 in Vancouver, and has continued to grow exponentially. Every day, more young doctors are joining the JDN to connect with colleagues and work towards matters of interest to them locally and nationally, but also current issues in the global health realm.

Once more, I would like us to remember the mission we set for our network to: "Empower young physicians to work together towards a healthier world through advocacy, education and international collaboration".

I would like to thank the management team, and each and every one of you who has spent time and effort for the advancement on our network this year. This tremendous work would not have been possible without your dedication.

Please remember that the JDN team is always open to your suggestions and feedback,

Looking forward to meeting many of you in Iceland,

Opportunities to talk to doctors around the world across generations

Kazuhiro Abe, MD
Publications Director, Junior Doctors Network,
World Medical Association

Dear JDN colleagues,

I am pleased to present the 14th issue of the Junior Doctors Network (JDN) Newsletter to junior doctors around the world.

The 13th issue of the JDN Newsletter was published by the JDN in April 2018. For the first time in two years, it was also released on the World Medical Association (WMA) website and mailing list. We were very pleased that our dedicated efforts to promote this high-quality scientific product were acknowledged. I believe that the JDN newsletter should empower critical analysis and reflection on essential global health topics among junior doctors around the world. In addition, I expect that the JDN Newsletter will be a catalyst to encourage communication between WMA and JDN members as well as between national medical associations and junior doctors in each country across generations.

This 14th issue includes thought-provoking articles prepared by junior doctors about their community health initiatives and experiences. I hope that these articles will add value and insight for all readers.

In publishing this issue, I sincerely express my appreciation for the outstanding efforts of all editors of the JDN publications team, officials of the JDN management team, and leaders of the WMA. Please enjoy the articles published in this 14th issue.

Editors in the Publications Team 2017-2018

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* The JDN Publications Team requests volunteers to assist with editing article submissions and checking English grammar. If you are interested in this opportunity, please feel free to email our team at jdn-publications@googlegroups.com.

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The Junior Doctors Network (JDN) is made up of junior doctors who independently join the World Medical Association (WMA) as Associate Members, although many are also representatives of their respective National Medical Associations.

Its mission is:
"Empowering young physicians to work together towards a healthier world through advocacy, education and international collaboration".

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