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empowering young physicians to work together towards a healthier world through advocacy, education, and international collaboration

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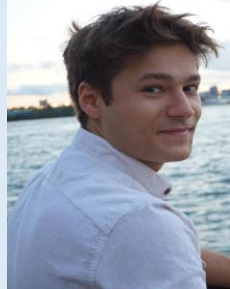
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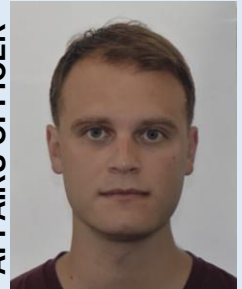
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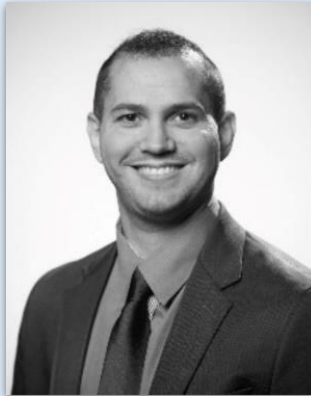


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Words from the Chair

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Dear colleagues from around the world,

Over the past eight years, we have seen a growing interest in the Junior Doctors Network (JDN) from colleagues all over the world. This is a reflection of the progress that we have made over the years, ensuring that the JDN remains an avenue for young doctors to gain the capacity to achieve their professional goals in medicine and public health leadership.

We are appreciative for the World Medical Association (WMA) leadership, which continues to support the JDN activities, including our attendance and ability to represent the WMA at various high-level international meetings. As the JDN membership continues to grow, JDN members are able to become more involved in the decisions that shape our future as well as the health and well-being of our patients.

Internally, we continue striving to utilize approaches that can increase JDN members' participation in JDN meetings and activities. We now have an operational 'Terms of Reference' and 'Strategic Plan', which aim to help our future generations to understand where we have come from and the direction we are headed. We also regularly track the task completion of JDN officers and work groups in order to record improvements as well as encountered challenges.

As our meetings have had increased attendance and participation, we are gradually implementing changes that enhance JDN member involvement. In efforts to strengthen our capacity as the next generation of physician leaders, we have adopted the theme, *Gender Equity in Medical Leadership*, for our JDN meeting (October 2019) in Tbilisi, Georgia.

Finally, as we wind up the 2018/2019 term, our progress and direction reflect our stated mission: *"Empowering young physicians to work towards a healthier world through advocacy, education, and international collaboration"*. Increased collaboration and feedback from all JDN members will allow us to maintain and improve on our past and present accomplishments, which will dually benefit our future medical leadership and growing patient populations across the world. It has been an amazing period of my life chairing the JDN management team, enjoying the support of the management team and general membership. I most sincerely appreciate our JDN community and hope that our paths continue to cross in the future. I look forward to seeing many of you in Tbilisi.

Words from the Communications Director

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Dear colleagues,

Once more, it is my pleasure to welcome you to the 16th issue of the *Junior Doctors Network (JDN) Newsletter*. This newsletter serves as an editorial trademark while we work together towards a healthier world through advocacy, education, and international collaboration.

This feature has continued its mission and vision of this totem, which aims to indoctrinate, inculcate, and fascinate junior doctors worldwide on contemporary issues affecting them. This effort can encourage junior doctors to share their experiences, become empowered, and find opportunities to better themselves and their communities via sound apprehension and grasp of these issues.

My profound respect goes to our wonderful Publications Team, ably led by Dr Helena Chapman, for their invaluable role in maintaining the high-quality standards of the *JDN Newsletter*. I am always delighted and proud of what the Publications Team has orchestrated on the pages that follow.

I hope that these articles will stimulate informed debate and a lively exchange of ideas. We look forward to receiving your feedback on this issue. We also encourage your input on topics to be covered in future issues, especially those local and global subjects that directly impact the work of junior doctors across the world.

Stay with us, enjoy the read, and expect more!

Words from the Publications Director

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Dear JDN colleagues,

On behalf of the Publications Team (2018–2019) of the Junior Doctors Network (JDN), we are honored to present and share the 16th issue of the *JDN Newsletter* to junior doctors across the world.

The 15th issue of the *JDN Newsletter*, published in April 2019, included contributions from junior doctors from Belgium, Canada, Denmark, Dominican Republic, Greece, India, Japan, Malaysia, New Zealand, Nigeria, Singapore, United Kingdom, and the United States. These articles offered summaries of international health conferences, JDN activities, and other reports and updates on important global health subjects.

Likewise, this 16th issue of the *JDN Newsletter* includes additional articles from junior doctors from Belgium, Democratic Republic of Congo, Dominican Republic, India, Japan, Kenya, Korea, Myanmar, Nepal, Nigeria, South Africa, United Kingdom, the United States, and Venezuela. These articles incorporated updates on JDN activities, summaries of international health conferences, narrative pieces on scientific perspectives, and reflections on community health topics. Notably, a special series on medical ethics was incorporated into this issue.

As an international platform for the global community of junior doctors, the *JDN Newsletter* provides an avenue for junior doctors to share their expertise and reflections about trending topics in clinical care, research, and community practice. Their dedication to scientific communication continues to inspire other junior doctors and facilitate communication between World Medical Association (WMA) and JDN members. Through this network, junior doctors can learn about emerging global health challenges and advocate for transdisciplinary collaborations to safeguard population health for local, national, and regional communities.

We recognize the dedicated efforts of all editors of the JDN Publications Team 2018–2019 as we completed the editorial tasks for this 16th issue. We also acknowledge the continued support of the JDN management team and WMA leadership for this indispensable resource for junior doctors across the world. We hope that you enjoy reading the articles in this 16th issue!

Communication and the Junior Doctor

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In the United Kingdom, the term 'junior doctor' applies to medical practitioners, ranging from newly qualified doctors to those who are completing specialty programs. This large cohort makes up more than 50% of hospital doctors. As junior doctors, we have the unique opportunity to develop rapport with patients and their families, especially during distressing situations. Patients may find us more approachable and readily available, compared to more senior members of the clinical team. Although studies have shown that levels of empathy are highest among medical students and junior doctors, these levels decline steadily as doctors progress in training and experience, a term described as 'ethical erosion' (1). Burnout, fatigue, high patient load, time pressures, and lack of senior support are factors that decrease empathy and lead to inadequate communication skills. This may result in low patient satisfaction, breakdown of trust, inadequate adherence, and formal patient complaints (1,2).

Junior doctors are well-positioned to develop cordial relationships with patients, encouraging them to choose healthy lifestyle behaviours.

As junior doctors, we are usually the first clinical team member to evaluate the patient. We take the relevant medical history, conduct a physical examination, formulate preliminary diagnoses, and describe the appropriate management plan. Furthermore, breaking bad news is also a frequent responsibility of junior doctors. Hence, strong communication skills are essential to delivering effective healthcare services.

Since the bedrock of the doctor-patient relationship is communication, failure in this skill may result in unintended consequences. Poor communication skills in medical history taking may lead to misdiagnosis, while miscommunication in conducting intimate physical examinations could lead to an accusation of sexual abuse. Studies have shown that inappropriate communication remains a top reason why patients complain about the healthcare services that they seek and receive (2).

The earliest example where I valued good doctor-patient communication and rapport occurred during my internship year on the paediatric ward of a teaching hospital in Lagos, Nigeria. A male child was diagnosed with a kidney tumour that required urgent chemotherapy. As the most junior doctor on the team, my responsibility included explaining

to his mother the severity of the medical condition, encouraging treatment adherence, and highlighting possible side effects of chemotherapy. We developed strong rapport through an open communication channel, where I kept her informed about her son's response to chemotherapy, any arising complications, and respective clinical management. She highlighted that this communication differed to her previous experiences in the paternalist healthcare system. Unfortunately, her son passed away suddenly overnight from treatment complications. To my surprise and initial trepidation, I received an unexpected telephone call from his mother, verbally thanking our team for the high-quality healthcare services that her son received during his hospitalization.

As a doctor now practicing in the United Kingdom, a different sociocultural environment from my internship in Nigeria, communication is a recognized aspect of clinical practice and education, particularly for junior doctors. While some doctors are naturally skilled communicators and effortlessly develop good patient-doctor relationships, formal training on effective communication skills is essential to enable all junior doctors to adequately conduct their roles. This can be done through advanced communication courses, resources, and workshops, which empower and better prepare junior doctors to have complex and difficult discussions about resuscitation (e.g., Do Not Attempt Resuscitation Orders), advanced care plans, palliative care, and end-of-life discussions. Communication skills, rapport, and genuine displays of empathy can be improved through formal training, regular practice, feedback, and mentorship within a structured framework. This allows junior doctors to identify areas of strengths and weaknesses, and work towards self-improvement to deliver better patient care and healthcare experience (3).

Communication challenges differ across healthcare settings. In low- and middle-income countries (LMICs), junior doctors may be confronted with difficult discussions relating to distrust of Western medicine, which may lead to reduced compliance to treatment plans and poor health-seeking behaviors. Difficult communication may also centre on health promotion and cessation of harmful traditional practices.

Formal communication training for junior doctors focused on sensitive clinical topics, is essential for the delivery of patient-centred healthcare, which can improve treatment adherence and overall patient satisfaction and well-being. This is an area of development, especially among doctors from LMICs, if global health inequalities are to be bridged.

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The Physicians' Five Keys to Making Lasting Impact

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Globally, medical doctors complete years of classroom education and clinical training, gaining expertise in the basic and clinical sciences for their clinical and community practice. They are trained to understand disease pathophysiology, complete the diagnostic work-up, and provide the appropriate treatment plan for patients. As the main drivers of biomedical research, their contribution to medical sciences can improve population health and lead to potential scientific discoveries.

However, many doctors have underutilized the great potentials of our creative and intellectual capacity. Some have continued to set goals that are based on financial incentives, rather than the patient's satisfaction and self-actualization. The desire to accumulate financial wealth in the medical field does not lead to lasting impact or fulfillment in life. Fulfillment is achieved by sharing our lives with others (e.g., leadership or mentorship roles) and rendering beneficial services to mankind, in order to reach the goals of self-actualization.

**“We know what we are, but not what we may be”
- William Shakespeare**

A strong desire to do well is a major key to making a lasting impact, which culminates in a positive permanent influence and an indelible mark on colleagues and humanity. This expectation should be placed upon every doctor, which can be achieved if the desire is appropriately stimulated. To encourage doctors to demonstrate leadership, collaborate with colleagues, and generate scientific knowledge for the medical discipline, they must follow five key elements to make a lasting impact. These elements include passion, memory, discipline with adaptability, favor, and courage.

PASSION

To make a significant impact, doctors must exhibit strong emotions that focus on a dream and determination to find a solution that benefits an individual or group of individuals. Without this quality, there would be no will to persevere or reach any significant discovery. Passion is the key to impact and can sustain enthusiasm despite temporary failures. If doctors are passionate, the obstacles will seem smaller.

MEMORY

Memory, a process of remembering the past, is the cornerstone of training and learning. Doctors experience life in three phases: past (memories), present, and future (action). They must examine the past in order to understand how to conduct present affairs as well as use the present to learn how to create a more enlightening future. Hence, past experiences benefit the present and help in proper planning for the future.

DISCIPLINE WITH ADAPTABILITY

Discipline is the act of training where individuals adhere to specific codes of conduct, and penalties exist for individuals who do not comply. The need to adjust and reflect on personal beliefs (*ethos*) incorporates the concept of adaptability. Together, these elements highlight that learning remains above irrational, emotional or sentimental behaviors. As doctors must attain a high sense of discipline with adaptability, they can focus on goal-setting and be intentional and productive with assigned tasks, which can lead to achieving established goals.

FAVOR

Favor is believed to incorporate attributes of divinity, defined as a belief that external forces control and direct our activities and efforts as humans. To experience favor, doctors must exhibit emotional stability and a positive mental attitude. Favor is an advantage in every position of life, from a subordinate role to every level of authority. Humility, gratitude, and being at the right place at the right time complement favor toward making a lasting impact.

COURAGE

No pioneer has been recognized by traveling on familiar paths. Courage means taking action and moving forward, despite the presence of internal or external limitations. Internal limitations include doubt, shyness, fear, low self-esteem, little or no education, and other negative self-attributes. External limitations are issues emanating from outside sources, which include ridicule, opposition, and discouragement from friends and associates. Courage is the quality of mind or spirit that will prepare doctors to face the aforementioned limitations without fear. Without courage, they cannot make a difference or initiate the appropriate conversations that lead to lasting impact.

As junior doctors, how do we want to be defined? Are we motivated to make a positive, lasting impact on society? Through patience and sacrifice, these five keys will help doctors identify small observations about reality, demonstrate excitement and motivation through beneficial pursuits, and exhibit perseverance to explore scientific discoveries. They surely will guarantee that a lasting impact and an indelible mark are just around the corner.

By dedicating our time, energy, and resources to helping others, junior doctors can create a deep sense of personal fulfillment and make a positive impact on those around us.

Acknowledgments: I would like to thank Dr Michael Obaro, Senior Lecturer and Consultant in the Department of Pharmacology and Therapeutics at the University College Hospital Ibadan, for his mentorship during the preparation of this manuscript.

Health Inequities: Challenges for Doctors in Low- and Middle-Income Countries

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Variations in health and health care are evident worldwide, but low household incomes and the lack of social health insurance in low- and middle-income countries are alarming situations (1). In 1941, Julian Huxler was the first to use the slogan “Health for All” in the *Picture Post*, a weekly *British Post* magazine. He called for “a healthy diet for all, everyone to have a chance to reach known health standards, public health as a positive service, health put on a family basis, a real family and population policy...” (1). In 1948, many of these principles were included in the National Health Service policy in the United Kingdom. Later in 1978, the World Health Organization (WHO)’s initiative regarding “Health for All”, encouraging each country to formulate national policies and strategies for health, was emphasized at the global conference on Primary Health Care in Almaty, Kazakhstan.

The notion of “Health for All” is still far from being achieved in the world, particularly in low-income countries. Many patients with preventable or treatable conditions cannot easily access health care services due to geographic distance or financial limitations. Sadly, some patients pass away right before their doctors’ eyes, with little that can be done by medical and nursing teams. As a junior doctor, I have cared for children with chronic diseases such as diabetes and sickle cell anemia in clinical practice, where our health center did not have insulin or hydroxy-urea management, respectively. Other patients required chemotherapy or surgical procedures, such as surgical repair of congenital cardiac defects, but were unable to afford these necessary treatment modalities.

As medical graduates, we took the Hippocratic Oath (2), which serves as the pillar of medical practice, where doctors accept their professional devotion to patient care.

“I SOLEMNLY PLEDGE to consecrate my life to the service of humanity... THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration... I WILL MAINTAIN the utmost respect for human life...”

However, doctors in low-income countries face significant limitations in providing clinical care, including inadequate medical and pharmaceutical supplies. Also, widespread poverty challenges patients’ ability to care for themselves and their families.

Where is the actual problem? A political or economic system like capitalism? Inadequate resource management in Africa? Although a controversial topic, some economists believe that capitalism is the only economic system viable for the foreseeable future, because there are no workable alternatives (3). As free markets and consumer choices have led to competition and creativity, great wealth has been generated in these societies. As such, more resources have become available to invest in all sectors, particularly in the health sector.

However, there are still many ethical questions unresolved with capitalism: Are private property and free markets morally acceptable? Does great wealth enable groups and individuals to buy political power and influence? Is capitalism compatible with factors that we value, such as family, community, and friendship? All these values are highly important for equitable global resource sharing, which can lead to improved health care access for all. Moreover, capitalist societies still struggle with unresolved issues of exclusion, violence, political power and influence, environmental destruction, and poverty (3).

Although global poverty has been clearly associated with poor health, we still observe a significant gap between persons associated with high and low socio-economic levels. Hence, by promoting health equity, the intention is to sensitize the capitalist class to reconsider the concept of “profit” in order to facilitate how low-income communities can increase their household incomes. The low household incomes limit access to health services and constitute one of the main factors contributing significantly to malnutrition of children under five years (4). Malnutrition affects the intellectual development of children, which then reduces their future productivity in society.

As health leaders prepare the agenda of the high-level meeting on Universal Health Coverage in September 2019, junior doctors’ voices should be heard.

Junior doctors expect concrete actions from the capitalist class – our national and international leaders – including resource allocation to build sustainable primary health care and social health insurance. With more than 30 years of HIV/AIDS global initiatives, we have observed the impressive results of participating stakeholders and billions of dollars mobilized. Hence, real scientific progress requires the same mobilization in order to assure universal health coverage. This challenge will be the responsibility for our generation.

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Water in a Landlocked Country

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Nepal has a population of 29.3 million people. An estimated 42 percent of the population lives below the poverty line, and the majority of its citizens lacks sanitary water supply. Both rural and urban populations of Nepal face problems of water scarcity and pollution. While rural populations walk hours to gain access to natural sources of water, urban populations rely on commercial water dealers. There are over 250 water bottling factories in the Kathmandu Valley alone. Over-extraction of groundwater by unlicensed water sellers prevents the government from using these sources to augment the city supply (1).

Water pollution in Nepal is due to domestic, industrial, and untreated sewage from highly populated communities. Domestic neighborhood and district water supplies, such as wells, tanks, and reservoirs, may be contaminated by poorly designed or maintained sewage disposal systems (2). When toxic water seeps through the ground, it pollutes the underground water source. With the recent earthquake, continuous flooding, and landslides, increasing population size has contributed more to this problem (**Photo 1**).



Photo 1. Sewage and household waste dumped in the river of the Kathmandu Valley.

Credit: Nepalireporter, Binit Aryal.

In 2011, the Nepal Demographic and Health Survey reported findings that the prevalence of diarrhea in children under five years of Nepal was 14% (3). According to the Asian Development Bank (ADB), 21% of households in the Kathmandu Valley did not have access to a piped-water supply in 2009 (4). Due to the exponential rise in population and failure of national drinking water projects, this rate increased to 34% in 2015 (2).

Households that had access to piped water, received this supply for fewer than six hours per week (4).

***Escherichia coli* contamination of drinking water is one of the biggest public health hazards in Nepal.**

One study reported that *E. coli* was detected in 61% of the groundwater samples (5). It showed that consumers served by an untreated groundwater supply were at risk of enteric diseases. A high risk of diarrhea from groundwater was estimated in a risk assessment study conducted in the Kathmandu Valley, and the implementation of risk reduction programs was recommended (6).

Apart from drinking water, causes of *E. coli* infection that remain less explored are bathing and swimming, which contribute to the transmission of diarrheal diseases. People accidentally ingest water during swimming and bathing, and children ingest higher amounts than adults (6). Bathers in polluted water sources are exposed to an increased risk of gastrointestinal infections (7). These outcomes have alerted the public about the need for researching the role of bathing in disease transmission, focusing on young children.

As a country with high morbidity and mortality rates due to the lack of medical care during diarrheal illness, sanitary water supply remains a mainstay of a solution to this public health hazard. Collaborations between government and stakeholders are necessary for tackling this problem. Water in this landlocked country needs to be purified to open the gates for improved population health outcomes.

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Kenya's Path to Universal Health Coverage: Seizing the Political Commitment

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On December 12, 2017, His Excellency Uhuru Kenyatta, Kenya's fourth president, announced the '*Big Four*' priority areas that would set Kenya on an economic growth trajectory towards achieving Vision 2030 and the global Sustainable Development Goals (SDGs). The

'*Big Four*' agenda encompasses food security, affordable housing, manufacturing, and universal health coverage (UHC) for all Kenyans by 2022 (1). While the '*Big Four*' priority areas are all critical in transforming Kenya into a rapidly growing, middle-income nation by the year 2030, UHC has gained significant traction and popularity. There seems to be more urgency in achieving essential health care for all, as good health ensures that the population remains productive, for nations to reap greater economic and social benefits.

The World Health Organization defines UHC as ensuring that all people and communities have access to needed health services of sufficient quality, while guaranteeing that the use of these services does not expose the user to financial hardship (2). UHC seeks to promote equity by providing health for all and is entrenched in the third SDG.

Kenya, a lower-middle income country, has embarked on the path to UHC with considerable political goodwill. Looking at the history of health reforms in the country and many other Sub-Saharan African countries, political clamor and skewed priorities have seen health care trail behind other sectors. This is evidenced by budgetary allocation and major development projects, where other sectors like defence and education receive more resources.

Kenya's current regime and devolved governance structure has implemented remarkable reforms in health care – free maternity services, free primary health care services in all level 1 to 3 hospitals, and increased autonomy in decision making at county levels.

The Government of Kenya has also expanded the National Hospital Insurance Fund (NHIF) pool by including students in public secondary schools, elderly, orphans, people with disabilities, and other vulnerable groups. All these efforts have increased access to health care and reduced financial risk to the most vulnerable in society. Albeit fragmented, improvements in health indicators have been reported (3).

On December 13, 2018, the Ministry of Health led by the president, launched UHC pilot programs, 'Afyu Care,' in four devolved counties in Kenya. The counties were selected based on the triple burden of disease prevalence, which includes infectious diseases such as HIV/AIDS, non-communicable diseases, and trauma injuries. Residents of these counties can access a range of both inpatient and outpatient health care services at a subsidized rate. The government hopes to learn from these pilots and minimize failure risks when the programme becomes scaled-up to the entire country (4).

The Ministry of Health and various stakeholders (e.g., donors) are developing frameworks for the UHC countrywide scale-up. However, one question is yet to be explicitly defined and answered: How will the government finance this ambitious, yet crucial goal? The current health budgetary allocation is 6.7% of the total government expenditures and 5.2% of the total health spending, as a percentage of GDP. Out-of-pocket spending contributes up to 27.7% of the current health expenditures. Statistics also show that a significant proportion of Kenyans experience catastrophic health expenditures to the extent that most Kenyans believe that they are one medical condition away from poverty (5).

UHC seeks to reduce household financial burden, mainly out-of-pocket spending by increasing budgetary allocation to health care services and increasing the proportion of Kenyans under insurance coverage (e.g., voluntary NHIF). This is both an uphill task, considering the limitations in revenue collection through taxation and challenges interacting with the hard-to-reach rural population and large informal economic sector, which has resulted in lower insurance uptake. Beyond limited financial resources, Kenya also needs to eliminate corruption. Some experts argue that there are enough resources to implement UHC, if available resources are put into efficient use, backed with transparency and good governance.

Achieving UHC is not an easy task, but the health sector needs to collaborate with various stakeholders and capitalize on the current political goodwill from the highest political office and global momentum. There has never been a better time for Kenya to lay a strong foundation to strengthen its health care systems and achieve health for all sooner than later.

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Surgical Site Infections in Venezuela: Global Call to Action

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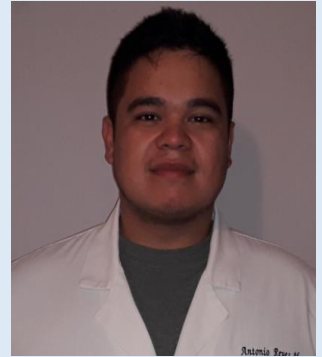
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Surgical site infections (SSIs) are a significant health burden for patients and health care providers. They are the most common postoperative complication and cause pain to patients. SSIs are universally expensive and could result in catastrophic health expenditure and impoverishment to patients who are required to pay for their own treatment. In low-income and middle-income countries (LMICs), single-center retrospective studies have reported that SSIs could be the most common infection associated with health care service delivery (1).

New resistance mechanisms are emerging and spreading globally, threatening the ability to treat common infectious diseases, resulting in prolonged illness, disability, and death. To address this burden, the World Health Organization (WHO) has supported a standardized approach to data collection, analysis, and sharing related to antimicrobial resistance at a global level to inform decision-making and drive local, national, and regional action (2).

Currently, SSIs are used as quality measures for surgical care in health institutions. It represents a public health problem exacerbated by the growing antimicrobial resistance with the new generation of multidrug-resistant bacteria (MDR), disabling a wide range of antibiotics in health facilities.

Specific to Venezuela, the authors conducted a descriptive study in a local hospital and reported that SSIs had increased over time, from 10% in 2017 to 12.2% in 2019, with peaks of 15% and 18% during some months (unpublished data) (**Photos 1–2**). Since data on SSIs are not easily accessible or available to clinicians and researchers, working groups cannot be established to further examine this national health burden. Some challenges include limited health research data and infrequent publications of epidemiological bulletins by the Ministry of Health. In fact, one scientific article described that weekly epidemiological bulletins have not been authorized to be published by the Ministry of Popular Power for Health since 2015 (3). Ultimately, this scientific isolation may halt scientific advancement and collaborations with other nations in the Region of the Americas.



Photo 1. “Dr Alfredo Van Grieken” University Hospital, located in Coro, Falcón, Venezuela, where the latest surgical site infection data were collected.
Credit: Antonio Reyes.

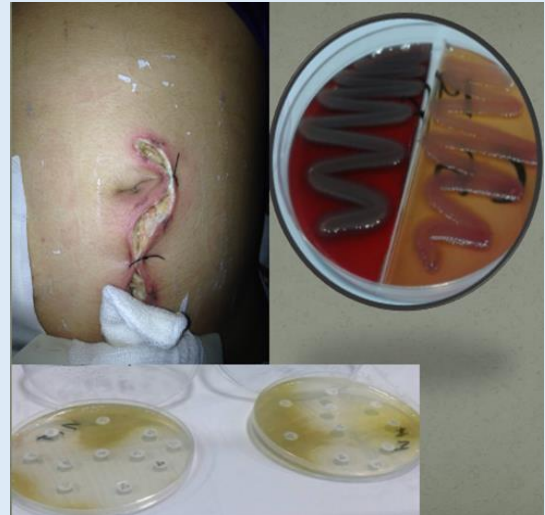


Photo 2. Clinical case of a patient with an infected wound after exploratory laparotomy (upper left), culture assay (upper right), and antibiogram (bottom left), from “Dr Alfredo Van Grieken” University Hospital.
Credit: Genesis Naranjo.

Junior doctors living in LMICs face major challenges in their research contributions to SSIs. First, to detect potential etiologies of SSIs per geographic region, junior doctors need economic resources and access to specific and high-quality laboratories for diagnostic procedures. This technology is usually limited or unavailable in LMICs. Second, there are limited academic platforms and funding opportunities to encourage the call for research about SSIs and other health care challenges. Finally, limited government funding hinders opportunities to publish and share data that can inform health decision-making and policies.

In LMICs like Venezuela, SSIs and antimicrobial sensitivity are infrequently studied, hindering how health institutions obtain information, manage and distribute resources, and mitigate risk of infection.

Recently, the Global Surgical Outcomes Collaboration (GlobalSurg) and their Global Health Unit on Global Surgery are working together through annual research prioritization workshops to set the research agenda based on patients' needs in LMICs. These efforts aim to represent surgeons from around the world and support collaborative international research to examine surgical outcomes, resulting in expanded local, national, and international research networks (2).

To address these challenges, junior doctors can support current global surgery programs and share data through social media, an innovative tool that has transformed global communication.

Globally, reducing SSIs will contribute to ensuring safe and essential surgery techniques to improve patient outcomes. Health care costs of patients living in LMICs are a significant burden on financial resources and sick leave. Following the WHO's recommendations, to address this global burden in resource-limited settings, robust policies should be the primary dialogue among health authorities. The global call to action must emphasize the need for high-quality evidence to inform their health decisions that promote population health (4,5).

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CHARTING Study: A Trainee Collaborative Research Study

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The Early Career Doctors (ECDs) are medical or dental interns, medical or dental officers below the rank of principal medical officer, and resident doctors who are in postgraduate training. ECDs constitute a significant proportion of medical human resource for health in Nigeria (1). Many of this subgroup of medical or dental doctors in Nigeria are within their first 10 years of graduating from medical and dental schools. They are represented by the National Association of Resident Doctors of Nigeria (NARD), which is one of the affiliate institutions of the Nigerian Medical Association (1,2).

Although the ECDs play a critical role in the country's health sector, they are faced with numerous psychosocial, demographic, and workplace-related issues (2–4). Unfortunately, there are few research studies that have explored relevant themes related to these challenges (1,2). In January 2019, the 2018–2019 National Executive Council of the National Association of Resident Doctors of Nigeria, led by Dr Olusegun Olaopa, approved the newly created Research & Statistics Committee (RSC)'s proposal to investigate themes relevant to ECDs. The key component of the proposal was the CHARTING study, short for the CHallenges of Residency Training and Early Career Doctors in NiGeria Study (1).

The CHARTING study is the largest multi-centred and multi-disciplinary research project on ECDs in Nigerian history (1,5). Driven by the 46 members of the Research Collaboration Network (RCN) that serves as a sub-structure of the RSC, the study aims to investigate issues and challenges of ECDs in Nigeria. The key themes the study will explore include demographic issues (e.g., migration), workplace issues (e.g., practice satisfaction and dissatisfaction, training and skills acquisition, conflict and conflict resolution, leadership), and psychosocial issues (e.g., burnout syndrome) (2). The study incorporates a mixed-methods design with quantitative and qualitative aspects (5). In the quantitative portion, the RCN will administer structured questionnaires to 1,554 ECDs representing 21 of the 74 branches of the NARD. In the qualitative component, the RCN will conduct four focus group discussion sessions with nine ECDs per group, for a total sample of 36 ECDs. Study advisors from the RSC/RCN will include six fellows with multidisciplinary backgrounds who represent several postgraduate medical colleges within Nigeria (1).

Achievements

So far, the key milestones attained by the project team include securing the necessary approvals, setting up of the operational structure to execute the project, obtaining funding from NARD, and publishing preliminary manuscripts.

Future Directions and Conclusions

The team is committed to the gathering and processing of robust data regarding ECDs in Nigeria, which would lay a solid basis for more advanced research of ECDs at their workplace in the country. It is anticipated that the study findings would improve the interaction of the various stakeholders who liaise with the ECDs in Nigeria. Our findings will also be published in a high-impact peer-reviewed journal in order to permit worldwide dissemination. Furthermore, we believe that this initiative will greatly enrich the development of evidence-based policies on relevant themes among Nigerian junior doctors.

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Physicians' Work Style Reform in Japan: Gender Equality

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The entrance examination into the Faculty of Medicine has irreplaceable value, serving as the beginning of the journey to becoming a physician. As junior doctors, many believe that to select competent students for medical education and training, this examination should be conducted fairly. However, is this a reality?

In Japan, unfortunately, the score adjustment of the entrance examination has become a controversial issue, after third-party investigations reported that female students' test scores were reduced uniformly to minimize their potential to reach the passing exam score (1). Furthermore, a third-party committee found that some university officials had believed that female physicians were less likely than male physicians to take important academic positions and more likely to retire early due to life events (e.g., pregnancy, child-rearing). This score adjustment of the entrance examination was unjustified and discriminatory against female students who aimed to pursue a medical career.

To further examine this score adjustment issue, the Ministry of Education, Culture, Sports, Science and Technology (MEXT) conducted a survey in 2018 of all Faculties of Medicine across the country (2). Of the 81 Faculties of Medicine, the survey revealed that 57 Faculties (70.4%) had a greater number of male medical students than female medical students, with a ratio of 1.18 male to female students on average over the previous six years. In particular, MEXT identified four Faculties of Medicine with prevalent gender discrimination during enrollment via the entrance examination. It is believed that this gender discrimination was partly responsible for the imbalance observed among genders.

Gender equality is an important element during the recruitment process as well as formal employment. In 2018, the World Medical Association (WMA) issued a statement on gender equality in medicine, which demonstrated support for female medical students and asserted the need for their encouragement in academia, leadership, and managerial roles. Following the United Nations 2030 Agenda of Sustainable Development, this statement emphasized the fifth goal (Gender Equality) of the 17 Sustainable Development Goals (SDGs).

Notably, health care became the largest global industry of young people over the past 10 years, and females account for more than 70% of health care workers.

If gender discrimination is not eliminated, more women engaged in the health care sector may experience gender discrimination in the future.

How can we overcome this gender inequality?

This problem raised the question about how these entrance examinations should be conducted. In response, the Association of Japan Medical Colleges established a standard for the entrance examination of the Faculties of Medicine, which aimed to ensure fairness and equity during recruitment (3). Recently, the Japanese government promoted the *Physicians' Work Style Reform*, to ensure physicians' health while maintaining high-quality medical care. The shortage of physicians in Japan has historically led to an increase in their working hours. In their report, this reform committee highlighted the importance to create a safe and nurturing environment for female physicians with specific time constraints related to personal life scenarios (e.g., childbirth, child-rearing). To promote gender equality, the Japan Medical Association has conducted numerous surveys, presented forums, and disseminated publications on gender equality.

What should we require for the Physicians' Work Style Reform?

The physician shortage in Japan has demonstrated the importance to improve work efficiency and increase opportunities for female physicians to maintain medical care. Current discussions are underway on a system of childcare leave and shorter working hours for physicians.

How should our personal perspectives regarding physicians' work be linked with public interest?

Junior doctors should reflect upon the meaning of their work and actively seek to reach established professional and personal goals. These goals can be achieved through dedicated work and self-actualization, not only material wealth. Previous surveys have suggested that young physicians emphasize skill development and professionalism in their career development (4). More research studies should investigate these critical topics for junior doctors and medical students.

In Japan, with few opportunities for young physicians and medical students to discuss their perspectives regarding working styles, Japanese junior doctors will organize a summer workshop on advocacy with medical students. Using the theme, *Physicians' Work Style Reform in Japan: Gender Equality*, the agenda will include a description of future activities based on two lectures: 1) six actions for systematic advocacy by Dr Trevor Shilton (5); and 2) past efforts about the physicians' work style reform in Japan with a view of management strategies.

As junior doctors, we should continue to apply our leadership to practice, starting with promoting health advocacy and capacity building.

We hope that this summer workshop will provide an opportunity to empower young doctors to develop their advocacy skills on these essential and timely topics.

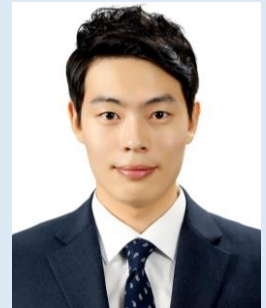
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Junior Doctors Improve Medical Training Environments in the Republic of Korea

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The Republic of Korea (hereafter, Korea) experienced exponential development over a short period of time, rising from the ashes of World War II. Currently, Korea stands strong on numerous public health statistics. The Korean population and residing foreigners enjoy excellent healthcare services for less than US\$10 for any simple visit to a primary health center. However, these results are made possible by the unreasonable sacrifices of medical residents. Until recently, medical residents in Korea were required to work more than 100 hours per week or occasionally 100 days of consecutive duties (1).

Established in 1998, the Korean Intern Resident Association (KIRA) has continuously advocated for the reformation of these medical residents' working hours.

However, due to a lack of understanding by political sectors regarding the circumstances of medical training, coupled with practical roadblocks such as a low medical reimbursement rate and inefficient healthcare delivery system, collective efforts have advanced slowly. Thus, KIRA concluded that further legislative action should be considered.

In 2012, the death of one medical resident after continuous work duties ignited the debate and led to the passing of the *Act for the Improvement of Training Conditions and Status of Medical Residents* (Medical Residents Act, MRA) in 2015. The four essential elements of the MRA (**Figure 1**) also coincide with the World Medical Association (WMA)'s statement of physicians' well-being (2,3).

Protect the rights of medical residents by regulating training environment and advancing their status
Limit medical residents' working hours by a maximum of 80 hours per week
Ensure in written form the national support for medical residency programs
Establish the Training Environment Evaluation Board to manage the general quality of training

Figure 1. Essential elements of the Medical Residents Act (2).

The MRA enactment holds significant meaning for physicians, as medical residents are the primary focus, and the law enshrines guaranteed basic human rights. The MRA also ensured direct participation of medical residents on decision-making committees. This direct participation can improve the training of future medical residents, clarifying the establishment and operations of the mandatory Training Environment Evaluation Board. Overall, KIRA aims to refine the MRA and improve its implementation related to three specific factors.

Working Hours

Since the MRA enactment, the training environment has slightly improved (**Figure 2**), although the Ministry of Health and Welfare statistics show that 38.5% of training centers do not abide by the residency policy.

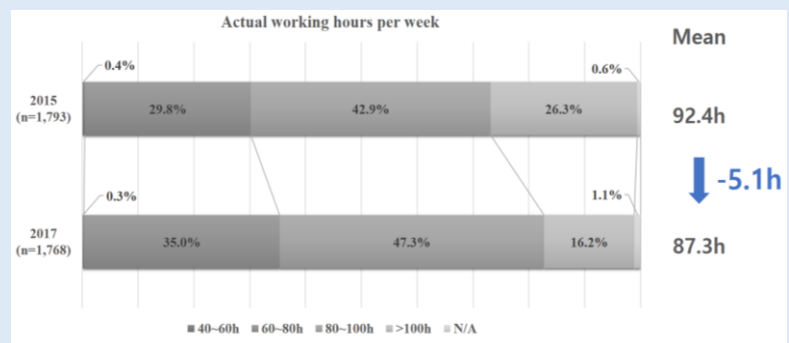


Figure 2. Comparison of changes in the training environment after the Medical Residents Act enactment, in 2015 and 2017.

Credit: Korean Medical Association.

Quality of the Residency Program

The Korean residency curricula lack detailed syllabi and content, such as mandatory patient cases and education checklists. Discrepancies among institutions are vaguely acknowledged and poorly managed, since there are no standardized criteria (4). Moreover, efforts by the medical societies are limited since curricula reform can lead to practical strains for hospitals and academic institutions. The MRA mentions national support for residency programs, but there are no feasible agreements to date. By benchmarking against other countries' training programs, Korea could actively improve the quality of residency programs.

Reinforcement of Residents' Rights for Safety and Health

Verbal, physical, and sexual harassments were traditionally common in the authoritarian medical system and unfortunately are still prevalent (**Table 1**). Gender inequality and violence in hospitals are also critical issues (5). For example, the results of a KIRA-led survey indicated that nine of 10 residents in emergency medicine have experienced either physical or verbal violence from patients and other healthcare workers. Survey results reported similar statistics for residents working in other clinical disciplines (5). Although doctors' safety and health are related to their efforts for population health, the MRA lacks authority to impose adequate sanctions. Corroborated above, although most of the physicians admittedly regard the MRA enactment as a milestone that improves the medical training environment, there is still a long way forward to perfect the environment.

	Verbal violence	Physical violence	Sexual Harassment (total)	Sexual Harassment (female)	Sexual Assault (total)	Sexual Assault (female)
2015	86.2	30.5	33.0	54.6	13.7	23.7
2017	71.2	20.3	28.7	48.5	10.2	16.3

Table 1. Percentage of medical residents' experience on violence, sexual harassment, and assault.
Credit: Korean Intern Resident Association.

In February 2019, another medical resident was found deceased in the on-call room during his night shift, after working 110 hours per week for four consecutive weeks. In order to address this growing concern for Korean medical students and trainees, KIRA held a press conference and alerted the public about the MRA enactment and unacceptable tragedies of 2012 and 2019 (**Photo 1**).



Photo 1. Korean Intern Resident Association press conference after medical resident's death in 2019.
 Credit: Korean Intern Resident Association.

By collectively sharing our medical training experiences with other junior doctors from all over the world, we hope to create an international dialogue and expect to break through the various challenges that young doctors face in today's medical society.

Nonetheless, young doctors have a myriad of other reasons for continuing to be proactive and to advocate for critical topics in their medical training. Korean junior doctors continue to remain motivated about improvements in their working environments for both doctors and patients. We remain optimistic and envision a future clinical workplace that is free of any unjust practices.

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Fourth General Assembly of Japan Medical Association/ Junior Doctors Network

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The Japan Medical Association and Junior Doctors Network (JMA-JDN) held the 4th General Assembly on July 20-21, 2019, in Tokyo, Japan. Using the theme, *The Role of Junior Doctors in the Current Trend of Global Health*, the purpose of this meeting was to provide JMA-JDN members, other junior doctors, and medical students with opportunities to identify global health challenges, discuss potential approaches to minimize these challenges, and form professional networks.

Day 1: Symposium

Using the theme of the 4th General Assembly, this symposium included presentations by four panelists who were members of the JMA Global Health Committee. First, **Dr Hideko Yamauchi**, Director of Breast Surgical Oncology of St. Luke's International Hospital, highlighted that comprehensive patient care should incorporate medical care and health promotion activities related to the social determinants of health. As a surgeon and clinical researcher in the United States, she recommended that junior doctors establish their dreams and develop a plan to achieve those dreams.

Junior doctors serve as advocates on diverse issues, including challenges related to health care systems' adoption and implementation of remote medicine.

Second, **Dr Mari Urabe**, President of Uzawa Kokusai Gakkan, introduced the concept of "social common capital", which was developed by her father, Professor Hirofumi Uzawa, a Japanese economist. This concept "*provides members of society with those services and institutional arrangements that are crucial in maintaining human and cultural life*" (1). She emphasized that the existence of the hospital and primary care doctor are important for social stability, and that physicians should view patient care in a holistic manner.

Third, **Dr Yasuhide Nakamura**, President of the World Health Organization's Association of Japan, mentioned the importance of equal relationships related to international humanitarian efforts to achieve the Sustainable Development Goals. He urged junior doctors to carefully think about how their training could positively influence the delivery of primary healthcare services to all.

Fourth, **Dr Hiroki Nakatani**, Director of Human Resource Strategy Center for Global Health, described that domestic medicine has been affected by globalization, including the increase of international patients and healthcare workers in Japan. He emphasized the importance of becoming involved in global health opportunities and highlighted the possibility of harmonizing medical careers at both domestic and international levels.

In the discussion period following the lectures, participants shared experiences and perspectives and discussed the future roles of junior doctors in global health topics. They suggested creating e-learning opportunities for Japanese junior doctors on global health topics, including using innovative technology to develop surveys.

Day 2: Skill-based Workshops

Two skill-based workshops were coordinated to provide learning opportunities for symposium participants. First, the **2nd Annual Advocacy Skill Workshop** was held for Japanese junior doctors to learn about the concept of advocacy and how to use advocacy as an effective strategy (2). **Dr Masamine Jimba**, Professor in the Department of Community and Global Health Graduate School of Medicine at the University of Tokyo, led the workshop and educated participants on the use of advocacy frameworks, which were developed by Dr Trevor Shilton to construct the strategy for effective advocacy (2). He then provided personalized tutorial sessions, while participants formed small groups for the simulation of these advocacy strategies.

Second, the **Localize, Centralize Workshop** was organized by medical students of the International Federation of Medical Students' Associations (IFMSA-Japan), Asian Medical Students' Association in Japan, and the Japan Association for International Health Students section. Workshop participants included junior doctors and medical students. They formed two small groups to discuss challenges related to healthcare service delivery in rural and urban communities across Japan. Then, they developed potential solutions and identified how junior doctors could collaborate to minimize these described challenges. Collaborative learning was observed as junior doctors were inspired by the innovative ideas from medical students, and medical students were exposed to the challenges of clinical practice and influence of health policy through junior doctors' experiences.

Through the symposium and skill-based workshops, junior doctors demonstrated enthusiasm to collaborate on health initiatives that can minimize risk to future health threats to the global population.

Their continued leadership can provide new insights into the use of innovative technology, methods, and resources to solve global health challenges.



Photo 1. Participants and panelists of the 4th General Assembly of the Japan Medical Association/Junior Doctors Network, held on July 20, 2019.
Credit: JMA-JDN.

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Introduction to the Special Series on Medical Ethics

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Dear JDN members,

We are pleased to announce that the Junior Doctors Network (JDN) Medical Ethics Working Group has taken an initiative to highlight the problems faced by junior doctors around the globe.

The *JDN Newsletter* will now have a dedicated space for JDN membership, in efforts to share unique experiences and challenges faced in the workplace. In early 2020, the Working Group plans to prepare one special edition of the *JDN Newsletter* that focusing on the Medical Ethics challenges faced by junior doctors.

Stay connected, and let your voice reach the world!

Hands that Heal are not Meant to be Broken

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Since the advent of human civilization, the medical profession has been a respected field. Doctors have been revered, well educated, and part of the noble working class. Over the past few years, however, numerous global incidents of violence against doctors in the workplace have instilled anxiety and fear among doctors. These actions have led to suffering of doctors and patients alike, where doctors often leave health institutions to strike within the medical community, and patients are devoid of timely treatment.

India, with a population of 1.3 billion, is on the verge of a health crisis as there are not enough doctors to manage the population health priorities. According to Medical Council of India, there are 529 medical colleges, with more than 75,893 graduates per year (1). Many of these medical graduates work as junior doctors in remote areas of the country, experiencing limited basic infrastructure of health facilities. Hence, these junior doctors are the torchbearers of the health care delivery system in these remote areas, yet may suffer physical or emotional abuse by their patients.

A study conducted by Indian Medical Association reported that nearly 75% of doctors have faced some form of violence in the workplace, and most of these assaults occurred in emergency services and intensive care units (2). A large portion of these violent assaults happens within government hospitals, where medical services are provided gratuitously to patients. With limitations in proper infrastructure, medications, and supportive materials, doctors are frequently blamed as the root cause for these health care challenges.

Recently, assaults on doctors have caused physical and emotional pain, hindering the delivery of medical services to patients.

A recent example from June 2019 exemplifies this current challenge facing doctors in India. In West Bengal, one doctor was brutally assaulted and was transported to the intensive care unit with a lacerated wound on his head. Following this incident, 800,000 doctors across India participated in a national strike, demanding that security be improved in the workplace (3).

These shared stories about violent assaults among doctors are not isolated to India, but rather have become a global epidemic. For example, in Nepal, doctors have been

experiencing these same challenges and are forced to work in a constant state of stress and fear of violence. Attacks on doctors are a daily phenomenon, and people often vandalize hospital premises and demand exorbitant compensation for any harm produced during the course of treatment. These factors have motivated doctors to unite and demand for safety and stricter legal provisions to higher authorities. Likewise, these incidents have occurred in other nations, such the United States, where one study showed that nearly 78% of doctors working in the emergency department have faced physical violence and verbal threats (4).

The overall solution to prevent assaults lies with the government, hospital authorities, doctors, and the general public. First, the government should make stricter laws to prevent future attacks on doctors, like categorizing assaults on doctors as a non-bailable offense and establishing sanctions such as fines or imprisonment. Second, hospital authorities should improve their basic infrastructure by adding more hospital beds and confirming that treatments are available. They can recruit more medical personnel to enhance the delivery of high-quality health care services to patients. Third, doctors should collaborate to strengthen trust and transparency in the medical community and emphasize robust communication skills that foster positive doctor-patient relationships in clinical practice. Finally, the public should be educated about medical ethics and protocol, where communication with doctors is essential, and violence is not tolerated. Hospitals and medical personnel should coordinate meetings with the public, which will instill faith in the responsibilities and actions of health professionals.

Restoring faith in doctors is the urgent need of our society. As the common phrase, “*Love conquers everything*”, junior doctors should aim to be empathetic and develop rapport with patients and their families. As such, Dr Morgan Martin has beautifully described the importance of communication in the health care setting.

“The physician treats with words; within the physician-patient social system, the patient is moved by fears and other sentiments, and these are modified by the physician's words and phrases. Physicians dispense not only medicines but words that influence medicines or, all by themselves that affect the patient more than the medicine.”

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Untold Stories of Young Doctors from the Land of the Himalayas

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Nepal, a small country enriched in cultural diversity, is known as the land of mountains with a population of 29.94 million. Doctors are scarce in number, accounting to approximately 22,000 registered with the Nepal Medical Council and licensed to practice medicine in Nepal. The doctor to population ratio is 1:1,360, which falls short of the World Health Organization (WHO)'s recommendation of 1:1,000. This number further suffers a huge setback when we consider that only 30–35% of them have attained a post-graduation degree, and the majority practice medicine in the capital city of Kathmandu.

“An educated workforce is the foundation of every community and the future of every economy” – Brad Henry

There are two main challenges that medical graduates encounter in their training. First, in recent times, a number of private medical colleges has been established in different geographic regions, resulting in 2,000 medical graduates annually. With only 200–300 post-graduate seats available per year, the competition for a medical residency spot has become fierce. Second, different government quotas have resulted in an even further reduction of available seats for individuals applying without having a government job. However, the process to obtain a government job seems to be an uphill task, as only 80–100 doctors are recruited annually, and they become eligible to apply for a medical residency spot only after a minimum of two years of service. Hence, each year brings more medical graduates who are added to the competitive wait list for medical residency spots, with the numbers often reaching 8,000 to 10,000 applicants.

While awaiting their medical residency, young doctors work as medical officers in hospitals and frequently encounter workplace-related challenges and stress. For example, they may observe or experience violence, which has become a major arising issue in the Indian sub-continent. While a substantial number of cases is being reported on a weekly basis, the government has failed to acknowledge this burden. Doctors have also become an easy target for the media, and the government and policies (e.g., life imprisonment, monetary reimbursement amounting to US\$30,000) have been imposed on them due to patient deaths during treatment, irrespective of the prognosis. After many protests made by the

medical societies, these policies were abandoned, leaving doctors feeling rejected and isolated. Unfortunately, following numerous defaming articles and rumors spread by the national media, the general population has lost their trust and respect for doctors.

Furthermore, Nepalese doctors receive minimal financial compensation for their job responsibilities, which challenges their ability to support household expenses. While monthly living expenses in Kathmandu reach approximately US\$361 (excluding rent), the monthly salary ranges from US\$220–500. In order to overcome this struggle, doctors join multiple institutions and work overtime, which has consequently resulted in lower quality of life, limited family time, and substandard patient care. While the general public may view these actions as doctors' "greed for money", only few seem to understand the challenges doctors face in Nepal.

In summary, the lack of educational opportunities, workplace insecurities, and financial limitations have significantly degraded the quality of life experienced by doctors across Nepal.

This has resulted in a generation of young doctors who prefer to embark on different career paths, pursuing medical training in other countries, such as the United States or the United Kingdom. Every year, these numbers are increasing exponentially, as around 200 doctors have applied for the United States Medical Licensing Examination (USMLE) match in 2018, and hundreds are planning to apply in the future. This trend demonstrates that nearly 20–30% of annual medical graduates are opting for a career in a foreign country. This highlights the "brain drain" phenomenon in its true form. Our country is losing skilled manpower at an alarming rate, alas with few concerns demonstrated by the government. In a few years, Nepal will be facing an acute shortage of doctors, which will lead to countless preventable deaths.

In the end, it comes down to the saying, "*You reap what you sow*". Forward steps call for creating an environment where young doctors can thrive and inspire younger generations to follow their footsteps, and not the other way around.

KMA Young Doctors Network Pre-Conference: Mentorship and Innovation in Medicine

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In April 2018, while celebrating their 50th year anniversary, the Kenya Medical Association (KMA) commissioned the Young Doctors Network (YDN) as a standing committee of the association. KMA sought to increase participation, mentor, and champion the welfare of junior doctors in Kenya.

One year after the commissioning, the YDN held its inaugural event in Naivasha, Kenya. The KMA YDN Pre-Conference was a one-day meeting held before the KMA Annual Scientific Conference on April 24, 2019. Under the theme, *Mentorship and Innovation in Medicine*, the pre-conference was well-attended with over 100 participants, including medical practitioners, residents, specialists, and students from Kenya and East Africa. The agenda included invited speakers with diverse backgrounds in entrepreneurship, innovation, advocacy, academia, and leadership, who aimed to mentor and inspire the young doctors and participants.

Mentorship

The keynote speaker, **Dr Andrew Odhiambo**, a young respected medical oncologist and lecturer, emphasised that mentorship is an essential component of medical education. It is especially critical in medicine, where training moves each young doctor to the next level, and then this position is replaced by the next trainee. Dr Odhiambo highlighted that mentorship needs to be continuous and bilateral, adding that a mentee can indeed mentor the mentor. Likewise, other speakers, including **Dr Jacqueline Kitulu**, the KMA president, stated their overall appreciation for younger tech savvy doctors, who mentor older colleagues on technology and innovation.

**Since medical education and practice can be demanding,
having a good mentor can guide medical trainees and
junior doctors to survive this dynamic journey.**

With technology, e-mentorship becomes a feasible option, where mentor-mentees can uphold a relationship beyond physical presence. **Dr Ahmed Kalebi**, an entrepreneur and experienced pathologist, demystified the need for physical presence for mentorship to occur, recognizing that distant and virtual platforms facilitate a productive mentor relationship. He also encouraged participants to draw inspiration from hard-to-reach role models.

Innovation

Innovation is the art of joining the dots by efficiently utilizing available resources to solve problems. In Kenya, the devolution of health care services has resulted in structural changes and emerging challenges such as unemployment among doctors. The conversation is moving from traditional roles of practitioners in health care service delivery to offering potential solutions in other spheres of health care, such as entrepreneurship, policy, and advocacy.

Entrepreneurship was featured with significant discussions around how to tap into health care as a business. Health care needs are largely unmet locally, presenting future opportunities that strive to increase economic productivity and improve population health.

Seasoned entrepreneurs provided their insights on what approaches were successful in their work, underscoring the element of courage, resilience to push through challenges, and passion to acquire new knowledge and skills.

Dr Maxwell Okoth, founder Ruai Family Hospital, shared his entrepreneurial journey that started with a one-roomed clinic and grew to a chain of health care facilities, including a specialist hospital. In a comical manner, he narrated his encountered challenges and described taking small and large risks, such as selling his wife's car to finance the next step of his career path.



Photo 1. KMA YDN Pre-Conference speakers: Dr Elizabeth Gitau, Dr Rowena Njeri, Dr Paul Yonga, Dr Nyachira Muthiga, Dr Ryan Nyotu, Dr Thomas Kirengo, Dr Elizabeth Wala, Dr Lyndzie Wanjiku, Dr Lyndah Kemunto (Left to Right).
Credit: Kenya Medical Association.



Photo 2: KMA YDN Pre-Conference participants.
Credit: Kenya Medical Association.

Overall, pre-conference participants listened to high-quality presentations, engaged with speakers, and gained insight about key lessons in mentorship and innovation in medicine. First, forming professional networks within and beyond KMA can serve as an important support and mentorship group during medical training and practice. Second, seeking entrepreneurial and innovative solutions for the delivery of health care services, coupled with consistently upholding ethical standards, can refine and advance current clinical practices.

Persistent and intentional actions to maintain lasting relationships with mentors and role models can facilitate valuable career advisement.

KMA YDN looks forward to engaging more young doctors and providing interactive platforms to share experiences, challenges, and solutions that promote high-quality health care. The next YDN Pre-Conference will be held on April 24, 2020, and KMA's Annual Scientific Conference will occur on April 24–26, 2020, in Kisii, Kenya.

Acknowledgment: The authors acknowledge the Kenya Medical Association for supporting the Young Doctors Network Inaugural Pre-Conference in April 2019.

Health Professional Meeting 2019: Road to Universal Health Care

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Chair (2018-2019)
Junior Doctors Network
World Medical Association



The Health Professional Meeting (H20) 2019, which was organized by the Japan Medical Association (JMA) and the World Medical Association (WMA), was held from June 13-14, 2019, in Tokyo, Japan. Using the theme, *Road to Universal Health Coverage*, this event served as a physician pre-conference to the G20 Summit in Tokyo, with the attendance of 220 participants representing 38 countries. These representatives included medical students of the International Federation of Medical Students' Associations (IFMSA) and junior doctors (Dr Chiaki Mishima, Dr Chukwuma Oraegbunam, Dr Wunna Tun) of the Junior Doctors Network (JDN), providing an opportunity for the voices of the next generation of physicians to be heard (**Photos 1-2**).

Notably, this meeting aimed to implement the April 2018 memorandum and reinforcement of emergency disaster control, between the WMA president and the Director-General of the World Health Organization (WHO).

In conference sessions, participants shared experiences and perspectives, discussed challenges, and identified potential solutions to implement universal health coverage (UHC) across nations and improve access and availability to high-quality health care services without any financial barrier.

The opening ceremony counted with the attendance of the Crown Princess Kiko of Japan, top members of the Japan Ministry of Health, and key medical leaders including Dr Yoshitake Yokokura (JMA president and immediate WMA past president) and Dr Leonid Eidelman (WMA president). Three medical leaders delivered outstanding keynote speeches for the conference sessions. **Sir Michael Marmot** (WMA past president and professor of epidemiology at the University College in London, United Kingdom), highlighted the social determinants of health that influence health inequities. **Dr Naoko Yamaoto** (assistant director general, UHC and Health Systems), described the WHO efforts and plan toward achieving UHC. **Dr Mukersh Haikerwal** (WMA past chair of council) discussed primary health care as the unit of effective health systems and discussed the roles and functions in primary health care teams.



Photo 1. Dr Chukwuma Oraegbunam (JDN chair), Dr Batool Al-wahdani (IFMSA President), Dr Daisuke Kato (JMA Japan), and Dr Wunna Tun (JDN past communications director) (Left to Right) at H20 2019.
Credit: Dr Chukwuma Oraegbunam.



Photo 2. Mayo Clinic Caring Physicians of the World Alumni Group: Dr Wunna Tun (JDN past communications director), Dr Chiaki Mishima (JDN membership director), Dr Otmear Kloiber (WMA secretary general), and Dr Jacqueline Kitulu (KMA president) (Left to Right) at H20 2019.
Credit: Dr Wunna Tun.

In his presentation titled, *Invest in Young Doctors Now*, **Dr Chukwuma Oraegbunam** spoke on the health workforce aspects of UHC. He described the impact of poor job satisfaction, little or no incentives to accept jobs in rural areas, and the quest for better work-life balance. He suggested these factors as reasons that have inspired junior doctors to move from low- and middle-income countries to more developed countries. As a result, this transition has produced significant negative impacts on the UHC goals of stakeholders.

Dr Chukwuma Oraegbunam encouraged world leaders to invest in the appropriate training and incentives of doctors to serve in primary health care centres in rural communities, as one strategy to achieve high-quality UHC systems.

After these conference sessions, the Memorandum of Tokyo was adopted. This declaration reinforced the understanding of high-quality primary health care as the core element of UHC. It also highlighted the scarce human resources available for health care across countries, motivated governments to invest in the education and retention of health professionals to promote UHC, and encouraged physicians and their associations to play a significant role in the advocacy for UHC.

In summary, junior doctors from all over the world, in line with WMA policy and Memorandum of Tokyo, must now join the global dialogue to ensure that high-quality primary health care systems are prioritised as the core of UHC, with adequate attention given to the training and retention of physicians (**Photo 3**).



Photo 3. Participants at H20 2019. Credit: H20 2019 staff.

Medical Ethics Working Group Update

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Medical Ethics forms the foundation of the medical profession and comprises an integral part of global health. Over the past decade, health professionals have encouraged and stimulated discussions on diverse topics related to medical ethics, including clinical competencies and responsibilities, human and animal research, patient confidentiality, and end-of-life care.

**Junior doctors should be engaged as active leaders,
encouraging continued dialogue amongst the global health
workforce on these diverse themes.**

To address this important global health issue, the Junior Doctors Network (JDN) formed the Medical Ethics Working Group on June 22, 2019. Chaired by the medical ethics officer of the JDN management team, the Medical Ethics Working Group is geared to strengthen a global network, where junior doctors can share essential information, resources, and activities on Medical Ethics topics with the JDN membership.

The Medical Ethics Working Group has three main objectives. First, it aims to increase awareness about Medical Ethics amongst junior doctors through innovative and scholarly activities. Second, it plans to encourage the active participation of junior doctors in policy analysis, policy review, and research collaborations related to Medical Ethics topics. Finally, it seeks to foster collaborations that can lead to junior doctors' exchange for professional experiences related to Medical Ethics in clinical and community settings.

During the inaugural meeting on July 27, 2019, the Medical Ethics Working Group formalized the first set of projects. Over the next nine months, junior doctors will be focused on five main activities (**Figure 1**).

Activity	Projected Date
Implementation of a Medical Ethics activity at the JDN Annual General Meeting (Republic of Georgia)	October 2019
Preparation of an article series for the <i>JDN Newsletter</i> , focusing on Medical Ethics topics such as work-life balance and challenges encountered by junior doctors	October 2019
Preparation and dissemination of an online survey to examine Medical Ethics challenges faced by junior doctors	December 2019
Preparation of an activity at the 14th World Conference on Bioethics, Medical Ethics, and Health Law (Portugal)	May 2020
Development of a Medical Ethics database as a resource for learning, training, and exchange opportunities for junior doctors	October 2019 – May 2020

Figure 1. Description of five main activities with projected dates for the JDN Medical Ethics Working Group.

The Medical Ethics Working Group has a vibrant and diverse membership. Members represent the majority of World Health Organization regions as well as various medical and surgical specialties. If you are interested in Medical Ethics and would like to participate with other JDN colleagues in numerous activities, please contact our team (Dr [Lwando Maki](#), Chair of the Medical Ethics Working Group) to learn about more information.

Global Surgery Working Group Update

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Surgery has historically been a neglected and absent specialty in the global health sphere. Various reasons can be named for this unfortunate course of history, ranging from the rise of HIV to the persistent belief (however, incorrect) that surgery is not cost-effective in low- and middle-income countries (LMICs). Various professional surgical associations created working groups or even new separate organizations to help address this burden of surgical disease in LMICs. The International Student Surgical Network (InciSioN) was founded a few years ago to represent the voices of medical students in a unified manner at various fora and events. However, the unified voice of junior doctors and residents has remained absent on the international level. It is exactly this gap that created the opportunity for the Global Surgery Working Group to be created, and it is exactly this gap that we aim to fill.

The Global Surgery Working Group is the youngest working group of the JDN, formally established in February 2019, with 25 members from 20 countries. We have truly grasped the opportunity to create a platform where junior doctors can contribute to Global Surgery within the JDN. Led by Dr Manon Pigeolet and Dr Victoria Von Salmuth, this Global Surgery Working Group aims to provide a platform for residents and young doctors alike to increase professional networks, exchange essential information about global surgery, advocate for surgical patients at the local level and effective surgical health systems at international meetings, and provide opportunities for collaborations on policy or scientific papers on global surgery (**Photo 1**).

This working group was charged with creating a statement on *the Access to Surgery and Anesthesia Care*, to which various members of the working group provided feedback for the final content. The statement has been sent to the World Medical Association (WMA) Secretariat for further consideration and should be voted upon at the upcoming WMA General Assembly in the Republic of Georgia.



Photo 1. Dr Manon Pigeolet and Dr Victoria Von Salmuth are the co-chairs of the JDN Global Surgery Working Group. Credit: Manon Pigeolet.

Within the working group, members continue to collaborate on several projects related to research, education, and advocacy in Global Surgery. To further our efforts in research and advocacy, various contacts have been established with the G4 Alliance (an organization grouping over 75 surgical and anesthesia organizations worldwide) as well as the Alliance for Surgery and Anesthesia Presence (ASAP) from the International Surgical Society (ISS-SIC).

The Global Surgery Working Group plans to coordinate four upcoming projects for JDN members (**Figure 1**).

Activity	Description
Peer-reviewed Letter to the Editor	Members will prepare a collaborative letter with InciSioN titled, <i>Junior Doctors: The Missing Piece in Global Surgery</i> .
Informational Brochure	Members will develop a two-page summary about global surgery within the JDN framework. This document intends to provide an introduction of activities that support global surgery advocacy and increase awareness about the work of the JDN Global Surgery Working Group.
Survey	Members will prepare a survey titled, <i>Mapping of Exchange/Elective Opportunities in Global Surgery for Residents and Junior Doctors</i> . After survey pilot testing (August 2019) and launch (October 2019), members will disseminate the survey to National Member Associations, JDN members, universities, teaching hospitals, and national and international professional organizations.
Webinar Series	Members will prepare a webinar series titled, <i>What is Global Surgery, and How can Junior Doctors Contribute?</i> , to be launched in October 2019. Dr Kathleen Casey (ASAP) will present the first webinar titled, <i>An Introduction to Global Surgery</i> .

Figure 1. Description of four activities for the JDN Global Surgery Working Group.

If you are interested in Global Surgery and would like to participate with other JDN members in the Global Surgery Working Group, please contact our team (Dr [Manon Pigeolet](#), Co-Chair of the Global Surgery Working Group) to learn more information. This working group is open to all interested junior doctors who are working in surgical fields, completing subspecialty training, or training in other medical disciplines. We welcome new members on a rolling basis and are open to discuss ideas for future projects and collaborations.