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WORLD MEDICAL ASSOCIATION OFFICERS, CHAIRPERSONS AND OFFICIALS

Dr. Osahon ENABULELE

President
Nigerian Medical Association
8 Benghazi Street,
off Addis Ababa Crescent
Wuse Zone 4, P.O. Box 8829
Wuse, Abuja
Nigeria

Dr. Lujain ALQODMANI

President-Elect
Kuwait Medical Association
123 Fifth Avenue,
1202
Kuwait

Dr. Heidi STENSMYREN

Immediate Past President
Swedish Medical Association
(Villagatan 5) P.O. Box 5610
SE-114 86 Stockholm
Sweden

Dr. Jung Yul PARK

Chairperson of Council
Korean Medical Association
Samgu B/D 7F 8F 40
Cheongpa-ro,
Yongsan-gu
04373 Seoul
Republic of Korea

Dr. Otmar KLOIBER

Secretary General
World Medical Association
13 chemin du Levant
01212 Ferney-Voltaire
France

Dr. Tohru KAKUTA

Vice-Chairperson of Council
Japan Medical Association
113-8621 Bunkyo-ku, Tokyo
Japan

Mr. Rudolf HENKE

Treasurer
German Medical Association
(Bundesärztekammer)
Herbert-Lewin-Platz 1
(Wegelystrasse)
10623 Berlin
Germany

Dr. Steinunn

THÓRDARDÓTTIR
Chairperson,
Medical Ethics Committee
Icelandic Medical Association
Hlidasmari 8
201 Kópavogur
Iceland

Dr. Jack RESNECK

Chairperson,
Finance and Planning Committee
American Medical Association
AMA Plaza, 330 N. Wabash,
Suite 39300
60611-5885 Chicago, Illinois
United States

Dr. Zion HAGAY

Chairperson,
Socio Medical Affairs Committee
Israeli Medical Association
2 Twin Towers, 35 Jabotinsky St.,
P.O. Box 3566
52136 Ramat-Gan
Israel

Dr. Jacques de HALLER

Chairperson,
Associate Members
Swiss Medical Association
(Fédération des Médecins Suisses)
Elfenstrasse 18, C.P. 300
3000 Berne 15
Switzerland

www.wma.net

OFFICIAL JOURNAL OF THE WORLD MEDICAL ASSOCIATION

Editor in Chief**Dr. Helena Chapman**

Milken Institute School of Public Health, George Washington University, United States

editor-in-chief@wma.net

Assistant Editor**Mg. Health. sc. Maira Sudraba**

Latvian Medical Association

lma@arstubiendriba.lv, editor-in-chief@wma.net

Journal design by**Erika Lekavica**

dizains.el@gmail.com

Publisher**Latvian Medical Association**

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Editorial

The world has transitioned to a post-pandemic world, as the World Health Organization (WHO) Director-General confirmed the end of the coronavirus disease 2019 (COVID-19) as a global emergency, with over 765 million cases and 6.9 million deaths, on 5 May 2023. As our medical community reflects upon the emerging health risks that affect physical and mental health and well-being, our collective expertise can contribute to advancing the global health dialogue that drives the development of relevant policy and guidance documents to promote population health. Our strengths lie in using innovative approaches to widely disseminate accurate health messaging for our patients and communities, including easy-to-read infographics, smartphone apps, and social media tools, and identify existing disparities in access and availability of health services. As a call to action, World Medical Association (WMA) members can lead efforts that reinforce national and global political commitment to support relevant mitigation and adaptation plans and strengthen health system resiliency.

The WHO held the 76th World Health Assembly from 21-30 May 2023. Using the theme, “WHO at 75: Saving lives, driving health for all”, health leaders discussed an array of topics, including the burden of communicable and non-communicable diseases, emergency preparedness, indigenous health, and refugee and migrant health, and they shared the draft roadmap of the Global Health and Peace Initiative. This initiative, which underscores the interconnectedness between health and peace, aims to address the social and structural determinants, among other driving factors, that affect health in conflict and other vulnerable settings. Recent global initiatives, such as the UN Early Warnings for All initiative and the WHO Global Digital Health Certification Network, can help propel future collaborations that incorporate technology into risk assessment or exposure tools (including disease forecasting) and other nature-based solutions. Also, we continue to recognize WMA members and collaborating regional and national medical associations (NMAs) who have supported the Ukraine Medical Help Fund and the earthquake response efforts in Turkey and Syria.

After an energising 223rd World Medical Association (WMA) General Assembly (<https://www.wma.net/news-post/world-medical-association-council-meeting-17/>) in April 2023, we are excited to support the 224th WMA General Assembly that will be held in Kigali, Rwanda, from 4-7 October 2023. This meeting will offer opportunities for WMA members to engage in dialogue that will propel revisions to WMA statements and resolutions and information sharing about NMA priorities and activities.

In this issue, Mr. Nigel Duncan prepared a comprehensive summary of the event proceedings and incorporated three resolutions related to events occurring in Sudan, Uganda, and the United Kingdom, which were presented at the 224th WMA Council session. The One Health Initiative autonomous pro bono team prepared a historical review of the One Health Initiative and the “One Medicine – One Health” movement. Dr. Todd Sack shared the WMA’s My Green Doctor resource and the educational webinar on the harmful effects of gas stoves. Notably, 26 NMAs shared highlights on their leadership, history, mission and objectives, national and international collaborations, current challenges, and future vision. Finally, WMA members representing 16 countries described their tobacco control policies and community activities that support World No Tobacco Day 2023.

As a global organisation, we hope that WMA members can continue to reflect on our key clinical contributions to improve the health and well-being of our local and national communities. Together, our valuable leadership can truly advance scientific knowledge and develop and refine relevant health policies and guidelines that can mitigate risk of emerging One Health risks. We look forward to connecting and discussing important NMA topics in Kigali!

Helena Chapman, MD, MPH, PhD
Editor in Chief of the World Medical Journal
editor-in-chief@wma.net

WMA Council Report *Nairobi, Kenya, 20-22 April 2023*



Nigel Duncan

Thursday, 20 April

Council

The 223rd Council session, attended by around 200 delegates from almost 40 national medical associations (NMAs), was called to order by the Secretary General, Dr. Otmar Kloiber. He welcomed new Council members and read out apologies for absence.

Elections

Professor Jung Yul Park, Vice President of the Korean Medical Association, was elected unopposed as Chair of Council, to succeed Dr. Frank Ulrich Montgomery, who stood down after four years.

Dr. Tohru Kakuta (Japan) was re-elected Vice Chair of Council.

Mr. Rudolf Henke (Germany), was elected Treasurer in a contest against Dr. Phippe Cathala (France). He succeeds Dr. Ravindra Sitaram Wankhedkar (India).

Chair of Council's Report

Dr. Park said that physicians around the world were only just emerging from the long tunnel of the COVID-19 pandemic and that they were still facing many other local and global health challenges.

They would only succeed in tackling these challenges by working together, and he believed that the WMA had a crucial role by representing almost 15 million physicians worldwide. He was convinced that the WMA would become a more important international organisation in the future.

President's Interim Report

The WMA President, Dr. Osahon Enabulele, said that six months had gone by since his inauguration as the 73rd President. He reported on deeper relations with the World Health Organization (WHO), the landmark Memorandum of Understanding between the WHO and the World Health Professions Alliance, and that the top priority was strengthening of the health workforce in the pandemic treaty, particularly as it concerned their well-being, rights, working conditions, safety, and protection. He referred to the WMA support for their Ukrainian colleagues in the Russian invasion of Ukraine, and the public campaign to halt oppression and violence against physicians and other health professionals in Turkey and Iran. He also spoke about two new initiatives - the Meet the WMA President Roundtable and Leadership Series - to improve physicians' awareness of the WMA, and a WMA Global Healthcare Excellence Award Scheme.

Secretary General's Report

Dr. Kloiber reported on the successful dissolution of the WMA as an incorporated association in the state of New York. The Association was now registered in France only.

He spoke about the Ukraine Medical Help Fund, which had been set up with the Standing Committee of

European Doctors and the European Forum of Medical Associations. They had just received another grant from the Japan Medical Association of €1.4 million. The money was being used mainly on goods shipped to Ukrainian physicians and the Ukraine health system, and the Fund had now spent a total of €2.5 million. Since they believe that the conflict would continue, with subsequent recovery efforts, they hoped to receive more donations.

He also thanked the Taiwan Medical Association for making a donation to the WMA's travel stipend fund to help junior doctors when they were commissioned to attend meetings.

Immediate Past Chair of Council's Report

Dr. Frank Ulrich Montgomery said this was his last report as Chair of Council after four years. He said that the WMA had grown from a handful of medical associations at its foundation to a world-spanning membership of nearly 120 professional organisations of physicians. The WMA had become a 'United Nations of Physicians' – an organisation of debate and discussion – and recognised that they did not always have same opinion on issues. However, he said that they talked to each other, tried to understand one another, and where they did not understand or follow the position of their colleagues and friends, they formulated clear standpoints and firm positions of medical ethics and deontology.

He referred to the Russian invasion of Ukraine, sharing that physicians on both sides were fighting for their patients, and that physicians, nurses, and other health personnel had been killed in pursuit of their profession. He wrote: 'As a European citizen, I had

believed that this type of imperialistic and inhumane warfare was no longer possible on a civilised continent – but the Russian Government has proven me wrong. We mourn over the lives lost.’

He said that he had started work with the WMA in the early 1980s. During that time, the WMA had grown and become ever more important. He stated that: ‘If I had a wish for the future, I hope it will be possible to maintain the concept of a “United Nations of Physicians”, maintaining and expanding a platform for debate and discussion. We must not fall back into templates of “right or left” or “democratic versus autocratic” – we must not go into the trenches of a global political discussion. We must maintain our potential to talk to each other, argue, convince each other – and where that doesn’t seem possible, we have to make clear statements of opposing opinions – on a factual matter, not on personal injuries and insults.’

Matters of Urgency

Sudan

Dr. Kloiber submitted an emergency resolution from the Executive Committee on the conflict in Sudan. They had all seen reports of attacks that had not spared the health care system, with attacks on hospitals and other health care facilities. Since three or four ceasefires were not held, the resolution called for an effective ceasefire. During a brief debate, it was suggested by the British Medical Association (BMA) that the resolution should specifically mention the need for a safe passage for health care workers and patients, while the South African Medical Association proposed that reference be made to facilitating humanitarian aid.

The amendments were accepted and

the Council unanimously supported the resolution (see box).

Anti-LGBTQ Legislation in Uganda

The American Medical Association submitted an emergency Resolution calling on the Ugandan President to veto the proposed Bill that would criminalize certain homosexual acts, making them punishable by death or life imprisonment. The WMA shared a policy condemning stigmatisation and discrimination, as well as a policy which stated that homosexuality was a natural variation within the range of human sexuality.

The Secretary General said this was a matter of urgency as they still had time to intervene.

The Council agreed to the Resolution (see box).

Finance and Planning Committee

The Chair of Council welcomed the Committee members.

The Committee approved the report of the previous meeting held in Berlin from 5-8 October 2022.

Election of Chair of the Committee

Dr. Jack Resneck, President of the American Medical Association, was elected unopposed as Chair of the Committee to succeed Dr. Jungyul Park.

Membership Dues Payments

Mr. Adolph Hällmayr, the financial adviser, reported on the state of membership dues, comparing the membership dues paid to the number of declared members paid. The Committee considered the membership dues arrears. Mr Hällmayr said that those members in dues arrears were regularly contacted

by the secretariat and encouraged to return to good standing.

The Secretary General informed the Committee that the New Zealand Medical Association had now been removed from the membership since it was dissolved in 2022, and no longer existed. There were currently no organisations that met the criteria for membership.

Financial Statement

The Committee considered the pre-Audited Financial Statement for 2022, and the Treasurer, Mr. Rudolf Henke, and Mr. Hällmayr, reported that the WMA’s finances in 2022 were once again very solid.

The Committee recommended that the Statement be approved by the Council.

Finance Group

An oral report on the Finance Group was given by Dr. Montgomery, Immediate Past Chair of the Group. He referred to an increase in the cap amount of membership dues and a proposed increase in membership dues.

The Committee approved the increases for forwarding to the Council.

Statutory Meetings

The Committee considered plans for future meetings and recommended that the 229th Council Session be held from 15-17 April 2027, that the 77th General Assembly be held from 20-23 October 2027, and that the invitation from the Serbian Medical Chamber for Belgrade, Serbia, to host the 226th Council Session in 2024, be accepted.

World Medical Journal



It also recommended that the theme of the Scientific Session of the General Assembly in Helsinki 2024 be “Inequalities in health and health care – how to tackle them?”

Special Meetings

A report was given on future WMA special meetings, including:

- Regional meetings on the Declaration of Helsinki revision planned in the European, Pacific, and African regions
- Ethics conference in Ottawa in October 2023

Associate Membership

An oral report given by the Chair of the Associate Members, Dr. Jacques de Haller. He said that the number of associate members was nearly 1,900, composed of medical students, junior doctors, past Presidents, past Chairs of Council and independent physician members. The main activities of the Associate Members had included the formation of a steering Committee, active involvement in numerous workgroups and task forces, the coordination of a plenary meeting twice a year, and the organisation of webinars.

Junior Doctors Network

The JDN Chair, Dr. Uchechukwu Arum, reported that the Network continued its activities with external organisations, like the WHO, the International Federation of Medical Students' Associations, the Student Network of the International Physicians for the Prevention of Nuclear War, the European Junior Doctors Association, and the WHO Global Health Workforce Network Youth hub. The Network would create a toolkit to support existing and new national junior doctors' networks.

The JDN was increasing and welcoming new members from different parts of the world. It had continued quarterly newcomer sessions and also held regular monthly meetings. It had been active in contributing to WMA policy discussions and had represented the WMA at the 152nd WHO Executive Board Meeting. The Network had eight active working groups, and it was working on producing special editions of its *JDN Newsletter*. Finally, the Network had been active in regularly posting on social media platforms.

Past Presidents and Chairs of Council Network

A report of the Past Presidents and Chairs of Council Network (PPCN) was given by Past President, Dr. Kgosi Letlape. He reported that a new Chair had been elected, Dr. Kati Myllymäki from Finland, WMA President from 2002-2003, and as deputy chair, Dr. Wonchat Subhachaturas, WMA President from 2010-2011. Dr. Jón Snædal, WMA President from 2007-2008, had been re-elected as Secretary. He reported on the various activities of the Network and he welcomed Prof. Montgomery as a new member. He said the PPCN planned to have regular meetings.

Environment Caucus

Dr. Ankush Bansal, co-Chair of the Caucus, said that the first meeting of the group was in 2012, after it had been set up as an informal forum to discuss issues relating to environment and health. Since then, the group had met twice a year. Now, the environment had become a key topic globally, and he was proposing that the Caucus be set up as a workgroup with a defined mandate and membership. The Secretary General explained how the work of the Caucus could be streamlined if it was converted to a

workgroup.

The Committee recommended that a Caucus workgroup be set up and that the Legal Advisor consider whether the terms of service of the group should be amended, and if so and if approved by the Chair of Council, that this recommendation be forwarded to the Council.

World Medical Journal

An oral report was given by the *World Medical Journal's* Assistant Editor, Ms. Maira Sudraba. She said that author guidelines had been updated. All NMAs had been invited to write an article for the *World Medical Journal* about their national activities. She thanked those NMAs who had replied and urged others to contact the editorial team.

Public Relations

The Committee received a report from the Press Officer, Mr. Nigel Duncan. He encouraged members to cite WMA press releases and policies in their own press. He announced that this would be his last meeting, after 28 years of engagement. The Chair expressed gratitude for his many years of dedication to the WMA.

WMA Global Healthcare Excellence Award

A proposal for a WMA Global Healthcare Excellence Award was put forward by the President, Dr. Enabulele. He said that the aim was to create a platform for strengthening health systems and the WMA brand, through promotion of healthcare excellence among physicians and other critical stakeholders. The objectives were to improve the awareness and perception of the WMA as a global brand, to motivate physicians towards the strengthening of health systems, and to improve

the participation of physicians and NMAs in the affairs of the WMA.

He suggested three categories of awards - Global Physician of the Year, Global Young Physician of the Year, and Global Healthcare Excellence Award of the Year - to the country with the best efforts at attaining Universal Health Coverage. The overarching theme would be centred around 'Human Resource for Health and Quality Patient Care.' After a brief debate, the Committee recommended that the Secretariat should study the proposal and report back at the next meeting with further information and analysis of benefits, risks, financial impacts, and possible implementation strategies for further discussion.

Medical Ethics Committee

The Chair of Council called the meeting to order.

The Committee approved the report of the previous meeting held in Berlin on 5-8 October 2022.

Election of the Chair of the Committee

Dr. Steinunn Þórðardóttir, President of the Icelandic Medical Association, was elected unopposed as Chair of the Committee.

Declaration of Helsinki

Dr. Resneck, Chair of the workgroup, presented an update on the workgroup's progress and a timeline of the revision process for the coming months. They were six months into what they expected to be a two-year process. Since the last Committee meeting, regional meetings had been held in Israel on data collection, and in Brazil, focusing on the use of placebo. The next regional meetings were scheduled for September (Copenhagen, Denmark), November

(Tokyo, Japan), and early 2024 (South Africa).

The Committee recommended that the workgroup continues its work and proceeds with the several regional meetings.

Organ Procurement from Prisoners

The Committee considered a proposed revision of the WMA Declaration on Organ Donation for Transplantation from Executed Prisoners, submitted by a workgroup chaired by the Spanish Medical Association. This reiterated the Association's absolute opposition to human trafficking in organs and the use of organs from executed prisoners for transplantation purposes. It called on NMAs to work to ensure that physicians in their countries were not involved in any way in trafficking in organs or in the removal or transplantation of organs from executed prisoners. The proposer spoke of the strong determination that the Chinese Medical Association (CMA) had shown in trying to combat these deplorable practices.

A letter, just received from the CMA, was read out to the meeting. This said that the CMA fully supported China's complete prohibition on the use of organs from death penalty prisoners for transplantation, implemented on 1 January 2015. The CMA encouraged all her members to participate in China's efforts to establish a self-sufficient organ donation system in line with WHO guiding principles, and condemned the practice of using organs from executed prisoners for transplantation.

The Secretary General, Dr. Kloiber reminded the Committee of the extensive discussions between the WMA and the CMA over the past 18 years, during which the CMA said it would support the WMA's policy

opposing the transplantation of organs from death penalty prisoners. The WMA had asked the CMA to make a clear statement to this effect before it agreed to rescind its 2006 policy statement. He said that the letter now received from the CMA, fulfilled the WMA's request, allowing the 2006 WMA Declaration to be rescinded and rendering the revised Declaration proposed by the workgroup unnecessary.

A lengthy debate followed, during which the CMA explained what they had done in combating the transplant of organs from executed prisoners, but indicated that the practice was still going on elsewhere. Many speakers congratulated the CMA, although there were different views about whether the revised Declaration was necessary, as strong WMA policy already existed.

The Committee voted to rescind and archive the WMA Council Resolution on Organ Donation in China from 2006.

After further debate, the Spanish Medical Association said that in view of the new CMA letter, it would withdraw its revised Declaration.

On a vote, the Committee agreed to the retraction.

Medical Ethics during Public Health Emergencies

A proposed revision of the WMA Statement on Medical Ethics in the Event of Disasters was submitted by the Thailand Medical Association, Chair of the workgroup. The revised policy focused on the medical ethical aspects of public health emergencies. It was proposed that the title be changed to Statement on Medical Ethics during Public Health Emergencies, and if that was adopted, to rescind and archive the Statement

on Medical Ethics in the Event of Disasters.

During a brief debate, several friendly amendments were proposed and agreed.

The Committee recommended that the proposed Statement be approved and forwarded to the Council for adoption by the General Assembly, and that the Statement on Medical Ethics in the Event of Disasters be rescinded and archived.

Medical Technology

The Committee considered a proposed revision of the Declaration on Medical Ethics and Advanced Medical Technology submitted by the workgroup chaired by the Israeli Medical Association. This updates ethical guidelines for physicians in their use of medical technology. While welcoming the growth of medical technology and the enormous benefits it brings for the medical profession, patients, and society, the revised document warns that the rapidly developing use of big data could challenge confidentiality and privacy.

The Committee was told that the reasoning behind the revision was to produce a concise document with the principles from a number of WMA policies on this issue.

During the debate that followed, several editorial amendments were accepted, and the Committee agreed to recommend that the revised Declaration, as amended, be sent to the Council for approval and forwarded to the General Assembly for adoption.

Friday, 21 April

Resumed Medical Ethics Committee

Biological Weapons

A proposed major revision of the Declaration of Washington on Biological Weapons was submitted by the Swedish Medical Association. This declared that scientists working in biomedical research have a moral and ethical obligation to consider the implications of possible malicious use of their findings.

After a brief debate, during which several small amendments were accepted, the Committee agreed to recommend that the revision be sent to the Council for approval and forwarded to the General Assembly for adoption.

Armed Conflict and Other Situations of Violence

The Associate Members submitted a proposed major revision of the WMA Regulations in Times of Armed Conflict and Other Situations of Violence. The revised policy condemns the military targeting of health care facilities and personnel, as well as using the denial of medical services as a weapon of war, by any party, wherever and whenever it occurs. The Committee was told that this was a very relevant policy. One paragraph related precisely that when Turkish doctors pressed their government not to use chemical weapons, they were jailed. Several friendly amendments were suggested and approved.

The Swedish Medical Association proposed amending the sentence that physicians 'must not take part in any act of hostility and to the extent possible, refuse any illegal or unethical order'. They proposed deleting the

words 'to the extent possible', arguing that this weakened the sentence. The BMA supported this proposal, arguing that there should be no exemption. On a vote, it was agreed to delete the words.

The Committee recommended that the revised policy, as amended, should be forwarded to the Council for adoption by the Assembly.

International Medical Meetings

A proposed Statement on International Medical Meetings was submitted by the Associate Members. The Statement called on the medical community worldwide to refrain from holding international scientific medical events or conferences in countries where physicians are persecuted for speaking out for human rights or for their ethical principles, unless by holding the event, the medical community was able to show support for these physicians. It was argued that having a WMA meeting somewhere gave a strong signal of support to the local physicians and to the local health system. But if it was understood as support for authorities which oppressed physicians, then the WMA should refrain from having meetings in these locations.

During a lengthy debate, speakers supported the intention behind the Statement, but questioned how such a policy would be implemented. Would an NMA be contacted in advance of arranging a meeting? Would it cover only physicians' human rights or would it include the population? Should a list of negative countries be drawn up?

The French Medical Association proposed an amendment that read 'The WMA calls on the medical community worldwide to carefully evaluate the suitability of holding international medical events in

countries where physicians are persecuted and where appropriate to take a decision on whether to refrain from such events or to provide clear and explicit support for these physicians at such events’.

The Committee approved the amendment and agreed that the proposed Statement, as amended, be sent to the Council for approval and for adoption by the General Assembly.

Classification of Policies

The Committee agreed to recommend that the:

- WMA Statement on the United Nations Resolution for a Moratorium on the Use of the Death Penalty be reaffirmed with a minor revision
- WMA Statement on Advance Directives (Living Wills) be reaffirmed with a minor revision
- WMA Resolution on Prohibition of Physician Participation in Capital Punishment be reaffirmed with a minor revision

Human Rights

The Committee received the activity report of the Council with reference to work in the field of right to health, actions protecting patients and doctors and the Health Care in Danger Initiative.

Socio-Medical Affairs Committee

The meeting was called to order by the Chair of the Council. The Committee approved the report of the previous meeting held in Berlin on 5 October 2022.

Election of the Chair Committee

In a vote for Chair of the Committee, Dr. Zion Hagay (Israeli Medical Association) was elected in a contest with Dr. Alvaro Dendi (Uruguay Medical Association).

Health and Environment

Dr. Maki Lwando, Co-Chair of the Environment Caucus, reported on a recent meeting of the Caucus when delegates discussed the WMA contribution to the 2022 UN Climate Change Conference in Egypt, global activities on climate and health, and implementation and monitoring of Green Guidelines for WMA meetings to create more sustainable events.

Medical Technology

The Israeli Medical Association reported on the activities of the workgroup since the last Council meeting. One of its discussions was whether to formalise networking between NMAs. The reason for this was that members believed that different NMAs were in different stages of engaging with the idea of medical technology. Some were heavily involved, while others were less involved. One idea was to set up a WMA platform to enable and facilitate collaboration among member associations in the area of medical technology and to promote exchange of best practices.

The Committee was told that the workgroup would work on a more detailed proposal for discussion at the next Committee meeting.

Acknowledgement and Condemnation of the Human Rights Violations against the Uyghurs and other Minorities in China

The Committee considered a proposed Resolution from the BMA calling on the CMA to acknowledge the human rights violations against the Uyghurs and other minorities in China. The Resolution read ‘In light of the mounting body of evidence, including the report of 31 August 2022 from the OCHCR of medical involvement in severe human rights violations against the Uyghur people and other minorities in China, the WMA requested that the CMA acknowledges and condemns these violations’.

The BMA said that there was a very high degree of agreement with CMA, but they did not reach full agreement. As doctors, committed to alleviating suffering, they could not stand by while those who claimed to represent them acted in a way that threatened the health and dignity of their fellow human beings. They were independent medical associations, and it was their duty to speak out when they became aware of physicians falling below the standards they should uphold. Silence was complicity. The BMA had listened to the CMA and had made major changes to its Resolution, such as no longer referring to genocide. They requested that the CMA respond to these very serious issues and speak out against what was happening with the Uyghurs. The BMA answered those who asked why they were doing this, by saying that one day, a future historian would prepare the WMA history, and they were afraid that there would be documented evidence when the WMA should have spoken out but did not. It was the WMA’s duty to speak out. The report from the UN High Commissioner for Human Rights was a detailed,

well-documented analysis of the situation. It had concluded that serious human right violations had been committed in the Xinjiang Uyghur autonomous region.

Several delegates from the CMA responded strongly, saying that there was no evidence of genocide. They described the accusations from the BMA as vile and unfounded, and based on press reports. They spoke about China's one child policy introduced in 1980, which had led to a lower birth rate, and which had now changed. There was nothing special about the population and births in Xinjiang, as compared to other parts of China. The CMA invited other NMAs to visit China to see for themselves what was happening. They strongly opposed the BMA's resolution, and called for mutual communication and discussion.

A lengthy debate followed, with delegates speaking for and against the BMA's resolution. Several speakers urged the BMA to withdraw its resolution in order to create better harmony. It was also suggested that the WMA should visit the Xinjiang region to find out for themselves what was happening.

The Committee decided that a vote on the Resolution should be by secret ballot. The Resolution was approved for forwarding to the Council by 13 votes to 11.

Electronic Cigarettes and Other Electronic Nicotine Delivery Systems

The Committee considered a proposed revision of the Statement on Electronic Cigarettes and Other Electronic Nicotine Delivery Systems. The major revision, under the rule of revising all policies that are 10 years old, calls on the WMA and its members to support further research on the 'harmful effects of

e-cigarettes and electronic nicotine delivery systems (ENDS)', especially in children, adolescents and young adults.

Both the Danish and the German Medical Associations argued that the wording of the Statement should be much stronger and suggested various amendments. They suggested including the sentence that 'evidence already exists that e-cigarettes and ENDS are harmful and not safe'. Additionally, they recommended the addition of 'the belief promoted by manufacturers that these devices are acceptable alternatives to scientifically proven cessation techniques, when neither their value as therapeutic aids for smoking cessation nor their safety as cigarette replacements is established.' The suggestions were accepted as friendly amendments.

The Committee agreed that the Statement, as amended, be approved by the Council and forwarded to the General Assembly for adoption.

Support of the Medical Associations in Latin America and the Caribbean

The Committee considered a proposed major revision of the Resolution in Support of the Medical Associations in Latin America and the Caribbean. This condemns any government actions that undermine the policy requiring physicians working, either permanently or temporarily, in a country other than their home country to be treated fairly in relation to other physicians in that country.

The Committee approved the revised Resolution, as amended, for sending to the Council to forward to the General Assembly for adoption.

Forced Sterilisation

A proposed revision of the Statement

on Forced and Coerced Sterilisation was introduced by the American Medical Association. It was explained that minor changes had been made to the original document to make it stronger and align it with United Nations policy.

The Swedish Medical Association proposed deleting the statement advocating for appropriate disciplinary action, including possible licence revocation, against physicians who participated in such practices. They argued that the WMA did not usually suggest disciplinary action against physicians. This sentiment was agreed upon.

The Committee recommended that the proposed Statement, as amended, be approved by the Council and forwarded to the General Assembly for adoption.

Human Health as a Primary Policy Focus for Governments Worldwide

The BMA submitted a proposed Statement on Human Health as a Primary Policy Focus for Governments Worldwide. This proposal aimed to understand how they measured health and the wealth of nations. This resonated with the growing focus on the well-being economy and was an attempt to restate what they were asking their governments to do to promote that progress. Much of what it stated was in other WMA policy documents, especially about the primacy of the way in which Gross Domestic Product (GDP) was used as a measure of progress. As Robert Kennedy said in 1963, the GDP measured everything except that that makes life worthwhile. The BMA proposed that the document be recirculated within the membership for comments.

The Committee recommended that the document be recirculated.

Primary Health Care

A proposed Statement on Primary Health Care was introduced by the Junior Doctors Network, recommending ways in which primary health care can be strengthened to ensure adequate financial resources and equipment provision and a well-trained supply of primary care physicians.

A lengthy debate followed about the sentence which read, 'PHC should be provided in a manner that is accessible, comprehensive and coordinated by a physician to ensure appropriate and high-quality care.' A suggestion was made that the sentence should be amended to read 'ideally led by a physician'. Several speakers questioned the word 'ideally', as some governments favoured non physicians as a cheaper alternative. The Secretary General warned that in the international sphere there was a strong belief that primary care physicians were unnecessary and that such care could be provided by nurses and others.

Arguments were made for using the words 'physician-led', which did not mean that a physician had to be present, but that he or she was responsible. The Committee was warned against 'poor medicine for poor people'.

The Committee voted to amend the document to read that primary health care should be provided in a manner that was accessible, comprehensive 'and led by a physician' to ensure appropriate and high-quality care.

Another lengthy debate then followed, about the sentence calling for NMAs to 'promote that PHC services, whenever possible and appropriate, are provided by physician-led, multi-professional teams with an adequate

skill-mix.' After several suggested amendments, it was decided to delete the whole sentence.

The Committee voted that the amended Statement, as whole, should be sent to the Council for forwarding to the General Assembly for adoption.

Medical Workforce

The Committee received a report from the workgroup, revising the WMA Resolution on Medical Workforce from 2009. The revised document made a series of recommendations to tackle the global shortage of medical staff. The Committee was told that the Review Committee had pointed out that some of the sections of the proposed revision overlapped with existing WMA policies and needed to be shortened to address the core issues in a more concise way.

The Committee recommended that the revised Resolution be circulated within the membership for comments.

Epidemics and pandemics

The Junior Doctors Network proposed setting up a workgroup to to revise the WMA Statement on Epidemics and Pandemics from 2017. Although recognised as a strong statement, it argued that it needed to be strengthened in the light of the lessons learned from the COVID-19 pandemic response.

The Committee agreed to recommend this to Council.

Postgraduate Medical Education

The Committee considered the (WFME) Global Standards for Quality Improvement: Postgraduate Medical Education 2023.

It recommended that the document be endorsed by the Council, and that the WMA Resolution on WFME Global Standards for Quality Improvement of Medical Education be updated, accordingly.

Classification of Policies

The Committee agreed to recommend that the:

- WMA Statement on Forensic Investigation of the Missing undergo a minor revision
- WMA Statement on Fungal Disease Diagnosis and Management undergo a minor revision
- WMA Statement on Right of Rehabilitation of Victims of Torture undergo a minor revision
- WMA Resolution on Supporting the Ottawa Convention on the Prohibition of the use, stockpiling, production and transfer of anti-personnel mines and on their destruction undergo a minor revision
- WMA Resolution on Collaboration Between Human and Veterinary Medicine undergo a minor revision
- WMA Statement on Natural Variations of Human Sexuality undergo a major revision and that in the revision process, the Statement be kept distinct from the Statement on Transgender People. And that a workgroup be set up to undertake the revision of the Statement
- WMA Statement on Human Papillomavirus Vaccination undergo a major revision

World Medical Journal



Saturday, 22 April

Plenary Council

The Council resumed to consider reports from the three Committees.

Medical Ethics Committee Report

The Council agreed that the following documents be forwarded to the General Assembly for adoption of the:

- proposed revision of the WMA Declaration on Medical Ethics and Advanced Medical Technology
- proposed major revision of the WMA Declaration of Washington on Biological Weapons
- proposed major revision of the WMA Regulations in Times of Armed Conflict and Other Situations of Violence
- proposed WMA Statement on International Medical Meetings
- proposed WMA Statement on Medical Ethics during Public Health Emergencies and that the Statement on Medical Ethics in the Event of Disasters be rescinded and archived

It was recommended that the workgroup revising the Declaration of Helsinki should continue its work.

Organ Procurement from Executed Prisoners

The Council considered the Committee's recommendation that in light of the official statement from the CMA, the existing WMA Council Resolution on Organ Donation in China be rescinded and archived.

The Danish Medical Association said that rescinding the WMA Resolution

of 2006, and withdrawing the WMA's criticism of the donation practice in China was unfortunate. They appreciated the steps taken by the CMA, but believed that the WMA should maintain its pressure on the Chinese authorities to stop the use of prisoners for organ donation and not only against death penalty prisoners. They proposed that rather than rescind WMA Resolution of 2006, it should be amended and adopted or circulated for comment. They suggested that the Resolution read as follows: 'The WMA reiterates its position that organ donation be achieved through the free and informed consent of the potential donor. The WMA demands that Chinese authorities immediately cease any remaining practice of using any prisoners or detainees as organ donors'.

This was supported by the American Medical Association who believed that the WMA should take a strong stand, as they continued to receive reports of Chinese prisoners being subjected to organ donation. They proposed Denmark's amended Resolution.

The CMA opposed the Resolution. They said there was a law in China banning any use of organs from death penalty prisoners or detainees. This applied to all hospitals, including military hospitals. There had been no use of death penalty organs for transplantation since 2015. The CMA said that disinformation was being spread, and they asked NMAs, when they cited evidence, to confirm basic due diligence.

The Israel Medical Association said the simplest thing would be for the CMA to say they were completely against organ donation from prisoners. The Chinese argued that other countries allowed the voluntary donation of organs from detainees, and they repeated that they

were against any use of organs from prisoners.

The Australian Medical Association said that existing WMA policy did leave the door slightly open for prisoners to be able to donate, so a complete prohibition would not be in line with their policy.

Several speakers expressed concern about the proposed Resolution. Some believed that it referred to all prisoners and not just to death penalty prisoners, while others argued that the issue had been resolved by statements from the CMA.

One speaker argued that if they were going to discuss taking organs from any prisoners, from all of the transplantation societies in the world, then this was a no go. However, there were discussions now in the United States on prisoners donating organs as a trade-off for a reduction of sentence. To date, it had been refuted from the transplantation societies.

The Germany Medical Association said that they had to be careful not to conflict the two documents and contradict WMA policy. The issues of general donations and donations from death penalty prisoners should be separated.

It was eventually suggested that the proposed Resolution should be withdrawn for further consideration. It was argued that this was a very complex topic, and it was suggested that the discussion be postponed for a short break to see if some agreement could be found. On a vote, this was agreed by the Council.

The Council was later told that agreement had proved impossible and it was agreed that the matter should be postponed until the next meeting in Kigali.

Finance and Planning Committee Report

The Council approved the following items:

- pre-Audited Financial Statement for 2022
- increase in the cap amount for forwarding to the General Assembly for adoption
- 229th Council Session being held from 15-17 April 2027 and the 77th General Assembly being held from 20-23 October 2027
- invitation from the Serbian Medical Chamber for Belgrade, Serbia, to host the 226th Council Session in 2024, and the theme of the Scientific Session of the WMA General Assembly, Helsinki 2024 be “Inequalities in health and health care – how to tackle them?”
- setting up of an Environment Caucus workgroup
- WMA Secretariat study the proposal for a WMA Global Healthcare Excellence Award and report back at the next meeting with information and analysis of benefits, risks, financial impacts, and possible implementation strategies for further discussion

Socio-Medical Affairs Committee Report

The Council agreed that the following documents be forwarded to the General Assembly for adoption:

- the proposed revision of the WMA Statement on Electronic Cigarettes and other Electronic Nicotine Delivery Systems

- the proposed revision of the WMA Statement on Forced and Coerced Sterilisation

Acknowledgement and Condemnation of the Human Rights Violations against the Uyghurs and other Minorities in China

The Council considered the WMA Resolution from the Committee on Acknowledgement and Condemnation of the Human Rights Violations against the Uyghurs and other Minorities in China. The Resolution read as follows: ‘In light of the mounting body of evidence, including the report of 31 August 2022 from the OCHCR of medical involvement in severe human rights violations against the Uyghur people and other minorities in China, the WMA requests that the Chinese Medical Association acknowledges and condemns these violations’.

The BMA proposed an amendment to the Resolution, requesting the CMA ‘to acknowledge the concerns set out in the report by the UN High Commissioner for Human Rights and comply with the 2020 WMA Resolution on Human Rights Violations against Uyghur People in China.’ The BMA said it would be a problem for the WMA if it could not request its members to uphold established policies.

The CMA said that it was inappropriate and unjust to rush to a vote on this Resolution, targeting a NMA. Full deliberation had not been given to this issue in Committee due to lack of time. They highlighted once again their criticism of the BMA’s argument, emphasising the decline of China’s birth rate as a result of its birth control policy. They acknowledged the existence of the UN report, but they did not agree or accept the content, and they stated that there were errors in both the BMA’s report

and the High Commissioner’s report.

A lengthy debate followed, during which the BMA accepted an amendment to use the word ‘ask’ instead of request.

On a secret vote, the Council agreed to the amended Resolution by 15 votes to 11:

In light of the mounting body of evidence, including the report of 31 August 2022 from the OCHCR, of medical involvement in severe human rights violations against the Uyghur people and other minorities in China, the WMA asks the Chinese Medical Association to acknowledge the concerns set out in the report by the UN High Commissioner for Human Rights and comply with the 2020 WMA Resolution on Human Rights Violations against Uyghur People in China.’

Support of the Medical Associations in Latin America and the Caribbean

The Council considered the proposed revision of the Resolution in Support of the Medical Associations in Latin America and the Caribbean. The Council was told by the Spanish Medical Association that the statement needed some textual changes in relation to the accreditation of physicians’ training and how that was assessed. In addition, new evidence had been received that the More Doctors Program, which was located in deprived areas in Latin America and the Caribbean to provide doctors to support primary health care, no longer existed.

As a result, the Council agreed to recirculate the document.

Primary Health Care

The Committee considered the proposed WMA Statement on Primary Health Care. The Spanish

Medical Association suggested a friendly amendment to add to the recommendations the sentence as follows: 'To promote, through PHC a more accessible, close and humane medicine, centred in the person, and prioritising the needs and interest of patients.'

The amendment was supported, and the Council recommended that the Statement be forwarded to the General Assembly for adoption.

Migrants

An emergency Resolution was introduced by the BMA. It argued that the WMA had committed to uphold international law and specifically human rights law on numerous occasions. They knew that they had to be constantly vigilant in the face of continued threats to the rule of law. Since the British Government was a signatory to the European Convention of Human Rights, British officials played a leading role in drafting the Convention. Unlike many international agreements, individuals could take cases before the European Court of Human Rights. Recently, the British Government had adopted legislation that would allow it to send asylum seekers to Rwanda. They would then be able to continue their asylum applications there, but not for asylum in the United Kingdom which they had reached, but for asylum in Rwanda, and they would have no right to return. The UK Government recently attempted to fly a small group of these asylum seekers to Rwanda, but the plane was stopped on the runway by a ruling under article 39 of the Convention, which can impose interim measures to prevent a breach of human rights. This event had infuriated the British Government, which had now proposed legislation that would allow ministers to disregard such orders in the future. In other words, they could send asylum

seekers to another country, and those asylum seekers would then have a right to take a case, although no longer in the United Kingdom. The special rapporteur for the UN High Commissioner for Human Rights, an organisation for whom the BMA had the highest respect, had set out a series of concerns about the Rwanda policy and its lack of safeguards for human rights. The BMA had spoken out strongly about this on several grounds, but particularly because of the trauma it imposed on physicians caring for these desperate people, suffering from moral injury and burnout as a result of the COVID-19 pandemic, and looking after people whose rights were being overridden. The BMA was asking the WMA to condemn a government that was blatantly proposing disregarding an instrument of international law that it had freely signed up to.

The Council agreed that this was an emergency item, and the Resolution was approved.

Advocacy and Communications

An oral report was received from the Advocacy and Communications Workgroup. The aim of the group was to propose actions that WMA constituent members could take to help broaden the knowledge of the Association and strengthen the transmission of WMA ideas in the medical community, the public, and politicians. Progress was being made to take forward this activity.

Disciplinary Matters

Dr. Montgomery, past Chair of Council, presented a report on the WMA's rules for dealing with disciplinary matters, in relation to two issues where proposals had been made for excluding various medical associations – China and the Uyghur problem, and Russia and Belarus in

relation to the Russian invasion of Ukraine. He tabled a detailed report from the Executive Committee that set out the processes involved. He spoke about the historical background of the WMA following the Second World War and its development as a global consensus platform for medical ethics.

He was supported by the Secretary General who spoke about the importance of being able to discuss difficult problems without splitting up.

The Executive Committee's report was received.

World Health Assembly

The Secretary General reported on the forthcoming World Health Assembly (WHA), mentioning two items of concern. The first was the continuing discussion on a pandemic treaty, and the second was the review of the international health regulations, as the agreement between states on how to interact and report when epidemics occur.

On the pandemic treaty, the WMA had been trying to concentrate on the role of health personnel, because they observed that health professionals had suffered tremendously from the COVID-19 pandemic through unfair treatment and workplace stressors.

Other issues on the WHA agenda were the extent to which health personnel would be involved in the global peace initiative, universal health coverage, and the need for more investment and support for the health workforce.

IPPNW Presentation

A brief presentation was given by Mr. Charles K. Johnson, Program Director of the International Physicians for the

World Medical Journal



Prevention of Nuclear War. He spoke about the Russian invasion of Ukraine and the threat of nuclear weapons, as well as the consequences of any war between India and Pakistan. To prevent a nuclear war, he suggested the continued participation in joint statements and getting more nations to join the treaty on the prohibition

of nuclear weapons. He said that the WMA and NMAs could help by advocating for the revision and refreshment of the WHO study on the effects of nuclear war on health and health services, which was completed in 1987.

The Council meeting ended with a

round of thanks from the Secretary General to all those who had made the meeting such a success.

Nigel Duncan

Public Relation Consultant

World Medical Association

nduncan@ndcommunications.co.uk



Photo 1. Group photo of the Council Meeting in Nairobi. Credit: World Medical Association

WMA COUNCIL RESOLUTION FOR AN IMMEDIATE AND EFFECTIVE CEASEFIRE IN SUDAN AND THE PROTECTION OF HEALTH CARE

Adopted by the 223rd WMA Council, Nairobi, Kenya, April 2023

PREAMBLE

Since Saturday, 15 April, violent fighting has broken out in Khartoum and several cities of Sudan between the Sudan Armed Forces (SAF) and Rapid Support Forces (RSF), an independent paramilitary force.

Since the outbreak of the conflict, water, electricity, and medicine have been in short supply in the capital, and the humanitarian situation is deteriorating by the day. Hospitals are closing due to a lack of equipment and staff who are prevented from going to work. Medicines, oxygen bottles, and blood bags are running out. Five facilities have been evacuated after being riddled with bullets and

partially destroyed by rockets. Media reports increasing numbers of civilians killed in the fighting.

On 20-23 April, the WMA Council met in Nairobi and condemned in the strongest terms the outbreak of fighting in the country, which has a devastating impact on the healthcare system, and warns that hospitals and healthcare facilities must never become targets in a conflict.

RECOMMENDATIONS

The WMA Council supports the call for an 'immediate' and effective ceasefire in Sudan by UN Secretary-General António Guterres on Monday, 17 April, urging "*all those with influence over the deteriorating situation to press for peace, and support efforts to end the violence*

[and] restore order," and calls upon all parties to the conflict to:

- Respect the ethical principles of healthcare, including medical neutrality, to guarantee the safety of patients and health personnel, and take immediate steps to ensure that they are not targeted or affected by the fighting, including the provision of safe passage of healthcare workers and patients, where evacuation is required;
- Ensure that hospitals and healthcare facilities have adequate supplies and staffing to provide care to those in need and facilitate humanitarian aid.

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

Adopted by the 223rd WMA Council, Nairobi, Kenya, April 2023

The WMA expresses its grave concern about reports that the United Kingdom (UK) government has proposed legislation that would allow ministers to disregard the injunction interim measures issued by the European Court of Human Rights (ECHR) under Rule 39 of the rules of the court in relation to the treatment of migrants. The

WMA is committed to the principle of respect for international law. If enacted, this legislation would remove an important protection for people seeking asylum, other migrants, and those health workers caring for them.

Rule 39 interim measures have prevented the forced removal of asylum seekers from the UK to Rwanda, under a controversial offshoring scheme that the UK medical community

has condemned on medical, ethical, and humanitarian grounds.

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

WMA COUNCIL RESOLUTION ON ANTI-LGBTQ LEGISLATION IN UGANDA

**Adopted by the 223rd WMA Council,
Nairobi, Kenya, April 2023**

PREAMBLE

The WMA Council is gravely concerned about the “Anti-Homosexuality Bill,” which makes certain homosexual acts punishable by death, that was passed in the Ugandan Parliament on 21 March 2023. The WMA originally condemned the bill in a press release issued on 24 March 2023.

The Ugandan bill would criminalize certain homosexual acts and make them punishable by death or life imprisonment. As stated in the WMA Statement on Natural Variations of Human Sexuality, “The WMA condemns all

forms of stigmatisation, criminalisation and discrimination of people based on their sexual orientation.” Further, “Homosexuality is a natural variation within the range of human sexuality” and “Discrimination, stigmatisation, peer rejection and bullying continue to have a serious impact upon the psychological and physical health of people with homosexual orientations.”

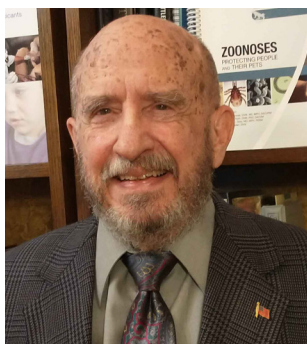
The Ugandan bill would also criminalize an individual who “holds out” as transgender or queer. As confirmed in the WMA Statement on Transgender People, “The WMA condemns all forms of discrimination, stigmatisation and violence against transgender people and calls for appropriate legal measures to protect their equal civil rights.”

RECOMMENDATIONS

Therefore, the WMA Council, reaffirming its statements on Natural Variations of Human Sexuality and on Transgender People, calls on:

1. Ugandan President Yoweri Museveni to veto the Anti-Homosexuality Bill and prevent it from becoming law;
2. WMA Constituent members to condemn the proposed Ugandan bill and any similar legislation that is proposed or enacted.

'One Medicine–One Health': An Historic Perspective



Bruce Kaplan



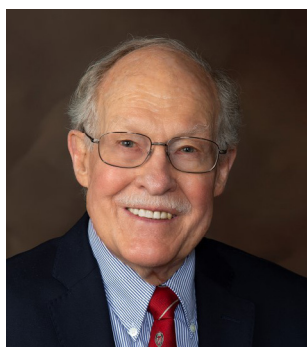
Lisa A. Conti



Craig N. Carter



Laura H. Kahn



Thomas M. Yuill



Becky Barrentine



Thomas P. Monath



Helena J. Chapman



Richard Seifman



Jack P. Woodall

Adapted with permission from the One Health Initiative [1]

As we reflect upon the array of global health challenges that affect morbidity and mortality rates, we recognize the need to better understand the determinants of health that influence health outcomes. The One Health concept offers a holistic perspective of the interconnectedness between

human, animal, and environmental health [2] (Figure 1). In short, One Health is defined by the One Health High Level Expert Panel (OHHLEP), supported by the World Health Organization (WHO), Food and Agriculture Organization (FAO), World Organisation for Animal Health (OIE), and the United Nations Environment Programme (UNEP) [2]:

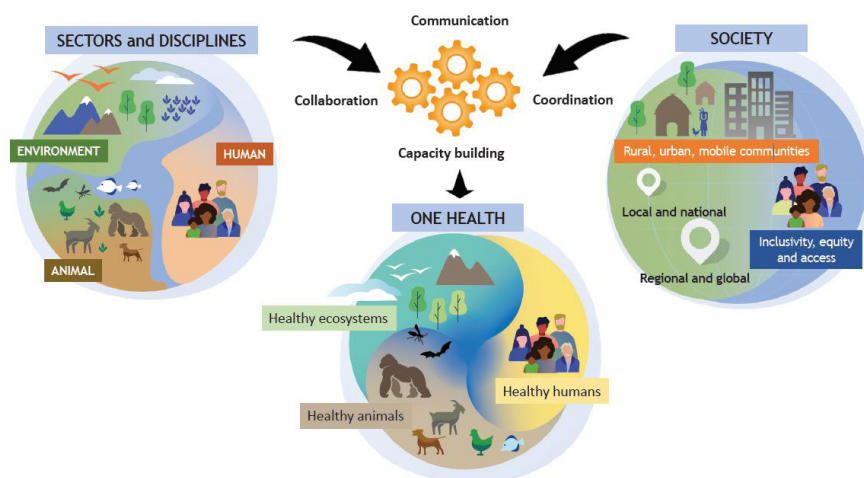


Figure 1. Definition of the One Health concept [2].

“One Health is an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems.

It recognizes the health of humans, domestic and wild animals, plants, and the wider environment (including ecosystems) are closely linked and inter-dependent.

The approach mobilizes multiple sectors, disciplines and communities at varying levels of society to work together to foster well-being and tackle threats to health and ecosystems, while addressing the collective need for clean water, energy and air, safe and nutritious food, taking action on climate change, and contributing to sustainable development.”

The One Health implementation's *raison d'être* is to significantly help protect and save untold millions of lives in our current and future generations. The One Health Joint Plan of Action (2022–2026), which was published by the Quadripartite Organizations (WHO, FAO, OIE, UNEP) in October 2022, offers specific guidance on how to support the One Health concept in practice and strengthen resilience of local,

national, and global health systems [3]. In this article, authors will offer a historical review of One Health, where they will describe the main scientific leaders – from human, animal, and environmental health sciences – who propelled the One Health movement since the 1880s to present day.

Before the Modern “One Health” Era

Two main scientists led efforts to expand the connections between human and animal medicine. First, Dr. Rudolf Virchow is recognised as the father of cellular pathology. He noted that disease transmission was possible from animals to humans and subsequently coined the term “zoonosis”. He stated that *“Between animal and human medicine there are no dividing lines--nor should there be. The object is different but the experience obtained constitutes the basis of all medicine”* [4]. Second, Dr. William Osler is known as the father of modern medicine and founder of veterinary pathology [5]. By 1884, Dr. Osler had made significant strides in medical and veterinary sciences, academic teaching, and laboratory sciences.

Origin of the Present Day’s “One Health” Concept

Two leading 20th century national and international veterinarian leaders paved the way as influential synergistic One Health champions. Dr. James H. Steele, who is recognised as the Father of Veterinary Public Health, was founder of the U.S. Centers for Disease Control and Prevention (CDC)'s Veterinary division in 1947 [6]. This division advocated for One Health principles, zoonotic disease management, and other prioritised global health endeavours. Dr. Calvin W. Schwabe, who is recognised as the Father of Veterinary Epidemiology, had monumental intellectual contributions, including coining the “One Medicine” term [7].

On 24 July 2007, Dr. Steele wrote a note to the author saying, *“Congratulations. You have moved OH [One Health] to a higher level with your [OHI team] campaign, One World, One Medicine, One Health.”* Deliberately, Dr. Steele routinely included the term One Medicine prior to One Health, in oral communications with the author, during the late 20th and early 21st centuries. As a former OHI Advisory Board member, Dr. Steele followed Dr. Schwabe's One Medicine concept, and helped usher in the historically modern-day One Health movement. These steps subsequently eventually led to the American Veterinary Medical Association (AVMA) and American Medical Association (AMA), together adopting and highlighting the 21st century's most significant One Health forefront.

In the One Health vanguard, many luminous One Health leaders emerged, including physicians, and highlights the *‘lest we forget’* phrase about other physician and veterinarian historic One Medicine–One Health

pioneers [8,9]. Early appreciation and acknowledgment of comparative medicine and translational research [10] – now recognised in the One Health umbrella (Figure 2) – was presciently discussed in Dr. Schwabe’s book, *Cattle, Priests, and Progress in Medicine*, which was published in

a much greater role in the training of persons for research in human medicine.

To illuminate the historical link between animals and man in medical progress, Professor Schwabe recounts highlights in the history of medicine from ancient times onward. He describes the early history

The 21st century physician trailblazer, instrumental in establishing the modern One Health movement, was the late Dr. Ronald M. Davis, who was the former president of the American Medical Association (AMA) and former director of the Henry Ford Health System’s Center for Health Promotion and Disease Prevention [12]. A visionary physician One Health leader, Dr. Davis adroitly guided the passage of the landmark AMA One Health resolution that has propelled further into the 21st century “One Health” movement lexicon.

On 3 July 2007, Dr. Davis and the AMA shared a message with the OHI team: “I’m delighted that the AMA House of Delegates has approved a resolution calling for increased collaboration between the human and veterinary medical communities and I look forward to seeing a stronger partnership between physicians and veterinarians. Emerging infectious diseases, with the threats of cross-species transmission and pandemics, represent one of many reasons why the human and veterinary medical professions must work more closely together.” Dr. Davis’ prophetic coalition with Dr. Roger Mahr, the former president of the American Veterinary Medical Association, signaled the re-emergence of the human medical profession’s participation in the rekindling of a One Health surge for the betterment of humankind, animals, and the environment.

In 2006, Dr. Laura Kahn, a physician and policy researcher at Princeton University, published *Confronting Zoonoses, Linking Human and Veterinary Medicine* in the *Emerging Infectious Diseases* journal [13]. Dr. Bruce Kaplan, a veterinarian, contacted her to discuss the implications of the article. Their conversations led them to co-found the One Health Initiative, a *pro bono*

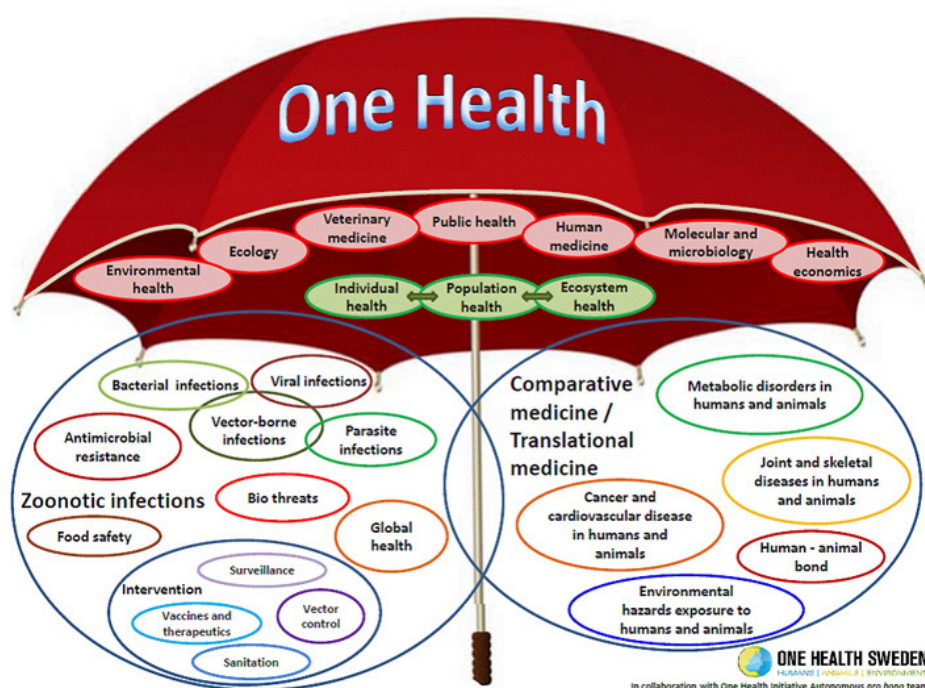


Figure 2. One Health umbrella (Credit: <https://onehealthinitiative.com/the-one-health-umbrella/>)

1978. This book was an expansion of the 1977 fourth series of Spink Lectures in Comparative Medicine, especially the fourth volume of the Wesley W. Spink Lectures on Comparative Medicine that highlighted Dr. Spink’s work as a physician who “maintained a deep interest in comparative medicine for almost forty years...” [11], as stated:

“...The author [Dr. Schwabe] shows that over the centuries many of the most significant breakthroughs in improving human health have been closely associated with observations and experiments on animals other than man. Because human medical progress has been so dependent on veterinary studies, he urges that schools of veterinary medicine assume

of man in terms of animal cultures, focusing on the prehistoric Nile Valley, and points to similarities in medical knowledge between present-day “cattle” societies in Northeastern Africa and the ancient people of the Nile. He discusses the comparative healers of ancient Egypt, the comparative foundations of Greek medicine, the Arabic contribution, Sicily and the beginnings of modern medicine, and subsequent developments through the Renaissance. Bringing the history down to modern times, Professor Schwabe emphasizes the role of veterinary medicine in medical research. He outlines specific reforms in the curricula of schools and colleges of veterinary medicine which would provide for the education of medical investigators.”

group of individuals dedicated to promoting the One Health concept. Dr. Kahn has served as a columnist with the *Bulletin of the Atomic Scientists* (<https://thebulletin.org/biography/laura-h-kahn/>) and has authored several books, including *Who's in Charge? Leadership During Epidemics, Bioterror Attacks, and Other Public Health Crises and One Health and the Politics of Antimicrobial Resistance* [14,15]. She has also created a free, online Coursera course entitled, *Bats, Ducks, and Pandemics: An Introduction to One Health Policy* (<https://www.coursera.org/learn/onehealth>). Currently, she is working on her next book using the One Health concept as a framework to examine coronaviruses.

Important “One Health” 21st Century Events

The AMA One Health resolution was originally drafted by Dr. Kahn, with guidance by Dr. Davis, and contributions by Dr. Kaplan and Dr. Thomas P. Monath. Dr. Davis, Dr. Mahr, and Dr. Kahn testified at the AMA convention in Chicago, urging the organisation to support the resolution. After the AMA unanimously passed the resolution, Dr. Davis and Dr. Mahr led the historic One Health liaison between the AVMA and the AMA. In response, the AVMA passed a One Health resolution concomitant with the AMA House of Delegates annual meeting on 24 June 2007.

One highly influential on the world scene was the 2012 World Medical Association (WMA) and World Veterinary Association (WVA) One Health statement published in 2012 [16]. Dr. Cecil B. Wilson (<https://www.wma.net/blog-author/cecil-b-wilson/>), who was the WMA president at the time and AMA past president, led this Memorandum of Understanding, together with the

current and past WVA presidents, in October 2012.

In November 2012, the American Association of Public Health Physicians (AAPHP) (<https://www.aaphp.org/OneHealth/>) became a supporter of OHI and the One Health concept/approach. Dr. Virginia “Ginny” Dato, who served as AAPHP president and Dr. Dave Cundiff who was the AAPHP’s AMA representative, strongly endorsed One Health. This lent considerable impetus to the validity of implementing and institutionalising the One Health approach for efficaciously expediting national and global public health and clinical research endeavours. Dr. Wilson and Dr. Dato are members of the OHI Advisory Board (Hon.).

The World Bank recognised the One Health concept, noting that, “*Public health systems have critical and clear relevance to the World Bank’s twin goals of poverty eradication and boosting shared prosperity. ...*” [17]. Detailed documentation and evaluation guidelines helped established an essential financial underpinning and support for the One Health concept [18-19].

In August 2022, Dr. Kahn, co-founding physician member of the OHI team, collaborated with the OHI team’s prolific new member associate and eloquent wordsmith. Together with Mr. Richard Seifman, former World Bank Senior Health Advisor (<https://onehealthinitiative.com/former-senior-health-adviser-at-the-world-bank-joins-one-health-initiative-team/>), they published a far reaching proposal with, expressing the vision that “*A new World Bank/WHO Fund could treat prevention as a priority and for which the One Health interdisciplinary approach is critical*” [20].

An important One Health

concept is the development of disease countermeasures through coordinated efforts of veterinary and human medicine, that benefit both animals and humans. Examples of specific products that address diseases common to both include vaccines for prevention of rabies in raccoons, foxes, dogs, cats and humans, and ivermectin for prevention of heartworm and other parasites of animals and of onchocerciasis (river blindness) in humans. Other examples are vaccines in development against West Nile virus disease in horses and humans; against coccidioidomycosis in dogs and people; and against Lyme disease in dogs, wild rodent reservoir hosts and humans. Vaccination of animals plays a potentially expanding role in the prevention of zoonotic diseases affecting humans [21-24].

In 2018, Dr. Fauci notified the OHI team that he recognised and endorsed the One Health concept (<https://onehealthinitiative.com/again-follow-dr-faucis-lead/>).

Important “One Health” 21st Century Leaders

Three visionaries – Dr. Schwabe, Dr. Steele, and Dr. Davis – were arguably the historic titans of the expanded and dynamic One Health era in today’s 21st century. Other health scientists have helped propel the One Health movement over the next years.

Dr. Roger Mahr [25] and Dr. Lonnie King (<https://vet.osu.edu/deanking>), select members of the 2008 AVMA One Health Task Force, and European and Asian leaders contributed immensely during the 21st century. These countries included Australia, Canada (<https://onehealth.uoguelph.ca/>), China, Greece, India, Japan, Portugal (<https://onehealth.icbas.up.pt/en/>), South America, Sweden, Switzerland, and the United Kingdom [26-35]. A promising

newcomer to the world's One Health scene is Africa [36].

Since 2010, the One Health Commission (OHC) (https://www.onehealthcommission.org/en/leadership__board_of_directors/) and One Health Platform (OHP) leaders have staunchly helped elevate and propel the One Health movement in the United States and worldwide. Since 2013, Dr. Cheryl M. Stroud has served as OHC executive director and developed a comprehensive educational website (<https://www.onehealthcommission.org/>), and together with the OHI and OHP, initiated the popular One Health Day concept (<https://onehealthday.com/>). During the last two decades, EcoHealth Alliance (<https://www.ecohealthalliance.org/senior-leadership>) leaders of a major environmental and wildlife silo have given One Health impetus.

The One Health for One Planet Education Initiative (1 HOPE) has been indefatigably led by Dr. George Lueddeke (<https://onehealthinitiative.com/wp-content/uploads/2022/08/22.08.2022-pdf-1-HOPE-Updated-Regional-Consortia-1.pdf>). Dr. Lueddeke's publications have included *Survival: One Health, One Planet, One Future* (Routledge Studies in Sustainability), *Planet Earth: Averting a Point of No Return?*, and a three-part *Reflections on the Transformation of Higher Education in the 21st Century* [37–39].

Another remarkable trailblazer physician One Health contributor has been and is Dr. Gregory Gray. Among many extraordinary One Health accomplishments, including the Duke One Health Newsletter (<https://onehealthinitiative.com/duke-one-health-newsletter/>), Dr. Gray had established the first doctoral degree with a concentration

in One Health (<https://egh.phhp.ufl.edu/education/degree-programs/phd-in-one-health/>), while directing the University of Florida's One Health program (<https://onehealth.ifas.ufl.edu/>). Dr. Gray recently left Duke University and launched an extraordinary One Health Program at the University of Texas Medical Branch (UTMB) at Galveston, Texas (United States) (<https://www.utmb.edu/one-health>).

The landmark textbook, *Human-Animal Medicine: Clinical Approaches to Zoonoses, Toxicants, and Other Shared Health Risks* (2010), was prepared by Dr. Peter Rabinowitz (<https://deohs.washington.edu/faculty/peter-rabinowitz>) and the late Dr. Lisa A. Conti [40]. This physician-veterinarian collaboration set a high bar in the scheme of One Health textbook publications. Other important textbook contributions followed (https://www.onehealthcommission.org/en/resources__services/one_health_library/books/), including excellent international educational endeavours of 1 HOPE and One Health Lessons (<https://onehealthlessons.org/>).

One major physician One Health leader, Dr. Monath, an internationally recognised virologist and vaccinologist [41], co-founder of the OHI team, and AVMA taskforce member, voiced a suggestion to members of the new OHI team alliance (2007) regarding the value of instituting a unique DVM (VMD)/MD (DO) degree program. There are many examples of where various individuals have attained both degrees and went on to become exceptionally prominent and productive international health care participants.

One such dual degree professional is Dr. Steven W. Atwood, who practises veterinary medicine at Animal Health Care Associates in West Tisbury,

Massachusetts (United States). Dr. Atwood, an avid One Health advocate (<https://onehealthinitiative.com/portrait-of-a-dedicated-u-s-one-health-leader/>), co-authored a paper discussing Dr. Monath's suggestion of combining medical and veterinary medicine programs [42]. This article was revised and reprinted in the *One Health & Implementation Research* journal. Also, one renowned physician is Dr. Gary S. Roubin, who served as an interventional cardiologist, with the Cardiovascular Associates of the Southeast Birmingham in Alabama, endorsed the One Health concept [43].

A strong longstanding One Health advocate, Dr. Myron “Mike” G. Schultz, a trained veterinarian and physician, detected a cluster of pneumonia cases in the early 1980s, which helped public health officials identify the acquired immunodeficiency syndrome (AIDS) epidemic [44]. As an infectious disease epidemiologist with the U.S. CDC, Dr. Schultz created the Parasitic Diseases Drug Service to provide physicians with medicines to treat rare illnesses, including pentamidine. Prescribed for patients with African sleeping sickness, it was also made available to treat patients with pneumocystis pneumonia in the early years of the AIDS epidemic, when few alternatives were available. He published more than 110 papers and book chapters, including epidemiology and the history of medicine, in the *New England Journal of Medicine*, the *Journal of the American Medical Association*, the *American Journal of Tropical Medicine & Hygiene*, and the *Emerging Infectious Diseases* journal. He also served as an epidemiology consultant to the WHO, the Pan American Health Organization, and the Ministries of Health of the Egypt, Federal Republic of Germany, Haiti, Indonesia, Israel, Poland, People's Republic of China,

Republic of China (Taiwan), Republic of South Vietnam, Saudi Arabia, and Zimbabwe.

An excerpt of his career path was shared in the *Emerging Infectious Diseases* journal: “...With DVM and MD degrees in hand, Mike interned at the US Public Health Service Hospital (Boston, MA, USA). This internship led to his recruitment by Alexander D. Langmuir (1910–1993) and a transformative 2-year stint in Langmuir’s Atlanta-based Epidemic Intelligence Service (EIS) training program at the (then-named) Center for Disease Control (CDC). Mike’s EIS experiences included a 1964 deployment to Vietnam to investigate infectious disease threats in the war and an important friendship with James Harlan Steele, DVM (1913–2013), the renowned veterinary epidemiologist/epizootiologist whose leadership helped to formulate their shared concept of “One Health”—the idea that humans, animals, and the environment are all part of an intertwined ecosystem with respect to disease occurrence and microbial evolution—and to shape the conceptualization of emerging infectious diseases...” [44]. His biography continues to inspire future generations in veterinary medicine and environmental health sciences [44]. In July 2018, Dr. Schultz was posthumously awarded the American Veterinary Epidemiology Society’s (AVES) (<https://www.avesociety.org/>) coveted Gold Headed Cane award.

The One Medicine–One Health extensive 20th century dissertations and public speaking engagements – inspired by Dr. Schwabe’s and Dr. Steele’s work – examined disease transmission among humans, domestic animals, and wildlife. This was reaffirmed and expanded upon in 2004, with the organisation of the One World, One Health

conference in New York (http://www.oneworldonehealth.org/sept2004/owoh_sept04.html), which aimed to explore how to best combat health threats to humans and animals from disease transmissions, using a One Health approach. This was widely documented well before the 21st century surge in awareness and recognition, with various quests for exclusive provincial nomenclature credit and tribalism.

Indeed, the author personally recalls telephone conversations in the 1990s, wherein Dr. Steele expressed the phrase, “One World–One Medicine–One Health”, in the context of discussing Dr. Schwabe’s contribution to One Health origins [45]: “...I met and spent part of a morning and lunch with Dr. Schwabe at the home of one of his close friend(s) [a leading New Jersey Department of Health]—public health authority in Princeton, N.J. (USA), Oscar Sussman, DVM, MPH, JD...in the early 1960s...” (<https://onehealthinitiative.com/20th-century-public-health-leader-and-unheralded-early-one-health-practitioner-dies>). Memorably, veterinarian Dr. Sussman and his arbovirus research physician collaborator, then New Jersey’s laboratory director Dr. Martin Goldfield, helped inspire this author and contributor to further appreciate the potent influence a One Medicine–One Health approach (i.e. transdisciplinary paradigm offered to ‘grease the skids’ for advancing society’s health care strategic management).

A foundational public health physician and One Health leader, Dr. D. A. Henderson, professor of medicine and public health at the University of Pittsburgh, collaborated extensively with Dr. Steele. He is the late legendary leader of the worldwide smallpox eradication program. On 22

April 2007, he commented to the OHI team: “I thank you for your email and congratulate you and your colleagues in promoting the “One Medicine” concept. It is an initiative that is long overdue but, at the same time, I don’t personally identify dramatic solutions that are apt to change the landscape in the short term. I would note that when one has had the good fortune to have enjoyed the tutelage of Jim Steele during my tenure at CDC and periodically ever since, as a friend, the one medicine concept becomes well engrained. Indeed, when I came to Hopkins as Dean in 1977, I cast about to determine how we might link up with a veterinary school for research and educational purposes. Unfortunately, geography was simply too great a hurdle to overcome. Bottom line: I would be more than happy to do whatever I could in support of your efforts” (<https://onehealthinitiative.com/endorsements/>).

There were abundant descriptive publications and lectures from both iconic leaders, Dr. Steele and Dr. Schwabe, cogently and powerfully voicing the One Medicine–One Health concept during the latter half of the 20th century. Dr. Steele continued promoting One Health activities for 13 years into the 21st century, which were documented in his biography [46–48].

The essence of how Dr. Steele and Dr. Schwabe influenced the One Health movement was captured by Dr. King, Chair of the AVMA One Health Initiative Task Force, in his special report [49]. Dr. King was recognised as a living “giant” in the One Health movement, as the then director of CDC National Center for Zoonotic, Vectorborne, and Enteric Diseases (<https://www.cdc.gov/nceid/index.html>) and member of the AVES Board of Directors. In 2009, he proposed and established the CDC One Health Office (<https://>

www.cdc.gov/onehealth/index.html). Currently, Dr. Casey Barton Behravesh is the director of the CDC One Health Office.

The author suggests that readers review the History of the One Health Initiative CDC’s One Health Resource Library, which offers comprehensive websites including the historic One Health chronicle [50–51]. More than ample generational evidence exists to literally scream out, “Why was this One Health modality not widely implemented much earlier? While exponentially expanded on the world stage today, why is it still not ramrodded above and beyond its current status?! Additional resources can be found in the *Impakter Magazine* collection of One Health articles (<https://impakter.com/tag/one-health/>), including a brief analysis on innovative applications of artificial intelligence for the future [52].

Conclusion

As we join forces in the One Health movement, we appreciate the complementary poetic words by two authors. Lewis Carroll wrote the “Walrus and the Carpenter” poem, where he highlighted the urgency of the moment: “*The time has come,*” *the Walrus said*” [53]. Edwin Milliken published the “Finest Hour 131, Summer 2006” poem, where he reflected on a train wreck and individual responsibility: “*Who is in charge of the clattering train?*” [54]. Adapting these poetic references to the One Health concept, we must act promptly, take responsibility for our actions, and promote transdisciplinary collaborations to develop innovative solutions to complex global health challenges.

Hence, to the crewmen of the world’s political and health establishments’ powers-that-be, WAKE UP!

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Authors of the One Health Initiative Autonomous pro bono Team

Bruce Kaplan, DVM
Contents Manager/Editor, One Health Initiative website
Co-Founder, One Health Initiative team/website
Sarasota, Florida, United States
bruce@kaplandvm.com

Laura H. Kahn, MD, MPH, MPP, FACP
Co-Founder, One Health Initiative team
Former Research Scholar, Program on Science and Global Security, Princeton School of Public and International Affairs, Princeton University
Bethesda, Maryland, United States
lkahn@alumni.princeton.edu

Thomas P. Monath, MD
Co-Founder, One Health Initiative team/website
Managing Partner & Chief Scientific Officer
Crozet BioPharma LLC
Lexington, Massachusetts, United States
tom.monath@crozetbiopharma.com

Lisa A. Conti, DVM, MPH*
**Deceased 6 November 2020*
Read about Dr. Lisa A. Conti <https://onehealthinitiative.com/prominent-one-health-initiative-team-member-and-public-health-leader-dies-at-57/>

Thomas M. Yuill, PhD
Professor Emeritus, Pathobiological Science, Forest and Wildlife Ecology
Director Emeritus, Nelson Institute of Environmental Studies School of Veterinary Medicine
University of Wisconsin–Madison
Madison, Wisconsin, United States
thomas.yuill@wisc.edu

Helena J. Chapman, MD, MPH, PhD
Milken Institute School of Public Health,
George Washington University
Washington, DC, United States
hjchapman@gwu.edu

Craig N. Carter, DVM, PhD
Department of Veterinary Science, College of Agriculture, Food & the Environment
College of Public Health
University of Kentucky
Lexington, Kentucky, United States
craig.carter@uky.edu

Becky Barrentine, MBA
Partner, Head of Business Operations & Communication,
Crozet BioPharma
Lexington, Massachusetts, United States
becky.barrentine@crozetbiopharma.com

Richard Seifman, JD, MBA
World Bank Senior Health Advisor (retired)
Washington, DC, United States
seifmanrichard@gmail.com

Jack P. Woodall, PhD*
**Deceased 2016*
Read about Dr. Jack P. Woodall:
<https://www.archive.onehealthinitiative.com/news.php?query=Extraordinary+Scientist%2C+Admired+One+Health+Supporter+Activist+Leader+Dies>

WMA Members Share Perspectives about World No Tobacco Day 2023



Credit: Attasit saentep / shutterstock.com

According to the World Health Organization (WHO), tobacco use is attributed to more than 8 million annual deaths, with 7 million due to direct exposure and 1.2 million due to indirect (or second-hand) exposure [1]. With an estimated 1.3 billion tobacco users across the world, more than 80% reside in low- and middle-income countries [1]. Over the past two decades, the global prevalence trends of tobacco use in adults (15 years and older) have declined – 33.3% in 2000, 27.3% in 2010, and 22.8% in 2020 – with significant reductions in adult males (50.0% 2000 to 37.5% in 2020) and females (16.7% in 2000 to 8.0% in 2020) and across the Americas [2]. However, not all countries in a given WHO region have reported similar declines in prevalence trends. Hence, although these global prevalence rates are expected to decrease even more by 2025, strict adherence to tobacco

control policies will be fundamental to decrease prevalence rates of all forms of tobacco use and ultimately mitigate risk across all communities.

Each year, World No Tobacco Day (WNTD) (<https://www.who.int/campaigns/world-no-tobacco-day/2023>) is commemorated on May 31, where the global community aims to increase awareness about the tobacco epidemic and its harmful effects on health and well-being. The WHO supports this international health day, as an opportunity to showcase historical, current, and future efforts to combat the global tobacco epidemic. First, the WHO Framework Convention on Tobacco Control (FCTC) (<https://fctc.who.int/who-fctc/overview>) was adopted in 2003, allowing WHO Member States and participating countries to promote tobacco control policies and initiatives [1]. Second, the MPOWER – Monitor tobacco use and prevention

policies; Protect people from tobacco use; Offer help to quit tobacco use; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion, and sponsorship; Raise taxes on tobacco – was established in 2007, which provided on-the-ground opportunities to scale up activities of the WHO FCTC [1]. Third, the UN Sustainable Development Goal 3 (*Ensure healthy lives and promote well-being for all at all ages*) highlights target 3.a (*Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate*) [2]. These efforts support national health systems and the health workforce, as they organise educational initiatives that highlight the risks of tobacco use and emergence of new nicotine and tobacco products as well as develop relevant policies that regulate tobacco production, commercialization, and sales to protect population health.

The WNTD 2023 theme entitled, “Grow food, not tobacco”, offers a unique perspective of the lives of tobacco farmers, including intense physical labor and risk of pesticide exposure, stressors related to the effects of climate change and contracts with tobacco industries, and economic sustainability. With over 124 tobacco-cultivating countries, the WHO has presented examples of tobacco farmers who have rotated diverse crops (e.g. beans, cashews) for increased economic benefit and support for agricultural production and food security [3,4]. In this article, physicians from 16 countries – Argentina, Australia, Brazil, Chinese Medical Association, Dominican Republic, India, Kenya, Nigeria, Portugal, Spain, Taiwan, Thailand, Trinidad and Tobago, Turkey, United States, and Uruguay – shared meaningful reflections about WNTD activities and germane national policies that support tobacco control across their countries.

Argentina

In Argentina, the third-leading tobacco growing country in the Americas, tobacco use is a significant health challenge in Argentina [4]. Since the 1970s, the tobacco industry has greatly influenced policymaking related to tobacco control, which has effectively slowed national efforts to reduce the prevalence of tobacco use in the populace [5]. Over the past two decades, the prevalence rate of adult smokers has decreased from 34% (39.6% in males, 28.4% in females) in 2000 to 24.5% (29.4% in males, 19.6% in females) in 2020 [6]. Health leaders have reported that tobacco smoking causes 123 deaths each day across the nation – recognised as 14% of the mortality burden – and that the annual health care expenditure associated with tobacco use across Argentine hospitals is estimated at nearly Arg \$200,000 million pesos

(equivalent of US \$846,000) [6].

With a national population of 45 million residents, the government of Argentina and health leaders recognize that the prevalence rate of tobacco users remains high, and they continue to strive toward improved tobacco control. In 2004, the Ministry of Health developed a toll-free number (0800-999-3040), where trained personnel helped tobacco users reduce their smoking habits with the overall goal to quit smoking [7]. In 2011, the federal government approved the *Law for the Regulation of the Publicity, Promotion, and Use of Tobacco Products (Ley de Regulación de la Publicidad, Promoción y Consumo de Productos Elaborados con Tabaco, N° 26687)*, which prohibited the sale and distribution of tobacco products to minors [8]. In 2016, the Executive Branch of Argentina approved Decree 626, which raised domestic cigarette taxes by 15% (60 to 75%), which directly impacted tobacco costs [9]. Currently, Argentina adopted, but has not ratified, the WHO FCTC [5].

As physicians of the Confederación Médica de la República Argentina (COMRA), we believe that health professionals, representing diverse medical specialties, have a fundamental role in the promotion and prevention of risk factors associated with tobacco use. We can refine our health counseling with our patients and families, by tailoring the public health message about the harmful effects of direct and secondhand smoke exposure and encouraging them to select tobacco-free lives. We can continue our advocacy efforts to develop relevant and timely tobacco control policies to support the health system and guide health professionals in their clinical and public health duties. Finally, we can support legislature that aims to increase restrictions for individuals working in tobacco production, distribution, and sales, and hence

promote a tobacco-free nation and world.

Australia

WNTD prompts Australian doctors to reflect on how far we have come, and how much further we need to go in tobacco control. We have a lot to celebrate – Australia’s smoking rate is low compared to other Organisation for Economic Cooperation (OECD) countries. We have reduced the proportion of daily smokers from 24.3% in 1991 to 11% in 2019 [10]. But tobacco remains the leading cause of preventable death and disability in Australia, killing an estimated 20,500 people in 2018 [10]. Populations more likely to smoke in Australia are those already experiencing social and health inequities.

Smoking and vaping have recently been prominent topics in Australia. Earlier this month, Australia’s Minister for Health and Aged Care, the Hon Mark Butler MP, released the *National Tobacco Strategy 2023–2030* [11]. The Strategy includes a suite of measures to reach a target of 5% or less daily smoking prevalence by 2030, and a target of 27% or less by 2030 for the Aboriginal and Torres Strait Islander population. The government is increasing the successful tobacco tax by 5% for three years, while also aiming to reduce the tobacco industry’s ability to influence policy decisions on smoking by either prohibiting political donations or increasing transparency of such donations. In medicine, the government will aim to improve methods to identify patients who smoke and, at every health system intervention, ensure that they are provided with best practice cessation support and treatment. The Australian Medical Association (AMA) is pleased to see tobacco regulation reinvigorated under this Strategy.

The Strategy also outlines important vaping (or e-cigarette) reforms. The AMA has been advocating tirelessly for stricter, more tightly enforced regulation and welcomes the announcement that the government will be banning the retail sale of vapes and making them prescription only, with restrictions on nicotine concentration, flavours, and packaging. Vaping is the new smoking in Australia, and its previous lack of regulation has resulted in a new generation of younger people becoming addicted to nicotine. The prescription-only model ensures that patients are provided with reliable, effective medical advice if they wish to stop smoking or vaping. It also works to prevent never-smokers from taking up vaping in the first place. This emerging threat has the potential to undo all our important work in tobacco control.

We cannot make the same mistakes we made with conventional cigarettes. This WNTD, I implore doctors around the world to work together to prevent new and emerging threats around nicotine addiction, while not giving up the patients whose smoking cessation journey has been more difficult due to broader social and health inequities.

Brazil

Although Brazil is the leading tobacco exporter and the third-largest producer, its three-decade leadership in tobacco control is recognised across the region. These efforts led to historic achievements to reduce the prevalence rate of adult smokers from 35% in 1989 to 9% in 2021 [12]. This national success started with the inaugural WNTD campaign that was held on 31 May 1993, at the Heart Institute (INCOR) of the University of São Paulo, and was coordinated by Dr. Claire Chollat Traquet (WHO) and supported by Dr. Adib Jatene

(INCOR co-founder and director). Brazilian leaders even implemented the WHO FCTC in Brazil [13]. To educate about dangers of tobacco smoking, the WHO prepared health visualizations and videos for WNTD events (<https://www.youtube.com/watch?v=7189anrfIQE>), and the Brazilian Medical Association (Associação Médica Brasileira, AMB) used pop culture symbols and humor in public health messaging (<https://www.youtube.com/watch?v=t3ADnztN7eQ>).

The main transformation started when Dr. Adib Jatene became the Minister of Health in 1996, and developed the *Federal Law 9294/96*, creating tobacco-free spaces and restricting tobacco advertising. As Dr. José Serra became the next Minister of Health, he maintained these policies and approved additional laws that permitted graphic images of tobacco-related diseases on cigarette packages, prohibited cigarette advertisement in the media, and banned tobacco smoking in indoor settings. The Brazilian health system implemented diverse clinical and community health campaigns to educate the public about the harmful effects of direct and indirect exposure to tobacco use as well as created tobacco treatment programs. National research studies demonstrated the beneficial effects of this smoking ban law, including reduced carbon monoxide concentrations in hospitality venues and reduced hospitalization and mortality rates of myocardial infarction [14,15].

Recognizing these historical achievements, the Brazilian Medical Societies strongly believe that smoking cessation is the best way to reduce risk of non-communicable diseases and premature deaths. In July 2022, the Brazilian Health Regulatory Agency (Agência Nacional de Vigilância Sanitária, ANVISA) endorsed the

ban on e-cigarette sales in July 2022, aiming to reduce e-cigarette use among youth and young adults. With a total of 216 million residents, of which 20 million are tobacco smokers, our efforts should support health policies (like *Federal Law 9294/96*), widely share public health messages with youth, and offer effective treatment options like cue restricted smoking and smoking cessation drugs (like varenicline) [16,17].

Chinese Medical Association

As the world's largest tobacco producer and consumer, Chinese leaders have recognised that tobacco control is a long-term endeavor to protect population health. With a population of 1.4 billion, the prevalence rate of smokers aged 20-69 is an estimated 25.1% (47.6% in males, 1.9% in females) [18]. The increasing trend in tobacco use among the Chinese population is largely attributed to tobacco dependence [18].

Pledging to make progress toward fulfilling national objectives in tobacco control, China formally joined the WHO FCTC in 2006. Over the past two decades, national educational efforts have continued to encourage all citizens to avoid smoking initiation and exposure to secondhand smoke. In 2017, the government adopted measures where tobacco advertising was banned in public settings and mass media, stores were forbidden from selling tobacco products to minors, and smoking scenes were eliminated in popular movies and television programs. In fact, more than 20 cities have adopted laws banning smoking in indoor public settings, at workplaces, and on public transport [19].

The *Healthy China Action Plan 2019-2030*, established in 2019, incorporated a tobacco control action plan that set a target of reducing

national tobacco prevalence to below 20% by 2030 [20]. The plan highlights the valuable role that physicians serve in guiding patients to meet their smoking cessation goals, promoting smoking cessation services, and supporting the development of a “12320” national smoking cessation hotline. Innovative approaches, such as message-based tobacco cessation programs, may enhance health educational initiatives for the public as well as strengthen rapport between physicians and patients, which can lead to reduced tobacco use across China and the world [21].

Dominican Republic

Of the tobacco growing countries, the Dominican Republic (DR) is recognised as the eighth-leading in the Americas and 40th in the world [4]. Significant measures are needed to strengthen tobacco control programs in the DR and across the Americas region, as nine countries (including the DR) have not yet joined the WHO FCTC [22]. To address the national tobacco burden, the DR government and the Ministry of Health leaders have taken diverse measures to recognize and promote WNTD.

First, the DR government approved the *General Health Law 48-00* in July 2000, to implement measures that control the publicity of tobacco use, including prohibiting tobacco advertisements on massive communication media, eliminating sponsorship by the tobacco industry at sporting or cultural events, and restricting the sale of tobacco products to minors (under 18 years) [23]. It also established national regulations for the production, distribution, and commercialization of tobacco products and prohibited smoking in closed public and private settings (including modes of public and passenger transportation) [23]. To

build upon the *General Health Law 48-00*, they authorized the *General Health Law 42-01* in March 2021, to ensure that adequate health messages (“Smoking is harmful for your health” / “Fumar es prejudicial para la salud”) was placed on tobacco packages [24]. These laws were amended by the *Resolution 000018* in May 2015, and subsequently revised by the *Resolution 000066* in February 2022, to mandate that all closed public and private settings across the country, including restaurants, bars, workplaces, and public transportation, were smoke-free establishments [25].

Second, the DR government has augmented the tobacco tax, as a strategy to disincentive consumption and reduce the harmful exposure of direct or indirect tobacco use on population health [26]. Third, the DR Ministry of Public Health has collaborated with other institutions and organisations to develop educational campaigns about the risks of tobacco use and the importance of adopting a healthy lifestyle. These events are widely shared through social media as well as television commercials, radio shows, primary and secondary school activities, and community-wide celebrations. Finally, they have developed treatment programs, including nicotine replacement therapies, medications, and personalized counseling, to help smokers reduce and ultimately stop tobacco use [27].

The DR government has supported these laws and regulations, as part of a national effort to increase awareness of the health risks associated with tobacco use, control the access of tobacco, and reduce the harmful effects of tobacco use in the DR population. As a medical community, it is our moral obligation to continue advocating for research investment, including social science approaches to better understand the tobacco

culture, as well as supporting local and national efforts to implement effective policies and regulations that ensure compliance, reduce tobacco use (including e-cigarettes and hookah), and protect population health [28].

India

According to the 2016–17 *Global Adult Tobacco Survey* (GATS), India represents one of the top three countries associated with smoked or smokeless tobacco use among the populace, where 28.6% (or an estimated 267 million) of Indian adults use tobacco [29]. The burden of this tobacco epidemic drives the participation of healthcare professionals to promote WNTD and increase public awareness regarding the detrimental effects of tobacco use and encourage individuals to quit smoking. This awareness is raised through various social media platforms (like YouTube), displays with WNTD posters in hospitals, and health educational events in hospitals and local communities.

Through several legislature actions, national leaders have implemented several tobacco control policies that support efforts to combat the tobacco epidemic in India. First, the *Cigarettes and Other Tobacco Products Act* (COTPA) was passed by the Indian government in 2003, in efforts to regulate tobacco products, prohibit the sale of tobacco products to minors, and mandate pictorial warnings on packaging [30]. This act warranted that smoking was illegal in public settings, including offices, restaurants, educational institutions, and public transportation, and a fine (up to 200 Indian Rupees) could be imposed for smoking in public places, selling tobacco products to minors or marketing tobacco products within a radius of 100 meters from any educational institution. Second, India was one of the first countries to

implement graphic health warnings on tobacco product packaging, and such warnings (covering 85% of the package surface area) have been mandated on tobacco products since 2016.

Third, India's Ministry of Health launched the National Tobacco Control Program in 2007, to implement tobacco control policies and programs at the national and state levels. This program focuses on raising awareness about the harmful effects of tobacco use, providing cessation services, and enforcing tobacco control laws. In 2016, they established the National Tobacco Quitline Services (NTQLS) (<http://ntqls.in/>), as the first national telephone counseling service for tobacco cessation. This program operates through a toll-free number (1800-11-2356) and offers behavioral counseling services, health information, and relevant community resources to callers. Fourth, the government banned the production, sale, and importation of e-cigarettes in India in 2019. Finally, the government has regularly increased taxes on tobacco products, to discourage their use and generate revenue for tobacco control programs.

Although these policies have contributed to a decline in tobacco use in India, tobacco use remains a significant public health problem. Moving forward, doctors can lead efforts to reduce tobacco use through robust educational efforts, by educating patients about the harmful effects of smoking and recommending counseling and supportive services. They can also promote tobacco-free workplaces, support employers to offer comprehensive smoking cessation resources, and serve as role models by incorporating tobacco-free lifestyles. They can work with local and national health organisations to promote policies that reduce tobacco

use, such as higher taxes on tobacco products, smoke-free environments, and advertising restrictions. We hope that doctors can collaborate with other healthcare professionals (e.g. nurses, pharmacists) to organise campaigns and events that raise public awareness about the harmful effects of smoking throughout the year.

Kenya

In Kenya, a country of 57 million residents, an estimated 13.3% of adults (older than 15 years) and 9.9% of adolescents (13-15 years) use tobacco [31]. As physicians, we understand that tobacco use is a risk factor that can increase risk of non-communicable diseases, which with other risk factors, are collectively attributed to 60% of hospital admissions and over 55% of deaths [31]. With the rise in the use of novel tobacco products (e.g. electronic cigarettes, nicotine pouches) that primarily target youth, with the covert goal of creating a new generation of tobacco users, there is a grave need to continue educating the public, especially youth, on the harmful nature of all tobacco products.

As one national survey reported that over 80% of smokers in Kenya were unaware of the availability of tobacco cessation services, the Ministry of Health (including the Tobacco Control Board) and civil society organizations within Kenya have developed and continue to strengthen various initiatives to enhance tobacco control and support tobacco cessation [32]. First, the National Authority for the Campaign Against Drugs and Alcohol (NACADA), as part of the Ministry of Interior and Coordination of Government, developed an operational toll-free helpline 1192 in 2015, which offers counselling and appropriate referrals to the public [32]. Second, the Ministry of Health

developed the tobacco cessation guidelines in 2017, which grants clinicians access to contextualized guidelines for tobacco dependence treatment and cessation [33].

Third, the Ministry of Health updated the Kenya Essential Medicine List in 2019, by including pharmacological agents (e.g. bupropion, nicotine gums, patches) that are proven to improve the efficacy of cessation [34]. Fourth, as part of section 7(4b) of the *Tobacco Control Act 2007*, the Tobacco Control Fund was established and operationalized to support cessation and rehabilitation programs [35]. Fifth, the Ministry of Health ensured that the National Health Insurance Fund would cover the expenses of citizens seeking drug deaddiction services at rehabilitation centers, among other tobacco cessation services [36]. Finally, Kenyan leaders – together with the UN Food and Agriculture Organization, WHO, and Farm to Market Alliance (FtMA) – collaborated on the inaugural tobacco free farms initiative, to help farmers transition from growing tobacco to alternative crops (like beans) [37].

Across Africa, our call to physicians is that we must work together to understand the tobacco epidemic and educate communities about the harmful impacts of tobacco use on health, especially novel tobacco products. With the support of National Member Associations (NMAs), such as the Kenya Medical Association, we continue to advocate for robust policy advocacy to emphasize capacity building of healthcare workers on tobacco harms, offer cessation support and psychological counselling, and initiate appropriate referrals. Furthermore, adopting tax exemptions on effective pharmacological agents may support comprehensive care as well as reduce the prevalence of tobacco users in

Kenya and across Africa.

Nigeria

In Nigeria, common tobacco practices include cigarette smoking, chewing raw tobacco, and sniffing ground tobacco powder (snuff) [38]. Notably, snuff – known as ‘suadiri’ in Ibaní, ‘ifienya’ in Izon, ‘utaba’ in Igbo, and ‘yaba’ in Yoruba local languages – is frequently used among the Nigerian populace for recreational, spiritual, medicinal (common cold, toothache), and prevention (e.g. snake repellent) purposes. These unproven scientific medicinal beliefs, coupled with readily available tobacco plants perceived as snake repellents, can increase its usage and lead to addiction.

With an estimated population of 210 million residents, Nigeria represents a nation with accelerated economic growth and cross-border migration that can drive the tobacco market [39]. According to the WHO, the prevalence rate of tobacco use in adults (15 years and older) in 2020 was 3.4% (6.2% in males, 0.5% in females), declining from 8.5% in 2000 (15.2% in males, 1.7% in females) [2]. Since 1970, national tobacco control legislation and initiatives have been proposed, including the first *Tobacco Smoking (Control) Decree 20* established in 1990, but the influence of the tobacco industry has hindered significant progress in such implementation [40].

To address this burden, the federal government of Nigeria and health leaders have led efforts to enhance tobacco control across the populace. First, Nigeria joined the WHO FCTC in 2006, leaders enacted the *National Tobacco Control Act* (NTCA) in 2015, which formed the National Tobacco Control Committee [2]. Second, the federal government banned the advertisement and promotion of cigarettes in mainstream and social

media, cigarette sales to minors, and smoking in public places or within 10 metres from health facilities, public transportation, and vehicles carrying minors. Cigarette packaging was mandated to include health advisories (“The Federal Ministry of Health warns that smokers are liable to die young”), and the sale of cigarettes were required in the form of a pack (20 sticks) rather than single cigarette sticks. Third, the federal government established the *National Tobacco Regulation* in 2019, with approval by the House of Representatives and the Senate [41]. Finally, professional associations (e.g. Nigerian Medical Association, Nigerian Association of Resident Doctors, Medical Women’s Association of Nigeria), non-governmental organisations, and community support groups have regularly organised campaigns on smoking cessation at open markets, motor packs, and schools, as well as television and radio shows and social media.

Although significant policy and community education efforts have been conducted across Nigeria, no current strategies or policies exist to tackle non-smoking tobacco use [38]. At the national level, the government should prioritize steps to achieve universal health coverage, which will offer sufficient resources for Nigerian citizens to seek traditional treatment options. Nigerian physicians should also lead advocacy efforts that enforce current laws and propose new laws and initiatives to reduce the use of all tobacco forms as well as continue educational efforts that dispel myths of using tobacco as a cure for common colds, coughs, toothaches, and headaches.

Portugal

Portugal, a country with 10 million residents, has a reported prevalence rate of tobacco smoking in adults

(15 years or older) of 17.0% (23.9% in males, 10.9% in females) [42]. Compared with the *National Health Survey 2014*, the prevalence of tobacco use has dropped by 3% and decreased across all age groups of both sexes [42]. To address this health burden, the Portuguese Respiratory Society has led an array of activities that engage other Portuguese medical societies, health professional organisations, patient associations, and civil society, in raising awareness of the health, environmental, social, and economic consequences of the tobacco epidemic. Physicians have also highlighted the health policies of the WHO FCTC, describing deceptive strategies of the tobacco industry and publicising smoking cessation programs of the Portuguese Health System [43].

After Portugal joined the WHO FCTC in 2005, national leaders have led efforts to improve tobacco control. In 2007, the Portuguese Government adopted *Law No. 37/2007*, which restricted tobacco use in closed public settings [44]. In 2016, they adopted *Law 109/2015*, which allowed the inclusion of pictorial health warning labels on tobacco product packaging, limited harmful components in cigarettes, further strengthened the smoke-free policy, and expanded the smoking ban to vaping [44].

In January 2023, an amendment of the smoke-free law was implemented, which further restricted smoking in closed public places. Although the Portuguese smoking ban was not comprehensive, compliance with the ban was optimal, and public spaces for smoking were difficult to find. To support these efforts, the Portuguese Respiratory Society and the Brazilian Respiratory Society launched an ongoing social media campaign to educate youth and young adults about the harmful health effects of using e-cigarettes

and vaping and dispel myths (<https://www.instagram.com/p/CosURt-Orgd/?igshid=OWEyOTRmYTI=>). Also, the Portuguese government approved a set of innovative tobacco control measures that aimed to contribute to a tobacco-free generation by 2040. This initiative included comprehensive restrictions of tobacco sales (e.g. retailers, vending machines) and extended smoke-free policies to outdoor settings (e.g. hospitals, schools, universities, terraces, bus stations, sports stadiums). This law, which transposes the *European Directive 2022/2100* that banned flavours from heated tobacco and removes member states' right to exempt heated tobacco products from the required health warnings, is currently being discussed within the National Parliament [45].

Taking into account the WHO's and the European Respiratory Society's recommendations, we urge physicians to act as role models and tobacco control leaders for their patients and their communities. They can advocate for comprehensive tobacco control and prevention of nicotine use among adolescents and young adults and effective regulations (and possibly restricting sales) for e-cigarettes and heated tobacco products. Physicians can also offer evidence-based treatment and pharmacotherapy approaches that empower their patients with smoking cessation and adopting healthier lifestyles [46].

Spain

In Spain, a country of 46 million residents, has experienced a steady decline in tobacco use over the past two decades. In 2020, the prevalence of tobacco use among adults estimated at 23.3% in males and 16.4% in females, as compared to 43.5% in males and 24.5% in females in 1998 [47]. This trend has significantly declined in the 15–24-year

population group, which was reported 16.4% in males and 12.0% in females in 2020, as compared to 39.0% in males and 40.5% in females in 1998 [47]. Since adolescents and young adults are smoking less than previous generations, tobacco industries have developed innovative campaigns to widely promote their new products (like e-cigarettes) among this population group.

To support tobacco control efforts, the Spanish Parliament approved the *2005 Tobacco Control Law*, which prohibited smoking across public settings, including universities, restaurants, and bars [48]. In 2020, more than 50 civil rights and health organisations in Spain (<https://nofumadores.org/end-game-del-tabaco-en-espana-2030/>) joined forces and submitted the *Tobacco Endgame by 2030 Declaration* to the Ministry of Health, which aimed to reduce the prevalence of smoking rates to less than 5% by 2030 [49]. In 2018, with only 3% of beaches declared as smoke-free, the Nofumadores.org organisation (<https://nofumadores.org/>) led efforts to ban cigarette smoking on beaches, supported by several regional health authorities in the Canary Islands, Balearic Islands, Galicia, and Catalonia [50]. Subsequently, Spain's Congress and Senate authorized an ecological law that instilled authority upon local councils to sanction individuals who smoked tobacco on beaches.

To continue supporting tobacco control initiatives in Spain, the Spanish government recently approved two resolutions that amend original legislation. In December 2022, the Ministry of Health adopted the resolution (to *Article 48.8 of Law 40/2015*) that highlighted a joint collaboration between the Ministry of Health and the National Commission for the Prevention of Smoking (Comité Nacional para la Prevención

del Tabaquismo, CNPT) (<https://cnpt.es/>), to leverage prevention and control efforts that aim to reduce the prevalence of tobacco smoking across the nation [51]. In March 2023, the Ministry of Treasury and Public Functions added the resolution (to *Article 4 of Law 13/1998*) that obligated the Presidency of the Commissioner for Tobacco Markets to publish the retail prices of tobacco products in federal records [52].

As a medical community, we recognize that tobacco use and nicotine dependence represent a serious health risk factor. The Spanish General Medical Council, as a member of CNPT, supports strict tobacco control measures, ranging from graphical health warnings on product packages and bans of flavored cigarettes, that prioritize population health [53]. Physicians have important clinical, educational, and advocacy roles in providing the best care for our patients and supporting community-wide initiatives to encourage tobacco-free lives.

Taiwan

Taiwan, with 23 million residents, has an estimated 2.7 million smokers and a prevalence rate of tobacco smoking in adults of 13.1% (23.1% in men, 2.9% in females) [54]. The Taiwan Health and Promotion Administration reported that the use of novel tobacco products, such as e-cigarettes and heated tobacco products, has doubled over the past few years in Taiwan. Tobacco use has also impacted the adolescent population, as the prevalence of senior high school students using e-cigarettes was 8.8% in 2021, up from 3.4% in 2018 [55].

Since 2020, the Taiwan Medical Association, Taiwan Medical Alliance of Tobacco Control, Taiwan Tobacco Control and Smoking Cessation

Education Association, and 170 non-government organisations have collaborated to combat the influences of big tobacco companies that interfered with tobacco control efforts. The Taiwan Ministry of Health and Welfare adopted the *Tobacco Hazards Prevention Act* in 1997, with subsequent amendments in 2009 and 2023. This recent amendment raised the smoking age from 18 years to 20 years, banned flavored tobacco products (e.g. chocolate, fruit, mint), and prohibited smoking on all campuses including colleges and universities [56].

This recent amendment may permit the legalization of heated tobacco products, if tobacco companies pass the “Health Risk Assessment” before the sale of these products. Through this risk assessment, tobacco companies are requested to provide evidence that the new product does not cause higher health risks than current market products. Another remarkable achievement is that the manufacture, importation, sale, distribution, presentation, advertisement, and use of e-cigarettes are all prohibited across Taiwan. Violators of this amendment could be fined up to NT \$50 million (equivalent to US \$1.6 million).

As the next steps, the medical community should continue to engage in education and advocacy efforts to combat all forms of tobacco use across the country. Although the proposition to quit heated tobacco products is emerging, tobacco companies are promoting these products as safer alternatives to traditional cigarettes. Hence, we must collectively fight against this tactic, as all tobacco products are harmful to health and well-being.

Thailand

Thailand, a country of 70 million residents, has reported a high

prevalence of tobacco use (11 million adult smokers), where half of adults aged 35–54 years smokers [57]. Despite these statistics, the nation has taken proactive strides to develop relevant legislation, public health messaging, and community projects. In 2004, King Bhumiphol of Thailand expressed his concern about the harmful effects of tobacco smoking among youth and elderly in his public address, and the Medical Association of Thailand was inspired to take action.

Starting with the “The Role of Health Professionals in Tobacco Control” theme in 2005, the Medical Association of Thailand has regularly contributed to WNTD events [58]. They launched the project entitled, “Thai Physicians Alliance and Tobacco Control”, to educate the public about the hazards of tobacco use and non-communicable disease risks caused by tobacco consumption. Over the next decade, this project expanded across the country to include health professionals and 23 health agencies as the “National Alliances for Tobacco Free Thailand (THPAAT)”. Notably, the World Health Professional Assembly awarded this project team an honorary award in 2015.

One landmark legislation was the *Thai Tobacco Products Control Act of 2017*, which continued to enforce the minimum age for tobacco purchases as well as bans on tobacco advertisement, packaging, and sponsorship [57]. According to a recent survey conducted by the National Statistical Institute of Thailand, smoking rates in Thailand had declined from 23% in 2005 to 17.4% in 2021 [59]. The national collaboration to promote smoking cessation and preserve public health aims to reduce the prevalence of adult smokers to 14% by 2027. To support these efforts, the Medical Association of Thailand has signed a memorandum of understanding

with the Hospital Accreditation Institute of the Thai Ministry of Public Health, to ensure that hospital patients will be screened for a medical history of smoking and provided with appropriate treatment and resources.

Today, one of our primary concerns is the emergence of e-cigarettes, which are strongly supported by the tobacco manufacturers with high marketing technologies, budget, and tricky information. For this reason, we would like to urge the world – especially health professionals – to collaborate on novel initiatives that protect youth, reduce risk of non-communicable diseases, and promote community health and well-being.

Trinidad and Tobago

Tobacco use is a significant public health concern, as it remains the single most preventable cause of death in the world today [1]. For physicians in Trinidad and Tobago, WNTD motivates us to increase awareness of the harmful effects of tobacco use and encourage smoking cessation in our population. Our medical community supports this important day by conducting health promotion activities such as community outreach, public speeches, social media posts, and radio broadcasts. Notably, Trinidad and Tobago leaders joined the WHO FCTC in 2005, and adopted the *Tobacco Control Act in 2009*, which establish strict requirements for advertising and selling cigarettes and prohibits smoking in indoor public settings [60].

Using the theme, “We need food, not tobacco,” the Trinidad and Tobago Ministry of Health’s Tobacco Control Unit has developed the campaign, taking a multisectoral approach to engage smokers and non-smokers in healthier lifestyle practices. They have launched the campaign entitled,

“Healthy Lifestyle Alternatives to Smoking Campaign”, which includes a community gardening initiative and digital advocacy for healthy lifestyle practices. As physicians, we understand that tobacco use affects us all, and we are committed to improving the health and well-being of our patients. Educating our population including smokers, non-smokers and adolescents on the dangers of tobacco use including e-cigarettes must be a priority. As we move closer to achieving our goal of a tobacco-free Caribbean, we urge persons who wish to quit smoking tobacco to join the Smoking Cessation Clinics at our Regional Health Authorities for additional support

Turkey

In Turkey, with a population of around 85 million people, the Ministry of Health reported that the rate of tobacco use in adults (older than 15 years) was 28.0% (41.3% in males, 14.9% in females) in 2019 [61]. From 2000 to 2012, the prevalence rates in tobacco use had showed steady decline, but then in 2012, the rates increased [61,62]. This trend is thought to have resulted from weak compliance to tobacco control legislation, including an increase in tobacco promotional advertisements and violations of such policies across communities.

As part of the national tobacco control efforts, the Turkish Medical Association (TMA), the organisation of national medical associations, leads the National Coalition on Tobacco OR Health (NCoTOH) (<http://www.ssuk.org.tr/>). The NCoTOH is composed of a variety of public and private sector organisations, including non-governmental organisations. The executive committee of NCoTOH represents the Association of Public Health Specialists (HASUDER) (Türkiye), the Health Institute Society, the Turkish Medical Association, and

the Turkish Thoracic Society.

The first national anti-tobacco legislation, *Legislation on the Prevention of Harms of Tobacco Products No. 4207 (Tütün Mamüllerinin Zararlarının Önlenmesine Dair Kanun No:4207)*, was adopted in 1996 [63]. Türkiye joined the WHO FCTC in 2004 [64], which propelled the anti-tobacco activities across the country, including the foundation of the National Tobacco Control Program and revision of current legislation [62,65]. The revision of the first legislation was approved in 2008 and renamed, *Legislation on the Prevention and Control of Harms of Tobacco Products No. 4207 (Tütün Ürünlerinin Zararlarının Önlenmesi ve Kontrolü Hakkında Kanun No:4207)* [66]. With its broader perspective, the law added sanctions for non-compliant organisations, and stronger policies and guidance for the tobacco industry, which ultimately contributed to a decrease in tobacco use in 2012 [67]. These national milestones were strongly supported by the wider community of health professionals, non-governmental organisations, and private businesses. Based on the recent observations that the rate of tobacco users is increasing, the Turkish health system is recommended to plan to target ongoing and future efforts on tobacco control covering all the population.

The TMA, as a strong supporter of WNTD events and tobacco control activities throughout the year, calls on all the doctors in Turkey to unite and advocate for a tobacco-free world. This year (2023), the TMA prepared a social media campaign that disseminated public health messages about the harmful effects of tobacco use. TMA members plan to continue their advocacy work on encouraging adolescents and young adults to avoid tobacco and other addictive substances, as well as

developing appropriate policies that improve restrictions on tobacco use in closed settings and protect vulnerable populations.

United States

The American Medical Association (AMA) has a long history of advocating for control of tobacco use and supporting the U.S. Centers for Disease Control and Prevention's and the U.S. Food and Drug Administration's (FDA) efforts to do the same. An area of concentration for AMA's initiatives is tobacco and health equity. The tobacco industry has successfully and intentionally marketed mentholated cigarettes to African Americans [68]. The AMA and 14 other organisations called on the FDA to prioritize enforcement against two manufacturers for introducing new flavored tobacco products in defiance of the FDA review requirements. The AMA has also been involved in multiple legal cases against tobacco companies through its Litigation Center [69].

Another area of emphasis is preventing youth use of e-cigarettes, vaping, and use of other electronic nicotine delivery systems. Manufacturers of these devices have tried to evade FDA rules by switching to synthetic nicotine. As a result, the AMA and other public health organizations called upon the U.S. Congress to give the FDA the authority to regulate synthetic nicotine. Most recently, WNTD in the United States has focused on the enormous detrimental environmental impacts of the tobacco lifecycle, including growing, curing, manufacturing, transporting and disposal [70].

Uruguay

Over the past decades, Uruguay has implemented comprehensive tobacco control policies and has

successfully achieved favourable health outcomes. After becoming the first indoor smoke-free country in the Americas in 2006, a comprehensive tobacco law was passed in 2008, enacting the world's largest pictorial health warning labels and the single presentation per brand requirement for cigarette packs. In 2010, Philip Morris International (PMI) claimed that this law was unreasonable and sued Uruguay at the the International Centre for Settlement of Investment Disputes (ICSID), which after six years of arbitration, ruled in favour of Uruguay and its sovereign right to protect people [71]. In 2020, the government approved the policy for plain packaging of tobacco products, which has proved to protect consumers and future smokers from misleading terms, increasing risk perception, and avoiding fancy design features that attract youth [72].

Over the past two years, several decrees were adopted – allowing the import and sales of heated tobacco products and loosening restrictions of plain packaging – which appear contrary to the provisions of the WHO FCTC [73]. Hence, physicians representing civil society organisations, medical unions, and academic sectors have strongly and publicly opposed these new regulations. In fact, the Uruguayan Society of Tobaccology (Sociedad Uruguaya de Tabacología), as a group of health providers who are actively involved in tobacco control efforts, has successfully filed a legal act against these decrees [74].

Nevertheless, several WNTD activities are being planned by the government and civil society, including health seminars, conferences, short courses, and community-based activities, which highlight the importance of tobacco control, tobacco cessation, healthy behaviors. Specifically, the “Dr. Manuel Quintela” Clinic Hospital (Hospital de Clínicas “Dr.

Manuel Quintela”), which is the largest hospital in the country and located in Montevideo, visitors will be able to obtain health information about tobacco cessation as well as interact with the tobacco cessation health team for brief counselling and carbon monoxide measurements.

As physicians, we should lead the call to action to engage with other health professionals and collectively organize timely tobacco control activities across our institutions, regions, and countries. A strong and organised civil society is a key factor to defend public health policies and people's rights, recognizing the potential influences from industries and government administrations.

Conclusion

The tobacco epidemic is a significant global challenge for health systems, especially for tobacco-cultivating countries and the emergence of new tobacco products (e.g. e-cigarettes, heated tobacco products) [4]. As the global prevalence trends of tobacco use in adults have decreased over the past two years, global leaders remain optimistic about their collective progress – including contributions to the WHO FCTC and MPOWER – to combat the tobacco epidemic [2]. They understand, however, that each nation has not observed similar trends, signifying that leaders should identify limitations in their tobacco control programs, adopt relevant policies to support tobacco control, and implement innovative solutions to enhance public health messaging.

As WMA members represent diverse clinical and surgical specialties, our expertise is essential to increase awareness about the harmful effects of tobacco use (nicotine dependence) and gain trust during our close interactions with patients and the general public. This collective article

offers other NMAs an opportunity to learn about the robust national policies and community activities that support tobacco control and prevention across 16 countries. These collaborations highlight the value of strong health systems and political commitment across the African, Americas, European, South-East Asian, and Western Pacific regions, which have highlighted the successful adoption and implementation of comprehensive tobacco control policies. Hence, these national and global efforts can guide future legislation and educational initiatives that can advance progress toward achieving target 3.a of the Sustainable Development Goal 3.

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Authors

AMA's Office of International Relations
Chicago, Illinois, United States

Samprith Ala, MD
JDN Member
Narasaraopet, India

María Rosa Arroyo, MD
Vice-Secretary, Spanish General Medical Council (CGCOM)
Madrid, Spain

Dilek Aslan, MD, MSc
Hacettepe University,
Faculty of Medicine,
representing Association of Public Health Specialists (HASUDER)
Ankara, Turkey

Sofia Belo Ravara, MD, MSc, PhD
Coordinator, Tobacco Working Group,
Portuguese Respiratory Society
University of Beira Interior Covilhã
Covilhã, Portugal
Public Health Research Centre,
National School of Public Health,
Nova University of Lisbon
Lisbon, Portugal

Dabota Yvonne Buowari, MBBS
Department of Accident and Emergency,
University of Port Harcourt
Teaching Hospital
Port Harcourt, Nigeria

Carolina Cardozo
Press Officer, Confederación Médica de la República Argentina (COMRA)
Buenos Aires, Argentina

Brian Bib-Jeng Chang, MD
Secretary General,
Taiwan Medical Association
Taipei, Taiwan

Helena Chapman, MD, MPH, PhD
Milken Institute School of Public Health,
George Washington University
Washington DC, United States

Shiyi Chen, MD
President, Chinese Society of Sports Medicine, Chinese Medical Association
Department of Sports Medicine,
Huashan Hospital, Fudan University
Shanghai, China

Ching-Ming Chou, MD
President, Taiwan Medical Association
Taipei, Taiwan

Jorge Coronel, MD
President, Confederación Médica de la República Argentina (COMRA)
Buenos Aires, Argentina

Fei-Ran Guo, MD
Adjunct Assistant Professor,
National Taiwan University
Hospital and College of Medicine
Taipei, Taiwan

Laura Llambí, MD, PhD
Hospital de Clínicas,
Universidad de la República
Sindicato Médico del Uruguay
Montevideo, Uruguay

Rohit Nayyar, MD
Director, Surgical Oncology,
Max Institute of Cancer Care
Saket, New Delhi, India

Brenda Obondo, MBChB, MBA
Chief Executive Officer,
Kenya Medical Association
Nairobi, Kenya

Leon Ogoti, MBChB, MSc
Public Health Committee,
Kenya Medical Association
Nairobi, Kenya

Sara K. Ramjit, BSc, MBBS, PG Dip, MSc, DM
Family Medicine Primary Care Physician 2
South-West Regional Health Authority
Port of Spain, Trinidad and Tobago

Prof. Steve Robson, BMedSc, MBBS, MPH, MMed, MD, PhD, FRANZCOG, FRCOG, FACOG, FAMA, CertGovPract
President,
Australian Medical Association
Canberra, Australia

Francisco Rodríguez Lozano, MD
Board member,
Cancer Patients Europe &
Former President,
European Network for Smoking and Tobacco Prevention,
Brussels, Belgium &
Former President,
National Committee for Tobacco Prevention, Madrid, Spain

Jaqueline Scholz, MD, PhD

Director, Smoking Cessation

Program, Heart Institute

University of São Paulo Medical School

São Paulo, Brazil

Wonchat Subhachaturas, MD

Past President, Medical

Association of Thailand

Past President, WMA (2010)

Bangkok, Thailand

Bienvenido Veras-Estévez,

MD, MPH

Department of Epidemiology,

Hospital Regional Universitario

José María Cabral y Báez &

Faculty of Health Sciences,

Universidad Católica del Cibao

Santiago de los Caballeros & La Vega,

Dominican Republic

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History in brief

The American Medical Association (AMA) is the largest and only national association that convenes more than 190 state and specialty medical societies and other critical stakeholders. For more than 170 years, the AMA has worked to create a better future for patients and physicians, including being at the forefront of advocating against racial and ethnic disparities in health care. The AMA has always put patients first.

- **1847:** founded.
- **1849:** AMA established a board to analyse quack remedies and nostrums and to enlighten the public in regard to the nature and danger of such remedies. The Department of Investigation (1913-1975) gathered and disseminated health fraud and quackery information for the public for more than 60 years.
- **1873:** AMA Judicial Council was founded to deal with medical ethical and constitutional controversies (<https://www.ama-assn.org/delivering-care/ethics>).
- **1883:** *Journal of the American Medical Association* (<https://jamanetwork.com/journals/jama>) is first published, and Nathan Davis is first editor.
- **1910:** *Medical Education in the United States and Canada*, funded by the Carnegie Foundation and supported by the AMA, is published and facilitates new standards for medical schools.

- **1943:** AMA opened an office in Washington, D.C.
- **1961:** AMA recommended a nationwide vaccination using the Sabin oral vaccine against polio.
- **1966:** AMA published the first edition of the Current Procedural Terminology (CPT®) (<https://www.ama-assn.org/practice-management/cpt>), a system of standardised terms for medical procedures used to facilitate documentation.
- **1972:** AMA launched a war on smoking, urging the government to reduce and control the use of tobacco products and supporting legislation prohibiting the disbursement of tobacco samples.
- **1986:** Resolution passed opposing acts of discrimination against AIDS patients and any legislation that would lead to such categorical discrimination or that would affect patient-physician confidentiality.
- **1990:** AMA Fellowship Residency Electronic Interactive Data Access System (FREIDA) (<https://freida.ama-assn.org/>) describing residency programs in the United States was available in electronic form.
- **1997:** AMA launched the National Patient Safety Foundation (<http://www.npsf.org/>) to help ensure that all patients in all health care settings receive health care services safely.
- **2008:** Ronald M. Davis, MD, then the AMA's immediate past president, apologised for more than a century of AMA policies (<https://www.ama-assn.org/about/ama-history/history-african-americans-and-organized-medicine>) that excluded African-Americans from the AMA and that also barred them from some state and local medical societies.
- **2022:** AMA marked its 175th anniversary.

Mission

"To promote the art and science of medicine and the betterment of public health."

As the physicians' powerful ally in patient care, the AMA delivers on this mission by representing physicians with a unified voice in courts and legislative bodies across the nation, removing obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, driving the future of medicine to tackle the biggest challenges in health care and training the leaders of tomorrow.

Current challenges

- Physician burnout
- Physician payment reform
- Supporting telehealth
- Scope of practice issues
- Cost of prescription drugs
- Ensuring adequate supply and equitable distribution of physicians
- Overdose epidemic
- Liability and risk in digital health innovation

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Future vision

- Share opportunities, best practices, and learnings for how digitally-enabled care can address workforce issues and industry-wide burnout through AMA convened efforts, pilots, and organised (virtual and in-person) learning collaboratives
- Commit to the principles of equity and innovation
- Help ensure that the physician-patient relationship continues as the “heart and soul” of medicine and support physician-led team-based care
- Collaborate on aligned advocacy efforts focused on addressing industry fragmentation and payment reform as well as advancing digitally-enabled care

Contact information

Address: 330 N. Wabash, Suite 39300, Chicago, Illinois, United States 60611

Email: elizabeth.larocca@ama-assn.org,

hannah.longstaff@ama-assn.org

Website: <http://www.ama-assn.org>

AUSTRALIAN MEDICAL ASSOCIATION



Stephen Robson

Leadership

President: Prof. *Stephen Robson*

History in brief

The Australian Medical Association (AMA) is a federation of the AMA state and territory bodies and a federal secretariat, which is based in Canberra, Australia.

- **October 1961:** it was founded after many decades of doctors trying to form a body autonomous and independent from the British Medical Association.
- **May 1962:** the six former state branches of the British Medical Association became branches of the AMA, and the first AGM of the organisation was held at the University of Adelaide, in Adelaide, the capital of South Australia., Dr Cecil Colville

became the AMA's first president. The AMA has published the *Medical Journal of Australia* since 1914.

Mission

The AMA's motto – pro genere humani concordia – means “united for humanity” or “all as one for mankind”. The AMA, which represents and supports all Australian doctors and medical students, works with governments to develop and influence health policy to provide the best outcomes for doctors, their patients, and the community.

Objectives

The AMA aims to preserve, maintain, promote, and advance the intellectual, philosophical, social, political, economic, and legal interests of its members and to promote the wellbeing of patients. The AMA participates in promoting health care programs for community benefit and addressing major social and community health issues. The AMA also works with affiliate organisations and publishes and circulates the *Medical Journal of Australia*.

National collaborations

The AMA has partnerships with the Doctors for the Environment Australia.

International collaborations

The AMA is a member of the Council of the World Medical Association (WMA) and the Confederation of Medical Associations in Asia and Oceania (CMAAO).

Current challenges

The Australian health system is under significant pressure, due to growing demand and efforts by governments to constrain the funding available to deliver patient services as well as evidence of medical workforce shortages across geographies and clinical specialties. Some non-medical professionals are pursuing a role substitution agenda, often outside of the team-based approach supported by the AMA.

Future vision

The AMA's vision supports a first-class health system in Australia, supported by the government that works to meet the demands of a changing society and environment, including COVID-19, increasing incidence of chronic diseases, and effects of climate change. The AMA is working on an urgent reform agenda to improve Australia's chronically underfunded public hospital and primary care systems and defend the hybrid public-private model in Australia over the past 50 years.

Contact information

Address: 39 Brisbane Avenue, Barton, Canberra, Australia

Email: president@ama.com.au

Website: www.ama.com.au

AUSTRIAN MEDICAL CHAMBER (ÖSTERREICHISCHE ÄRZTEKAMMER)



Johannes Steinhart

Leadership

President: Dr. *Johannes Steinhart*

Vice Presidents: Dr. *Harald Schlögel*, Dr. *Harald Mayer*

International Affairs: Dr. *Edgar Wutscher*, Dr. *Christian Toth*

Directors: Dr. *Lukas Stärker*, Dr. *Johannes Zabrl*

History in brief

- **1891:** the first medical chambers were created in Austria and lasted until 1938, when the provisions of the German “Reichsärzteordnung” were enforced in Austria and the Austrian medical chambers were dissolved.
- **1938:** they were replaced by the “Reichsärztleitung” with its headquarters in Munich. After the end of the Second World War, professional associations of doctors were provisionally formed in all provinces on the basis of the regulations of the Austrian Medical Association Act of 1891.
- **30 March 1949:** associations were later essentially legalised by the Austrian Medical Act. This precursor of the modern Austrian Medical Act was also first in establishing an umbrella organisation in the form of the Austrian Medical Chamber to represent the collective interests of the provincial medical chambers.
- **1998:** the Medical Act led to a complete restructuring of the medical chambers, involving the creation of separate bodies (“curiae”), in order to address specific concerns of different groups within the medical profession. Three of them were originally created: one for doctors employed by medical institutions, another for self employed doctors running their own practice, and a third group for dentists.
- **2005:** the third curia was split off, to form the Austrian Dental Chamber, leaving the two current curiae.

Mission

In accordance with the Austrian Medical Act, the Austrian Medical Chamber (Österreichische Ärztekammer, ÖÄK) represents the collective professional, social, and economic interests of all physicians working in Austria. It works to preserve and further the public standing and the rights of physicians,

while ensuring their compliance with the duties of the medical profession. It acts as an umbrella organisation under public law for the nine provincial medical chambers, which are considered its members.

The ÖÄK pays special regard to socially oriented, universal, modern healthcare, provided by doctors in hospitals and private practices. For this purpose, doctors in Austria are committed to a high medical standard with special consideration to ongoing quality management to increase patient safety. The medical profession is headed by the President of the ÖÄK, who is supported by three Vice-Presidents, one of whom heads the curia of employed doctors; a second heads the curia of self employed doctors.

Objectives

The Austrian health care system and its financing are socially oriented and based on the principles of solidarity and subsidiarity. The goals of a sustainable reform of the Austrian healthcare system must be to ensure a continuing, universal access to medical care of a high standard for all insured persons and dependents, and to guarantee that the ethical principles, in accordance to which doctors practise medicine, as well as protect their professional independence. Patient services should not be decided by medical and health-political expertise of doctors and politicians, respectively, rather than based on economic interests.

National collaborations

The ÖÄK collaborates on a national level with other chambers, professional societies, and organisations on diverse projects: “Arznei und Vernunft” (Medicine and Reason) represents an initiative for a reasonable and evidence-based use of medicines at all levels of the healthcare system, in collaboration with the Austrian Chamber of Pharmacists, the Association of the Austrian Pharmaceutical Industry and the Umbrella Organization of the Austrian Social Insurance Institutions; “Du + Ich = Österreich” (You + Me = Austria) serves as a campaign that promote a respectful exchange of opinions, in collaboration with the Austrian Broadcasting Services, the Austrian Red Cross, and the Austrian Health Insurance Fund; “Doctors Against Smoking” Initiative promotes the protection of non-smokers, in collaboration with the Austrian Society of Pneumology and the Institutes of Environmental Hygiene and Social Medicine of the Medical University of Vienna.

International collaborations

Besides its WMA membership, the Austrian Medical Chamber is also a member of European Association of Senior Hospital Physicians (AEMH), the Standing Committee of European Doctors (CPME), European Working Group of Practitioners and Specialists in Private Practice (EANA), European Junior Doctors Association (EJD), Federation of European Microbiological Societies (FEMS), European Union of General Practitioners (UEMO), European Union of Medical Specialists (UEMS), and Symposium of the Central and Eastern

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European Chambers of Physicians (ZEVA). The ÖÄK actively participates in the work of these organisations and regularly attends meetings.

Current challenges

Over the next few years, the most pressing challenges will be to:

- improve the working conditions for hospital physicians
- increase the attractiveness of the social health insurance sector
- ensure low-threshold healthcare services close to where people live
- significantly reduce the bureaucratic burden for the medical profession

These steps will help address the acute shortage of doctors in Austria, which is projected to increase in the social health insurance sector amidst a steadily growing and ageing population.

Future vision

The ÖÄK aims to achieve a positive framework for medical practice in Austria, including the improvement of doctors' specific working conditions. The work of the ÖÄK constitutes a major contribution to patients' wellbeing within the Austrian healthcare system.

Contact information

Address: Weihburggasse 10-12, 1010 Wien, Austria

Email: post@aerztekammer.at

Website: <https://www.aerztekammer.at/>

President photo: Picture credit: © ÄK Wien / Anna Rauchenberger

BANGLADESH MEDICAL ASSOCIATION



Mustafa Jalal Mohiuddin

Leadership

President: Dr. *Mustafa Jalal Mohiuddin*

Secretary General: Dr. Md. *Ehteshamul Huq Choudhury*

History in brief

Founded in 1971, the Bangladesh Medical Association (BMA) represents an active service oriented organisation in Bangladesh. There are 67 branches of the Association around the country.

Mission

To promote dignity of its members, encourage members to pursue continued medical education on the latest health innovations, ensure workplace safety, and guide government leaders to develop suitable health policies for the populace.

Objectives

The BMA participates in public health related activities, ethical issues and laws relevant for health professionals, research and publications, activities with other organisations, social welfare activities, education and training, and foreign affairs.

National collaborations

The BMA collaborates with Directorate General of Health Services at the Ministry of Health and Family Welfare, Directorate General of Medical Education at the Ministry of Health and Family Welfare, National Heart Foundation of Bangladesh, Bangladesh Medical Research Council, Bangladesh Medical and Dental Council, and Directorate General of Drug Administration (DGDA).

International collaborations

The BMA collaborates with the Confederation of Medical Associations in Asia and Oceania (CMAAO), the World Medical Association (WMA), and the South Asian Association for Regional Cooperation (SAARC) (medical association conferences and assemblies). It also has continued medical education programs with the Bangladesh Medical Association's North America Chapter.

Current challenges

Workplace safety for health professionals

Future vision

- To assist the Government in developing a legislature that will ensure workplace safety for health professionals
- To establish modern health care facilities at the root level and promote the best health care delivery system in Bangladesh

Contact information

Address: BMA Bhaban, 15/2 Topkhana Road, Dhaka-1000, Bangladesh

Email: bma.org.bd@gmail.com

Website: bma.org.bd

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BELGIAN ASSOCIATION OF MEDICAL UNIONS (ASSOCIATION BELGE DES SYNDICATS MÉDICAUX - BELGISCHE VERENIGING VAN ARTSENSYNDICATEN)



Johan Blanckaert

Leadership

President: Dr. *Johan Blanckaert*

Vice Presidents: Dr. *Bart Dehaes*, Dr. *Gilbert Bejjani*,

Dr. *Luc Herry*, Dr. *Marcel De Clercq*

General Secretary: Dr. *Yves Louis*

General Secretary for International Affairs: Dr. *Vincent Lamy*

Treasurer: Dr. *Alin Derom*

History in brief

The history of Belgian unionism has been marked by major doctor's strikes, national institutional reforms, and the adopted law on the status of hospital doctors.

- **17 May 1962:** the first Chamber in Liège – Luxemburg was established.
- **21 March 1963:** the Chamber of the provinces of Hainaut, Namur, and Walloon Brabant established.
- **31 May 1963:** the Chamber of the doctors of Brussels agglomeration established.
- **23 August 1963:** the Dutch-speaking part followed this movement by creating the Chamber of Doctors of the provinces of Antwerp, Limburg, and Flemish Brabant, and later the chamber of West and East Flanders. These five chambers acted on the national level through the Federation of Syndicate Chambers of Doctors. During the national communitarisation, this federation was renamed the Belgian Association of Medical Unions (ABSYM-BVAS), whose operation is conducted on a joint basis of general practitioners and specialists and the Flemish community as well as the Walloon and German-speaking communities.
- **2022:** the Union chambers of physicians of Hainaut, Namur, and Walloon Brabant as well as those of Liège and Luxembourg merged to form ABSYM Wallonia.

Mission

Building the medicine of tomorrow means continuing to defend doctors and their patients.

Objectives

- **Freedom:** Defending freedom of doctor-patient engagements in health decision-making
- **Respect:** Supporting doctors in their right to find a balance between their profession and their private lives
- **Protection:** Defending doctors' rights to professional insurance (accident and illness) as well as to civil liability insurance
- **Quality:** Promoting accessible medicine for patients with best doctors' practices

National collaborations

The ABSYM-BVAS representatives support more than 350 mandates in the various bodies of INAMI, Public Health, and e-Health, including the National Medico-Mutualist Commission (INAMI-RIZIV) for doctor-insurer engagements and agreements, General Health Care Council for guideline development on health care policies, Medical Technical Council for proposal development, and Medical Assessment and Control Service (SECM).

International collaborations

The ABSYM-BVAS collaborates with the European Union of General Practitioners (UEMO), the World Medical Association (WMA), Standing Committee of European Doctors (CPME), European Working Group of Practitioners and Specialists in Free Practice (EANA), and European Association of Senior Hospital Physicians (AEMH).

Current challenges

Some challenges include:

- limited commitment by younger generations to medicine
- current focus on work-life balance of the medical profession
- support for the independent status of the medical profession

Future vision

At the legislative level, we continue to defend:

- liberal installation of doctors
- fees for service payment
- intramural and extramural equilibrium in respect and payment
- reviving the moral role of doctors
- defending free standing centres of specialised medicine
- administrative help so that doctors can focus on main duties

Contact information

Address: Terhulpesteenweg 150 – 1170 Brussels, Belgium

Tel: 02/644.12.88

Email: international@cn.medecin.fr

Website: www.absym-bvas.be

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CROATIAN MEDICAL ASSOCIATION



Željko Krznarić

Leadership

President: Prof. *Željko Krznarić*

Vice Presidents: Prof. *Boris Brkljačić*, Dr. *Hrvoje Pezo*

Secretary General: Prof. *Adriana Vince*

Treasurer: Dr. *Neven Miculinić*

Head office: *Ivona Matišić*, Mag.oec., univ.mag.admin.sanit.

History in brief

- **26 February 1874:** the Croatian Medical Association (Association of Physicians of the Kingdom of Croatia and Slavonia) was founded to protect people's health, support professional and scientific work, and foster medical ethics.
- **January, 1877:** the first issue of the oldest *Croatian medical journal*, *Liečnički viestnik*, was published.
- **1919:** the Association changed its name to the Association of Doctors of Croatia, Slavonia and Međimurje 1923: the Association changed its name to the Croatian Medical Association (CMA).
- **1945:** the Association changed its name to the Association of Doctors of Croatia.
- **1971:** the Association changed its name to the Academy of Association of Doctors of Croatia.
- **1991:** the Association changed its name to the Croatian Medical Association.

Mission

Active communication and cooperation with all doctors and medical associations in order to preserve the dignity and quality of profession at all levels.

National collaborations

The CMA collaborates with the Ministry of Health in Croatia, Croatian Health Insurance Fund, Croatian Institute for Public Health, Croatian Medical Chamber, Croatian Dental Chamber, Croatian Medical Union, hospitals, and medical schools in Croatia.

International collaborations

The CMA collaborates with the European Union of Medical Specialists (UEMS), European Society for Clinical Nutrition and Metabolism (ESPEN), the World Medical Association (WMA), National Guideline Alliance, and Slovensko Zdravniško Društvo.

Current challenges

Strengthening the European Standards of Postgraduate Medical Specialist Training, including the actual use and implementation of the European Training Requirements (ETR).

Future vision

The Croatian doctor is a representative of the progress of the Republic of Croatia and the guarantor of preserving the health of citizens of the Republic of Croatia. A Croatian doctor should uphold high ethical principles within the medical profession, ranging from primary care to specialised medicine of the 21st century.

Contact information

Address: Zagreb, Croatia, Šubićeva 9

Tel: +38514693300

Email: tajnistvo@hlz.hr

Website: www.hlz.hr

CZECH MEDICAL CHAMBER



Milan Kubeš

Leadership

President: Dr. *Milan Kubeš*

Vice president: Dr. *Zdeněk Mrozek*

History in brief

- **1894:** the Medical Chamber, as part of the Austro-Hungarian Monarchy, was founded.
- **1929:** after the declaration of the independent Czechoslovak Republic on 28 October 1918, the new Act on Medical Chambers (Bohemia, Moravian-Silesian, Slovakia including Subcarpathian Rus) was adopted.

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- **March 1939:** the Chambers maintained their independence until the Nazi occupation in March 1939, and then Communist dictatorship resulted in February 1948.
- **1950:** the Act on Medical Chamber was illegally abolished by a simple decree of the officiating Minister of Health.
- **1989:** democracy was established.
- **8 May 1991:** the Czech Medical Chamber was restored by law.

Mission

The Czech Medical Chamber (CMC) is a guarantor of the quality of medical care and a guardian of medical ethics. We defend the professional and economic interests of members so that doctors can perform their profession to the highest possible standard. The existence of a strong and independent professional self-government is a basic condition for preserving the autonomy of doctors, which is of vital importance for patient safety.

Objectives

- Administer the Registry of All Physicians Working in the Czech Republic
- Guarantee proper qualification and certify fulfilment of the conditions required for optimal professional performance
- Be a guarantor of a lifelong learning
- Conduct professional supervision and disciplinary power toward all physicians

National collaborations

The CMC collaborates with the government, Parliament, regional and municipal self-governments, medical schools, professional medical associations, health care providers, trade unions, and health insurance companies.

International collaborations

The CMC collaborates with the Standing Committee of European Doctors (CPME), the World Medical Association (WMA), and the CMC Division of Junior Doctors.

Current challenges

Although doctors, nurses and other healthcare professionals have helped save more than tens of thousands of lives and keep an active economy during the pandemic, they have experienced reduced income and compensation. Furthermore, as the CMC has provided support, medical care, and asylum for half a million Ukrainian refugees in 2022, future efforts may be needed to address the ongoing conflict.

Future vision

The strategic goals of the CMC include:

- quality, safe, and accessible medical care for all citizens
- fair cost of labour and acceptable working conditions for all doctors
- quality and accessible training for doctors
- preservation of professional autonomy and dignity of the

medical profession

- advocacy of humanity, solidarity, and democracy

Contact information

Address: Česká lékařská komora, Drahobejlova 1019/27, 190 00 Praha 9, Czech Republic

Email: foreign@clkcr.cz

Website: <https://www.lkcr.cz/>

ESTONIAN MEDICAL ASSOCIATION



Jaan Sütt

Leadership

President: Dr. *Jaan Sütt*

President-Elect: Prof. *Neeme Tõnisson*

Secretary General: Dr. *Katrin Rehema*

History in brief

- **28 February 1921:** the Estonian Medical Association (EMA) was founded in Tallinn, Estonia. During the Soviet occupation (1944-1987), the Association was prohibited in Estonia, and the Estonian Physicians Society in Sweden (EASR) conducted traditions of the doctors' union.
- **11 June 1988:** the EMA activities were restored.

Mission and objectives

EMA supports the development and reputation of the medical profession, protects the interests of doctors, promotes medical ethics and medical culture and represents the views of the medical profession in shaping health care policy.

National collaborations

EMA works in close collaboration with the local organisations representing patient interests, other healthcare specialists, and relevant state institutions.

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International collaborations

EMA is a full member of leading international medical organisations: the World Medical Association (WMA), Standing Committee of European Doctors (CPME), European Union of Medical Specialists (UEMS), and European Junior Doctors Association (EJD).

Current challenges

EMA's main areas of activity are related to promoting the quality of medical care, improving the working and salary conditions of doctors, promoting continuing medical education and medical ethics. The main challenges in Estonian healthcare are:

- shortage of medical workforce
- overworking specialists
- burnout of doctors

Future vision

EMA aims for the healthcare system which is accessible, affordable and provides high-quality care for our patients.

Contact information

Address: Pepleri Str 32, 51010 Tartu, Estonia

Email: arstideliit@arstideliit.ee

Website: <https://arstideliit.ee/>

FINNISH MEDICAL ASSOCIATION



Niina Koivuviita

Leadership

President: Dr. Niina Koivuviita

Chief executive officer: Dr. Janne Aaltonen

History in brief

- **1910:** the Finnish Medical Association (FMA) was established and the first President expressed the hope that it would become "the heart and conscience of the medical profession". This mission has been implemented by promoting

ethical principles and guidelines to members. The FMA celebrated its 100-year anniversary in 2010, with international guests, and published a comprehensive history of the organisation.

- **1964:** the FMA hosted the WMA General Assembly, when the WMA Declaration of Helsinki was adopted. FMA also hosted 2003 WMA General Assembly as well as 50-year celebration of Declaration of Helsinki in 2014. We look forward to hosting the WMA General Assembly in 2024 and celebrating 60 years of the WMA Declaration of Helsinki.

Mission

Doctors together for the benefit of the patient.

Objectives

The FMA is a professional organization and a trade union. Almost all doctors practising in Finland are members although the membership is voluntary.

- Add Values promoted by the FMA include advancement of medical expertise, humanity, ethics, and collegiality. The FMA binds its members together to support these values, and represents their common professional, social and economic interests.
- The FMA also works in numerous ways to develop health care and advance medical expertise on the basis of the professional knowledge of its entire membership. The Association is active in relation to ethical issues and safeguarding the interests of doctors and patients in Finland and internationally.

National collaborations

The FMA collaborates with the government and parliament as well as national, regional, and local authorities.

International collaborations

In addition of being a member of the World Medical Association (WMA), the FMA is a member of four European Medical Organizations: Standing Committee of European Doctors (CPME), European Union of Medical Specialists (UEMS), European Union of General Practitioners/family doctors (UEMO), and European Junior Doctors (EJD). The FMA also closely collaborates in different fields with Nordic countries.

Current challenges

With the Finnish social and health care reform on 1 January 2023, the organising responsibility of social and health care services shifted from around 200 municipalities to 21 counties. As the employer of social and health care workers including physicians changed, many questions were raised from our members. We support physicians in this changing working environment, including negotiations on salaries and other working conditions.

Future vision

The FMA is a strong influencer and a respected trendsetter, as stated in the FMA 2022-2024 Strategy.

Contact information

Address: Mäkeläkatu 2, 00501 Helsinki, Finland

Email: international@laakariliitto.fi

Website: www.laakariliitto.fi

FRENCH MEDICAL COUNCIL



François Arnault

Leadership

President: Dr. *François Arnault*

Secretary General: Dr. *Pierre Maurice*

Treasurer: Dr. *Pierre Jouan*

Vice Presidents: Dr. *Marie-Pierre Glaviano-Ceccaldi*,

Dr. *Jean-Marcel Mourgues*, Dr. *Gilles Munier*,

Dr. *Jacqueline Rossant-Lumbroso*

General delegate for EU and international Affairs

Dr. *Philippe Cathala*

History in brief

- **24 September 1945:** the current French Medical Council (Ordre National des Médecins, CNOM) was created, which highlighted the role of medical ethics. The members of the Council were elected by the doctors listed on the Register.
- **1947:** the first code of ethics was published.
- **2002:** the Council mission was expanded by the Law on the Quality of the Health System, establishing regional councils and entrusting the Council to ensure that doctors' competences were guaranteed throughout their career.

Mission

The commitment of the French Medical Council is "At the service of doctors in the interest of patients".

Objectives

The CNOM fulfils its mission as a private organisation assigned to a public service mission. It is the only body in France that unites doctors of all specialties and practice types. It completes

its duties through Departmental Councils, Regional Councils, and the National Medical Council. Through its moral, administrative, consultative, mediation and jurisdictional roles, the CNOM contributes to building trust in the doctor/patient relationship. Its members also support:

- **Guaranteeing professional ethics**
Compliance with medical ethics and deontology is one of the main areas of competence of the Council which is responsible for drafting the code of medical ethics that is enshrined in the public health code. The Council also prepares comments on the code to make it easier for doctors to understand and comply with the code in their daily work. It also acts as a disciplinary body for doctors who fail to comply with the principles of professional ethics.
- **Ensuring the competence of physicians**
The law has given the Council the role of ensuring that the competence and probity of the medical profession are maintained. It maintains an up-to-date list of doctors authorised to practise. It manages the registration of doctors on this list.
- **Supporting and helping doctors**
The Council supports doctors in their daily work. In an increasingly complex legal and societal environment, it acts as an advisor to help them set up in business, choose the status best suited to their mode of practice and carry out their activity as serenely as possible throughout their career. The Council provides doctors with tools to facilitate their professional practice: model contracts, practical guides, etc. It provides legal advice, particularly when drawing up contracts and statutes, in matters of insurance or in the event of a dispute between the doctor and the patient or between colleagues. Finally, the Council manages a mutual aid fund to help doctors in difficulty and their families.
- **Ensuring access to and quality of care**
Alongside the representatives of other health professionals, the Council monitors the quality of care, access to it and respect for patients' rights. It ensures the professional independence of all its members in their relations with the pharmaceutical and biomedical industries.
- **Dialogue with the public authorities**
The Council is a key player in discussions on changes in the healthcare system. It is present in many bodies and acts as an expert for ministries, regional health agencies (ARS) and French public health bodies (Haute Autorité de Santé, Agence Nationale de Sécurité du Médicament, etc.). As an interlocutor with the public authorities, it issues opinions on draft laws and decrees relating to health. To reinforce its role as an expert, the Council carries out various surveys on medical demography, physician safety and the availability of care.

National collaborations

The Council is a valued partner at local and regional level in every part of France.

International collaborations

The Council has established strong links with Medical Councils and similar bodies from other European countries. It has a permanent office in Brussels and is represented in several organisations and networks of doctors in Europe, including the European Council of Medical Orders (CEOM), Standing Committee of European Doctors (CPME), European Association of Senior Hospital Physicians (AEMH), European Network of Medical Competent Authorities (ENMCA), Conference of French-speaking Medical Councils (CFOM), and World Medical Association (WMA).

Current challenges

- Guarantee for patients access to high-quality, safe care. Implement a local health organisation under the coordination of the doctor and in partnership with other health professionals.
- Ensure that the physician remains at the core of this organisation, as a real pillar of the healthcare team around the patient and his or her health care pathway.
- Adopt a position on the societal and ethical issues it faces today, particularly the issue of the end of life, in line with current national legislation (Claeys-Leonetti Act).
- Enhance the value of the medical profession and improve its attractiveness, especially for the younger generations. The latter must continue to consider practising this profession with passion and pride.
- Continue its modernisation. It already ensures a strict parity of elected representatives and enhances the role of practising doctors. It also fully meets its mission to serve doctors throughout their career.

Contact information

Address: 4 Rue Léon Jost - 75855 PARIS CEDEX 17, France

Email: international@ordre.medecin.fr

Website: <https://www.conseil-national.medecin.fr>

GEORGIAN MEDICAL ASSOCIATION



Gia Lobzhanidze

Leadership

Chair, Board of Directors: Dr. *Gia Lobzhanidze*

Vice Chair, Board of Directors: Dr. *Gia Tsilosani*

Secretary General: Dr. *Tinatin Supatashvili*

History in brief

Founded on 5 May 1989, the Georgian Medical Association (GMA) is an independent, professional union of doctors that supports the professional and personal needs of doctors working in Georgia.

Mission

The GMA aims to protect the civil, professional, legal, and socioeconomic interests of the medical community, by serving as the voice and uniting doctors of all medical disciplines within the country. It encourages active member participation in strategic development and health policy of the country.

Objectives

Some GMA tasks include supporting decentralisation of the health system, protecting doctors' rights, fostering junior doctors' professional development, prioritising biomedical ethics, organising and managing educational, scientific, and practical actions, and assisting with licensing and accreditation.

National collaborations

The GMA collaborates with federal departments, like the Georgian Parliament, the Ministry of Refugees from the Occupied Territories of Georgia, and the Ministry of Labor, Health and Social Affairs of Georgia. They also are connected to more than 90 professional associations in Georgia.

International collaborations

The GMA collaborates with the European Forum of Medical Associations (EFMA), World Health Organization (WHO), World Medical Association (WMA), South-East European Medical Forum (SEEMF), and European Permanent Committee (CPME).

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Current challenges

- Insignificant number of public hospitals (federal and municipal hospitals) and university clinics
- Postgraduate medical professional development
- Workforce shortage, especially nursing staff
- Unsafe work conditions of medical personnel in private clinics
- Financial problems to solve everyday tasks, pay membership fees for international organisations, and send delegates to international events
- Working with the government to give the NMA more rights and responsibilities in the medical field

Contact information

Address: 11 Budapeshti Str. 0160 Tbilisi, Georgia
 Phone: (+995 32) 2 39 86 86; (+995 32) 2 18 00 19
 Email: Georgianmedicalassociation@gmail.com;
info@gma.ge
 Website: GMA.GE

BRITISH MEDICAL ASSOCIATION



Philip James Banfield

Leadership

Chair of the Council: Professor *Philip James Banfield*
 Chair of the Representative Body: Dr. *Latifa Patel*

History in brief

- **July 1832:** the Association was originally set up as the Provincial Medical and Surgical Association, a collective organisation for doctors. Established in the midst of a cholera outbreak, the association was established for exchanging scientific knowledge and ideas.
- **1855:** the body became known as the British Medical Association (BMA), following the weekly publication of the British Medical Journal.
- **1971:** the Association was officially recognised as a trade union, representing and negotiating on behalf of all doctors and

medical students in the United Kingdom. As a professional association, the BMA also campaigns on a range of global health issues that impact doctors.

Mission

The BMA is defined by its mission: we look after doctors so they can look after you.

Objectives

The BMA represents, supports and negotiates on behalf of all UK doctors and medical students. We are member-run and led, and fight for the best terms and conditions as well as lobbying and campaigning on the issues impacting the medical profession. The Association also provides individual advice pertaining to employment, immigration, ethics, pension, and contract matters.

National collaborations

The BMA undertakes research and produces recommendations for both national and local government on a variety of public and population health issues, as well as health system and delivery models. The Association works with Westminster, the Northern Ireland Assembly, Scottish Parliament and the Welsh Assembly to ensure doctors' voices are heard and their views are taken into account by policymakers. We issue briefings to Members of Parliament and peers, influence consultations and inquiries, and seek members' views to influence legislation. As the collective voice for doctors on population and global health issues, we collaborate with civil society to develop analysis and take part in campaigns for change.

International collaborations

The BMA works closely with international organisations such as the World Medical Association (WMA) and the Commonwealth Medical Association (CMA) as well as various European Medical Organisations including the Standing Committee of European Doctors (CPME), European Union of General Practitioners (UEMO), European Union of Medical Specialists (UEMS), and European Junior Doctors (EJD).

Current challenges

There are currently a number of key challenges facing the National Health Service (NHS) including immediate health system pressures and funding pressures - yet the single most important challenge for UK doctors is the workforce crisis. First, staff shortages have been growing in the NHS for years. This has been driven by inadequate workforce planning and lack of government accountability - including insufficient funding and infrastructure to train enough new doctors. Second, increasing workload and bureaucracy have made the NHS a 'leaky bucket'. Additional issues - like years of demoralising pay erosion and punitive pension taxation rules - have made it even harder to retain the doctors we have. As a result, Junior Doctors in England, Scotland and Wales are campaigning for full pay restoration, with Junior Doctors in England voting

overwhelmingly for industrial action.

Future vision

Our guiding vision is to ensure 'A profession of valued doctors delivering the highest quality health services.' We will achieve this through:

- actively increasing our membership density by listening to our members and improving services
- representing the profession by acting on their concerns to achieve the best possible outcomes, both individually and collectively
- external influencing on issues that matter the most to the profession
- building a sustainable organisation with a supportive culture

Contact information

Address: BMA House, Tavistock Square, London, England WC1H 9JP

Email: info.international@bma.org.uk

Website: <https://www.bma.org.uk/>

ITALIAN NATIONAL FEDERATION OF THE ORDERS OF DOCTORS AND DENTISTS



FNOMCeO

Federazione Nazionale degli Ordini
dei Medici Chirurghi e degli Odontoiatri



Filippo Anelli

Leadership

President: Dr. *Filippo Anelli*

History in brief

The National Federation of the Orders of Doctors and Dentists (FNOMCeO) is a public body that unites 106 provincial Orders of Doctors and Dentists in Italy.

- **1910:** the Orders of Doctors were established by the Giolitti Government by Constitutive Law No 455.
- **1946:** after the fascist regime in 1935, the Orders were reconstituted by the Legislative decree No 233.

- **1985:** the Medical Orders changed their legal denomination to "Provincial Orders of Doctors and Dentists", following the enactment of Law No 409, which established the profession of dentistry, creating a Registry of Dentists within the Order of Doctors.
- **2018:** the legal status of the Order was modified by Law No 3, which stated that the auxiliary bodies are subsidiary bodies of the State, with the aim of protecting public interests, when connected to professional practice.

Mission and objectives

The FNOMCeO directs, coordinates, and administratively supports the provincial Orders in conducting institutional tasks that include maintaining the Registers of Doctors and Dentists and establishing the Code of Medical Deontology.

National collaborations

The FNOMCeO collaborates with the Ministry of Health, Ministry of University and Research, Ministry of Finance, and State-Regions Commission of the National Observatory on Training in General Medicine.

International collaborations

The FNOMCeO collaborates with the World Medical Association (WMA), European Union of Medical Specialists (UEMS), European Union of General Practitioners (UEMO), European Association of Senior Hospital Physicians (AEMH), European Council of Medical Orders (CEOM), Federation of European Dental Competent Authorities and Regulators (FEDCAR), Association for Dental Education in Europe (ADEE).

Current challenges

- Environmental protection
- Violence against healthcare professionals
- Infodemics and misinformation in science and medicine
- Fundamental rights, such as self-determination, cultural pluralism, freedom of research and science
- Communication, in the context of doctor-patient relationships and relationships with other health professions and society
- New technologies, including artificial intelligence, robotics, and telemedicine
- Responsibility, autonomy and clinical risk, which considers conflicts of interest and relationships between the Code and the Law

Contact information

Address: Via Ferdinando di Savoia, 1 - 00196 Rome, Italy

Email: estero@fnomceo.it; presidenza@fnomceo.it

Website: <https://portale.fnomceo.it/>

LATVIAN MEDICAL ASSOCIATION



Ilze Aizsilniece

Leadership

President: Dr. *Ilze Aizsilniece*

Vice Presidents: Dr. *Maris Plavins*, Prof. *Angelika Krumina*

History in brief

- **1988:** the Latvian Medical Association (LMA) was founded.
- **1993:** started certifying doctors.
- **1998:** the Latvian Code of Ethics for Doctors was approved

The LMA aims to defend the legal, professional and economic interests of Latvian doctors. Currently, they have organised 9 Latvian Doctors' Congresses, and the total membership is 3336 physicians.

Mission

The purpose of the association's activities is the continuous improvement of the health care system and the qualifications of doctors, the promotion of public health and health literacy, the improvement of the health care organisation and medical education system, and the promotion of the principles of medical ethics.

National collaborations

The LMA collaborates with the Ministry of Health of Latvia, National Health Service, State Agency of Medicines of the Republic of Latvia, and Centre for Disease Prevention and Control of Latvia.

International collaborations

The LMA collaborates with the World Medical Association (WMA), Standing Committee of European Doctors (CPME), and European Union of Medical Specialists (UEMS).

Current challenges

- Implement the developed new salary model in accordance with the "Public Health Guidelines for 2021-2027", and ensure that the salary of those working in the health care sector is increased by 10% every year until it reaches the EU average

- ratio against the national average salary from 2021 to 2027
- Make the necessary changes in the regulatory framework so that government spending on health care increases to at least 6.5% of GDP and Latvian government spending on health care (% share of all spending) approaches the EU average of 15%
- Use the latest version of the International Code of Medical Ethics in the development of existing legislation
- Create a code of ethics/principles for the actions of LMA institutions, boards, vice presidents and president Raise discussions and reach common understanding with the Ombudsman and politicians on issues of medical ethics
- Cooperate with patient organisations on issues of medical ethics
- Inform and educate the public about ethical issues
- Increase active involvement of colleagues working in the regions in the Association's work, ensuring the exchange of opinions
- Involve Latvian specialists in international cooperation, thus increasing the competences of specialists and strengthening the country's international visibility
- Restore health education in school programs as well as improve health literacy in Latvian society, thus increasing patient satisfaction and participation in the treatment process
- Ensure the availability of rehabilitation at all stages of treatment, including rehabilitation as a mandatory component also in currently prioritised sectors - psychiatry and oncology
- Plan the associate degree and postgraduate education of doctors according to health care needs. Young doctors should be provided with the opportunity to continue postgraduate training in Latvia, thus reducing the outflow of young colleagues to other countries.
- Implement qualitative and functional digital solutions in healthcare. Health data and their analysis must become the basis for decision-making, creation of new strategies and implementation of health sector reforms, therefore it is necessary to reduce data fragmentation. Special attention should be paid to the use of secondary data and the security of personal data, which should not be an obstacle to the implementation of public interests in the field of health.

Future vision

- Promoting person-centred and result-oriented healthcare as well as equal access to healthcare services and medicines for all Latvian citizens
- Increasing state support for research work in both the biomedical field and public health
- Increasing the number of LMA active members
- Collaborating with LMA institutions and corresponding institutions within the European Union
- Supporting federal investment in health care services for Latvian citizens, reducing individual health care expenses, like in other Baltic countries (Estonia, Lithuania)

Contact information

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Address: Skolas iela 3, Riga, Latvia, LV-1010
 Email: lma@arstubiedriba.lv
 Website: www.arstubiedriba.lv

MALAYSIAN MEDICAL ASSOCIATION



Muruga Raj Rajathurai

Leadership

President: Dr. *Muruga Raj Rajathurai*
 Immediate Past President: Dr. *Koh Kar Chai*
 President-Elect: Dr. *Azizan Binti Abdul Aziz*
 Honorary General Secretary: Datuk Dr. *Thirunavukarasu A/L Rajoo*
 Honorary General Treasurer: Dr. *Vasu Pillai A/L Letchumanan*

History in brief

The Malaysian Medical Association (MMA) is the main representative body for all registered medical practitioners in Malaysia. With more than 15,000 members, the MMA (initially known as Malayan Medical Association) now embraces the largest number of doctors in the country.

- **9 November 1858:** the idea to form the MMA came at this meeting, attended by a group of doctors from Malaysia (formerly known as Malaya) and Singapore, the two countries that had just gained independence. The MMA was formed to take over the functions of the Malayan Branch of the British Medical Association following its dissolution in Malaya. It also took over the professional functions of the Alumni Association of the King Edward VII College of Medicine and the Faculty of Medicine, University of Malaya.
- **21 December 1959:** the MMA was officially registered in the Federation of Malaya. Due to its consolidation of objectives, the MMA became deeply involved in formulating the country's medical foundations and presenting a strong front for doctors in Malaysia.
- **1971:** the name Malayan Medical Association was changed to Malaysian Medical Association, with the addition of various

branches across Malaysia.

- **6 April 1973:** the MMA House was officially declared open by the then Prime Minister Tun Abdul Razak.

Mission

- Promote and maintain the honour and interests of the medical profession
- Sustain the professional standards of medical ethics
- Serve as the integrated voice of the profession
- Educate and direct public opinion on public health matters
- Participate in the conduct of medical education
- Promote social, cultural, and charitable activities in building a united Malaysia

Objectives

- Promote and maintain the honour and interest of the profession of medicine in all its branches and in every one of its segments and help to sustain the professional standards of medical ethics
- Serve as the vehicle of the integrated voice of the whole profession and all or each of its segments both in relation to its own special problems and in relation to educating and directing public opinion on the problems of public health as affecting the community at large
- Participate in the conduct of medical education, as may be appropriate
- Promote social, cultural and charitable activities in building a united Malaysian nation
- Participate in, or invest a portion of the Association's funds in any entity, corporation or association by way of joint venture, business partnership, commercial arrangement, transaction and/or any legal means permitted, which would be in the interest of and beneficial to the Association, and be advantageous, profitable or calculated directly or indirectly to enhance any or all of the Association's fixed, current, liquid assets, properties, business, investments, commercial arrangements, and rights, provided that they are never in conflict with the Code of Medical Ethics.

National collaborations

The MMA collaborates with the Ministry of Health, Malaysia (MOH), Ministry of Higher Education, Malaysia (MOHE), Ministry of Finance, Malaysia (MOF), Ministry of International Trade and Industry, Malaysia (MITI), FOMEMA Sdn Bhd (an appointed company to operate a comprehensive Foreign Workers' Medical Examination Screening System in Peninsular Malaysia on behalf of the Ministry of Health, Malaysia), Malaysian Medical Relief Society (MERCY Malaysia), Association of Private Hospitals, Malaysia (APHM), Academy of Medicine of Malaysia, Federation of Private Medical Practitioners' Association, Malaysia (FPMPAM), Medical Practitioners Coalition Association of Malaysia (MPCAM), Malaysian Organisation of Pharmaceutical Industries (MOPI), Pharmaceutical Association of Malaysia (PhAMA), Malaysian

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Pharmacists Society, Malaysian Society for Quality in Health (MSQH), Medico-Legal Society of Malaysia, Malaysian Professional Centre, and Federation of Malaysian Manufacturer's Infant Formula Ethics Committee (FIFEC).

International collaborations

The MMA is a member of the Medical Associations of Southeast Asian Nations (MASEAN), Commonwealth Medical Association (CMA), and Confederation of Medical Associations in Asia and Oceania (CMAAO). The MMA is affiliated to the Australian Medical Association (AMA), British Medical Association (BMA), Chinese Medical Association (CMA), New Zealand Medical Association (NZMA), Singapore Medical Association (SMA), Indian Medical Association (IMA), Hong Kong Medical Association (HKMA), Confederation of Medical Associations in Asia & Oceania (CMAAO), Medical Association of Southeast Asian Nations (MASEAN) and World Medical Association (WMA).

Contact information

Address: 4th Floor, MMA House 124, Jalan Pahang, 53000 Kuala Lumpur, Malaysia

Email: info@mma.org.my, secretary@mma.org.my

Website: <https://mma.org.my/>

MYANMAR MEDICAL ASSOCIATION



Aye Aung

Leadership

President: Professor *Aye Aung*

Vice President: Professor *Saw Win*

Secretary General: Dr. *Kyaw Lynn*

Joint- Secretary General: Professor *Khay Mar Mya*

Treasurer: Professor *Yin Yin Sein*

Joint-Treasurer: Professor *Yee Yee Khin*

History in brief

1949: The Myanmar Medical Association (MMA) was founded in 1949, as a non-governmental, non-political, non-profit, and independent organization in Myanmar. It stands for professional integrity and serves the health of the people. Nearly 22,000 registered members are involved in academic and technical activities with the Association. The MMA has a democratically elected executive committee with 42 specialty societies, 6 special interest groups, 5 social groups, and over 80 branches of the Medical Association in States, Regions, and Townships in Myanmar.

Mission

Continuing and updating medical education and maintaining professionalism and ethical conduct among the members of the MMA.

Objectives

- Promote the knowledge of medical doctors of the latest developments in medicine
- Improve quality of health care of the nation
- Maintain and promote high ethical standards
- Encourage and implement research activities
- Build unity, friendship, and co-operation
- Nurture newer generations of medical profession
- Participate in public health activities
- Correlate and co-operate with regional and international medical professional organisations

National collaborations

The MMA collaborates with the Ministry of Home Affairs, Ministry of Health, Ministry of Social Welfare Relief and Resettlement, and local non-governmental organisations (Myanmar Health Assistant Association, Myanmar TB Association, Pyi Gyi Khin, Myanmar Nurses Association).

International collaborations

The MMA collaborates with the World Medical Association (WMA) (since 2012, as the 111th member nation), Confederation of Medical Association in Asia and Oceania (CMMAO) (since 2009), and Medical Association of South-East Asian Nations (since 1996). They also work with the United Nations for Population Fund (UNFPA), World Health Organization (WHO), Global Fund (GF), Access to Health Fund (AHF), United Nations Office for Program Services (UNOPS), United Nations Development Program (UNDP), United Nations Children Fund (UNICEF), Three Diseases Fund (3D), German Fund, Bill Gate & Melinda Foundation (BGMF), Nippon Foundation (Japan), and international non-governmental organisations (World Vision International, Population Service International, Médecins du Monde, Care Myanmar).

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Current challenges

Due to the national situation and the COVID-19 pandemic, MMA members experience difficulties attending in-person continuing medical education courses, meetings, and conferences.

Future vision

As a professional organisation to continue supporting goals and maintaining high ethical standards for our medical professional members.

Contact information

Address: 249, Thienbyu Road, Mingalartaungnyunt Township, Yangon, Myanmar
Tel/Fax: 01-8378863, 8380899, 8388097, 8394141, 09 8601677
Email: mmacorg@gmail.com, mmacoffice249@gmail.com
Website: www.mmacentral.org

- Safeguard members' mental and physical health
- Promote medical education and medical scientific work
- Promote appropriate measures for the improvement of public health and address political issues related to health

Objectives

- Promote a public health service with universal access to equivalent health services
- Promote medical education, quality, patient safety, mental health, and global health collaborations
- Safeguard physicians' professional autonomy and improve physicians' working day and work environment
- Improve financing and resource efficiency and level of emergency preparedness within the health service
- Strengthen collaborations between health service departments
- Ensure a high quality specialist training and professional development and promote research and clinical application of new knowledge

National collaborations

The NMA is one of the largest professional trade unions in the country. Organising 94% of physicians in Norway, the Association is a key negotiating and discussion partner with national health authorities, regional health corporations, and municipalities.

International collaborations

The NMA is a founding member of the World Medical Association (WMA) and member of the Standing Committee of European Doctors (CPME) and European Union of Medical Specialists (UEMS). In addition, our medical societies and occupational branches participate in their corresponding European and global collaborations.

Current challenges

The Norwegian health care system is available to all residents across the country. To address emerging health priorities, the health care system will require regular monitoring and evaluation and make relevant modifications to maintain high-quality service delivery. The main challenges include:

- hospitals are constructed with an inadequate infrastructure for effective operations
- significant recruitment challenges exist in the primary health care system
- medical students experience limitations in their academic training

Contact information

Address: Christiania Torv 8, 0158 Oslo, Norway
Email: Legeforeningen@legeforeningen.no
Website: Legeforeningen.no

NORWEGIAN MEDICAL ASSOCIATION



The Norwegian Medical Association
DEN NORSKE LEGEFORENING



Anne Karin Rime

Leadership

President: Dr. *Anne Karin Rime*

Vice President: Dr. *Nils Kristian Klev*

History in brief

The Norwegian Medical Association (NMA) was founded in 1886. It includes more than 39,000 physicians and medical students, which corresponds to 94% of physicians practising in Norway. The NMA has three main constituencies, including local branches, occupation branches, and medical societies.

Mission

- Promote the highest medical and ethical professional standards among members
- Safeguard members' social, collegial, and economic interests

POLISH CHAMBER OF PHYSICIANS AND DENTISTS



Lukasz Jankowski

Leadership

President: Dr. *Lukasz Jankowski*

Vice Presidents: Dr. *Paweł Barucha*, Dr. *Klaudiusz Komor*, Dr. *Mateusz Kowalczyk*

Secretary General: Dr. *Grzegorz Wrona*

Deputy Secretary: Dr. *Paweł Doczekalski*

Treasurer: Dr. *Grzegorz Mazur*

History in brief

The Polish (Supreme) Chamber of Physicians and Dentists represents the professional self-government of physicians and dentists at state level, while the regional medical chambers serve at the regional level.

- **1921:** the Chamber of Physicians established.
- **1938:** the Chamber of Dentists established.
- **1952:** reactivated in 1945, the Polish medical chambers were dissolved by the communist government.
- the 1980s: democratic changes contributed to the restoration of the joint self-government of all physicians and dentists in Poland.
- **17 May 1989:** the Law on the Chamber of Physicians and Dentists was passed, the joint self-government was reactivated
- **2009:** the 1989 Law was renewed.

Mission and objectives

The Polish professional self-government of physicians and dentists determines the principles of professional ethics and deontology binding all physicians and dentists. It monitors compliance to the rules of professional ethical conduct and supervises proper and conscientious exercise of both medical professions. Other main tasks of the Polish Chamber of Physicians and Dentists include:

- awarding the right to practise the profession
- keeping registries of physicians and dentists
- delivering opinions on matters concerning public health, state health policy, and organisation of healthcare
- participating in legislative works regarding issues of the medical profession

- supporting under- and post-graduate training of physicians and dentists
- cooperating in the field of continuing professional development

National collaborations

The Polish professional self-government of physicians and dentists cooperates with public central and local authorities, administration agencies, scientific societies and associations, universities and research organisations, trade unions, other professional self-governments, and social organisations.

International collaborations

The Chamber actively collaborates with the Standing Committee of European Doctors (CPME), European Union of Medical Specialists (UEMS), European Forum of Medical Associations (EFMA), World Health Organization (WHO), Symposium of Medical Chambers of Central and Eastern Europe (ZEVA), Council of European Dentists (CED), World Dental Federation (FDI), and European Regional Organization of the World Dental Federation (ERO/FDI).

Current Challenges

One of the challenges is the introduction of the no-fault system (a solution aimed at improving medical treatment and safety) within the Polish healthcare system. The Polish Chamber of Physicians and Dentists has recently elaborated a draft of law based on three pillars:

- exclusion of doctors and dentists from criminal liability (with no exemption from liability in case of gross error or death of patient) with binding civil and professional liability
- introduction of a registry of adverse events that will reduce future medical errors
- implementation of a compensation fund

Contact information

Address: 110, Jana Sobieskiego Str., 00-764 Warsaw, Poland

Tel.: +48 22 559 13 00

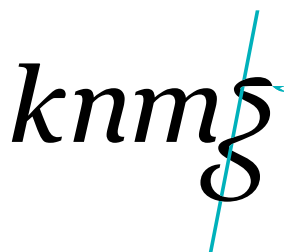
Email: sekretariat@nil.org.pl; polishchamber@nil.org.pl

Website: <https://nil.org.pl>

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ROYAL DUTCH MEDICAL ASSOCIATION



René Héman

Leadership

President: Dr. *René Héman*

History in brief

The Royal Dutch Medical Association (RDMA) was founded in 1849, to ensure that there was a quality requirement for doctors and that the profession would be protected. The RDMA has been committed to improving the quality of the medical profession and public health, by supporting agreements and guidelines that are relevant for all doctors. The RDMA represents a platform for discussion and participates in the debate about developments and bottlenecks in healthcare.

The RDMA is a leader for doctors and clinical care:

- in the quality of the profession by training, by (re)registering doctors, providing peer support, and establishing rules of conduct.
- when guiding doctors in ethical legal dilemmas, including euthanasia, dementia or problematic substance use.
- in providing support, by sharing workplace dilemmas and guidelines as well as providing a platform for strengthening care.
- in taking control of important objectives, such as community health promotion.
- by examining the intangible interests of more than 65,000 doctors and medical students.

National collaborations

The RDMA has eight members, our federation partners: seven professional organisations for doctors (and their scientific associations) and the association for medical students. Through these federation partners more than 65.000 doctors are connected with and have the possibility to give inside on the healthcare field to the RDMA. Doctors can also share their experiences, views and wishes through other channels, such as the RDMA Doctors' Panel, district meetings and expert meetings. The RDMA has a broad network of affiliated organisations in the Netherlands: the Dutch Patient Federation, the Dutch Association of Mental Health and Addiction Care the Dutch Healthcare Inspectorate

and the Ministry of Health, Welfare and Sport.

International collaborations

The RDMA collaborates with the World Medical Association (WMA), the Standing Committee of European Doctors (CPME), the World Health Organization (WHO), the European Forum of Medical Associations (EFMA).

Current challenges

Current challenges include

- shortages in healthcare staff and medicines
- availability and sustainability of healthcare services
- growing number of older persons
- influence of digitalization and the use of artificial intelligence in healthcare

Future vision

In the coming years, the RDMA wants to work together with partners educators to ensure high-quality health care services to support the nation.

Contact information

Address: 'Domus Medica', Mercatorlaan 1200, 3528 BL Utrecht, the Netherlands

Email: wma@fed.knmg.nl

Website: [Artsenfederatie](https://www.artsenfederatie.nl) | [KNMG](https://www.knmg.nl)

SERBIAN MEDICAL CHAMBER



Miodrag Stanic

Leadership

Director of the Medical Chamber: Dr. *Miodrag Stanic*

History in brief

1901: the Serbian Medical Chamber founded. It is an independent, professional organisation that was founded at a time when chambers were established in other European countries as professional associations that could self-regulate and control their membership.

2006: it was re-founded and currently has around 38,000 members. Its status is defined by the Law on Chambers of Health Workers, which prescribes obligatory membership in the Serbian Medical Chamber for all physicians in Serbia who perform health activities, as defined by the Health Care Law.

As entrusted tasks given by the Government of the Republic of Serbia and the Ministry of Health of the Republic of Serbia, the Serbian Medical Chamber performs the following activities:

- adopts the code of professional ethics
- registers physicians, under the conditions defined by law, and maintains the Directory of all members of the Chamber
- issues, renews and revokes approval for independent work licence to members of the Chamber and maintains a directory of issued, renewed and revoked licence mediation in disputes between members of the Chamber, that is between members of the Chamber and users of health services
- organises courts of honour to determine violations of professional duties and responsibilities of members of the Chamber as well as imposes disciplinary measures for those violations
- issues, for the needs of its members, various certificates, within its jurisdiction

Mission

- Preserving the quality and efficiency in the performance of entrusted tasks
- Ensuring the highest possible standard of medical ethics
- Fostering the best medical practice
- Representing and advocating all interests of members of the Chamber in performing their profession
- Protecting the medical branch, the honour, and reputation of medical profession
- Promoting continued medical education
- Counselling parliament and the government

Objectives

- Improve the status of medical doctors as well as to raise the level of expertise and ethics within the profession
- Ensure full equality of public and private practice
- Give initiatives to policymakers in order to improve the working conditions of medical doctors
- Propose to legislators a change of regulations in the field of health care and health insurance that is in the best interest of patients and health workers

National Collaborations

The Serbian Medical Chamber collaborates with the Ministry of Health of Serbia, National Health Insurance Fund, National Pension and Disability Insurance Fund, Institute for Public Health of Serbia “Dr. Milan Jovanović Batut”, Health Council of Serbia, Association of Patients, and other chambers of healthcare professionals.

They have representatives in many professional and advisory bodies, working groups, and commissions.

International collaborations

The Serbian Medical Chamber collaborates with numerous regional and European professional organisations and associations, such as the World Medical Association (WMA), European Association of General Practitioners (UEMO), European Association of Specialist Doctors (UEMS), Standing Committee of European Doctors (CPME), European Forum of Medical Associations (EFMA), ZEVA - Symposium of the Central and Eastern European chambers of physicians, and Southeast European Medical Forum (SEEMF).

Current challenges

- Serbia faces an upward trend in the migration of medical doctors to developed countries and internal migration towards large cities, which leads to human resource sustainability problems in general hospitals in smaller towns.
- Large private sector resources and over 5,000 medical doctors working in the private healthcare system of Serbia are not yet recognised, while the inclusion of the private healthcare system into the state system could raise the quality of healthcare services in Serbia.

Future vision

The Serbian Medical Chamber aims to position itself in the future as a sincere and indispensable partner to main institutions in the public health system and to be actively involved in the construction of the Serbian health system. Our goal is to continue working with fellow doctors on raising the reputation of the Serbian Medical Chamber in public and among the membership, and to continue to cooperate with the media on creating a good image of the medical profession.

- We will deepen our cooperation with patient associations in order to strengthen the patient's trust in medicine, and also with the private sector, the Association of Private Health Institutions and private practices, as well as with other chambers of our colleagues, health workers with whom we work intensively.
- We will work on maintaining and strengthening international collaborations with international organisations and associations in the process of harmonising legal acts, education, recognition of diplomas.
- Furthermore, we will work on the creation of an efficient, functional, sustainable health care system that cares for patients and their needs and encourages mutual respect between patients and doctors.

Contact information

Address: Kraljice Natalije 1-3, 11000 Belgrade, Serbia

Email: info@lks.org.rs

Website: <https://www.lks.org.rs/>

SLOVENIAN MEDICAL ASSOCIATION



Radko Komadina

Leadership

President: Prof. Dr. *Radko Komadina*

Vice President: Dr. *Breda Trzan Grozdanov*

Secretary: Dr. *Leon Herman*

History in brief

The Slovenian Medical Association (SMA) was founded in 1861, it was formed from the Reading Society. It is one of the oldest Central European medical organisations. It serves as the cornerstone of civil society, acts in the public interests, and is not subject to political pressure. It was awarded the Golden Order of Merit, the highest award given by the President of the Republic of Slovenia, for its contribution to the development of the medical profession. It has also awarded the highest prizes to individuals for their work in medicine.

Mission

Transfer the professional doctrine and knowledge through professional sections, societies, and associations, which bring together experts in specific sub-specialities and through a regional network of societies by:

- monitoring developments in medicine and health policy, and developing guidelines for specific fields of medicine
- proposing new methods of diagnosis, treatment, and rehabilitation for specific fields of medicine
- preparing expert opinions, analyses, proposals and assessments for administrations, institutions and organisations, in line with the latest recommendations from the profession transferring professional knowledge and modern medical doctrine to Slovenian doctors linking Slovenian medical science with the international environment;
- presenting key achievements, insights, innovations and relevant topics in the field of medicine to the general public
- highlighting the issues facing the medical profession
- networking with patient associations and other relevant organisations in Slovenia
- publishing *Zdravniški vestnik*, a professional medical journal in Slovenian

Objectives

- Maintain and promote the transfer of knowledge between the different health disciplines
- Support the publication of the medical journal *Zdravniški vestnik*
- Preserve its independence and fostering professional networks of doctors from all medical disciplines

National collaborations

SMA collaborates with the Slovenian Academy of Medicine, Medical Chamber of Slovenia, FIDES – Union of Doctors and Dentists of Slovenia, Professional Association of Private Doctors and Dentists of Slovenia, Commission for Medical Ethics of the Republic of Slovenia, Slovenian Ministry of Health, University of Ljubljana and University of Maribor's Faculties of Medicine, and Slovenian Research Agency (ARRS).

International collaborations

SMA collaborates with the World Medical Association (WMA), European Forum of Medical Societies (EFMA), World Health Organization (WHO), and European Union of Medical Specialists (UEMS).

Current challenges

- Maintain professional standards and norms while facing workforce shortage
- Establish and monitor comparable quality indicators with the European Union countries
- Update specialisation curricula
- Transpose the international guidelines and recommendations at national level

Future vision

- Maintain its prestigious status as one of the oldest Central European medical organisations, continuously operating since 1861
- Remain continuous agents for the renewal of the health profession
- Increase the number of affiliated doctors
- Increase visibility among the general public
- Facilitate the transfer of knowledge to all members via an online platform

Contact information

Address: Domus Medica, Dunajska 162,
1000 Ljubljana, Slovenia

Email: info@szd.si, tajnistvo@szd.si,

Website: www.szd.si

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SOUTH AFRICAN MEDICAL ASSOCIATION



Mvuyisi Mzukwa

Leadership

President: Prof. *HM Coovadia*

Chairperson: *Mvuyisi Mzukwa*

History in brief

- **19th century:** the history of the South African Medical Association (SAMA) starts when doctors practising in Cape Town, Grahamstown, Durban, Pietermaritzburg, and Kimberley Formed their own medical associations as branches of the British Medical Association.
- **1927:** these branches came together and constituted the National Medical Association of South Africa.
- **21 May 1998:** the unification of the pre-democracy medical groups in the formal reconstitution of the SAMA. Its new name was registered, under the same 1927 registration number, and is known as a Section 21 (non-profit) association in terms of the 1973 Companies Act. SAMA is a non-statutory professional association for public and private sector medical practitioners.

Mission

SAMA is a voluntary membership association, existing to serve its members' best interests and needs in all healthcare-related matters, the custodian of a growing advocacy platform that will unite, guide, and support members for the health of the nation.

Vision

To be the leading and preferred membership organisation advocating and supporting medical practitioners in South Africa.

Key strategic objectives

SAMA faces changed realities due to the pandemic and the piercing needs of our members and strategic stakeholders because of the shifting global, professional and lifestyle trends. The association needs to embrace the necessary changes by focusing on six key pivotal business objectives:

- preserving the medical profession by leading national and strategic engagements for the Re-engineering of Healthcare

in South Africa.

- corporately and legally representing our doctors in clinical challenges faced academically and professionally.
- future-proofing the profession by spearheading the transformational changes required in the regulatory environment.
- supporting doctors to navigate the digital healthcare landscape, understanding its challenges while leveraging its opportunities.
- focus on becoming a digitally led organisation, by transforming SAMA into an organisation that uses technology to continuously evolve all aspects of its business model (what it offers, how it interacts and operates).
- building a high-performing organisation, embedding a fit-for-purpose organisational blueprint that attracts, engages, and retains employees who will assist in transforming the business to reach new heights.

National collaborations

SAMA continues to pay attention to and maintain its partner and stakeholder relationships, to synergistically combine assets on an ongoing basis to achieve common goals.

- **Regulatory institutions:** National Department of Health (NDoH), Health Professionals Council of South Africa (HPCSA), Council for Medical Schemes (CMS), South African Health Products Regulatory Authority (SAHPRA), Board of Healthcare Funders (BHF).
- **Private sector organisations:** Medical Protection Society (MPS), Professional Provident Society (PPS), Health Quality Assessment (HQA), South African Dental Association (SADA), Foundation for Professional Development (FPD).
- **Specialist and General Associations:** South African Private Practitioners Forum (SAPPF), South African Society of Anaesthesiologists (SASA), South African Society of Obstetricians and Gynaecologists (SASOG), Unity Forum for Family Practitioners (UFFP), Alliance of South Africa Independent Practitioners Association (ASAIPA), Independent Practitioners Association Foundation (IPAF).
- **Medical Schemes:** Discovery Health, Government Employees Medical Scheme (GEMS), Medscheme.

International collaborations

SAMA collaborates with the World Medical Association (WMA), American Medical Association (AMA), and Coalition of African National Medical Associations (CANMA).

Current challenges

Among the plethora of global and national challenges, a few challenges facing SAMA include:

- the recovery and building of a new future post the COVID-19 pandemic
- the challenges against the commercialisation and corporatisation of the medical profession that is directly encroaching on the healthcare practitioners' clinical space

World Medical Journal



- the negative effect of managed healthcare and medical scheme rules on healthcare practitioners
- the mental and behavioural well-being of healthcare practitioners, as this has a significant and under-recognised burden on their social needs, and their basic human rights, further weakening public and private healthcare systems and the economy reimagining healthcare delivery as health systems nationwide are struggling with skyrocketing patient numbers, employee burnout, workforce shortages, supply chain disruptions, equipment scarcities, and insufficient and/or outdated facilities

Future vision

As the six strategic objectives underpin all the work that drives the association, the future is embedded in establishing a new growth trajectory by reorienting our operating model for maximal effectiveness and leveraging digital technology to deliver results with maximum efficiency. Over the next few years, SAMA continues to be a thought leader, advocate for change, and industry pioneer. The association is cementing the foundations of being a digitally-led institution, by developing a deep capability in member intelligence and the science of data to deliver an exceptional value proposition for our members and stakeholders.

Contact information

Address: Block F Castle Walk Corporate Park, Nossob Street, Erasmuskloof Ext 3, 0181

Email: online@samedical.org

Website: www.samedical.org

SWEDISH MEDICAL ASSOCIATION



**Sveriges
läkarförbund**
Den medicinska professionens organisation



Sofia Rydgren Stale

Leadership

President: Dr. *Sofia Rydgren Stale*

Vice Presidents: Dr. *Lars Rocksén*, Dr. *Marina Tuutma*

CEO: Mrs. *Anna Ingmanson*

History in brief

The Swedish Medical Association (SMA) was established in 1903. It serves as a trade union and professional organisation for physicians. The SMA aims to support physicians throughout their careers and enters into collective agreements on behalf of its members regarding employment conditions such as salaries, working hours, sick and parental leave, and pensions. The SMA also plays a key role in society in providing the physicians' perspective on health and health care related issues, and thus fostering positive developments in health care for patients' benefits.

Current policy areas

- Physician status and working conditions
- Research and education
- Health care policy

National collaborations

Nationally, the SMA collaborates with the Swedish associations focusing on health professionals' career development, including the Swedish Confederation of Professional Associations (SACO).

International collaborations

Internationally, the SMA has a long-standing cooperation with the medical associations from other Nordic countries as well as the World Medical Association (WMA), Standing Committee of European Doctors (CPME), and the European Union of Medical Specialists (UEMS).

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Contact information

Address: Swedish Medical Association, Box 5610, 114 86 Stockholm, Sweden

Email: info@slf.se

Website: www.slf.se

SWISS MEDICAL ASSOCIATION



Yvonne Gilli

Leadership

President: *Yvonne Gilli*, MD

VicePresidents: *Christoph Bosshard*, MD, *Philippe Eggimann*, MD

General Secretary: *Stefan Kaufmann*, MBA, PMP

History in brief

Similar to the Swiss federal state, the Swiss Medical Association (Foederatio Medicorum Helveticorum, FMH) originated from a federation of cantonal societies.

- **18th century:** by the end of the century, the first cantonal medical societies were established.
- **1901:** the societies united to form the Swiss Medical Association.
- **1920:** the FMH revised the statutes and established its own journal.
- **1923:** the General Secretariat was established.

Mission

As an independent organisation, the FMH represents physicians' interests and supports their professional activities. It is committed as a credible partner in cooperation with other actors to a forward-looking and sustainable improvement of the health care system. The FMH is committed to ensuring that all patients have access to high-quality and financially-sustainable health care.

Objectives

As the voice of the medical profession, the FMH successfully campaigns for strong patient care and optimal population health. As it actively shapes the framework and future of the medical profession, it is committed to transparent high-quality work and

freedom of collective bargaining and digitization, in order to benefit patients and health professionals.

National collaborations

As the umbrella organisation of Swiss physicians' societies, the FMH works with all national stakeholders in the Swiss health care system – patient organisations, professional associations, interest groups or representatives of insurance associations, or politicians or governing authorities.

International collaborations

The FMH is in close exchange with other national physician organisations and is involved in the World Medical Association (WMA) and the Standing Committee of European Doctors (CPME).

Current challenges

- Transnational problems, such as shortages of specialists and drugs, have been exacerbated by one-sided cost-oriented policies in Switzerland
- Political activism has increased the density of regulation and administrative tasks
- The need to ensure workplace safety and reduce health care expenditure for patients remains a significant priority

Contact information

Address: Elfenstrasse 18, Postfach 300, 3000 Bern 15, Switzerland

Email: info@fmh.ch

Website: www.fmh.ch

THAILAND MEDICAL ASSOCIATION



Sukhum Karnchanapimai

Leadership

President: Dr. *Sukhum Karnchanapimai*

President Elect: Prof. Dr. *Prakitpunthu Tomtitchong*

VicePresident: Prof. Dr. *Krisada Ratana-Olarn*

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Secretary General: Prof. Dr. *Keerati Charoencholvanich*
Deputy Secretary: Prof. Dr. *Thawatthai Akaraviputh*
Treasurer: Assoc. Prof. Dr. *Juvady Leopairut*
Public Relations: Assoc. Prof. Dr. *Sakda Arj-Ong Vallibhakara*

History in brief

- **25 October 1921:** the Medical Association of Siam was first initiated.
- **April 1, 1928:** the Medical Union Club organised the first scientific meeting, focusing on scientific and social issues.

Mission and objectives

- Promote welfare and the welfare of members
- Promote unity and uphold the honour of the members
- Promote education, research, and knowledge of medicine and modern public health among its members
- Support members Practise the medical profession according to the ethics of the profession
- Support medical education
- Support the standardisation of national medical and public health systems
- Cooperate with government agencies and private sectors in developing medical system standards and public health of the country to be at the up-to-date international level
- Disseminate medical and public health knowledge so that people can take care of their own health, family, and community
- Give opinions to the government on medical and public health problems in the country.
- Cooperate with civilised nations in the development of modern medical and public health systems
- Liaise with international medical associations and the World Medical Association
- Run or cooperate with charitable organisations for charity and public benefit

National collaborations

The Thailand Medical Association collaborates with the Thai Medical Council, Ministry of Public Health, Medical Association of Thailand, and the Private Hospital Association of Thailand.

International collaborations

The Thailand Medical Association collaborates with the Medical Association in ASEAN Countries (MASEAN), Confederation of Medical Associations in Asia and Oceania (CMAAO), and the World Medical Association (WMA).

Current challenges

- Cooperation among members
- Budget support
- Collaboration among medical stakeholders

Contact information

Address: 6th Floor Chalermprabamee Building, Soi Soon Vijai, New Phetburi Road, Hui Kwang, Bangkok 10310, Thailand

Email: mat.thailand2464@gmail.com

Website: mat-thailand.org

TUNISIAN NATIONAL MEDICAL ASSOCIATION (LE CONSEIL DE L'ORDRE DES MÉDECINS DE TUNISIE)



Ridha Dhaoui

Leadership

President: Dr. *Ridha Dhaoui*

First VicePresident: Dr. *Mehdi Jaidane*

Second VicePresident: Dr. *Alaeddine Sabnoun*

Secretary General: Dr. *Nizar Ladhari*

Secrétaire General Adjoint: Dr. *Samia Ghouila Trabelsi*

Treasurer: Dr. *Khalil Boukhris*

Treasurer Adjoint: Dr. *Sonia Gloulou*

History in brief

- **1958:** the Tunisian Medical Council was founded. It oversaw the medical practice of 120 physicians. Since then, it was instrumental to the development and regulation of the practice of medicine in Tunisia.
- **1973:** the elaboration of the Tunisian Code of Medical Ethics (Code de Déontologie Médicale) as well as reforms in the field of medical insurance and medical responsibility.

Mission

The Council regulates the practice of medicine in accordance with deontological and ethical rules. It ensures the highest quality of care through the continued formation and information of physicians and their certification.

Objectives

The Council aims to monitor and promote scientific advances in the medical field as well as ensuring that physicians can practise medicine in the best conditions possible, offering legal and financial assistance when needed.

National collaborations

The Council collaborates with the Comité National d’Ethique Médicale, Instance Nationale d’Accréditation, Instance Nationale de protection des Données Personnelles, Syndicat Tunisien des Médecins Libéraux, and Union des Médecins Spécialistes Libéraux.

International collaborations

The Council collaborates with the Federation Maghrébine des Ordres Médicaux, Union des Médecins Arabes (UMA) (Arab Medical Union), Union Européenne Des Médecins Spécialistes (UEMS) (European Union of Medical Specialists), World Medical Association (WMA).

Current challenges

The rise of telemedicine highlights the need for fast regulation and international harmonisation of medical ethics, as well as the urgency of the protection of personal data use in the medical field.

Future vision

Continued studies and international certifications would allow for the latest scientific development to be shared across the medical profession and ease access to the highest quality care for all patients.

Contact information

Address: Maison du médecin, Rue Malaga El Manar 1,
2092 Tunis, Tunisia

Email: cnom@ordre-medecin.tn

Website: <https://www.ordre-medecins.org.tn/>

Teach Your Patients the Dangers of Gas Stoves: Free Education Webinar



Todd Sack

Gas cooking can expose individuals to harmful pollutants, like nitrogen dioxide, that can increase risk of asthma, respiratory irritation, and cardiovascular disease, especially among children and the elderly. This month, the World Medical Association (WMA)'s My Green Doctor provides a free 1-hour education webinar (<https://bit.ly/WMAStovesCME>), approved by the (Accreditation Council for Continuing Medical Education

(United States) at three different times on Thursday, 13 July 2023. Please learn more about this webinar by reviewing a brief article (<https://mygreendoctor.org/learn-the-health-risks-of-gas-stoves/> or scan the QR code below) on this vital topic.

My Green Doctor is a free money-saving membership benefit from the WMA. Members use the "Meeting-by-Meeting Guide" to learn how to adopt environmental sustainability, save resources, and help create healthier communities. The program adds just five minutes to each regular clinic staff meeting or weekly office "huddle", making small changes at each meeting that over time really add up.

Everyone in your practice can register as Partner Society members by visiting the websites in English (www.MyGreenDoctor.org) or Spanish (www.MyGreenDoctor.es). By using the discount code MGDWMA,

your team will to receive get full free lifetime access to My Green Doctor, save US\$60 instantly, and save US\$1000s in the first year. Ask your clinic manager to register today and add My Green Doctor on to your next agenda. My Green Doctor can help your practice educate your patients



about emerging health risks!

Todd Sack, MD, FACP

*Executive Director, My Green
Doctor Foundation*

*Clinical Associate Professor, Herbert
Wertheim College of Medicine,
Florida International University
Miami, Florida, United States*
tsack8@gmail.com

