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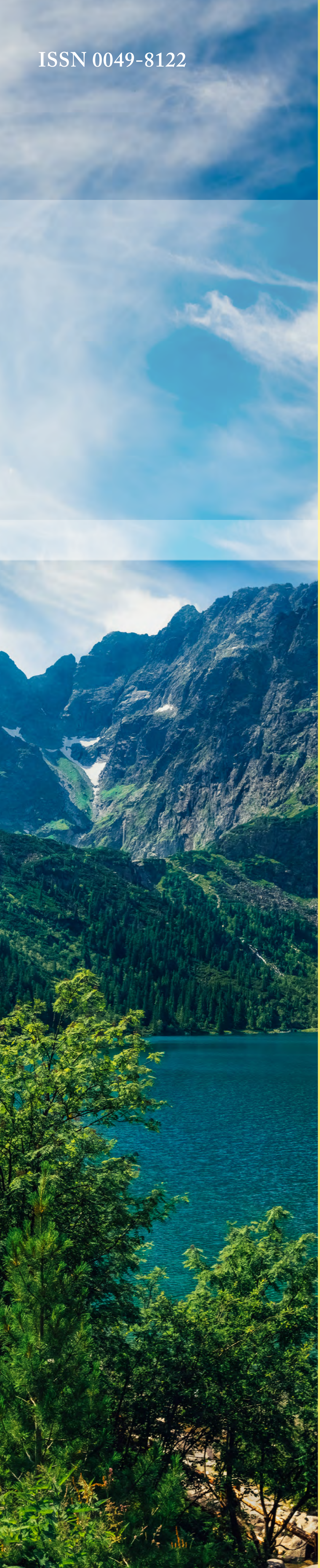

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WORLD MEDICAL ASSOCIATION OFFICERS, CHAIRPERSONS AND OFFICIALS

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Editorial

The recent publication of the World Health Organization (WHO)'s *World Health Statistics Report 2025* highlighted the substantial impacts of the coronavirus disease 2019 (COVID-19) pandemic on morbidity and mortality rates, with a reported reduced global life expectancy by 1.8 years. Although global initiatives have successfully led to reductions in tobacco and alcohol consumption and exposure to particulate matter ($PM_{2.5}$) emissions, one primary setback remains the limited coverage of essential health services. The urgent call to renew political commitment and investment in primary healthcare can help reinforce local and national capacity to target health priorities and address existing inequalities. Using the One Health framework, timely evidence-based data can offer a starting point for policy development and community health interventions, help combat misinformation and disinformation, and ultimately build health system resiliency throughout countries.

Understanding these challenges, global health leaders have collaborated on the development of landmark decisions and scientific advancements that directly influence health systems. First, the Pandemic Agreement was negotiated at the 78th World Health Assembly, confirming global commitment to support prompt and equitable responses for pandemic preparedness. Second, the World Meteorological Society's *Global Annual to Decadal Climate Update (2025-2029)* confirmed that global climate estimates are projected to increase to near-record levels over the next five years, which can impact national economies and sustainable development. Third, the Global Early Warnings for All Multi-Stakeholder Forum, which fused outcomes from five regional events held between October 2024 to February 2025, helped facilitate collective discussion on overall progress and novel solutions toward the implementation of the Early Warnings for All initiative and Sendai Framework for Disaster Risk Reduction (2015-2030). To support these global efforts, the World Medical Association (WMA) has shared nine press releases that advocate for protecting health professionals during conflicts, investing in the health workforce, and highlighting global progress on the historic Pandemic Agreement.

As WMA members met at the 229th WMA Council Meeting, which was held from 24-26 April 2025, in Montevideo, Uruguay, they celebrated individual and joint leadership achievements, discussed complex topics related to medical education and ethics, and identified pressing health issues for ongoing discussion. WMA members presented high-level overviews of selected regional events, where they presented scientific talks and contributed to group discussions. These leadership activities demonstrate that WMA members have significant footprints – and voices – within their specialty, countries, regions, and the world.

In this issue, Ms. Magda Mihaila prepared a comprehensive summary of the WMA proceedings and included four adopted resolutions, and Dr. Ankush Bansal shared the report of the WMA Environment Caucus. Dr. Ramona Coelho and colleagues provided a comprehensive overview of a multidisciplinary volume that examines medical assistance in dying (MAiD) in Canada. Mr. van Dijk and colleagues offered valuable insight on the option of voluntary stopping eating and drinking in the end of life. Dr. Steve Robson and Dr. Hilary Bambrick described the historical context of the 'doomsday clock'.

Also, WMA members highlighted health advocacy efforts, addressed existing challenges, and described emerging technology across the Americas, African, and Asian health systems. Dr. Saksham Mehra showcased how the Trinidad and Tobago Medical Association has reinforced national advocacy through global health policy, with special focus on climate and health topics. Dr. Diana Marion provided a historical review on health financing reforms in the Kenya health system. Dr. Cliffland Mosoti and Dr. Marie-Claire Wangari discussed shortages in dental professionals and the need for interprofessional collaborations between medical and dental professionals in sub-Saharan Africa. Finally, Dr. Yali Cong and Mr. Chunqi Liang offered a critical analysis on incorporating digital health applications in the Chinese health system.

WMA members, who represent more than 114 national medical associations (NMAs), collectively exemplify medical excellence and leadership across nations and geographic regions. In this issue, four NMA leaders of the Asian region described leadership experiences, ongoing NMA activities, and perceived strengths and challenges in medical education. Also, WMA members representing eight countries of the African, Americas, Asian, and Pacific regions shared their perspectives on the fundamental role of the nursing profession to strengthen health systems, in efforts to commemorate International Nurses Day. These professional and personal testimonies describe health professionals' remarkable achievements and encountered challenges while seeking to prioritise patient-centred care and improve healthcare service delivery.

We are eager to join discussions and networking at the 76th WMA General Assembly in Porto!

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WMA Council Report

Montevideo, Uruguay, 24-26 April 2025

Magda Mihaila

The 229th WMA Council session of the World Medical Association (WMA) convened in the city of Montevideo, Uruguay, from 24-26 April 2025 (Photo 1).

Uruguay's Vision for Health Equity

On 24 April, just ahead of the Council's formal proceedings, Dr. José Minarrieta, President of the Executive Committee of the Sindicato Médico del Uruguay, joined WMA leaders for a joint press conference. Addressing leading Uruguayan media outlets, the panel tackled timely questions around the ethical and operational pressures facing healthcare systems worldwide–particularly in conflict settings.

From safeguarding medical neutrality to addressing inequities in care delivery, the press event underscored a growing consensus: as violence and polarisation threaten the stability of many health systems, the responsibility of the global medical profession to uphold ethical norms becomes all the more urgent. Dr. Minarrieta's remarks echoed those of WMA leaders, reaffirming the indispensable role of physicians, not only as caregivers but also as advocates for humanity under strain.

The Council welcomed an address by Uruguay's Minister of Public Health, Dr. Cristina Lustemberg, who offered an overview of the country's healthcare landscape. A total of 18 years after the creation of the National Integrated Health System, Uruguay remains committed to universal health coverage, with a focus on equity, quality, and long-term sustainability. Dr. Lustemberg acknowledged both successes and continuing challenges, noting that while structural reform has yielded expanded access and improved standards, issues such as mental health–particularly suicide prevention and physician burnout–require urgent attention. She emphasised the need for a more collaborative care model, rooted in strong partnerships between physicians, nurses, and allied professionals.

Reaffirming Uruguay's solidarity with health professionals in zones of conflict, Dr. Lustemberg voiced hope that the Global Pandemic Agreement, years in the making, would soon be formally adopted. Her presence and message offered not just a national case study, but also a reaffirmation of values at the heart of the WMA's mission: equity, dignity, and ethical care, even in the most trying of circumstances.

Junior Doctors Network

On 22 April, the Junior Doctors Network (JDN) convened its Spring Meeting in the same city where it was first convened in 2011. Organised as a hybrid event, the meeting brought together early-career physicians from around the world for two days of intense dialogue, intergenerational engagement, and cross-border solidarity.

The gathering provided ground for reflection and momentum, as JDN members connected directly with WMA leaders and working group chairs, exchanging experiences and advocating for a more inclusive and responsive global health system. One of the event's highlights was the Non-Communicable Diseases panel, in which participants discussed the critical role that junior doctors play in direct patient care as well as prevention, advocacy, and policymaking. In a featured interview with the Sindicato Médico del Uruguay, Dr. Pablo Estrella Porter, Chair of the JDN, offered his perspective on the challenges facing junior doctors today. From precarious employment conditions to underrepresentation in decision-making forums, he outlined a roadmap for change rooted in ethics, equity, and leadership. His message was clear: supporting the next generation of physicians is essential for building stronger, fairer health systems.

WMA Environment Caucus

The meeting of the WMA Environment Caucus, chaired by Dr. Ankush Bansal, head of the WMA Workgroup on Environment, offered a space for delegates and observers to examine the urgent intersection of environmental policy and human health. The session included a report on the recent WHO Second Global Conference on Air Pollution and Health by Dr. Lujain Alqodmani, WMA Immediate Past President, and a keynote address on the role of health professionals in addressing the health impacts of fossil fuels by Dr. Ned Ketyer, President of Physicians for Social Responsibility Pennsylvania. The meeting fostered open exchange among WMA

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members on best practices and reaffirmed the profession's role in advocating for environmental health and planetary well-being.

Associate Members

The meeting, led by Dr. Jacques de Haller, chair of the WMA Associate Members, showcased the broad involvement of Associate Members across multiple dimensions of WMA activity. Dr. de Haller presented his Chair's report, followed by updates from two key networks – the JDN and the Past Presidents and Chairs of Council Network (PPCN) – which collectively emphasised that intergenerational exchange and leadership continuity were central themes echoed throughout the Council session.

Of particular note was the participation of Associate Members in WMA taskforces and workgroups. Dr. Ankush Bansal reported on developments from the Workgroup on Environment, reinforcing the link between environmental justice and global health ethics. Dr. Jon Snaedal (PPCN) delivered updates on the Workgroup on Medical Neutrality and on the Associate Members-led initiative addressing the needs of aging physicians, an increasingly important topic as healthcare systems face demographic shifts within the profession itself. The meeting also reflected on recent Associate Members hosted webinars, with participants encouraged to submit ideas for future topics.

229th WMA Council Session

Election of Chair of Council

The Council opened with a moment of both continuity and change. Dr. Jack Resneck Jr. (American Medical Association) was elected Chair of the Council, succeeding Dr. Jung Yul Park (Korean Medical Association), whose term had been defined by persistent advocacy during a politically turbulent era in his own country. Dr. Resneck's appointment set the tone for a session that would place great emphasis on principled leadership and the defense of professional autonomy.

In his inaugural remarks, Dr. Resneck acknowledged the rising threats to medical freedom and to the legitimacy of scientific institutions worldwide. He promised to serve as a neutral voice in his new role and highlighted the importance of remaining focused on the important work of the WMA and making the medical profession around the world aware of this work.

President's Interim Report

In his interim report to the Council, the WMA President, Dr. Ashok Philip, provided a comprehensive overview of his activities from October 2024 through March 2025, a period marked by international engagement and growing diplomatic alignment around medical ethics.

Since the WMA General Assembly in Helsinki, Dr. Philip has represented the Association at a series of high-level meetings across regions and cultures. In Paris, he attended sessions of the Conseil National de l'Ordre des Médecins (CNOM), where he held discussions with leaders of several Francophone medical associations. Notably, the Lebanese Medical Association expressed both a request for institutional support and a strong interest in joining the WMA – a development that Dr. Philip welcomed as a testament to the WMA's enduring relevance in regions facing political and health system strain.

In East Asia, Dr. Philip joined Dr. Otmar Kloiber, WMA Secretary General, and Dr. Jung Yul Park, Chair of Council, at a symposium on Universal Health Coverage in Taipei, Taiwan. The event underscored the WMA's ongoing role in shaping global debates on access, equity, and sustainability in health systems. One of the more politically sensitive visits was to Jakarta, where Dr. Philip participated in the triennial meeting of the Indonesian Medical Association, in the context of recent threats to its autonomy.

Dr. Philip concluded his report by highlighting his participation in the Global Patient Safety Summit in Manila, Philippines, where discussions cantered on a critical but often overlooked dimension of care: the psychological safety of health professionals. The issue, he noted, is increasingly urgent in a world where clinicians face not only medical risk, but also moral injury, burnout, and systemic neglect.

Secretary General's Report

The WMA Secretary General, Dr. Kloiber, highlighted the exceptionally positive response to the newly revised Declaration of Helsinki – a foundational document in global medical ethics. Since its adoption, the revised text has drawn considerable attention from a wide cross-section of the international medical community. Requests for presentations and discussions have come from academic institutions, ethics committees, industry associations, and regulatory bodies, who were eager to engage with its implications. He emphasised that this substantial feedback has signalled the Declaration's continued resonance in a rapidly evolving

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clinical research environment.

Dr. Caline Mattar, WMA Advisor, Dr. Julia Tainijoki, Senior Policy Advisor, and Dr. Lujain Alqodmani, Immediate Past President, presented updates on several of the WMA's thematic priorities. Their joint presentation offered a dynamic overview of the Association's work in critical public health and policy areas. These areas included WMA-led initiatives on antimicrobial resistance, efforts to address health workforce shortages and migration trends, ongoing input into the drafting of the WHO's Pandemic Agreement, and sustained advocacy on non-communicable diseases and air pollution. In particular, the group highlighted the WMA's proactive role in organising side events during the World Health Assembly (WHA) in Geneva, designed to elevate the physician perspective in global health negotiations.

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The Journal's December 2024 and March 2025 issues featured insightful analyses, commentaries, and meeting reports from WMA/JDN members and invited leading experts representing 19 countries. The collective article, with thematic coverage commemorating International Doctors' Day and World Cancer Day, showcased physicians' leadership, public health advocacy across 17 countries. These editions also integrated WMA declarations and statements, regional reports, and timely scientific articles, reflecting the Journal's commitment to advancing global health dialogue. The Journal's editorial team continues to welcome new voices and encourages national medical associations to submit brief articles for upcoming articles and collective features.

Finance and Planning Committee

The Council approved the pre-audited financial statement for 2024 and authorised the continuation of the audit process.

In a show of solidarity, the Council waived 2025 membership dues for the Myanmar Medical Association and approved a partial waiver for the Royal Dutch Medical Association moving forward. These gestures reflected the WMA's commitment to inclusive participation despite economic hardship.

Looking ahead, the Council confirmed the timeline for the development of the *WMA Strategic Plan for 2026–2030*, with final adoption expected at the General Assembly in Porto, Portugal. The Council finalised upcoming statutory meetings: Rio de Janeiro was selected to host the 235th Council session in 2027, Istanbul was confirmed for the 238th Council session in 2028, and the scientific session at the General Assembly in Rotterdam (2026) was confirmed with the "Moral Distress and its Effect on Healthcare Workers" theme.

The Council endorsed the admission of two new constituent members: the Canadian Medical Association and the Lebanese Order of Physicians. Both applications will proceed to the General Assembly for final approval. Other items approved included a revision to the JDN Terms of Reference, the creation of a workgroup on health-related crises, and a workgroup to revisit the option of hybrid sessions.

Medical Ethics Committee

The Council considered the committee's report in full, including a proposed friendly amendment to the draft resolution on the Ethical Framework of Healthcare. The amendment was accepted without opposition, and the updated resolution was approved for immediate release.

The Council approved a revised version of the WMA's Ethical Guidelines for the International Migration of Health Workers, which was forwarded to the General Assembly. In light of increasing global mobility and health workforce shortages, the document reaffirms ethical obligations on both source and destination countries.

A new workgroup was initiated to explore the WMA's stance on medical neutrality in armed conflict, responding to continued reports of violence against medical personnel. Associations from France, Kenya, South Africa, Switzerland, United States, and Uruguay joined the group.

The WMA Statement on Conflict of Interest was sent out for membership-wide consultation, acknowledging the growing complexity of ethical practice in research and clinical partnerships.

The Council agreed to launch a full revision process of the Declaration of Taipei, which addresses ethical concerns related to health databases and biobanks, which extends the Declaration of Helsinki – Ethical Principles for Research Using Human Participants – into the virtual world. The Israeli Medical Association volunteered to chair this workgroup, supported by a coalition of national medical associations (NMAs), the Past Presidents Network, and the Associate Members.

In addition, the Council affirmed several policy review actions for 2025, including revisions to key

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documents on mental illness, patient advocacy, and confidentiality, as well as reaffirmation – with minor updates – of the Declaration of Lisbon and the Resolution on the Designation of an Annual Medical Ethics Day.

Socio-Medical Affairs Committee

The WMA Statement on Obesity was forwarded to the General Assembly. This consolidated and replaced two older statements to reflect current understanding and ethical approaches to prevention and care.

The Council supported the initiatives of the Workgroup on Environment, which was renewed for another term, and agreed to circulate draft policies on physician well-being, task shifting, and the use of artificial intelligence in medicine. New statements on mental health, ageing, transgender care, and dementia will undergo further consultation.

The Council approved several urgent resolutions for immediate release.

Ethical Framework of Healthcare

The proposed WMA Resolution to Uphold the Ethical Framework of Healthcare was a timely reaffirmation of the profession's core ethical principles amidst rising global pressure on physicians and health systems. With growing concerns over political interference, misinformation, and the commercialization of care delivery, the Council swiftly accepted and assigned the resolution to the Medical Ethics Committee for consideration.

Global Health Funding

The proposed WMA Council Resolution on Public Health Funding Worldwide was submitted, highlighting the need for sustained, equitable investment in public health systems, particularly in low- and middle-income countries. In a context shaped by the aftermath of the COVID-19 pandemic and the impending adoption of the WHO Pandemic Agreement, the Council flagged the importance of this issue and adopted this resolution.

Role of Physician Assistants

The proposed WMA Council Resolution on the Role of Physician Associates and Other Non-Physician Providers in the United Kingdom and Other Countries reflected broader international questions around task shifting, scope of practice, and accountability in healthcare. Delegates acknowledged the topic's relevance not only to the United Kingdom, but also to many health systems grappling with workforce shortages and reform pressures. Recognising the increasing professional concern related to the evolving role of non-physician providers, the Council adopted this resolution as a matter of urgency.

Riot Control Agents and Human Rights Violations in Turkey

The proposed WMA Council Resolution on the Use of Riot Control Agents and Human Rights Violations against Protesters in Turkey drew attention to reports of excessive force and breaches of medical neutrality, with implications for both human rights advocacy and the safety of health professionals in protest and conflict zones. The Council adopted this resolution.

Collaboration with the World Health Organization (WHO)

In anticipation of the 78th WHA, the WMA Senior Policy Advisor, Dr. Clarisse Delorme, updated the Council on the Association's contributions to upcoming World Health Professions Alliance (WHPA) side events and official interventions. Joint statements were prepared on universal health coverage, climate change, and global emergency preparedness. The WMA will continue to make contributions to the topics of non-communicable diseases, mental health, and social connection.

The WMA Secretary General, Dr. Otmar Kloiber, highlighted the symbolic significance of the forthcoming pandemic treaty – expected to be signed during the WHA – while also sounding an alarm on the funding shortfalls facing the WHO following the withdrawal of U.S. support. He expressed concerns that unless other countries increase their contributions, the WHO may be forced to scale back or eliminate entire departments, risking the erosion of hard-won gains in health workforce policy and ethical governance.

Other Business

Dr. Jesse Ehrenfeld (American Medical Association) congratulated Chair of Council, Dr. Jack Resneck, on his first session and thanked the hosts in Montevideo for their hospitality. As his tenure on the Council concluded, he expressed the American Medical Association's continued commitment to international engagement despite inward-facing trends in U.S. politics.

Dr. Jung Yul Park (Korean Medical Association) introduced Dr. Haejoo Lee, who gave a stark and

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sobering account of the crisis facing physicians in the Republic of Korea. She described how sweeping government reforms – instituted without medical consultation – have led to untenable working conditions, mass resignations of medical residents, and threats of reprisal, including license suspension and physical intimidation. She called on the WMA to stand in solidarity with Korean physicians who continue to demand basic protections and professional dignity.

Dr. Kitty Mohan (British Medical Association) raised structural concerns regarding gender representation, noting the absence of female voting members on the Executive Committee. She urged colleagues to reconsider internal procedures to ensure that meaningful inclusion is achieved. The WMA Immediate Past President, Dr. Lujain Alqodmani, echoed her sentiments.

The Council also viewed a preview video of upcoming WMA webinars on artificial intelligence, introduced by Dr. Ehrenfeld, as well as an official video invitation from the Serbian Medical Chamber to attend the 232nd Council Session in Belgrade, Serbia, in April 2026.

Adjournment

As the session drew to a close, WMA Secretary General, Dr. Otmar Kloiber, announced his intention to retire following the 232nd Council Session in Belgrade, Serbia, in April 2026. His words marked not just the conclusion of a meeting, but also the beginning of a transition in leadership after years of steadfast service. Dr. Kloiber pledged to ensure a seamless handover, reflecting the same commitment and integrity that have defined his tenure. The moment was met with heartfelt appreciation – recognition that his leadership has been foundational to the WMA's global voice in medical ethics, policy, and solidarity.

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Photo 1. Group photo at the Radisson Montevideo Victoria Plaza Hotel during the 227th Council Session in Montevideo. Credit: WMA

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WMA COUNCIL RESOLUTION TO UPHOLD THE ETHICAL FRAMEWORK OF HEALTHCARE

Adopted by the 229th WMA Council Session, Montevideo, Uruguay, April 2025

PREAMBLE

Pillars of medicine which were until recently considered unquestionable, such as scientific evidence, human dignity and solidarity, are being increasingly challenged by the expansion of ideologies and political positions that reject or deny them.

In this context, the ability of physicians to work ethically and to follow the rules of the profession is threatened, as is also the autonomy of the profession; the intervention of politics, of the judiciary system or of the police in the care process is increasingly becoming a reality in many parts of the world.

The pressure exists on physicians being forced by their governments to treat detained patients in an unethical manner. There is also outright violence against healthcare personnel and healthcare facilities in areas with armed conflicts and other emergencies.

Pressure put on the professional autonomy of the physicians and on their ability to follow their ethical rules can negatively impact the quality of the care provided, and can finally compromise the population's trust in the profession.

The World Medical Association was founded with the explicit aim of setting the highest ethical and humanist standards for medicine throughout the world.

These standards are being challenged by ideologies and political stances that reject the societal achievements of the last 80 years.

These high ethical and humanist standards must, however, forcefully continue to be upheld by the medical profession with clear determination and strength.

RECOMMENDATIONS

1. The World Medical Association and all its Constituent Members are strongly committed to upholding the ethical standards of the medical profession, as they have been established by the profession itself during the last 80 years.

2. It is an essential role of the WMA and of its Constituent Members to advocate for a legal framework for healthcare in all our countries, which respects the ethical rules of our profession and allows practicing medicine according to them.

3. The WMA urges governments to secure the safety and lives of health care personnel whatever the actual circumstances, thereby enabling them to fulfill their duty to help any patient in need and act according to their ethical principles.

4. The WMA must actively advocate for the honor of the medical profession and the rights of medical personnel and of the patients wherever these are under threat.

5. It is the duty of the WMA and of all its Constituent Members to support individual physicians and their organizations whenever their ability to follow the ethical rules set by the WMA is threatened or limited by undue political or judiciary pressure.

6. The World Medical Association and all its Constituent Members strongly support and foster scientific, fact-based medicine, including evidence-based therapeutic and public health measures.

7. The World Medical Association calls for respect for the independence of research, in accordance with the ethical principles imbedded in its Declaration of Helsinki.

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WMA COUNCIL RESOLUTION ON THE ROLE OF PHYSICIAN ASSOCIATES AND OTHER NON-PHYSICIAN PROVIDERS IN THE UNITED KINGDOM AND OTHER COUNTRIES

Adopted by the 229th Council session, Montevideo, Uruguay, April 2025

PREAMBLE

The World Medical Association and its constituent members share the British Medical Association's concerns about the way in which non-physician practitioners including PAs (physician associates or physician assistants) and AAs (anaesthesia associates) have been introduced in the United Kingdom and other countries and makes the following recommendations in light of the independent 'Leng Review' into PAs and AAs commissioned by the UK government and other similar reviews.

RECOMMENDATIONS

In the interest of patient and clinician safety and to ensure broad clarity of understanding, the WMA affirms that:

1. The terminology used for physician associates and anaesthesia associates is confusing. These roles must be titled 'assistants' rather than 'associates' to make it clear that they assist physicians.

2. Terms previously used for physicians such as 'medical professionals' and 'medical practitioners' should not be expanded to include PAs and AAs, nor should they be described as being 'medically trained' or 'trained to the medical model'. This is because it is proving to be confusing for the public and misleading for physician supervisors and other members of the multi-disciplinary team who may wrongly presume that assistants have the same knowledge, skills and expertise of a physician, with adverse consequences for patients.

3. PAs and AAs should work under the supervision of physicians and within clearly defined scopes of practice with clear limits, and should undergo regular quality assurance and appraisal. Physicians and their representative bodies should be properly consulted on any proposed changes to these scopes given such roles utilise a limited subset of skills and knowledge of physicians.

4. PAs and AAs should be deployed to assist rather than replace physicians.

5. The training of PAs and AAs should not be prioritised at the expense of training for physicians and medical students, including the funding for such training.

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WMA COUNCIL RESOLUTION ON PUBLIC HEALTH FUNDING WORLDWIDE

Adopted by the 229th WMA Council Session, Montevideo, Uruguay, April 2025

PREAMBLE

Health care all over the world is under threat. Funding that has improved health by securing vaccines, medicines and health care professionals is being cut back or even completely dismantled. This creates a huge health risk, not only for those that cannot afford the costs themselves but also because this will increase the spread of communicable diseases like HIV, TB and malaria, and so puts everyone at risk. This is in addition to the threat that is caused by armed conflicts.

The WMA calls upon the leaders of the world to restore basic health care funding together. If the world sits back, we shall be confronted with a large increase of diseases and deaths.

Countries like the USA have made huge efforts in the last decades. Now, all nations shall have to contribute together to rescue our basic health system for those in need.

RECOMMENDATION

The World Medical Association urges world leaders to contribute together to the funding of public health facilities that improve health by securing vaccines, medicines and health care professionals and by doing so, help prevent a potential increase in the spread of communicable diseases like HIV, TB and malaria, which pose a risk to everyone. Nations have to contribute together to rescue basic healthcare systems for those in need.

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WMA COUNCIL RESOLUTION ON THE USE OF RIOT CONTROL AGENTS AND HUMAN RIGHTS VIOLATIONS AGAINST PROTESTERS IN TURKEY

Adopted by the 229th WMA Council Session, Montevideo, Uruguay, April 2025

PREAMBLE

In response to the arrest of Istanbul's mayor, Ekrem İmamoğlu, and other opposition figures last March, important demonstrations are taking place across Turkey. Media reports the use of tear gas, plastic bullets, and water cannons by the police as weapons against demonstrators and passers-by of all ages, including children.

The documented severe short-term and long-term health consequences of tear gas and other riot control agents include respiratory distress, ocular damage, skin irritation, and potential psychological trauma, affecting not only protesters but also bystanders, residents, and medical personnel.

Ill-treatment and other practices contrary to international standards, such as the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) and the WMA Ethical Guidelines, were also reported, in particular:

- Detainees were handcuffed behind their backs by police and searched while still handcuffed.
- Physicians are being forced to carry out medical examinations on detainees in conditions likely to compromise their professional ethics, their independence, and the well-being of the detainees.

RECOMMENDATIONS

Recalling WMA ethical principles and its commitment to the health and human rights of all people, including the right of peaceful assembly, the Council of the WMA, meeting in Montevideo on 24-25 April 2025:

- Denounces the inappropriate use of riot control agents which risks the lives of those targeted and exposes people around, amounting to a potential breach of human rights standards, as stated in WMA Statement on Riot Control Agents.
- Unequivocally condemns any pressure or coercion exerted upon physicians to perform medical examinations of detainees in detention centers.

The WMA Council, therefore, urges the Turkish authorities to:

- Immediately cease the use of tear gas and other riot control agents against peaceful protesters.
- Ensure unimpeded access to medical care for all injured individuals during protests, and refrain from any actions that obstruct or endanger medical personnel.
- Ensure that health professionals can carry out their work in accordance with their ethical obligations, without fear of reprisals.
- Respect and protect the rights of peaceful protesters.
- Conduct thorough and impartial investigations into allegations of human rights abuses against protesters, and hold perpetrators accountable.

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Information about the 76th WMA General Assembly, *Porto 2025*

Dear colleagues of the World Medical Association,

On behalf of the Ordem Dos Médicos (Order of Physicians), we cordially invite you to participate in the 76th General Assembly of the World Medical Association, which will be held on 8-11 October 2025, in Porto, Portugal.

The Ordem Dos Médicos is honored and humbled to serve as the host for this event, and we are excited to share the promotional video (https://youtu.be/_s5YfMmks4M). Our team has prepared a robust agenda of significant themes related to our medical profession, as well as leisure activities to learn about our city, its culture, and its hospitality.

Please mark your calendars and join us in Porto for this exciting event.

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Report of the WMA Environment Caucus

Ankush K. Bansal

The Environment Caucus met on 23 April 2025 during the 229th Council Meeting of the World Medical Association (WMA) in Montevideo, Uruguay. A total of 17 members (15 in-person, 2 virtual) attended the meeting. The purpose of the Environment Caucus is to educate members about pressing environmental concerns, collectively share ideas and local challenges, and highlight best practices experienced by members.

The Environment Caucus meeting opened with a general discussion of the geopolitical developments since the General Assembly in Helsinki, Finland, notably the United States (U.S.) presidential election. Dr. Ankush Bansal, Chair of the WMA Workgroup on Environment and of the Environment Caucus, summarised the pertinent developments since January 2025, including the U.S withdrawal from the Paris Agreement and World Health Organization (WHO) and funding halt to the U.S. Agency for International Development (USAID). The subsequent discussion focused on next global steps to ensure continued progress on climate change mitigation and adaptation, global health resources and alliances, education, information sharing (including battling misinformation and disinformation), and addressing health inequities. Although some members focused on increased educational opportunities and positive messaging, several members from other high-income countries were enthusiastic to actively contribute to next global steps. The take-home message was that this complex situation required further research, analysis, political and grassroots action, and multi-sector commitments by high-income countries.

Dr. Lujain Alqodmani, the WMA Immediate Past President, presented a report on her attendance as the WMA representative to the WHO 2nd Global Conference on Air Pollution and Health, which was held on 25-27 March 2025 in Cartagena, Colombia. While no firm commitments materialised from this event, she commented that the ongoing discussion confirmed aspirations to reduce air pollution, primarily from fossil fuel sources, and to share key updates at future conferences.

The keynote address was presented by Dr. Ned Ketyer, a retired pediatrician from the Pittsburgh, Pennsylvania area in the U.S., living in close proximity to the Marcellus Shale hydraulic fracturing sites. He is a member of the Council on Environmental Health and Climate Change for the American Academy of Pediatrics and serves as President of the Pennsylvania Chapter of Physicians for Social Responsibility (PSR), the U.S. affiliate for International Physicians for the Prevention of Nuclear War. Notably, climate change represents one of the two primary missions of PSR. This presentation was well-received and highlighted research data on hydraulic fracturing from Pennsylvania, Colorado, and Canada. It also provided insight into the dangers of fossil fuel production and the role of health professionals in protecting the public from these hazards.

Finally, the Environment Caucus concluded with an open exchange of ideas and best practices. Notably, Dr. Bansal presented his local experience of air pollution from the burning of sugarcane harvests in Florida. He described published health surveillance data by physicians and public health scientists on its direct effects on school and work absenteeism, childhood asthma, adult cardiovascular and respiratory health, allergy triggers, neurological symptoms, and premature death. He also pointed out the health inequities exist primarily among specific racial and socioeconomic groups.

The Environment Caucus is open to all interested attendees of the WMA Council and General Assembly meetings. The next Environment Caucus meeting will be held on 9 October 2025, in Porto, Portugal.

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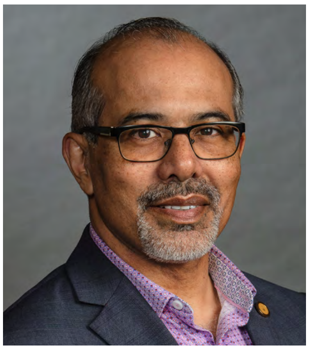
Unravelling MAiD in Canada: Euthanasia and Assisted Suicide as Medical Care

Ramona Coelho



K. Sonu Gaind

Trudo Lemmens

We are pleased to present *Unravelling MAiD in Canada: Euthanasia and Assisted Suicide as Medical Care*, a multidisciplinary volume examining the complex ethical, legal, social, and medical practice questions surrounding Medical Assistance in Dying (MAiD) in Canada [1]. Bringing together a diverse group of scholars, practitioners, cultural backgrounds, and persons with lived experience, this book offers an in-depth exploration of far-ranging aspects of Canada's rapidly expanding MAiD regime. Canada is quickly becoming a global point of focus for any jurisdiction considering assisted suicide and euthanasia policies. This volume should be of broad international interest, as it reveals key concerns both with legalizing assisted dying, as well as the flawed processes that have fueled Canada's MAiD expansion.

Since its legalisation in 2016, Canada's MAiD regime has expanded rapidly, with significant implications for medical practice, health law and policy, and vulnerable populations [2]. Criminal Code amendments lifted the absolute prohibition on homicide and aiding suicide, initially creating a route for euthanasia and assisted suicide for those approaching their death. Both assisted suicide and euthanasia are included in the term *medical assistance in dying*. This made Canada one of a small number of jurisdictions worldwide to legalize both practices–and notably, one where euthanasia, rather than assisted suicide, is the default method. Of over 15,000 annual MAiD deaths, almost all were euthanasia, a lethal injection administered by medical practitioners or nurse practitioners; fewer than a handful were self-administered assisted suicides via prescription of lethal medication.

Canada's approach has been internationally distinct not only for its scope, but also for the process through which it was enacted. Unlike most jurisdictions where assisted dying was introduced following extended legislative debate or referendum – such as in New Zealand – Canada's initial legalisation followed a judicial ruling. The Supreme Court's 2015 *Carter* decision found that the absolute prohibition of assisted dying violated constitutional rights and required the development of MAiD in some restricted circumstances [3]. A more recent expansion in 2021, beyond the end-of-life context, also occurred ostensibly in response to a lower court decision, issued by a single judge in Quebec. Despite the ruling having no binding authority nationwide, the Trudeau government voluntarily chose not to appeal the decision and instead pushed forward with MAiD expansion across the entire country, rushing legislation through Parliament during the coronavirus disease 2019 (COVID-19) pandemic. The legislation created a new MAiD pathway, Track 2, that did not include the "reasonably foreseeable death" safeguard, which had protected non-dying Canadians from being euthanized.

Currently, Canada has the fastest growth rate of euthanasia deaths globally, with the province of Quebec emerging as the jurisdiction with the highest percentage (over 7%) of administered deaths relative to overall mortality in the world. Canada has also seen a notable expansion of its legislation in a short period of time. As mentioned above, the initial safeguard requiring a person accessing MAiD to be near the end-of-life was removed

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in 2021, and MAiD is now accessible to persons with physical disabilities who are not near death. The 2021 law also eliminated other safeguards, such as a mandatory 10-day reflection period and the firm requirement of confirming consent immediately prior to receiving the lethal injection. In 2027, the government plans to extend eligibility to those suffering solely from mental illness or addictions. In Quebec, MAiD is already available on the basis of advance requests for persons who have lost capacity–even though such provisions remain prohibited under the federal Criminal Code. Remarkably, the former Trudeau government indicated that it would not launch any legal action to challenge the new Quebec law, even while acknowledging that the provincial law clearly violated federal legislation [4].

One of the striking things, as discussed in several chapters in our volume and also elsewhere, is that even more than in other liberal euthanasia regimes, such as Belgium and the Netherlands, Canada's law and policy emphasise the need to ensure broad access to MAiD, rather than protecting patients against wrongful death [5,6]. MAiD is not a last resort, and people who satisfy the broad access criteria can have MAiD, even if standard effective therapies and social support measures could provide relief but have not been tried or are inaccessible. The federal government has also extensively relied on individuals and organisations for policy guidance who have been pushing for the most flexible and open interpretation of the MAiD law. Rather than providing necessary clinical or medical input, many professional medical and psychiatric organisations have uncritically accepted, or propagated, the contested claim that there is a broad right to MAiD and that access must be facilitated. At the same time, these professional organisations have failed to provide the medical evidence that would typically be an expectation in consultations for any medical procedure. They have also refused to provide known evidence of risks to potentially suicidal individuals seeking death and being euthanised.

Canada's MAiD trajectory has drawn significant national and international human rights scrutiny. In March 2025, the United Nations (UN) Committee on the Rights of Persons with Disabilities issued a report with observations that included a recommendation for Canada to repeal Track 2 MAiD (for those not near death) and to revoke the planned 2027 expansion [7]. It further recommended against extending MAiD to mature minors or permitting advance requests and improving the monitoring of the practice and the safeguards. This is not the first time Canada's regime has been condemned for being based on ableist assumptions and for failing to account for risks to marginalised populations. Several UN human rights experts, the Canadian Human Rights Commissioner, and numerous disability rights and social justice organisations have raised serious concerns regarding its direction and impact in the years since its legalisation.

MAiD monitoring is largely post-factum and based on self-reporting by MAiD providers to federal, and in some provinces to provincial agencies, which limits its effectiveness. Still, Health Canada MAiD and other provincial reports provide relevant information, such as: how many people received MAiD; the percentage of persons dying by MAiD per province; what motivates people to ask for it; the underlying conditions; how many requests were rejected (less than 10%); and the profile of MAiD providers; and some socio-economic data.

In 2024, the Chief Coroner of Ontario, Canada's largest province with approximately 40% of the population, established a MAiD Death Review Committee – of which two of us are members – to review selected MAiD cases identified by the Chief Coroner's MAiD Review Team. Committee members contribute their expertise to help inform recommendations for future MAiD practice, aimed at improving public safety. Particularly these Coroner reports, along with numerous investigative journalism reports, document how some patients are receiving MAiD in circumstances where their suffering is largely driven by structural inequalities, including factors such as poverty, loneliness, feelings of being a burden, inadequate medical and social support, and even obesity [8-11].

Health Canada's report on the 2023 MAiD practice reveals that, for nearly half of the 622 Track 2 MAiD deaths (those not near death), loneliness or isolation was identified as a key component of their unbearable suffering [12]. In over 45% of all MAiD deaths, people also cited the perception of being a burden on family, friends, or caregivers. Several Chief Coroner of Ontario MAiD Death Review reports also contain case narratives that highlight, at times, highly questionable informed consent and capacity assessment procedures by MAiD providers.

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Despite growing concerns about whether Canada's MAiD expansion has already gone too far, the legacy legislation from the Trudeau government remains active, pushing for further MAiD expansion to Canadians suffering solely from mental illness and addictions by 2027. This expansion has already been delayed twice: first by one year in 2023, and then by three years in 2024. It remains to be seen whether the newly elected Carney government will continue to be influenced by those lobbying for the widest possible MAiD expansion, or whether it will recognize emerging concerns and adopt a more balanced approach.

Unravelling MAiD in Canada seeks to inform and elevate the ongoing conversation by providing an in-depth discussion of various components of the MAiD law, policy, and practice. The volume features contributions from disability authors and professionals across fields such as medicine, psychiatry, law, policy, and ethics, offering a range of professional, cultural and Indigenous perspectives grounded in scholarship, medical practice, governmental policymaking, and lived experience. It also provides detailed testimony on the rapid development of Canadian MAiD law and policy, which serves as a cautionary tale to other countries that are currently debating the legalisation of euthanasia and assisted suicide, or the expansion of existing legislation. Particular attention is given to the effects of MAiD on marginalised populations, including those affected by systemic discrimination based on Indigeneity, age, disability, and mental health status. Several chapters highlight how unmet social and healthcare needs may influence individuals to seek MAiD – not as a free choice, but as a response to inadequate supports.

As editors who have engaged directly in legislative and public discourse – especially in the years following *Carter* – we felt a strong need to convene this conversation in a comprehensive and scholarly format. Many of us could not have anticipated, even 15 years ago, that this issue would become so central to Canadian healthcare, health policy, and to our very lives. Yet its significance has grown, compelling us and many contributors to focus their academic and professional efforts on understanding and addressing its implications.

We are deeply grateful to the contributors who have shared their expertise and voices in this volume, offering essential perspectives that have too often been absent from public discourse. We hope this book will serve as a meaningful resource for scholars, clinicians, policymakers, and members of the public who wish to engage critically with the evolving Canadian experience of MAiD. We warmly invite readers to explore this volume and to join the broader national and international dialogue on this urgent and deeply complex issue.

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Disclosures

RC and TL are members of the Ontario MAiD Death Review Committee. RC, SG, TL presented as expert witnesses for federal parliamentary committees on MAiD. SG and TL were members of the Council of Canadian Academies Expert Panel on MAiD. SG and TL were expert witnesses for the Attorney General in the Truchon and Lamb cases. SG was Former Physician Chair Assisted Dying Team, Humber River Hospital.

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Voluntarily Stopping Eating and Drinking as a Self-Chosen Path for End of Life

Gert van Dijk *Veelke Derckx* *Alexander de Graeff*

Over the past few decades, patients have had an increased desire for autonomy and control, including control over the final stages of their lives. One available option is voluntary stopping eating and drinking (VSED), which refers to the decision made by a person to stop eating and drinking for the purpose of hastening the end of life. VSED is different from people who gradually eat and drink less as a result of a terminal illness or those who refuse food or liquid intake in the context of a hunger or thirst strike.

In the Netherlands, an estimated 0.4-2.1% of all deaths are attributed to VSED, where the majority of cases are women over the age of 80 [1-3]. Of all reported VSED cases in the nation, approximately 60% are linked to a serious physical illness, and 12-30% have associations with (incipient) dementia. In cases with no serious physical or psychiatric disorder (25%), there is an accumulation of age-related complaints or problems with a 'fulfilled life'.

Patients may choose VSED due to physical complaints (especially fatigue and pain), but other factors may include feelings of having no purpose in life, suffering from life, having a fulfilled life, dependency, disability, and loss of dignity. In the Netherlands, reports have shown that a total of 19-45% of cases where people died from VSED had made an earlier request for euthanasia to their attending physicians, although it is unknown why the request for euthanasia was not granted [3-5]. The only other country where prevalence of VSED is studied is Switzerland (estimated prevalence 0,5-0,7%) [6,7].

In January 2024, the Royal Dutch Medical Association (KNMG) revised the Caring for People who Stop Eating and Drinking to Hasten the End of Life guideline from 2014 (https://www.knmg.nl/download/guide-caring-for-people-who-stop-eating-and-drinking-to-hasten-the-end-of-life), as a revised resource for healthcare providers on how to inform and care for patients who choose VSED. To complement this clinical guideline, the KNMG prepared the Stopping Eating and Drinking to Die Sooner (Stoppen met eten en drinken om eerder te overlijden) brochure (https://www.knmg.nl/download/publieksbrochure-stoppen-met-eten-en-drinken-om-eerder-te-overlijden), so that patients and their families can make well-informed decisions about VSED and their end of life care.

Right to Self-Determination

All people with the decisional capacity have the right to choose VSED, a choice they can make for themselves without depending on the consent of others. The reason why people are allowed to choose VSED is based on the right to self-determination (every person is entitled to make their own decisions about their own life), which is enshrined in Article 10 of the Dutch Constitution and Article 8 of the European Convention on Human Rights (the right to respect for one's private life). A competent patient's refusal of treatment (including VSED) must be respected, as disregarding this decision would ultimately imply administering nutrition or fluids to people against their will. Various constitutional and human rights oppose this action, including the right to physical integrity, which is described in Article 11 of the Dutch Constitution.

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Provision of Information by Healthcare Providers

Since patients are increasingly seeking information on how to maintain control over their own end of life, they should have access to reliable information to be well-informed of their options. When patients share their death wish with a healthcare provider, it is important to inquire about the rationale of this wish. For example, a death wish may simply be a request for help or stem from a mental illness or existential distress. In that case, it may be desirable to refer patients to seek a consultation with mental health services, spiritual caregivers or other forms of assistance. Patients with a death wish may be unaware of options (like VSED) or may have inaccurate information based on misconceptions or myths. This situation may also raise questions as to whether physicians are allowed or prohibited from educating patients about VSED as well as other end of life options.

When competent patients and their families have questions about end of life options, we believe that healthcare providers have a responsibility to inform and educate them about all relevant end of life options (including VSED). If VSED is discussed, healthcare providers should provide information about the preparation and course of the VSED process, its advantages and disadvantages, any problems that should be expected, and available professional support (including psychological health services). This clinical encounter can foster a space for patients to understand all available options and tools to make an informed and well-considered decision about their own end of life, as well as healthcare providers to encourage shared decision-making and strengthen patients' autonomy.

(Assistance with) Suicide?

The question may arise as to whether or not VSED is considered to be (a specific form of) suicide. After all, by stopping eating and drinking, patients are hastening the end of their own life. However, linking VSED to forms of suicide remains a controversial topic in the literature [8]. Even if VSED is a considered as a form of suicide, it differs from other forms of suicide in several ways. First, VSED cannot be an impulsive act, and dying is gradual and not aggressive or violent. Second, patients have the option to change their mind during the process, and this voluntary nature is better guaranteed than with (other forms of) suicide.

However, we believe that making a decision on whether VSED is a specific form of suicide is unnecessary, as it is not relevant to the question of whether physicians should or should not provide care to patients who choose VSED. In our perspective, caring for patients during VSED is a form of palliative care aimed to alleviate suffering and not hasten death, which should be provided in all situations where people suffer. Furthermore, even if VSED would be considered a form of suicide, this would not automatically make it morally wrong [9].

In our opinion, there is no morally relevant distinction between palliative care for people who choose VSED and those who select other end of life options. After all, such a distinction would mean that people who choose VSED are denied adequate symptom relief. The 'own fault' perception should not play a role in considering whether someone's complaints should be remedied. All people who suffer have the right to relief from that suffering, even if that suffering is the result of a personal choice, such as VSED.

Course

Most patients who choose VSED as the end of life option usually die within one to three weeks upon the initiation of VSED [2,10,11]. With proper care, death usually occurs with relatively few symptoms and suffering. During this period, patients may reconsider their decision and start eating or drinking, so death may be postponed.

The process of dying occurs in three phases, which gradually merge into one another. The first phase (three to four days) is defined when eating and drinking are acutely or gradually stopped, and the feeling of hunger usually disappears, provided that no carbohydrates are ingested. During the middle phase (variable length) pain or signs of delirium can occur. Painkillers and sleeping pills are the most commonly prescribed palliative medication. Although thirst is generally not a prominent complaint, proper oral care is essential to prevent and alleviate complaints of thirst or dry mouth. The final phase (several days) is comparable to the dying phase of a terminal illness.

Conscientious Objections

Healthcare providers can have moral objections to providing care to people who choose VSED, as they may think that they are cooperating in someone's suicide. Stopping to offer food and drink because the patient chooses to hasten the end of life can also make healthcare providers feel that they are providing poor clinical care. In that case, the patient's choice conflicts with the caregiver's beliefs or personal values and norms, which

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may cause conscientious objections for a caregiver.

However, healthcare providers have a duty to act as a 'good healthcare provider' even if they disagree with their patient's choice that leads to health problems and/or hastening the end of life. Therefore, when a healthcare provider has conscientious objections, according to the Dutch Code of Conduct for doctors, care must be transferred to another healthcare provider who is willing to provide the necessary care. The initial healthcare provider must, however, continue to provide care until the moment of transfer to this colleague.

Palliative Sedation

VSED can result in one or more refractory symptoms, such as thirst, delirium and exhaustion. If existential suffering can no longer be relieved by, for example, conversations or spiritual support, this suffering may also be refractory. Existential suffering may thus be part of the refractory symptoms that lead to unbearable suffering of the patient. If the patient ingests little or no fluids, the criterion of a life expectancy of a maximum of two weeks is met. In these situations, palliative sedation may therefore be an option, provided that the conditions of the Dutch Guideline on Palliative Sedation are met [12].

Natural Death

Since opinions differ on whether VSED qualifies as a form of suicide, there may be uncertainty about how to complete the death certificate. In the Netherlands, the death of a patient who dies from VSED is seen as a natural death, and therefore does not have to be reported to the municipal medical examiner. The direct cause of death is recorded on the death certificate as 'deliberate refusal to eat and drink'. Notably, the clinicians in the United States published a comprehensive guideline for VSED, considering VSED as a natural death [13]. It is partly based on the original 2014 KNMG guideline, but adapted to the U.S. health system context, especially with regard to legislation, healthcare organization, and attitudes towards end-of-life care. In other jurisdictions, the legal situation regarding VSED might be different.

Conclusion

Moving into the future, it is likely that doctors and other healthcare providers will be confronted more often with patients who would like to explore options for controlling their end of life care. They should correctly inform patients about the various clinical care options, including VSED, and carefully guide them in the event of a decision to choose VSED. If healthcare providers have conscientious objections in providing care to people who choose VSED, then care must be transferred to a healthcare provider who is willing to provide the necessary care.

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The Great Silence: The Doomsday Clock is Ticking

Steve Robson

Hilary Bambrick

"It is very difficult to predict – especially the future." – Attributed to Nobel prize-winning Quantum physicist Neils Bohr

In January 2025, the famous 'doomsday clock' was reset to 89 seconds to midnight, the closest ever to human extinction. As a metaphor that was inaugurated in the aftermath of the Second World War, the doomsday clock represents how close humanity was to self-destruction amidst nuclear weapons [1]. This concern was recognised by a number of Manhattan Project atomic scientists from the University of Chicago who inaugurated the Bulletin of the Atomic Scientists (https://thebulletin.org/) in 1945.

In the 2025 Doomsday Clock Statement, the atomic scientists expressed the following sentiment: "*In 2024, humanity edged ever closer to catastrophe… despite unmistakable signs of danger, national leaders and their societies have failed to do what is needed to change course. Consequently, we now move the Doomsday Clock from 90 seconds to 89 seconds to midnight—the closest it has ever been to catastrophe. Our fervent hope is that leaders will recognize the world's existential predicament and take bold action to reduce the threats posed by nuclear weapons, climate change, and the potential misuse of biological science and a variety of emerging technologies*" [2].

By the end of the Second World War, the World Medical Association (WMA) was established in 1947, motivated by physicians who had been involved in the chaos and destruction of two global conflicts within their lifetimes. The practice of medicine in wartime had placed a severe strain on the profession as well as its practitioners, with many nearly impossible decisions compromised by resource constraints and military necessity. At the time, since few medical organisations explicitly stated their professional obligations, the WMA's highest priorities were to develop a code of ethics for medical practice and a personal 'pledge' for individual doctors to guide their approach to medical care. By the end of the 1940s, the WMA had released first iterations of the International Code of Medical Ethics ("*A doctor must always bear in mind the obligation of preserving human life*") and the Declaration of Geneva ("*I solemnly pledge myself to consecrate my life to the service of humanity*") [3]. Notably, the revised International Code of Medical Ethics clearly articulates the principle that each physician "*has a responsibility to contribute to the health and well-being of the populations the physician serves and society as a whole, including future generations*" [4].

In the current global environment, an obligation to the health and well-being of the current and future generations imposes an extraordinary responsibility on physicians. It goes well beyond that of simply providing healthcare to individual patients and within individual health systems, as it assumes a scope of practice that is expansive and perpetual for every physician. Observed from the highest level, transcending on the health of our individual communities, the emerging concept of planetary health recognises a transnational collaboration that promotes health for humans and the Earth's biosphere ('life support') [5,6]. However, is there certainty that human society will continue?

Published before the coronavirus disease 2019 (COVID-19) pandemic, an analysis of existential risk to *Homo sapiens* estimated a 10-20% risk of species extinction by the end of this century [7]. Our species, however, has likely existed for more than 150,000 years and survived many natural hazards over this timescale [8]. Yet some pessimism remains, as expressed by scientists [7]:

"Our longevity as a species offers no… grounds for confident optimism. Consideration of specific existential-risk scenarios bears out the suspicion that the great bulk of existential risk in the foreseeable future consists of

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anthropogenic existential risk – that is, those arising from human activity."

We have entered an epoch where many existential risks to human civilization are potentially self-inflicted and interactive, compounding the total risk through complex systemic feedback [9].

Where is Everyone?

Italian-American physicist and Manhattan Project member, Enrico Fermi, was awarded the Nobel Prize in Physics in 1938, and posed the famous question: "Where is everyone?" [10]. Fermi posited that since the universe is over 13 billion years old, any pre-existing civilization should have colonised much of the universe, yielding abundant evidence of life beyond Earth. Yet despite a substantial global effort over many decades, there is no evidence of life beyond our planet.

The 'great silence' of the universe beyond Earth troubled many scientists, including American astronomer, David Brin. In the early 1980s, his mathematical analysis–the sheer number of potentially biophilic planets would favour the emergence of life, yet we see no evidence beyond Earth – led him to hypothesise that the lifespan of technological species is short [11]. In response, Robin Hanson, an economist at George Mason University (United States), published a paper entitled, 'The great filter: Are we almost past it?', noting that *"life on Earth seems to have adapted its technology to fill every ecological niche it could…[and] species have consistently expanded into newly-opened frontiers"* [12].

Expanding beyond Earth, Hanson pointed out that, *"We have had great success at explaining the behavior of our… solar system, nearby stars, our galaxy, and even other galaxies, via simple 'dead' physical processes, rather that the complex purposeful processes of advanced life."* He proposed the idea that a 'great filter' operates between the emergence of single cell life forms and the 'explosion' of intelligent civilisation beyond its home planet. Brin, Hanson, and other scientists have expressed their great concern for our species with the failure to detect signs of life elsewhere. Hanson shared his sentiment about the future [12]:

"We should fear for our future…No alien civilizations have substantially colonized our solar system or systems nearby. Thus among the billion trillion stars in our past universe, none has reached the level of technology and growth that we may soon reach. This one data point implies that a Great Filter stands between ordinary dead matter and advanced lasting life. And the big question is: How far along this filter are we?"

Although the formal and informal analyses of physicists, mathematicians, and economists, such as Fermi, Brin, and Hanson, are difficult to interpret and not necessarily generalizable, limited proof for any long-term survival of complex, purposeful species across a cosmic population is concerning. Physicians should take this evidence as a poor prognostic sign.

Medicine and our Species

If the medical profession has a clear-cut ethical obligation for "future generations," then physicians should make every effort to ensure that future generations will actually exist [3]. How can the medical profession collectively maximise this chance? First, it is worth remembering that the *Bulletin of the Atomic Scientists* first unveiled the existential 'doomsday clock' at the same time that the WMA released its International Code of Ethics for physicians. Second, while we perceive that modern Homo sapiens have survived over time, 99% of species that have ever existed are now extinct [13]. Indeed, a number of epochs in Earth's history have hosted mass extinctions, and there is a concern that we may be living in such an epoch now with extensive biodiversity loss [14].

If we consider our position as a species using the framework of planetary boundaries, it is likely that we have transgressed six (anthropogenic climate change, biosphere integrity, land system change, freshwater availability, biochemical flows, novel entities) of the nine boundaries [15,16]. Of the three that have not yet been breached (ocean acidification, atmospheric aerosol loading, stratospheric ozone depletion), ocean acidification is approaching the 'safe operating zone' edge, due to the absorption of atmospheric carbon emissions and the burning of fossil fuels. Furthermore, the mechanisms ('great filters') that could be associated with the extinction of *Homo sapiens* can include future pandemics, environmental degradation and climate change, armed conflict, and natural disasters (including a large object from space striking Earth) [17].

Historical records have illustrated high mortality rates due to infectious disease outbreaks, including the more than 50 million global deaths during the 1918 influenza pandemic. Specifically, analyses suggest that during the COVID-19 pandemic, the high mortality rate in high-income countries was potentially preventable as it was attributed to polarization and noncompliance to recommended preventive

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actions [18,19]. Urbanisation, increased human-animal contact, anthropogenic climate change, health workforce shortages, and travel remain risk factors associated with future pandemics [20,21].

Across the 20th century, an estimated 231 million deaths resulted from wars and armed conflicts (*"killed or allowed to die by human decision"*) [22]. Lili Xia and colleagues have predicted that looking forward in an increasingly unstable world, the long-term effects of a major nuclear exchange would cost five billion lives [23]. We now hear concerns that nuclear conflict is becoming more likely, with many international actors either attempting to acquire atomic weapons for the first time, or expanding existing arsenals [24]. Kamran Abbasi and colleagues highlighted that *"Current nuclear arms control and non-proliferation efforts are inadequate to protect the world's population against the threat of nuclear war by design, error, or miscalculation"* [25]. Notably, the former U.S. Defense Secretary Robert McNamara expressed that the world was spared from a large-scale nuclear conflict in the last century, due to good fortune, not specific military leadership or technology: *"We lucked out. It was luck that prevented nuclear war"* [26].

Lessons from Space

At least one of the planet's mass extinctions was likely caused by the impact of an object from space. As the best-known example, the Chicxulub crater in the Yucatan Peninsula of Mexico occurred 66 million years ago, and it appears to have led directly to the extinction of 88% of all land-dwelling life forms (including dinosaurs) [27]. The historical record, however, depicts an example of near-misses to the planet. In 2013, a 20-metre meteor, travelling at an estimated 19 km/s, entered the atmosphere over the Russian town of Chelyabinsk, generating a shock wave sufficient to damage over 7,000 buildings and caused over 1,600 people to be injured and hospitalised [28].

The astrophysics community recognizes cosmic impacts as a potential risk to humanity, which has prompted coherent mitigation responses. Careful analysis has been performed to provide precise estimates of the risk of impacts and detailed mapping of near-earth objects (NEOs) – those large enough to cause significant harm and with an orbit likely to bring them into proximity to the Earth – has underpinned an impressive international collective effort to map NEOs [29-31]. First steps have been undertaken by the National Aeronautics and Space Administration (NASA) with a test mission to alter the course of Dimorphos, the 160-metre-wide moon of a larger asteroid. The Double Asteroid Redirection Test (DART) spacecraft struck Dimorphos and nudged it closer to its partner, Didymos, shortening its nearly 12-hour orbital period by 32 minutes [32].

Recognising and Responding to the Great Silence

Compared to other species, *Homo sapiens* have an extraordinary advantage with a capacity for reflection, shared knowledge in story-telling through generations, and imagining the future. We recognize the urgent need to respond to existential multiple and compounding threats – like climate change, pandemics, and armed conflicts – and collectively manage and mitigate their impacts [33]. These efforts will require strong institutional and political responses as well as global collaboration and cooperation, especially with the astronomical and medical communities [34,35]. The astronomical community has demonstrated how to address these existential risks by alerting us about the surrounding silent universe that points to a sombre prognosis for our species. The medical profession utilises guiding documents, like the International Code of Ethics and the Declaration of Geneva, to encourage physicians to reflect on their ethical obligation to support future generations. Together, the astronomical and medical communities can collaborate on increasing awareness of these existential threats, as the stakes are very high indeed.

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Interview with National Medical Associations' Leaders of the Asian Region

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Dr. Slamet Budiarto, Dr. Kalwinder Singh Khaira, Dr. Anil Bikram Karki, and Dr. Prakitpunthu Tomtitchong, the Presidents of the National Medical Associations (NMAs) of Indonesia, Malaysia, Nepal, and Thailand, respectively, join the interview with Dr. Helena Chapman, WMJ Editor in Chief. They share their perspectives on their leadership experiences, ongoing NMA activities, strengths and existing challenges in medical education, and how the World Medical Association (WMA) can support NMA initiatives in the Asian region.

As you reflect upon your journey as NMA president, please describe one memorable experience, one challenge and how you resolved the challenge, and one hope for the future of medicine.

Indonesia: As President of the Indonesian Medical Association, one of the most meaningful experiences was leading the organisation in responding to the controversial Health Bill (*Law No. 17/2023*) that was adopted in August 2023 [1]. This process involved the consolidation of more than 200,000 members to convey the aspirations of the medical profession collectively to policymakers through hearings, public discussions, and legal channels. Our biggest challenge is maintaining the independence of the medical profession amidst intense political dynamics and diverse public narratives. Our NMA choses the constitutional path through an ongoing judicial review to the Constitutional Court, which reflects our commitment to the supremacy of law and the importance of maintaining the dignity of the medical profession as the guardian of ethical and high-quality health services. Finally, my hope for the future of medicine is the creation of a fair and evidence-based system that ensures the welfare of patients and health professionals. Indonesian Medical Association members continue to strive to create space so that doctors are not only implementers, but also architects of a sustainable health system.

Malaysia: One memorable experience was when the Malaysian Medical Association (MMA) members held a peaceful assembly on 6 May 2025, offering a space for a total of 11 medical associations to highlight and discuss issues affecting private practitioners in the country [2]. This event, which was the first of its kind, demonstrated the determination of Malaysian doctors. One major challenge was how to convey these longstanding issues to the Prime Minister, while maintaining unity among all doctors nationwide. Our MMA leaders overcome this challenge by taking the lead, uniting all other associations, and preparing and submitting a memorandum. Finally, our hope for the future of medicine is that the values of service and empathy towards patients remain strong, while the medical fraternity continues to be vocal and united in advocating for policies that benefit the public.

Nepal: Reflecting on my tenure as NMA President, I have had memorable experiences, faced challenges, and envisioned a better

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future for medicine. A defining moment was being elected as the President-Elect of Confederation of Medical Associations in Asia and Oceania (CMAAO), a proud achievement that strengthened Nepal's presence in global medical leadership. At the same time, one major challenge was the rising violence against health professionals. To address this challenge, we took a firm stand – protesting through a call of duty, raising public awareness, and legally pursuing perpetrators. Filing cases in court sent a strong message that such acts would not be tolerated. Looking ahead, I see great promise in the new Doctors' Act under drafting, which will help ensure better pay, standardised care, and stronger legal protections for medical professionals, paving the way for a more secure and respected healthcare system in Nepal.

Thailand: One of the most memorable experiences during and even before my presidency was leading the nationwide initiative to promote physician resilience during the height of the coronavirus disease 2019 (COVID-19) pandemic. As frontline healthcare professionals faced physical exhaustion and emotional and ethical distress, the Medical Association of Thailand (MAT) launched a coordinated campaign across all regions of Thailand to provide mental health support, peer counselling, and practical well-being resources (including life insurance), for all physicians serving the Thai population during the COVID-19 pandemic. Notably, our fundraising efforts since 2020 allowed us to help support the dedicated efforts of over a million nurses and Village Health Volunteers (backbone of primary healthcare) in Thailand.

How would you describe the current opportunities for NMA members to help influence health care policy-making activities in your country?

Indonesia: The opportunities for Indonesian Medical Association members to influence healthcare policy-making are increasingly relevant, yet challenging. The ongoing healthcare reform process – including the passing of the new Health Law (*Law No. 17/2023*) – has sparked active participation from the medical community. Although many of the profession's aspirations have not been fully accommodated, the space for participation remains open, particularly through constitutional channels and public advocacy. We believe that physician involvement in policy not only strengthens the healthcare system, but also ensures that important decisions remain based on ethical principles and patient safety. This is where the role of the NMA becomes vital – strengthening the profession's voice in the complex flow of public policy.

Malaysia: The Malaysian Medical Association (MMA) has been able to successfully convey its views on healthcare policies affecting both the public and the medical fraternity, directly by engaging with the government, and indirectly by articulating views through press releases for the benefit of the public and health authorities. In the past, MMA leaders have also independently organised and conducted peaceful assemblies to express their views on pressing health topics, which were permitted and perceived positively by the government.

Nepal: The Nepal Medical Association and its members have been always been proactive and influential in health policy making, including the launch of the human papillomavirus (HPV) vaccination programme, *Nepal Cancer Control Strategy 2024-2030, Health Service Act*, and the *National Medical Education Act of 2018* [3,4]. We are involved in the ongoing drafting process of the *Drugs Act, Health Care Workers Protection Act, National Public Health Act*, and various digital health policies. Each year, we support the National Health Summit, as an opportunity to engage in policy dialogues, including national disease prevention and control, with multiple stakeholders and member societies. Our members represent various leadership roles across the government, non-governmental organizations, and academic sectors.

Thailand: The Medical Association of Thailand (MAT) maintains an advisory role in several key governmental bodies, including the Ministry of Public Health (MoPH), the Medical Council of Thailand, and the National Health Security Office (NHSO), which oversees universal health coverage (UHC). The establishment of UHC is one of Thailand's proudest national achievements, ensuring that every citizen has access to essential health services without suffering financial hardship. However, sustaining and strengthening UHC in the face of rising healthcare costs, demographic shifts, and constrained public budgets remains a serious challenge. We believe that addressing the funding challenge requires a multi-pronged, evidence-informed, and collaborative approach.

Recognising the urgent need to address junior doctor burnout as a systemic issue, MAT members collectively advocate for safer work hours and improved mental health support, including the use of artificial intelligence applications for mental health screening

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among medical personnel, to Thai policymakers. We are committed to fostering a respectful training culture, promoting work-life balance, empowering junior doctors to have a voice in policymaking activities, and ultimately creating a healthier, more sustainable environment for personal and professional excellence. Currently, we have been collaborating on a research project on mental health (e.g. depression, stress) with Thai medical students and the MAT Junior Doctors Network (JDN), and we will present the research findings through two e-poster presentations at the Association for Medical Education in Europe (AMEE) conference in August 2025, in Barcelona, Spain.

How do perceive the physician-patient relationship and rapport in the clinical setting in your country?

Indonesia: The doctor-patient relationship in Indonesia is the main foundation of quality and ethical healthcare. In the midst of a health system that still faces major challenges, such as limited resources and high patient burden, doctors continue to strive to build trust and good communication with patients. As physicians, we view this closeness not only as an ordinary clinical interaction, but also as a valuable partnership that bestows respect and understands the needs of each party. Doctors must be able to provide clear explanations, involve patients in medical decision-making, and respect patients' right to receive transparent information.

However, there are real challenges, including limited consultation time due to high patient volumes and various systemic pressures. To that end, Indonesian Medical Association members continue to encourage more effective doctor-patient communication training, as well as advocacy for improvements to the service system, so that doctors have more space for compassionate interactions with patients. We believe that strengthening the doctor-patient relationship will increase treatment adherence, reduce misunderstandings, and ultimately improve patient health outcomes. This is our NMA commitment to making medical services in Indonesia not only clinically effective, but also dignified and full of empathy.

Malaysia: Across the public and private sectors in Malaysia, the rapport between doctors and patients is strong, and patients have a high level of trust in their doctors. This positive relationship and support is the result of years of dedicated service by physicians, who have consistently provided quality care to all patients.

Nepal: The physician-patient relationship was once built on great trust, where physicians were regarded as caregivers and even revered as highly as God. In recent times, however, there has been a significant shift in the physician-patient relationship, leading to increased differences and distance related to this rapport. As government healthcare settings have observed surges in outpatient visits, due to health insurance and other schemes, the number of health professionals has remained the same. With a higher physician-patient ratio, physicians have less time to spend with patients, which challenges shared medical decision-making due to communication challenges like misinformation. Moreover, the private healthcare sector is often perceived as profit-driven, which has contributed to growing mistrust between patients and physicians. Hence, these combined factors have strained the once-strong physician-patient relationship, highlighting the need for systemic improvements in healthcare communication and accessibility.

Thailand: In the Thai culture, physicians are generally held in high regard among society, and patients often seek guidance from their doctors on medical treatment and reassurance. However, as healthcare becomes more complex and time-constrained, maintaining this rapport is increasingly challenged nowadays, which can negatively impact the physician-patient relationship and lead to malpractice lawsuits and risk of workplace violence. The Medical Association of Thailand (MAT) members support the Health Care in Danger (HCID) (https://healthcareindanger.org/hcid-project/), as a movement supported by the International Red Cross and Red Crescent to ensure workplace safety for healthcare service delivery. Furthermore, MAT members are committed to promoting effective communication, time management, shared decision-making, and cultural sensitivity through medical education and professional development (including the integration of electronic health records), to ensure that physician-patient relationships remain a cornerstone of high-quality, ethical care in Thailand.

How would you describe the anticipated challenges in medical education over the next decade in your country?

Indonesia: One of the biggest challenges in medical education in Indonesia today is related to the development and training of specialists. Residency facilities are a key element in producing competent health professionals who provide

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quality specialist health services across the nation. The Indonesia Ministry of Health has recently approved the Health Bill (*Law No. 17/2023*) in August 2023, which significantly limits and even stops several residency facilities [1]. This policy can significantly impact the process of education and specialist training in the country and reduce the availability of specialists in various regions. Our NMA has submitted an official letter to the President of the Republic of Indonesia, requesting the formal review of this policy for the sake of the continuity of quality and equitable specialist education throughout Indonesia.

Second, our NMA recognizes the need to build more robust connections among the Ministry of Health, educational institutions, teaching hospitals, and professional organizations to find the best solution that maintains the quality and continuity of specialist doctor education. Third, our NMA supports the adaptation of medical curriculum and learning methods to the latest developments in medical science and medical technology, as well as guarantee an even distribution of specialists throughout the Indonesian archipelago. The Indonesian Medical Association is committed to continuing to encourage improvements in policies that support the training and expansion of specialists so that competent medical personnel are responsive to community health needs of the future.

Malaysia: The intake of medical students in Malaysia is declining, due to concerns related to job security and career progression. This trend may affect the viability of some medical colleges and lead to a further reduction in the number of doctors being trained in the country. In addition, technological advancements of artificial intelligence will also transform the way medical education is delivered, which must adapt to incorporate these emerging technologies. While this shift is necessary, the use of artificial intelligence will give rise to ethical and medico-legal issues that need to be addressed collectively within our medical community.

Nepal: Medical education in Nepal is undergoing significant changes and challenges. In the past, the medical profession followed a strict hierarchy, and the essence of medical education was rooted in service and respect. However, with the privatisation of medical education and increasing numbers of students seeking their education abroad, the field has become monetised. Second, while the Nepal Ministry of Education supports a high national investment in medical scholarships, the retention of these medical graduates in Nepal remains low. Third, medical curricula require consistent revisions to maintain robust academic programs that align with the Ministry of Education requirements and prepare medical students to use novel technologies to address emerging global risks.

Fourth, medical residents endure long working hours without proper food and rest, which increases risk of mental stress (including burnout and suicide), rising security concerns, and violence against doctors. They receive low salaries for their clinical schedules: NPR 18,000 (approximately US$150) for students in private colleges and NPR 48,000 (approximately US$300) for students in government medical colleges. Finally, the bond system and the long duration of medical education pose significant challenges. Nepal follows a 6+3+3 system, with an additional two years of mandatory service, making the age of graduation relatively high. Over time, this prolonged training, coupled with better opportunities abroad, may reduce interest in pursuing medicine in Nepal, hence exacerbating the issue of brain drain and leading to a scarcity of physicians.

Thailand: With the help of the WMA, Thailand hosted the World Federation for Medical Education (WFME) conference from 25-28 May 2025 in Bangkok, Thailand. Over the next decade, we anticipate several significant challenges in medical education, including adapting medical curricula to rapidly advancing technologies (e.g. artificial intelligence, telemedicine), addressing disparities in training quality between urban and rural institutions, and responding to the evolving healthcare needs of an aging population. Additionally, there is an urgent need to foster resilience, empathy, and ethical leadership in junior physicians amid increasing stress and burnout, which can lead to increased resignations in the postgraduate years. Ensuring that medical education remains patient-centred, socially accountable, and globally relevant will require close collaboration among academic institutions, regulatory bodies, and professional associations like the Medical Association of Thailand.

From the medical education perspective, how has your NMA responded to the existing and emerging health challenges within your country?

Indonesia: The Indonesian Medical Association views that medical education must always be relevant and responsive to the dynamics of ever-evolving health challenges – both existing (e.g. non-communicable diseases) and

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emerging (e.g. pandemics, climate change, zoonoses, antimicrobial-resistance) risks. In this context, we emphasize the importance of competency- and evidence-based curriculum reform, with stronger integration of public health, global health, environmental health, and health emergency response. Medical education can no longer focus solely on individual clinical aspects, but rather must be able to equip doctors with systemic thinking, leadership, and cross-sector communication skills.

The Indonesian Medical Association encourages strengthening networks between medical schools and primary and referral healthcare facilities, so that students and junior doctors are exposed to real-time health challenges in clinical and community settings. These efforts include involvement in disaster response, disease outbreak investigations, and health promotion and disease prevention interventions oriented towards increasing the capacity of the healthcare system as a whole. Furthermore, NMA leaders actively encourage doctors and educational institutions to become consumers and producers of knowledge through local research that is relevant to the Indonesian context. We believe that scientific independence is an important part of the resilience of the national health system in facing ever-changing challenges. Institutionally, the Indonesian Medical Association also collaborates with other stakeholders to advocate for adaptive, inclusive, and community-oriented medical education policies. We want to ensure that medical graduates are clinically prepared and become "change agents" in facing current and future health challenges.

Malaysia: The Malaysian Medical Association (MMA) has always been forefront with public visibility, highlighting key health issues that arise in the country by issuing public statements and providing advice on emerging health concerns. For the medical fraternity, MMA members consistently organise continuing medical education (CME) sessions and webinars for the medical community, as opportunities to share scientific updates and enhance overall knowledge.

Nepal: The Nepal Medical Association is an officiating member of the Medical Education Commission, where we relentlessly advocate for the health and education ministries to act on timely reforms for medical curricula (including the five-year superspecialty), equal stipends, and removing the mandatory bonded service program. Recently, we organised a National Health Summit, uniting stakeholders (ministers, medical college representatives, Medical Education Commission) in public dialogue, where we discussed key issues like stipend delays, rote-learning curricula, and exploitative bonds for residents. By spotlighting the gaps between what is needed and what exists, we collectively drive accountability for widespread systemic change. Although resistance persists, these efforts have ignited discussions on modernising training, ensuring fair compensation, and aligning education with Nepal's evolving health needs.

Thailand: The Medical Association of Thailand (MAT) has responded to both existing and emerging health challenges by promoting the One Health concept in emphasising the need for curricula reform, capacity building, and interprofessional collaboration. First, MAT members have worked closely with Thai Veterinary Medical Association (TVMA) members to host the 4th One Health International Conference (OHIC) from 3-4 December 2026 in Bangkok, Thailand. Second, MAT members have collaborated with the Medical Council of Thailand and academic institutions (e.g. 14 of the Royal Colleges) to integrate priority health issues, such as non-communicable diseases, mental health, aging, and pandemic preparedness, into undergraduate and postgraduate medical training. Finally, they have supported the adoption of competency-based education, digital learning platforms, and community-based clinical rotations to prepare future physicians to serve diverse and underserved populations. Through these efforts, the MAT ensures that Thai medical education remains responsive, resilient, and aligned with the real-world needs of our healthcare system.

From your perspective and national experiences, how has the COVID-19 pandemic affected medical education in your country?

Indonesia: The COVID-19 pandemic has had a significant impact on all aspects of medical education in Indonesia. The traditional delivery of medical education was forced to transform, as the teaching and learning process quickly shifted to an online platform. Since few institutions had adequate digital infrastructure, and few lecturers and students were technically and pedagogically ready for complete virtual learning. Similarly, limited direct clinical practice, due to hospital restrictions, led to minimal exposure to real-world clinical cases for medical students and junior doctors.

Despite these challenges, the pandemic has driven innovation, highlighting the need for a

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resilient and adaptive medical education system. Many educational institutions have developed hybrid learning methods, utilised digital simulations, and integrated curricula with global health issues such as epidemiology, disaster response, and risk communication. Medical students have also been involved in various social and community education activities, strengthening their role as future clinicians and "change agents" in public health. The Indonesian Medical Association continues to encourage strengthening the capacity of educational institutions to be better prepared for future crisis situations, by encouraging curriculum flexibility, reinforcing educational technology, and fostering ethics and empathy when managing emergency situations. We believe that the COVID-19 pandemic offered a test and opportunity to accelerate medical education reform and health system responsiveness in Indonesia.

Malaysia: The experiences of the COVID-19 pandemic have motivated the Malaysian Medical Association and the wider medical community to emphasize preventive medicine and the importance of adhering to preventive practices (e.g. social distancing, proper cough etiquette when ill) and policies during medical education and training.

Nepal: The COVID-19 pandemic disrupted medical education severely, where clinical training halted as hospitals prioritised emergencies, and online learning exposed rural-urban digital divides. While telemedicine training and virtual case discussions offered partial solutions, hands-on skill gaps widened. Although the prolonged distance education challenges affected some nations that relied on remote learning, our education system is trying to adapt hybrid learning environments. Resident doctors faced dual burdens – frontline COVID-19 duties and systemic neglect – as governments denied them fair stipends or worker status, which further worsened exploitation. The crisis exposed flaws, as the rigid, theory-heavy curricula failed to teach adaptability or crisis response. The Nepal Medical Association advocated for hybrid learning, mental health support, and curriculum reform to integrate key lessons learned during the pandemic. However, sustainable change demands investment in infrastructure, faculty training, and policy reforms to prepare future doctors for evolving challenges.

Thailand: The COVID-19 pandemic significantly disrupted medical education in Thailand, prompting a rapid shift to online learning and limiting hands-on clinical training. This transition led to reduced confidence among students in their clinical skills and increased levels of stress and anxiety. In one national cross-sectional study, researchers reported significantly high prevalence of burnout among Thai medical interns, resulting in poor work performance and professional discontent [5]. In response, Thai medical schools incorporated simulations into didactic learning, enhanced mental health support and faculty mentorship, and advocated for oversight on clinical schedules. Despite disruptions experienced during the pandemic, digital technological advancements have helped build resiliency in Thai medical education, such as e-learning platforms, simulation-based learning, and telemedicine applications in clinical diagnoses, which support the healthcare innovations proposed in the Thailand 4.0 Strategy [6].

How does your NMA leadership implement the WMA policies in the organization?

Indonesia: Using an adaptive and strategic approach, Indonesian Medical Association leadership implements WMA policies through four main pillars, with aims to reinforce ethical guidelines and propel medical education reform in Indonesia. First, we harmonize the ethical principles of the WMA with local values, so that they remain relevant in the social and cultural context of Indonesia. This integration ensures that global ethical standards are accepted and implemented effectively by all doctors. Second, we actively convey information related to ethical policies, the social role of doctors, and health promotion and disease prevention approaches through seminars, training, and internal communication media. Third, the Indonesian Medical Association is actively involved in the WMA forum and other regional networks, such as the Confederation of Medical Associations in Asia and Oceania (CMAAO) and the Medical Association of South East Asian Nations (MASEAN). This collaboration enriches our perspectives and strengthens the organization's capacity to address transnational issues, including climate change, health crises, and medical ethics. Fourth, we apply the WMA values when advocating for medical education reform, particularly around high tuition costs, resident rights and well-being, excessive workloads, and protection from bullying, to help create a just and humane education system.

Malaysia: The Malaysian Medical Association (MMA) shares the WMA declarations, policies, and statements with MMA members

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and frequently with the public.

Nepal: The Nepal Medical Association actively integrates WMA policies – such as ethical medical practice, patient rights, and physician autonomy – into our national framework through advocacy, training, and policy alignment. For instance, we adopt the WMA Declaration of Geneva (physician oath) and Helsinki Declaration (research ethics) in medical education reforms, ensuring that curricula emphasize human dignity and informed consent. We advocate for laws protecting doctors from violence, which reflects the WMA's stance on safe work environments. During crises like the COVID-19 pandemic, WMA guidelines on equitable vaccine access helped shape our public health campaigns.

Our Association also addresses climate action and other global challenges, where we advocate for policies that support plastic-free initiatives and promote environmental sustainability. The WHO's funding crisis and geopolitical conflicts, such as the Israel-Gaza war, further impact global health priorities, underscoring the need for strong international cooperation. Collaborating with the WMA also strengthens our capacity-building workshops on emerging issues like the ethics of artificial intelligence, climate health, and crisis preparedness, bridging global standards with Nepal's health system and needs.

Thailand: The Medical Association of Thailand (MAT) ensures that WMA policies are actively integrated into our organisational practices through alignment, advocacy, and capacity building. First, we formally align the MAT's ethical guidelines, continuing professional development (CPD) programs, and public health stances with core WMA declarations, such as the Declaration of Geneva, the revision of the Declaration of Helsinki, the International Code of Medical Ethics, and various statements on human rights, equity, and physician well-being. Second, we use WMA policy frameworks to guide our advocacy on key national issues, including health equity, pandemic preparedness, Health Care in Danger (HCID), UHC, and patient safety. Third, we incorporate WMA principles into leadership training, JDN activities, and academic events, helping Thai physicians internalise global standards in professionalism, ethics, and social accountability. Recently, MAT leadership integrated the WMA policies into the Regional Meeting in Asia on the International Code of Medical Ethics (ICoME) on 7-8 June 2022 in Bangkok, Thailand. They also actively participated in the WMA Working Group on Organ Procurement from 2023-2024, and the results were presented at the 226th WMA Council Session in April 2024 in Seoul, Republic of Korea.

How can the WMA support the ongoing NMA activities in your country?

Indonesia: The WMA can play a strategic role in supporting the Indonesian Medical Association's activities in three main ways: strengthening international advocacy, transferring knowledge and best practices, and facilitating institutional capacity. First, the WMA's support in voicing the importance of the independence of the medical profession and the integrity of health systems to the global community and multilateral institutions will strengthen our position in national advocacy, especially amidst complex regulatory and political challenges. Second, the WMA can facilitate the cross-country exchange of experiences on medical education, professional ethics, and health systems, including responding to climate change, antimicrobial resistance, and other health crises. Third, the WMA's continued support of leadership, ethics, and global health policy training will strengthen the capacity of the Indonesian Medical Association cadres in managing organizations and contributing effectively at national and international levels.

Malaysia: Throughout the year, the WMA invites NMA leaders and JDN members to attend and participate in its formal meetings and webinars, which can help foster leadership development and enhance understanding of WMA policies. Moving forward, the WMA can further help support doctors' training by exposing them to its various WMA committees. In turn, doctors can share this acquired knowledge with their colleagues, and they can collectively leverage their expertise to develop new initiatives.

Nepal: The Nepal Medical Association seeks the WMA's support in JDN training and education, ensuring that young doctors receive quality learning opportunities and global exposure. We urge waivers on various charges for less-developed countries like Nepal, as financial constraints should not hinder participation in international medical initiatives. Additionally, we advocate for greater representation in WMA councils and meetings, allowing voices from resource-limited nations to be heard in global policy discussions. Furthermore, we expect the WMA to morally support and provide financial

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assistance for critical association's campaigns and help address our challenges, including advocacy for doctors' rights, workplace safety, and healthcare reforms. We encourage WMA leaders to visit Nepal, fostering stronger collaboration, knowledge exchange, and direct engagement with our medical community.

Thailand: The Medical Association of Thailand (MAT) believes that the WMA can play a valuable role in supporting our ongoing activities by serving as a strategic partner in both advocacy and capacity building. First, WMA's global policy frameworks, such as those on physician ethics, health equity, digital health, and climate-related health risks, help reinforce our national initiatives by lending international legitimacy and alignment with global standards. Second, we welcome WMA's continued support in providing technical expertise, training opportunities, and leadership development, particularly for junior physicians and future health leaders. Third, WMA can facilitate global exchanges that allow Thai physicians to learn from other NMAs and share innovations, especially regarding mental health, workforce resilience, and ethical responses to emerging technologies. Lastly, WMA's unified voice on global health issues strengthens our advocacy at both national and regional levels, where we can collectively elevate the impact of NMA-led efforts and help shape more resilient, ethical, and equitable health systems.

On behalf of the MAT, we are honoured to invite WMA members to attend the WMA General Assembly 2027, which will be held from 20-23 October 2027, in Bangkok, Thailand. We look forward to welcoming global medical leaders to share and exchange ideas, strengthen ethical practice, and advance our shared vision for global health. Please join us in Bangkok for meaningful dialogue and warm Thai hospitality!

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Strengthening National Advocacy through Global Health Policy: The Strategic Role of the Trinidad and Tobago Medical Association

Saksham Mehra

In an era marked by profound global interconnectivity, the boundaries between national and international public health priorities have become increasingly permeable. The Trinidad and Tobago Medical Association (T&TMA), as the premier professional body representing registered medical practitioners in Trinidad and Tobago, has recognised the need to harmonize its local advocacy with broader global health imperatives. Guided by its core mission to *Teach, Treat, Mentor, and Advocate*, the Association continuously seeks to elevate the standards of medical practice and contribute meaningfully to global health discourse.

Through mechanisms such as Small Working Groups (SWGs) and the planned formulation of the official policy document, the Association is laying the groundwork to ensure that its positions on key issues are evidence-informed, contextually relevant, and globally engaged. This strategic policy development framework is an initiative of the T&TMA External Affairs Committee, which has led efforts to align the Association's local advocacy with global health priorities. Central to this is the recognition that global health priorities must inform advocacy efforts that are locally relevant, serving as a bridge between domestic health concerns and the broader global discourse – ensuring that Trinidad and Tobago's medical voice contributes meaningfully.

Aligning with Global Health Priorities

The T&TMA has formally acknowledged the significance of global health priorities as an organising principle for advocacy and policy development. In 2025, the Council of the Association identified three primary global health focus areas – mental health, universal health coverage, and climate change and health – as the key themes for this term. These areas reflect both global urgencies and national relevance, and they will serve to guide the Association's strategic planning and public advocacy efforts.

Mental health, long under-resourced in many healthcare systems, has gained critical attention in light of increasing psychosocial stressors, economic instability, and the aftermath of the coronavirus disease 2019 (COVID-19) pandemic [1]. Universal health coverage represents a foundational goal of equity and accessibility, reinforcing the right of every citizen to receive quality health services without financial hardship [2]. Climate change, with its far-reaching implications for environmental stability, disease transmission, and disaster resilience, has emerged as a cross-cutting determinant of health [3]. Although these focus areas are not yet the subject of finalised policy document, they represent the thematic direction for future policy work. They underscore the Association's commitment to staying relevant within the global health community and aligning with the local context within Trinidad and Tobago.

Policy Documents as Instruments of Advocacy

At the heart of the T&TMA's advocacy strategy lies the policy document – a formal articulation of the Association's official stance on critical health issues. This document serves dual purposes: to inform internal decision-making and provide a credible foundation for external advocacy. It is meticulously crafted through research, stakeholder consultations, and professional input to ensure both relevance and authority.

In a policy environment where evidence-based and strategically articulated positions command influence, the creation of this framework represents both a necessity and a hallmark of professional leadership. To ensure integrity and rigor, the development of policy document follows a standardised process, including the establishment of a SWG dedicated to a specific priority area. SWG members are selected for their subject matter expertise and commitment to the Association's mission. Each SWG is coordinated by an appointed individual selected by the President in consultation with the External Affairs Chair – a testament to the deliberate and high-level oversight invested in the process.

Climate Change and Health: A Priority Area

Of the three global health focus areas identified for this term, climate change and health has

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been selected as a thematic priority for initial policy development. Trinidad and Tobago, as a Small Island Developing State (SIDS), faces unique vulnerabilities to environmental disruption – from extreme weather events and sea-level rise to shifts in disease ecology and public infrastructure stress [4]. These challenges highlight the need to better understand and respond to the health impacts of environmental change.

In response, the T&TMA has established a SWG tasked with drafting a formal T&TMA Policy Document on Climate Change and Health. This document will serve as a strategic guide to understanding and addressing the intersections between environmental change and public health within the national context. It will also act as a platform for the association's advocacy efforts with relevant stakeholders and the broader public. The SWG's responsibilities include reviewing global and local evidence, consulting with experts, and aligning their findings with national health objectives. The Policy Reviewing Committee, appointed by the President in consultation with the External Affairs Chair, ensures that the policy content is evidence-based, context-sensitive, and aligned with optimal health frameworks.

Strengthening Capacity through Structured Processes

The policy development framework, adopted by the T&TMA, reflects a deliberate and strategic approach to institutional governance. It is an effective model of how professional medical associations translate broad global priorities into locally relevant advocacy. The structured use of SWGs, oversight from high-level appointees, and commitment to evidence-based review ensures that the Association's voice is both informed and authoritative.

Importantly, this process cultivates leadership and professional engagement among members. By involving professionals in policy development, the T&TMA provides opportunities for mentorship, skill development, and interdisciplinary collaboration. The approach supports the Association's broader mission to build capacity within the medical community and reinforce its role as a proactive and responsible health leader.

Conclusion

The T&TMA continues to demonstrate institutional foresight and professional leadership through its structured engagement with global health priorities. By aligning its national advocacy efforts with key international themes – mental health, universal health coverage, and climate change and health – the Association exemplifies a model of how localised health policy by a national medical association can be informed by global imperatives. The establishment of Small Working Groups and the creation of policy documents are not only practical tools for advocacy, but also symbolic of a deeper commitment to ethical governance and public service.

As Trinidad and Tobago navigates the complexities of contemporary public health, the role of a strong, strategic, and globally connected medical association becomes ever more vital. The T&TMA's initiative to begin with climate change and health underscores both the urgency of environmental challenges and the Association's responsiveness to evolving threats. Through deliberate policy engagement and member empowerment, the T&TMA affirms its place as a key stakeholder in the national and global health landscape.

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Transformation of Kenya's Health Financing: A Journey towards Equity and Access

Diana Marion

The attainment of health equity and access requires robust health financing mechanisms, including diverse health revenue collection strategies, reducing catastrophic health spending through proper risk pooling, and prioritising health service purchasing. Over the last few decades, health leaders have seen a rise in global health expenditure from US $3.5 trillion to US $8.0 trillion in 2016 [1]. Low- and middle-income countries (LMICs) account for a disproportionate share of disease burden, and a large disparity exists between LMICs and high-income countries (HICs) [2].

Similar to many African countries, health financing in Kenya has undergone significant transformations over many decades, shifting from a predominantly government-funded system in the early post-independent era to a more diversified and structured financing model in the 21st century. These changes have been driven by the need to enhance healthcare access, improve financial protection, and attain health-related sustainable development goals (SDG), especially universal health coverage (UHC). This article explores the historical evolution, key reforms, and their impact on health financing in Kenya, highlighting challenges and exploring future prospects in achieving health equity.

Early Post-independence Era

In post-independence Kenya (1963-1989), the government primarily financed the healthcare system through general taxation. The existing user fees were abolished, and the state provided free medical services in public hospitals, ensuring access for the majority of the population. In 1966, the government introduced a mandatory National Hospital Insurance Fund (NHIF) to provide coverage of basic healthcare services to all formal sector government employees. Economic challenges in the 1980s necessitated the implementation of Structural Adjustment Programs (SAPs) by the World Bank and the International Monetary Fund (IMF), leading to a decline in government healthcare expenditure. These programs required liberalisation of the economy in developing countries, with catastrophic impacts on health financing in Kenya.

Introduction of User Fees

One of the most significant policy shifts occurred in 1989. With the aim of improving revenue generation, the government re-introduced user fees under the cost-sharing policy. This action had adverse effects, including reduced access to healthcare services, especially among vulnerable population's (e.g. children, women), unaffordability of healthcare services especially in rural communities, and increased morbidity and mortality rates among affected communities. This policy exacerbated existing disparities in healthcare access, further highlighting the need for a more equitable and sustainable healthcare financing system in the country.

Second National Health Sector Strategic Plan (2005–2010)

The Second National Health Sector Strategic Plan (NHSSP-II) (2005–2010) was developed in 2005, with the aim of enhancing efficiency in healthcare service delivery. The plan adopted a sector-wide approach in devising strategies meant to effectively operationalize the *Kenya Health Policy Framework (1994)* [3]. The major priorities of this plan were primary healthcare, improvements in health infrastructure, human resource development, and mechanisms for financial risk protection [4].

The need for *NHSSP-II* was informed by deteriorating health indicators, including rising infant and child mortality rates, significant decline in the utilisation of public healthcare services (e.g. new consultations per person as 0.6 in 1990 and 0.4 in 1996), reduced doctor-to-population ratio, and stagnation of public sector contributions to healthcare (e.g. per capita health expenditure dropping from US $12 in 1990 to US $6 in 2002) [4]. Furthermore, poverty levels increased from 47% in 1999 to 56% in 2002, exacerbating barriers to healthcare access.

NHSSP-II: Achievements and Challenges

The implementation of NHSSP-II marked significant progress in

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strengthening Kenya's healthcare system, particularly in health financing and service delivery. Some of the key achievements included increased investments in healthcare infrastructure, expanded access to medical services and enhanced efficiency and reach of the NHIF. In addition, the introduction of a community health strategy played a pivotal role in strengthening primary healthcare at the grassroots level.

Despite these advancements, high out-of-pocket expenditures continued to burden many households contributing about 26.1% of total health expenditure, and thus limiting access to essential healthcare services [5]. Health insurance coverage remained inadequate, particularly among informal sector workers, with about 19% of the population having insurance coverage, leaving a significant portion of the population without financial protection [5]. Furthermore, the heavy reliance on donor funding (e.g. 23.4% of total health expenditure) created sustainability concerns, making long-term health financing vulnerable to external economic, policy, and political shifts, which ultimately underscored the need for continued reforms [5].

The NHIF Reform

Established in 1966 to provide basic medical coverage for formal sector employees, the NHIF has undergone several reforms aimed at expanding its coverage and improving service delivery. First, the *NHIF Act No. 9 of 1998* transformed it from a ministerial department into a state corporation, allowing it to expand its scope beyond inpatient services to outpatient services. Income-tiered insurance provisions were also amended to expand coverage among the informal sector workers who were required to make voluntary contributions, as opposed to formal workers whose contributions are mandatory [6]. Second, the *Civil Servants Scheme (CSS) (2012)* provided an expanded coverage to formal sector government workers and their dependents, whose funds were managed separately from NHIF funds, and beneficiaries enjoyed a comprehensive benefit package [7]. Third, the Linda Mama Programme, established in 2013 and placed under the responsibility of NHIF in 2016, offered free maternity services in all public healthcare facilities [8]. Fourth, the Health Insurance Subsidy for the Poor (HISP) pilot program, initiated in 2015, provided fully subsidised comprehensive cover to selected orphans and vulnerable children under government cash transfer scheme [6]. Finally, the UHC policy of 2018 was adopted with mandatory NHIF enrollment for civil servants and other public sector workers, which increased financial protection for employees and introduced biometric registration and e-claims processing to enhance efficiency and transparency [9].

Beyond 2023: The Social Health Authority (SHA)

To further enhance sustainability and equity of health financing mechanisms, the government introduced further reforms leading to the establishment of the Social Health Authority (SHA) through the *SHA Act* [10]. Under one umbrella body, the SHA created three funds – primary healthcare, social health insurance, and emergency, chronic, and critical illness funds. It is designed to provide UHC for all Kenyan citizens, regardless of their employment status, by pooling resources, spreading financial risk across the entire population, reducing out-of-pocket expenses, reducing dependency on donor funding and improving access to quality healthcare services. Nonetheless, it is important to consider potential challenges and unintended consequences that may arise from such significant structural changes in healthcare financing. The success of these reforms will depend on effective implementation, ongoing evaluations, and necessary readjustments.

Kenya Vision 2030 and Health Financing

Kenya has made significant strides in healthcare reforms, aligning its efforts with Kenya Vision 2030 and the SDGs to achieve UHC. The adoption of the 2030 Agenda for Sustainable Development in 2015 reinforced Kenya's commitment to global goals such as ending poverty (SDG 1), reducing inequality (SDG 10), addressing climate change (SDG 13), and ensuring healthy lives and promoting well-being for all (SDG 3).

Kenya Vision 2030 has influenced healthcare infrastructure development by emphasising the need for comprehensive and interoperable health information systems that support primary and secondary healthcare roles [11]. For example, in rural areas of Kenya, the investment in Level 5 hospitals has led to an increase in the number of specialised medical services available to residents who previously had to travel long distances for care. Additionally, the rehabilitation of health centers has allowed for better preventative care and early intervention, ultimately reducing the burden on higher-level facilities and improving overall health outcomes in these underserved communities. Furthermore, the implementation of electronic health records has streamlined patient care and improved communication among

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different healthcare providers. Although Kenya is on track to provide quality healthcare services to all its citizens, there is a gap in structured guidelines for the development and implementation of digital health policies across the African continent.

A Roadmap to UHC

Kenya's commitment to achieving UHC was further reinforced through the *Kenya Health Policy (2014–2030)*, which aimed at attaining the highest possible health standards in a manner responsive to population needs [12]. The policy set ambitious targets, including increasing life expectancy from 60 years in 2010 to 72 years by 2030 and reducing annual deaths per 1,000 persons from 10.6 to 5.4 [12]. Additionally, the *Kenya Health Sector Strategic and Investment Plan (KHSSP) (2013–2017)* emphasised preventive, promotive, curative, and rehabilitative care to reduce the financial burden of healthcare on households [13]. The integration of SDGs into Kenya's health policies has influenced the health financing reforms for UHC by providing an enabling environment for necessary legislation, reforming health financing organisations, and revising national health policies to align with national commitments to UHC.

Towards Health Equity

At the heart of Kenya's health financing reforms is a commitment to addressing disparities in healthcare access, particularly among vulnerable populations, rural communities, and underserved regions. Over the past decade, the Kenyan government has undertaken significant policy initiatives to address financial barriers and improve health equity. The reforms introduced under *NHSSP-II*, NHIF, and subsequent transition to the SHA, as well as enshrining healthcare as a constitutional right of every Kenyan citizen, underscores this commitment to health equity.

The *Constitution of Kenya (2010)* introduced a transformative legal framework that reinforced a rights-based approach to healthcare. Under Article 43, healthcare was recognised as a fundamental human right, placing an obligation on the state to ensure accessible and affordable healthcare for all citizens [14]. The devolution of healthcare services to county governments improved resource distribution, helping to reduce regional disparities and enhance equity in service delivery. However, this is still fraught with challenges including mismanagement and understaffing of the health workforce and inadequate funding [15].

The *Free Maternity Services (FMS) Policy (2013)*, later renamed Linda Mama Initiative (2016), abolished user fees for all Kenyan women seeking maternity care in public health facilities leading to increased institutional deliveries vis-a-vis unsafe home deliveries. The government also rolled out the UHC Pilot Program (2018) in four counties (Kisumu, Nyeri, Isiolo, Machakos), which offered free healthcare services to registered members, with lessons learned informing the nationwide rollout. In order to improve the digital and physical infrastructure, the Health Infrastructure Development and *Digital Health Innovations Policies* were adopted and implemented in 2023. Investments in Level 5 hospitals and rehabilitation of health centers under Kenya Vision 2030, as well as the implementation of e-health systems, improved healthcare accessibility, particularly in marginalised regions, streamlined NHIF reimbursements, reduced fraud, and improved accountability in healthcare financing. In addition, through the Public-Private Partnerships and Health Insurance Innovations, Kenya has partnered with various private organisations and companies to provide quality and subsidised services to its citizens and improve the health infrastructure. These efforts included the Managed Equipment Service partnership (2015) that leases and maintains specialised medical equipment across county hospitals [16].

Conclusion and Recommendations

Kenya's health financing journey reflects significant progress in improving healthcare access, financial protection, and health equity. Despite these advancements, significant health financing challenges still exist. Government spending on healthcare accounts for only about 6.7% of total healthcare spending, which is less than half of the 15% benchmark recommended by the Abuja Declaration, thus limiting resources available for critical health services [6]. High out-of-pocket expenditures persist, placing a financial burden on many Kenyans and restricting access to necessary medical care. Although NHIF has expanded its coverage, informal sector workers and vulnerable populations remain underinsured with high attrition rates from the pool. Furthermore, inefficiencies and corruption within health financing institutions, including NHIF (now SHA), undermine service delivery and trust in the system.

To achieve sustainable health financing and equitable healthcare access, the Kenyan government must implement strategic reforms geared towards addressing these challenges.

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Increasing government investment in healthcare will reduce reliance on out-of-pocket spending and enhance service delivery. Expanding coverage to informal sector workers, improving governance, and increasing efficiency are essential steps to strengthening SHA. Public-private partnerships should be leveraged further to attract investment from private insurers, donors, and non-governmental organizations and boost health-financing resources. Additionally, embracing investment in digital health technologies, such as mobile health financing and digital insurance platforms, will enhance accessibility and transparency. Policy reforms supporting sustainable UHC and integrating community-based health insurance schemes will be crucial in achieving long-term health goals.

Ongoing reforms and innovative financing models hold promise for realising the country's long-term health objectives under the Kenya Vision 2030 and the SDGs, especially UHC. Effective implementation strategies, periodic evaluations, skilled workforce, and proper resource allocation will be critical in the success of these reforms. Through enhanced government commitment, effective health financing strategies, and robust partnerships, the Kenyan government can take forward steps to expand accessible and affordable healthcare for all its citizens.

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Bridging the Gap: Strategies to Address the Human Resource Shortage in Dentistry across Sub-Saharan Africa

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Sub-Saharan Africa faces a critical shortage of dental professionals, particularly dentists, significantly limiting access to oral health care and negatively affecting general health outcomes. Compared to the global average of one dentist per 5,000 people, the region reported just 3.3 dentists per 100,000 between 2014 and 2019, with some countries having only one dentist per 150,000 people [1]. Such stark disparities leave populations vulnerable to undiagnosed and untreated conditions like caries, periodontal disease, and oral cancers, underscoring the urgent need for strategic interventions to bolster the dental workforce.

Oral health profoundly affects an individual's physical, emotional, social, and economic well-being [1]. Beyond basic functions such as nutrition and communication, poor oral health contributes significantly to systemic conditions like diabetes, cardiovascular diseases, and adverse pregnancy outcomes [2]. For physicians, recognising the connection between oral and general health is crucial for comprehensive patient care and timely interventions, reinforcing the necessity of interprofessional collaboration between medical and dental practitioners.

Despite the clear importance, access to oral healthcare remains a challenge, especially in remote and underserved regions. This article identifies key barriers, including educational gaps, workforce distribution challenges, infrastructure deficits, and policy neglect, and proposes actionable strategies and case studies demonstrating successful approaches. By adopting an integrated and collaborative framework, stakeholders, including physicians, can contribute to targeted, sustainable improvements in oral healthcare delivery, enhancing overall health equity across sub-Saharan Africa.

Challenges to Providing Oral Health Care

In sub-Saharan Africa, the dental workforce is severely constrained by underdeveloped educational infrastructure, limited governmental support, and the migration of dental professionals to urban centres or abroad in search of better opportunities. These global disparities in dental care access are rooted in systemic issues that can lead to persistent inequities and poor oral health outcomes among vulnerable populations. These challenges include limited availability of dental care, inadequate educational infrastructure, workforce imbalance, and insufficient investment in healthcare policies.

Limited Availability of Dental Care

Understanding the impact of OHL on a person's capacity to use preventive oral health practices and access and navigate the oral health treatment system is essential [3]. Access to care is crucial in promoting health-seeking behaviour and improving health intervention outcomes. Poor oral health literacy can lead to misunderstandings about the importance of preventive care, such as regular brushing, flossing, and dental check-ups. Additionally, individuals with limited OHL may struggle to understand treatment options, follow post-treatment instructions, or even locate appropriate dental services, further exacerbating oral health disparities.

Inadequate Educational Infrastructure

Across most sub-Saharan African countries, undergraduate training in dentistry is only offered in a few public universities [4]. With the strict admission requirements and intensive dentistry curriculum, fewer students complete training and enter the workforce. Furthermore, many institutions have limited numbers of qualified faculty, outdated training equipment, and inadequate governmental funding [4]. This lack of prioritization in human resources for health significantly limits access to oral healthcare services.

Workforce Imbalance

A significant workforce imbalance

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exists as dental professionals are concentrated in urban areas, driven by better infrastructure, higher salaries, and access to professional growth opportunities. This imbalance leads to health disparities, leaving rural and underserved regions without adequate access to care [5]. Furthermore, the emigration of professionals seeking better opportunities abroad exacerbates the shortage of trained dentists (*brain drain*), limiting the capacity to expand oral healthcare services [6].

Insufficient Investment in Healthcare Policies

Oral health is frequently overlooked in national healthcare policies, resulting in insufficient investments in dental infrastructure and workforce development [6]. The absence of structured policies for integrating oral health into primary healthcare systems further deepens these disparities. This neglect contributes to a fragmented healthcare system, where oral health services remain isolated from general health services, restricting their accessibility and effectiveness. As a result, vulnerable populations are disproportionately affected, with limited opportunities for early intervention and preventive care.

Strategies to Address the Academic and Practice Gap

Expanding dental education programs, fostering public-private collaboration, and leveraging technology to improve access to care are essential strategies for addressing the gap between academic training and practical application in dentistry. Bridging this gap is crucial for achieving universal oral health coverage, a key component of universal health coverage (UHC), and for improving the overall quality of life in sub-Saharan Africa. Strengthening policy, health, and education systems, while adopting innovative workforce models, is necessary to support this goal.

Expanding Educational Opportunities

Innovative approaches, such as modular and community-based education, can help reach a wider pool of students and increase the number of public and private universities with dentistry programs [7]. Scholarships and financial incentives aimed at students from rural areas may encourage them to pursue dental careers and return to serve their communities. Standardisation of training can help maintain high professional standards, preventing unregulated short-course training programs that can compromise patient safety.

Enhancing Workforce Retention

Governments can implement policies to improve remuneration, benefits, and career development opportunities for dentists. Rural service programs offering incentives, such as housing, employment allowances, and student loan forgiveness, have been shown to encourage professionals to work in underserved areas [7]. Workforce planning can focus on ensuring that primary healthcare centres have stationed dentists under public health service programs, public-private partnerships, and private healthcare access systems.

Leveraging Technology

As tele-dentistry platforms can facilitate consultations and basic care in remote regions, mobile dental clinics can provide preventive and treatment services to underserved populations [8]. Investments in these technologies can dramatically improve access to dental care and mitigate workforce shortages. Transitioning from curative to preventive treatment can be greatly aided by remote oral screening, as frequent population screening can help decrease risk of oral health pathologies.

Fostering Public-Private Partnerships

To optimize the achievement of the national health objectives, public-private partnerships in health seek to strengthen the national health system by utilising the capabilities and full involvement of the private health sector. The major goal of a partnership is to create a pluralistic health care delivery system that is functionally integrated and operates sustainably by investing in each partner's comparative advantages and making the most equitable use of available resources. Collaboration between governments, private entities, and non-governmental organisations can increase resources for dental care delivery by funding dental services, providing training opportunities, and raising community awareness about the importance of oral health [9]. Increasing the number of skilled dental professionals will offer additional clinical support and services to the wider community.

Integrating Oral Health into Primary Healthcare

Incorporating basic dental care into primary healthcare systems can significantly expand access to care. Training primary healthcare professionals to screen for dental issues and make appropriate referrals enhances early detection and timely intervention. Oral health care supports health equity by emphasising disease prevention and health promotion through risk assessment, oral evaluations,

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preventive interventions, patient education, effective communication, and interprofessional collaboration.

Case Studies and Success Stories

By studying case studies on real-world scenarios related to service delivery, physicians can critically analyse complex health challenges and discuss lessons learned from novel interventions. This article provides four case studies that examine addressing human resource shortages in dentistry in Ethiopia, Kenya, Rwanda, and South Africa. These examples offer valuable insights into context-specific strategies that can be adapted and scaled to strengthen oral health systems in other low-resource settings. They also highlight the importance of multisectoral collaboration, innovative training models, and policy reforms in building sustainable oral health workforces. Understanding these interventions can guide future efforts to improve equitable access to dental care across similar contexts.

Ethiopia's Health Extension Program

The Ethiopia Ministry of Health launched the Ethiopia's Health Extension Program (HEP) in rural areas in 2003, to address gaps in healthcare delivery by leveraging the community health workforce [10]. Although initially focused on general healthcare needs, the Ethiopia Ministry of Health later integrated oral health education and basic dental care services in 2004-2005. Health extension workers, who receive training in oral hygiene promotion, early detection of dental diseases, and referral systems, had four main responsibilities – 1) illness prevention, 2) environmental sanitation, hygiene, and control, 3) health education and communication, and 4) family health services [10]. By incorporating oral health into primary healthcare, this program has successfully reduced the burden of untreated dental conditions by improving early detection and patient education, making oral health services more accessible to underserved populations.

Kenya's Mobile Dental Clinics

In Kenya, dental healthcare disparities have been alleviated by deploying mobile dental clinics to underserved areas, which are equipped with basic diagnostic and treatment tools and general services (e.g. dental checkups, fluoride treatments, extractions, minor restorative procedures). Operated by a mix of government and private-sector initiatives, these mobile units have served patients in remote and low-income communities where permanent dental facilities are unavailable. Since their introduction in the early 2010s, these mobile clinics have increasingly become a cornerstone of outreach dental care. Programs like the Smiles for Schools Initiative, launched in 2016, have also integrated mobile dentistry into school health programs, providing preventive care to children. The success of mobile clinics in Kenya has demonstrated the potential of mobile healthcare in expanding access and improving oral health outcomes in rural regions [11].

Rwanda's Rural Healthcare Investments

The Rwanda Ministry of Health has made significant strides in healthcare accessibility, particularly in rural areas, by investing in health infrastructure, training healthcare professionals, and implementing policies to retain medical personnel. In 2011, the Rwanda Ministry of Health incorporated oral health into its broader healthcare strategy by funding dental programs, deploying community-based oral health professionals, and equipping rural clinics with basic dental care tools. Additionally, Rwanda's investments in telemedicine and mobile healthcare units have helped reach remote communities. These initiatives have increased dental care accessibility, making Rwanda a model for other nations seeking to bridge healthcare gaps through strategic workforce planning and infrastructure development [12].

South Africa's Public-Private Partnerships

In 1999, South Africa established a formal public-private partnership framework within the National Treasury, aligning with a global rise in initiatives that seek to leverage expertise between both public and private sectors. The South Africa Ministry of Health has since utilised these partnerships to bolster the oral healthcare sector. Collaborations between government bodies, private dental institutions, and non-governmental organisations have led to increased funding, expanded training facilities, and improved service delivery. By working with private providers, the government has been able to offer subsidised dental care, making services more accessible to low-income communities. Furthermore, partnerships between private dental schools and public hospitals have created internship opportunities that enhance practical training for dental students, reduce patient backlogs, and expand the pool of qualified dental professionals [13].

Conclusion

The shortage of dental professionals in sub-Saharan Africa remains a critical barrier to equitable and comprehensive healthcare. Addressing this gap through expanded educational opportunities,

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workforce retention strategies, technological innovations, and integration of oral health into primary care systems will improve health outcomes and support progress toward UHC. For physicians and health leaders, oral health must be viewed as a vital component of systemic health. Strengthening interprofessional collaboration between medical and dental professionals through shared training, early referrals, and policy advocacy, will ensure that oral health is no longer treated in isolation. By embracing oral health as a core element of patient care, the medical community can help advance health equity across Sub-Saharan Africa and beyond.

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Digital Health Applications in the Chinese Health System

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Digital health, which is broadly defined as "*the use of information and communication technologies in medicine and other health professions to manage illnesses and health risks and to promote wellness,*" incorporates electronic health (eHealth), mobile health (mHealth), telemedicine, and advanced computer science fields (e.g. big data, bioinformatics, genomics) [1]. Technological advancements in telemedicine were observed during the coronavirus disease 2019 (COVID-19) pandemic, as social restrictions across communities expanded the use of digital health technologies for medical consultations [2]. Although digital health has improved its population health applications, some concerns remain on data privacy, doctor patient trust, equity, and overreliance on artificial intelligence (AI).

In October 2022, as part of the 73rd World Medical Association (WMA) General Assembly, members reviewed and adopted the WMA Statement on Digital Health [1]. This statement innovatively combined three different documents – WMA Statement on Guiding Principles for the Use of Telehealth for the Provision of Health Care in 2009, WMA Statement on Mobile Health in 2015, and WMA Statement on the Ethics of Telemedicine in 2018 – and described updates to key ethical standards. It also highlighted the use of digital health (namely, mHealth and telemedicine) as it relates to physician autonomy, patient-physician relationships, informed consent, quality of care, clinical outcomes, confidentiality and data security, and legal principles. Although AI is incorporated in its conceptual definitions, it is not highlighted as a focus area since ethical consensus was not reached, leaving the topic open for discussion.

Over the past decade, Chinese physicians have recognised challenges in the widespread implementation of mHealth, as the elder population is less familiar with smartphones and poor data quality cannot be used for medical services. As Chinese physicians and patients are open to AI applications, they are curious about how this WMA statement can guide clinical care. To explore the ethical concerns, the Chinese Medical Association (CMA) established a core working group and multidisciplinary advisory group between the Medical Ethics and Medical Engineering Branches, regularly shared perspectives and research on AI, and incorporated norms for the physician-patient relationship in telemedicine and AI. This article will present key elements of the WMA Statement on Digital Health and highlight practical scenarios for incorporating telemedicine (including internet hospitals) and AI applications into the Chinese health system.

Telemedicine in the Chinese Health System

Due to the development of information technology (IT), telemedicine has significantly improved the efficiency of medical resource utilization, increased accessibility and availability of healthcare services to urban and rural communities, and reduced healthcare expenditure and patients' financial burden. Over the past few years, Chinese health leaders have noticed that county centers and general hospitals have received financial support from the local and central government. Also, they noted that high-quality medical resources are concentrated in urban areas, while rural areas lag behind with few health professionals to manage complex health needs. With the urgent need to strengthen primary care services across the nation, they recognised the need to adapt the three-tier medical network from the 1970s to an internet-based diagnosis and treatment network with physicians providing follow-up services for acute and chronic conditions.

In 2017, the State Government issued the *Guiding Opinions of the General Office of the State Council on Promoting the Construction and*

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Development of Medical Alliances policy, which promoted the construction of medical alliances to further decentralise high-quality medical resources and strengthen primary care through telemedicine [3]. The policy proposed aims to increase access to essential medical resources of large hospital platforms by developing telemedicine collaboration networks reaching remote and impoverished areas. Although substantial progress has been achieved to date, further discussions with experts are necessary to help identify existing gaps and develop relevant interventions.

To support this national health system reform, CMA members visited several community health centers in the Xinjiang Uygur Autonomous Region in August 2024 and March 2025, noting that each center was equipped with a telemedicine room connected to county (or higher-level) hospitals. Through the formation of medical alliances between urban and rural areas, urban tertiary public hospitals served as the main units and could send expert teams to county-level hospitals. For example, between December 2020 and April 2022, the Ningbo-Kuke medical alliance platform conducted approximately 300 consultations and 4,080 two-way referrals for Xinjiang, successfully linking two hospitals in Ningbo with four hospitals and 18 primary care institutions in Xinjiang [4].

The WMA Statement on Digital Health summarised nine key ethical and legal principles related to digital health, while simultaneously describing and discussing primary ethical concerns from various social contexts. As next steps, health professionals worldwide can directly apply these principles in their respective health systems. Specifically, the authors have selected and analysed the incorporation of three described principles (data privacy and security, physician-patient communication and trust, payment policies) – as well as the integration of traditional Chinese medicine – demonstrating their importance and application within the Chinese health system. Meanwhile, further reflection on challenges to implement these principles in clinical practice remains an important part of the CMA goals.

1) Data Privacy and Security

Data safety. Data privacy and security can have ethical, legal, and security challenges, especially as telemedicine involves at least four main parties (patient, local doctor, third-party institutions, remote doctor). Special measures must be enforced to strengthen the security management of data collection, storage, and use in telemedicine services. Clinical case discussions with third parties should involve the sharing of highly sensitive personal health data, which may violate patients' privacy rights if obtained or leaked without authorisation. As the WMA statement ("Confidentiality and Data Security" section) highlights data privacy and security topics, it provides strong guidance to protect against potential security breaches and support capacity building programs for privacy officers.

- *Articles 29, 30, and 31* emphasise that the collection, storage, protection, and processing of digital health users' data, especially personal health data, must ensure valid informed consent and guarantee patients' rights. If data breaches occur, patients must be notified immediately in accordance with the law.

- *Article 32* supports the presence of privacy officers or data protection authorities, with whom patients can contact for protection, if their privacy rights are violated.

These four articles stress the need to consider legal and ethical requirements of digital health applications across health systems. The Chinese health system is currently working to improve data security in clinical practice, including training a team of data officers to lead the work of data privacy and security in China.

2) Physician Autonomy and Physician-Patient Communication and Trust

Communication. The physician-patient relationship is one priority area for health professionals, as patient satisfaction is an important evaluation criterion for physicians and hospitals. As the WMA statement ("Patient-physician Relationship" section) addresses physician-patient communication and trust topics, it offers practical guidance on how to maintain and improve harmony of physician-patient-relationships.

- *Article 9* addresses acceptable boundaries in the patient-physician relationship necessary for the provision of optimal in-person and virtual care. Physicians should inform patients about their availability and recommend services when unavailable, as the continuous availability of digital healthcare can interfere with a physician's work-life balance.

- *Article 11* states that face-to-face consultations should remain the gold standard for clinical practice, requiring a physical examination

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prior to establishing a diagnosis, or efforts to reinforce a trusting physician-patient relationship.

- *Article 14* addresses the trust and respect in the physician-patient relationship, especially as third parties ('surrogates') like family members become involved.

- *Article 15* states that physicians should give clear and explicit direction to patients during the telemedicine encounter, as they are responsible for any required follow-up and healthcare services.

- *Article 17* addresses proper informed consent, requiring that patients are fully informed about how telemedicine works, how to schedule appointments, privacy concerns, risk of technological failures (including confidentiality breaches), possible secondary uses of data, and policies for prescribing medications and coordinating care with other health professionals.

Quality of care. In the Chinese culture, although virtual communication with physicians is convenient, limited body language and emotional expressions may affect effective communication and emotional connections between physicians and patients. Also, the overreliance on online diagnoses and treatments may distance physician-patient relationships, as patients may be unable to judge the qualifications and diagnostic abilities of remote physicians, which can raise concerns about telemedicine safety, reliability, and clinical effectiveness. Moreover, since telemedicine involves at least two doctors, the rights and obligations in the physician-patient relationship may overlap and lead to ethical issues.

The WMA statement ("Quality of Care" section) describes the rights and responsibility topics for different roles of physicians. In the Chinese context, the remote physician only acts as a consultant, bearing the obligation of consultations and advice, while the local physician and the patient form a physician-patient relationship, bearing full responsibility for remote medical accidents. If the local physician does not accept the guidance of the remote doctor, however, patients' treatment may be delayed, leading to poor health outcomes.

- *Article 16* addresses consultations between two or more professionals, stating that the primary physician remains responsible for the patient's care and coordination.

- *Article 22* states that physicians should be aware of and respect the particular challenges and uncertainties that may arise when in contact with patients through telecommunication. They should recommend direct patient-physician contact whenever possible, especially if they believe that this contact is in the patient's best interests and will improve treatment compliance.

Considering China's numerous local language and dialects, efforts are required to overcome any communication barriers and ensure that accurate and effective information can be exchanged between physicians and patients. Different legal systems may define the legal relationships between patients and local doctors (typical physician-patient relationship), local doctors and remote doctors (consulting and collaborative relationship), and patients and remote doctors [5]. Sometimes, poor network quality, insufficient software functionality, and low convenience of use can severely impact the quality of diagnosis or consultation, reducing trust in primary care doctors and remote consultations [6].

- *Article 24* emphasizes that patient satisfaction with remote consultations depends on continuous monitoring and improving quality of service to achieve the best possible health outcomes.

Currently, the Chinese health system is working to improve technology and regulation standards, to fulfill the advantage of telemedicine as much as possible.

3) Payment Policies

Over the past few years, telemedicine services have expanded to include internet hospitals as a medical model that has been widely adopted across China. The general population embraces digital health technology, hoping that it can help to reduce healthcare and travel costs, especially for low-income communities. Some reimbursement policies, however, will require further review as they are not well incorporated into the health system.

- *Article 34* states that reimbursement models must be set up in consultation with national medical associations and healthcare providers to ensure that physicians receive appropriate reimbursement for providing digital health services.

Currently, China's medical insurance payment policies for telemedicine services are not yet fully developed, and some telemedicine service items cannot be reimbursed. To promote the popularisation and development of internet-based medical services, eligible internet-based medical services should be included in the scope of medical insurance payments

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to reduce the financial burden on patients. Hence, it is essential to address the coordination of online payments and medical insurance, approval of cross-province medical treatment, and application of laws in cases of medical accidents or disputes during telemedicine should be clarified and addressed.

4) Integration of Traditional Chinese Medicine

The Chinese health system strongly advocates for better integration of traditional Chinese medicine (TCM) services, ensuring the quality, safety, and regulation of online services, sales, and distribution (e.g. herbs), and it is encouraged to deliver services through telemedicine tools. TCM is trusted more by patients, especially by the elderly, patients living with chronic diseases, and disabled. Several studies have shown that TCM can improve patients' compliance to healthcare recommendations and raise their quality of their life, as well as alleviate health system challenges, such as insufficient medical resources and inconvenient medical treatment [7]. Although the WMA statement did not mention traditional or alternative therapies, the CMA working group aims to further specify the principles of integrating digital health in TCM practice when discussing the Chinese context.

Expanding Digital Health in the Chinese Health System

AI applications are increasingly demonstrated as a supportive tool for physicians in more clinical areas by enhancing disease diagnosis and treatment for patient care [8]. First, AI can automatically analyse electronic medical records through natural language processing technology, which can help balance differences in doctors' diagnostic findings and hence improve clinical standards. Second, AI can analyse patients' genetic information, medical history, and lifestyle habits, creating more precise and personalised treatment plans to improve treatment effectiveness and reducing adverse drug reactions. Third, through wearable devices and remote monitoring technologies, AI can monitor patients' real-time physiological indicators, promptly detect abnormalities, and provide warnings and personalised health advice, which can support health monitoring, risk assessment, and disease prevention. Finally, AI can help accelerate drug development in clinical practice and help doctors complete medical recording with summarised discharge summaries and disease analyses.

However, four specific ethical concerns should be carefully considered when expanding AI applications in digital health.

1. Intelligent imaging-assisted diagnosis and treatment systems require the collection and processing of large amounts of patient imaging data. *How can we ensure that the privacy and security of patient data are maintained during model training and deployment?*

2. Informed consent for patients and physicians can raise diverse questions ranging from individuals who have access to AI application. *Should patients have the right to know that they are receiving AI-assisted treatment? At the same time, do physicians have an obligation to inform patients the limitations of AI technology and the potential risks that may exist? What are the best practices for doctors to fully explain the role and limitations of AI technology to patients and respect their right to choose?*

3. Since training data for AI models primary originate from a specific region or population, data collection may be biased, leading to false positives or negatives. Multimodal AI models are usually more complex, making it difficult to explain their decision-making processes, which increases the difficulty of identifying and correcting algorithmic biases and makes accountability more challenging. *When intelligent imaging-assisted diagnosis and treatment systems misdiagnose a case, the issue of responsibility becomes prominent.*

4. Doctors may over-rely on AI systems that can weaken doctors' diagnostic abilities and accumulation of clinical experiences. *How will widespread AI applications influence traditional medical skills (e.g. image interpretation)?*

Conclusion

The *Article 6* of the WMA Statement on Digital Health clearly indicated that *"the scope and application of digital health, telemedicine or tele health are context-dependent. Factors such as human resources for health, size of service area and level of healthcare facilities should also be taken into consideration"* [1]. By considering the ethical concerns and suggestions of digital health applications, including nine evidence-based recommendations, the CMA can continue to lead efforts to improve digital healthcare services across the nation. By understanding the principles of the WMA Statement on Digital Health in the context of Chinese health system, Chinese physicians can engage in collective discourse, reflect on existing gaps, and implement

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approaches to accelerate progress in digital healthcare service delivery. Likewise, the CMA seeks to encourage formal opportunities with the WMA to facilitate knowledge sharing across national member associations.

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WMA Members Recognise International Nurses Day

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The nursing profession, with an estimated 29 million nurses worldwide, represents a fundamental pillar of global health systems, directly enhancing healthcare service delivery, economic growth, and health policy reform. Nurses, who comprise half of the global health workforce, serve across diverse primary care and specialty services, contribute to direct patient care in hospital and community settings, and promote optimal health and well-being throughout the lifespan [1]. Amidst changing health system priorities, nurses exemplify key health leaders who can help harmonize multidisciplinary health teams in clinical practice to foster interprofessional collaborations, prioritize patient-centred care, and advocate for safe and productive work environments.

As the founder of modern nursing, Florence Nightingale (1880-1910) cared for wounded soldiers during the Crimean War (1853-1856), often remembered as the "Lady of the Lamp" as she carried a lamp during her night shift assessments. She also stressed the importance of sanitation practices in patient care, applied her mathematical knowledge to public health data collection (e.g. mortality rates), and established the first professional nursing school (St. Thomas' Hospital in London, 1860) [2]. Through her dedicated efforts, she inspired a movement of scientific inquiry and holistic examination of social determinants of health, expanding our understanding of health promotion and disease prevention strategies.

Over the past five years, significant policy initiatives have streamlined the nursing profession as an integral part of global health systems. First, the World Health Assembly (WHA) approved the document A72/54 Rev.1 in 2019, designating 2020 as the International Year of the Nurse and the Midwife [3]. Second, the WHA adopted the decision WHA73(30) (*Human resources for health*) in 2020, which recognised 2021 as the International Year of Health and Care Workers [4]. The "*Protect. Invest. Together.*" theme was widely promoted for this celebration, as a tribute to global health professionals' steadfast dedication to patient care during the coronavirus disease 2019 (COVID-19) pandemic. Finally, the WHA accepted the resolutions WHA74.14 (*Protecting, safeguarding and investing in the health and care workforce*) and WHA 74.15 (*Strengthening nursing and midwifery: investments in education, jobs, leadership and service delivery*) in 2021 [5]. Recognising that investment in the nursing profession was essential for health systems, the WHA adopted the *Global Strategic*

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Directions for Nursing and Midwifery 2021-2025 in 2021, later extended to 2030, as a framework to guide and monitor progress related to four policy areas (e.g. education, jobs, leadership, service delivery) [5,6].

The *State of the World's Nursing 2025* report highlighted the projected global shortage of 5.8 million nurses by 2030, coupled with the uneven distribution across geographic regions, which will strain how health systems in low- and middle-income countries serve national needs [7]. As health professionals remain challenged by limited institutional resources, inadequate staffing, excessive work schedules, and unsafe work environments – acutely observed during the COVID-19 pandemic – they may experience physical and mental health strain (including burnout), low job satisfaction, high staff turnover or migration to high-income countries. Investment in nursing education, training, and mentorship can help address workforce shortages as well as enhance overall job satisfaction and retention, amidst emerging global challenges such as aging demographics, communicable and non-communicable diseases, and extreme weather events.

International Nurses Day (https://www.icn.ch/how-we-do-it/campaigns/international-nurses-day) is observed annually on 12 May, in commemoration of the anniversary of Florence Nightingale's birth. The *"Our Nurses. Our Future. Caring for nurses strengthens economies"* theme emphasizes the essential role of the nursing health workforce on health system resiliency, economic productivity, and community health and well-being. To support the sustainable nursing workforce well-being, the International Council of Nurses published the *Caring for Nurses Agenda* that identified seven key focus areas: 1) ensure adequate staffing and skill mix for effective care; 2) invest in the right resources and equipment; 3) provide safe and decent working conditions; 4) support education, professional development, and optimal scope of practice; 5) build supportive, high-performing organizational cultures; 6) improve access to healthcare and well-being support; and 7) provide nurses with fair, competitive compensation [8]. This resource offers recommended interventions that can help nations develop relevant policies and implement local and national initiatives that strengthen the nursing health workforce.

In this article, physicians from eight countries – Argentina, Colombia, Ivory Coast, Malaysia, Myanmar, Philippines, South Africa, and Trinidad and Tobago – described national policies that underscore the need for a competent nursing workforce with high-quality education and training programs, mentorship, and networking opportunities. They highlighted local activities that promote nursing excellence and honour nurses' contributions to health promotion and disease prevention across health institutions and community settings, which can ultimately improve retention and recruitment of the nursing workforce.

Argentina

As the backbone of global health systems, nursing professionals represent key leaders in health education, health promotion, and disease prevention, caring for people of all ages in clinical and community settings. In Argentina, with a health system serving an estimated 45 million habitants, the density of nursing and midwifery personnel (per 10,000 population) increased from 20.5 in 1992 to 47.5 in 2023 to 47.5 in 2023 [9]. This increasing trend is also attributed to the estimated 85,000 students who are pursuing their nursing education at 61 public and private institutions across the nation [10]. Although the nursing profession is widely recognised as a fundamental component of the national health system, nurses have reported that they experience prolonged working hours, low wages, lack of workplace security and safety, and stressful clinical responsibilities, which can negatively influence physical and mental health and well-being [11].

Since the 19th century, the government of Argentina has supported the nursing profession with several key historical events and policies. First, the first nursing school (Nursing School of the British Hospital) was established in 1890, led by Dr. Cecilia Grierson (first female Argentinian physician) [12]. Second, the Nursing Federation of Argentina (Federación Argentina de Enfermería, FAE) (https://www.fae-web.com.ar/) was founded in 1965, with the objective to promote nursing education and practice, support relevant nursing policies, and defend clinical workplace conditions. Finally, the *Law No. 24.004 (Ley Nº 24.004)* was adopted in 1991, providing a framework for professional guidelines of the nursing profession (professional or auxiliar) [13]. To support this policy (including three other educational and professional policies), the *Law No. 27.712 (Ley Nº 27.712)* was approved in 2023, which aimed to expand high-quality nursing education and training and boost academic enrollment across universities in the country [14].

In Argentina and across the Americas region, physicians can offer their voice to promote

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the indispensable role of nurses in the clinical and community workplace. Nurses can lead across health institutions and professional organisations, accelerating community and national action to ensure. Developing robust nursing education and training programs across academic institutions can help recruit and retain nursing professionals in the health system. Political commitment should ensure that nursing professionals represent an integral part of the healthcare solution to identifying and implementing best clinical practices in healthcare service delivery across urban and rural communities. Together, all health professionals can contribute their expertise and support the provision of safe and high-quality patient-centered care.

Colombia

The nursing profession, which focuses on the comprehensive care of the individual, family, and community, aims to promote health, prevent illness, intervene in treatment and recovery, alleviate pain, and contribute to well-being and dignity. The Colombia Ministry of Health and Social Protection has reported that of the 717,456 health professionals in 2018, 337,962 (47%) were professionals and specialists (including 66,095 nurses), and 379,494 (53%) assistants and technicians [15]. Health leaders have conveyed that more than 80% of the nursing workforce as women, noting that they often express a lack of support networks (serving as heads of households) as well as double workload and emotional burden between the workplace and home [15]. Notably, the density of nursing professionals has increased from 11.5 in 2015 to 14.6 in 2020 (per 10,000 population), despite a geographic disparity affecting rural regions (e.g. La Guajira, Chocó, Amazonas, Putumayo).

The Colombia Ministry of Health and Social Protection has prioritised the formalisation of the nursing workforce, as efforts to improve working conditions and recognise their strategic role in the health system. First, the nursing profession was formally established by *Law 266 of 1996 (Ley 266 de 1996)*, grounded in ethics, science, and theory [15]. Second, the *National Nursing Plan 2020-2030 (Plan Nacional de Enfermería 2020-2030)* was approved in 2019, establishing a framework to strengthen working condition and promote research and professional development [16]. Third, health leaders adopted the *Resolution No. 755 of 2022 (Resolución No. 755 de 2022)*, which launched the *National Nursing Human Talent Policy and Strategic Plan 2020-2030 (Política Nacional de Talento Humano de Enfermería y Plan Estratégico 2020-2030)*, providing key guidelines for strengthening nursing talent in Colombia through distribution, professional leadership, and training [15].

Furthermore, in 2023, the Colombia Ministry of Labor initiated the development of labor agreements for health professionals within the health system, prioritising nursing personnel and their professional recognition. As a result, more than 200 employees (e.g. laboratory technicians, nurses, paramedics) at one Barranquilla clinic (Clínica Altos de San Vicente) converted their employment status as union contractors to permanent staff [17]. In 2024, over $269,090 million Colombian pesos (estimated US $64,000) were allocated to strengthen access and availability of primary care services in rural and remote communities through the implementation of Basic Health Teams.

As physicians in Colombia and around the world, we cannot continue to be silent observers to the historical invisibility of nursing professionals in the clinical workplace. We must actively support the nursing profession, demand fair working conditions, and promote their contributions in local and national leadership positions. Their work represents the operational core of the health system, which must be recognised through timely political, labor, and educational decisions that guarantee their dignity. Health systems are dependent on the indispensable role of nursing professionals in patient care, and defending their rights is promoting public health.

Ivory Coast

In the Ivory Coast, International Nurses Day is a moment of both national pride and urgent reflection. For physicians and the broader health community, it serves as an opportunity to recognise the foundational role that nurses play in the Ivorian healthcare system, often under strenuous conditions and with limited recognition. Nurses are the first point of contact for most patients, particularly in primary health centres (centres de santé urbains ou ruraux), maternity wards, and rural mobile clinics across the country. Although nurses are recognised as pillars of the health system, however, they are often excluded from decision-making processes, and their voices remain underrepresented in the national policy dialogue.

According to the Ivory Coast Ministry of Health, a total of 32,000 nurses and midwives were employed in the health system in 2023, with the majority concentrated in urban regions (e.g. Abidjan, Bouaké, San Pedro) leaving underserved rural areas (e.g. Cavally and Bounkani regions) [18]. One recent study conducted among

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180 health professionals, including 113 nurses and midwives in the paediatric departments of university hospitals in Abidjan, revealed the significant psychological strain caused by high workload, which was further exacerbated without social support [19]. These findings underscore the mental burden that nurses and other health professionals may face in overwhelmed hospital settings, which highlight the urgent need for better organisational support systems.

In response to these longstanding challenges, the Ivorian government and civil society have launched several targeted initiatives to support and empower the nursing workforce. First, they adopted the *Strategic Plan for the Development of Human Resources for Health (2023–2027)*, which aims to train, recruit, and deploy over 6,000 new nurses by 2027, particularly in underserved regions [20]. The plan includes incentives for nurses to work in remote areas, such as housing allowances, accelerated promotion tracks, and training scholarships. Second, they established the National School and University Health Program (Programme National de Santé Scolaire et Universitaire, PNSSU), which integrates nurses into over 500 schools nationwide as frontline actors in adolescent health, mental health education, nutrition screening, and vaccinations [21]. Third, the National Order of Nurses of the Ivory Coast (Ordre National des Infirmiers de Côte d'Ivoire, ONICI) has partnered with the Virtual University of Côte d'Ivoire (Université Virtuelle de Côte d'Ivoire, UVCI) to launch a digital continuing education platform, allowing nurses to follow accredited training courses online – a game-changer for rural health professionals. Finally, nurses regularly coordinate impactful community campaigns, such as the "Free Screening Campaigns for Diabetes and High Blood Pressure" in Yamoussoukro and Man, leading to the screening of thousands of adults in 2024. Also, ONICI members led "Nurses Week 2024", with workshops on workplace safety, digital health, and interprofessional collaboration, culminating in a White Paper sent to the National Assembly.

Physicians in the Ivory Coast stand in solidarity with our nursing colleagues and are committed to promoting their recognition, protection, and inclusion within the health system. We call for the full implementation of the Nurses' Statute, a long-awaited legal framework that would secure fair wages, better working conditions, and a clear career progression for nurses working in public and private sectors. We also advocate for more interprofessional leadership programs, where nurses and doctors can co-develop public health strategies, particularly in areas such as maternal health, mental health, and non-communicable diseases. At a regional level, West African countries should consider the mutual recognition of nursing diplomas, easing mobility and knowledge exchange across borders, especially in humanitarian or post-crisis settings. Globally, physicians must join advocacy movements calling for increased international funding for nursing education, particularly in sub-Saharan Africa, where demographic pressure and disease burden remain high. Reflecting on the *"Our Nurses. Our Future."* theme, we must remember that caring for our nurses is about building a health system that is sustainable, equitable, and people-centred. The future of health in the Ivory Coast will be shaped by how well we care for our health professionals – especially nurses – who care for us.

Malaysia

International Nurses Day holds deep significance for physicians in Malaysia. Nurses are the pillar of our healthcare system — the unsung heroes who are often overlooked despite being at the frontlines of patient care. They work under immense pressure, balancing rising patient expectations, medico-legal risks, and complex clinical responsibilities [7]. In Malaysia, with over 95% of the nursing workforce as women, many forget that behind the uniform, they are also mothers, daughters, sisters, and wives — individuals who must balance their personal responsibilities with delivering the best care possible. This human reality must be widely acknowledged and addressed in national planning, policy, and healthcare workforce reform. With a population of over 33 million, Malaysia had more than 117,000 registered nurses as of 2022 — with approximately 61% in the public sector and 32% in the private sector [22]. Despite this, the country continues to face a growing workforce shortage, with more than 6,800 vacancies reported in the public healthcare system in 2023. This shortage is linked with overburdened clinical workloads, limited career progression, and negative public perception (especially after the pandemic), which significantly impacts nursing recruitment [23].

Malaysia is actively addressing long-standing challenges in its nursing workforce through targeted policy initiatives. The Ministry of Health has implemented the *National Strategic Plan for Nursing Development (Pelan Strategik Perkembangan Kejururawatan*

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Kebangsaan) (2021–2025), which aims to strengthen professional standards, expand specialisation, and improve nursing recruitment and retention. In the private sector, acute shortages of nurses — especially after the COVID-19 pandemic — prompted the government to make a major policy shift in 2023 [24]. Previously, internationally-trained nurses were largely restricted from practicing in Malaysia unless they held post-basic qualifications and fulfilled strict regulatory conditions set by the Malaysia Nursing Board. However, under a temporary exemption policy effective from 1 October 2023 to 30 September 2024, the Malaysia Ministry of Health allowed private healthcare facilities to employ internationally-trained nurses without post-basic qualifications. This permission came with a strict condition: internationally-trained nurses must not exceed 40% of the total nursing workforce at any private facility, and all must pass the Malaysian Nursing Board Qualification Examination for Foreign-Trained Nurses [25].

As physicians, we must work hand in hand with nurses to strengthen the delivery of care. Nurses are not just technical support — they are care leaders, educators, and community builders. Support for their work-life balance and private roles must also be integrated into workplace culture so they can thrive both personally and professionally. In 2025, with Malaysia chairing the Association of Southeast Asian Nations (ASEAN) Summit, Malaysian leaders are in a position to push for regional solidarity in supporting nursing systems across Southeast Asia. From Sabah to Sarawak, we can share real stories of nurses walking through jungle trails, taking boats across rivers, and conducting home visits in underserved areas. These realities are not unique to Malaysia alone, and widely shared across Southeast Asia with over 600 million people. At the Malaysian Medical Association (MMA), we continue to support initiatives that highlight nurses' contributions to clinical care within hospitals and communities, call for fairer policies, and promote interdisciplinary collaboration to build a stronger, more equitable health system [26].

Myanmar

International Nurses Day in Myanmar holds profound significance, representing a moment to honour nurses who continue to promote health, protect the sick, and support communities despite immense personal risk and hardship amidst the current military coup. Nurses in Myanmar have demonstrated extraordinary resilience, often working in dangerous conditions, facing staff shortages, and managing the psychological toll of conflict and displacement. The tragic testimonies of nurses – including physical harm in the workplace or interrogation centres – underscore the unimaginable daily stress and fear that they endure under military coup [27-30]. In 2021, the International Council of Nurses published a statement that condemns all forms of violence against healthcare organizations and their staff, as they endanger the health and human rights of the people of Myanmar and represent a violation of the Geneva Conventions [31].

The Myanmar health system has faced critical nursing shortages, particularly exacerbated by the COVID-19 pandemic and the ongoing military coup, with rural and frontline regions suffering the most severe deficits. In 2022, one recent World Health Organization (WHO) report highlighted the severe strain on the nursing and midwifery personnel (per 10,000 population) over the past two decades, declining from 7.7 in 2005 to 2.0 in 2022 [9]. To navigate this burden, the Myanmar's National League for Democracy government, led by the State Counsellor, has taken forward steps to improve leadership and enhance the quality of healthcare service delivery. First, the government established new medical universities and nursing/midwifery schools to enhance the training and supply of nurses and midwives in response to growing demand. Second, the nursing curriculum was revised to better prepare nurses with clinical competencies and skill sets to meet the evolving healthcare demands. Third, the government supported comprehensive continuing nursing education programs to empower nurses to maintain up-to-date on clinical knowledge and best practices. Leaders also provided incentives for nurses serving in marginalised areas, as well as expanded opportunities for overseas training with improved access to international examinations.

As physicians in Myanmar and across the globe, our call to action addresses initiatives that can ensure access to mental health support and result, considering the psychological toll of the military coup and stressful working conditions for all health professionals. Specifically, we can use our voices to highlight the plight and heroism of Myanmar nurses, mobilising international solidarity and resources to support their physical and mental health during this conflict. Although international humanitarian law explicitly protects medical personnel and facilities during conflict, Myanmar military and security forces attacks on hospitals and nurses violate these protections and are recognised as war crimes under the Geneva

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Conventions and the Rome Statute of the International Criminal Court. We urge Member States and international organisations, like the United Nations, World Medical Association (WMA), and WHO, to provide resources for documentation, legal support, and humanitarian assistance to affected nurses and their families. International Nurses Day in Myanmar is a powerful reminder of the courage and commitment of nurses working under fire. The international medical community must unite to support, protect, and empower Myanmar nurses – today and for the future.

Philippines

International Nurses Day serves as an important reminder for Filipinos to honour nurses both locally and abroad, who serve as the backbone of the healthcare system. This day offers a special opportunity to recognize the compassion, dedication, and resilience of nurses, who are critical in delivering patient care. As of 2024, the Philippine Statistics Authority estimates that there are approximately 509,297 licensed nurses in the Philippines, where an estimated 50-60% of nurses are working locally, since many nurses are migrating abroad in search of better opportunities [32]. This persistent shortage of nurses in local hospitals, especially in rural and underserved areas, has led to increased workloads and staff burnout.

Several initiatives have been launched to address these challenges. First, the "Magna Carta of Public Health Workers" (*Republic Act No. 7305*) safeguards the rights and benefits of nurses and other health professionals [33]. Second, the Department of Health (DOH) launched the "Nurses Deployment Program," which assigns nurses to remote and rural areas to improve healthcare access and augment staffing in primary and secondary hospitals. Third, the Presidential Communications Office (PCO) nationally honoured Filipino nurses for their "invaluable contributions" and "tireless service" to society in a public tribute [34]. Also, to sustain workforce readiness, health institutions are integrating universal health coverage training into onboarding and continuing education, ensuring that nurses and other healthcare professionals are equipped to support universal health coverage implementation effectively [35].

Professional organizations have also paved the was to showcase the valuable contributions of the nursing profession in the country. The Filipino Nurses United (FNU) led a grassroots movement during International Nurses Day 2024, organising advocacy campaigns that called for government reforms to increase wages, ensure safe nurse-to-patient ratios, regularize contractual nurses, and conduct mass hiring to address chronic understaffing [36]. Also, the Philippine Nurses Association (PNA) (https://www.facebook.com/pnaph.org) continues to champion the global competence, welfare, and positive professional image of every Filipino nurse. As PNA members regularly organise events, awards, and conferences, they coordinated the 9th Summer Conference in May 2025, featuring the Heroic Nurse ("Bayaning Nars") award ceremony for outstanding contributions to healthcare and nursing leadership across the country.

Our call to action as physicians is clear: we must advocate for stronger protection of nurses' rights, support policies that ensure fair wages and safe working conditions, and cultivate a culture of mutual respect. Filipino physicians and nurses engage in interprofessional collaboration to ensure that the ultimate goal of patient safety is achieved in all levels of healthcare in the Philippines. On a regional and global scale, we must work together to enhance nursing education, promote nurses into higher leadership roles, and fully recognize their indispensable role in strengthening health systems. These collective efforts-grounded in solidarity, equity, and shared purpose-are critical not only to addressing the ongoing health workforce crisis, but also to ensuring the long-term resiliency of our health systems. Only through genuine investment in and recognition of our nurses can we hope to realize the vision of universal health coverage, where every Filipino has access to safe, quality, and affordable healthcare services.

South Africa

In the South Africa's healthcare system, nurses are essential health professionals who work collaboratively with the healthcare team to provide high-quality patient care. Nurses serve in a variety of capacities within the healthcare system, including contributing to improving primary healthcare services, leading as frontline workers during the COVID-19 pandemic, and helping to control HIV transmission with the WHO-recommended "Universal Test and Treat" policy [37]. Academic nursing programs at universities and hospitals, regulated by the South African Nursing Council (SANC), is internationally recognised as high-quality training, which is why many South African trained nurses are employed worldwide [38]. With an estimated 10.4 nursing and

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midwifery personnel (per 10,000 population), nurses face a myriad of workplace challenges, including workforce shortage, unemployment, low pay, burnout, and violent acts by patients or criminals [39,40].

To support nursing education and training in South Africa, the Government of South Africa adopted the *National Health Act 2003 (Act No. 61 of 2003)* and *Nursing Act 2005 (Act No. 33 of 2005)*, to help regulate the nursing profession through the South African Nursing Council (SANC) [41,42]. Among many roles, the SANC implements national health policies related to nursing, maintains the national registry of the nursing workforce, reports disciplinary outcomes related to incidents of misconduct, violations or poor performance, ensures compliance to respecting patients' constitutional rights, and prepares strategic reports to the Ministry of the National Department of Health. In its regulatory role, the SANC oversees nursing education and practice by conducting inspections, monitoring the quality of training programs, evaluating criteria for academic accreditation, setting practice standards, and taking disciplinary action where necessary to protect the public. Furthermore, with workforce shortages across the South Africa health system, task shifting from physicians to nurses has emerged as a preventative medicine approach to ensure access to care for communicable and non-communicable diseases [43]. Consequently, primary healthcare nurses, especially in public sector clinics, are typically managed by nurses, who support physicians by providing direct patient care for outpatient visits (e.g. minor ailments, chronic disease management) and referring complicated cases to general practitioners (medical officers) in the respective districts [44].

Reflecting on the indispensable role of nurses within the South Africa's healthcare system, the National Department of Health, provincial health departments, professional councils, healthcare institutions, and civil society must prioritise their protection, employment, fair remuneration, and mental health and well-being. Sustainable investments should be made to absorb unemployed qualified nurses into the healthcare system, particularly in underserved areas, and guarantee improved security infrastructure and responsive policies. Furthermore, cross-sectoral efforts can help tackle health professionals' burnout risk and other mental health challenges, offering access to psychosocial support and safer working conditions. Moving forward, South Africa cannot achieve universal health coverage and health system resilience without a robust, protected, and empowered nursing workforce to support the diverse healthcare needs of citizens.

Trinidad and Tobago

International Nurses Day in Trinidad and Tobago is a moment of national reflection and gratitude for a workforce that forms the backbone of our health system. For physicians in our country, it is a time to acknowledge the tireless dedication of nurses who often serve on the frontlines, particularly during crises such as the COVID-19 pandemic. According to the Trinidad and Tobago Registered Nurses Association (TTRNA) (https://ttrna.org/), the shortage of nearly 3,000 nurses in the public health sector has led to an increased workload for existing staff, higher burnout rates, and delayed patient care [45]. The ongoing migration of nurses to countries with more favourable compensation and working conditions continues to pose a serious challenge to sustaining our local workforce.

In response to the nationwide shortage, policy, academic, and community initiatives have been implemented to strengthen and celebrate the role of nurses in Trinidad and Tobago. First, the *Nurses and Midwives Registration (Amendment) Bill of 2014 (Act No. 8 of 2014)* aimed to modernise the regulatory framework, include provisions for the temporary registration of overseas-trained nurses and midwives, and grant greater authority to the Nursing Council of Trinidad and Tobago. With goals to enhance the regulation of practice, accreditation, and registration, the amendment has helped align the country with international standards, reflecting national progress and the development of legislation to support this vital sector of Trinidad and Tobago's healthcare system [46].

Second, the University of the West Indies (UWI) has recognised the need to enhance midwifery services with a specialised Bachelor of Science in Midwifery (BSM) program, with courses that promote clinical competencies and leadership among mid-career nurses [47]. Finally, the "Nursing Now Trinidad and Tobago" national campaign, initiated in 2018, has intended to raise the profile and status of nursing, empowering nurses to collectively tackle emerging health challenges [48]. These national actions show promising steps towards elevating the profession's visibility and support within the health framework.

As physicians, our call to action is clear – collaborate, advocate, and

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innovate. We must advocate for equitable working conditions, invest in interdisciplinary training with nurses, and support research and policies that ensure retention and professional development. Regionally and globally, health organisations must amplify the voice of nurses in health policy discussions and promote nurse-led models of care. Our commitment must be more than symbolic; it must be systemic and sustained to secure a healthier future for all.

Conclusion

The global observation of International Nurses Day represents a crucial moment to recognise the fundamental role of the nursing profession across health systems and advocate for sustainable investment in nursing education, training, and mentorship. As pivotal community voices, nurses share their clinical expertise through empathetic communication with patients, by fostering safe and serene environments, humanistic behaviours, and reassurance that minimizes fear or discomfort [49]. With lessons learned during the COVID-19 pandemic, reinforcing the importance of a strong nursing workforce will be crucial to prepare for and manage the complex health challenges affecting community health and well-being [7]. Notably, collective action across health systems can accelerate progress toward reducing the projected global shortage of 5.8 million nurses to 4.1 million nurses by 2030 [50].

The *"Our Nurses. Our Future. Caring for nurses strengthens economies"* theme provides a space for health professionals to reflect on the numerous ways that the nursing workforce continues to galvanise positive change across national health systems. Health professionals should better understand nurses' lived experiences in promoting patient-centred care across hospital and community settings, including efforts to develop relevant clinical guidelines, lead educational programs, and support advocacy efforts [51]. These personal testimonies capture their "caring actions" in clinical practice – developing therapeutic nurse-patient relationships, looking beyond patients' physical needs, motivating patients toward success, and promoting patient self-care – which mark nurses' commitment and dedication to the improving health outcomes [51]. These attributes reflect Florence Nightingale's words: *"Nursing is an art: and if it is to be made an art, it requires an exclusive devotion as hard a preparation, as any painter's or sculptor's work."*

As next steps, WMA members can drive national and global discourse to analyse health systems' priorities, achievements, and challenges, promote interprofessional education, and advocate for opportune health policies that can revolutionize high-quality health service delivery. This collective article highlights inspirational efforts across countries to promote nursing excellence and support political commitment for the nursing profession. Specifically, it demonstrates that physicians can help build collaborative workplace environments that enhance physician-nurse collaborations and prioritize patient-centred care across the African, Americas, Asian, and Pacific regions.

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