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Editorial

As we reflect on the past year, our global medical community has consistently demonstrated excellence in patient care, community health and research programs, and policy development. They have acknowledged the urgent need to raise awareness about the health consequences of climate change, champion initiatives that address the risk factors of noncommunicable diseases (including mental health conditions), advocate for safe workplace environments, strengthen local capacity to implement community-based solutions, and improve accurate health messaging. With the increased use of artificial intelligence (AI) and digital technologies in health systems, physicians remain cautiously optimistic of the effective and ethical use in clinical diagnostics and patient care. Hence, as a global platform for the comprehensive discussion of timely medical education and ethics topics, we recognise the Sindicato Médico del Uruguay (Medical Union of Uruguay) and the Ordem dos Médicos (Portuguese Medical Association) for their leadership to organise the 229th World Medical Association (WMA) Council Meeting in April 2025, and the 76th WMA General Assembly in October 2025, respectively.

Over the past two months, global leaders have played a pivotal role in preparing key reports and contributing to events that directly shape health system resiliency. First, the World Meteorological Organization published the *Global Status of Multi-Hazard Early Warning Systems 2025* report, with 119 countries reporting measurable progress to the UN Early Warnings for All initiative. The World Health Organization released up-to-date assessments of tuberculosis and malaria epidemiology, emerging threats (including antimicrobial resistance), and global progress toward achieving milestones. Second, the UN Climate Change Conference (COP30), held in Belém, Brazil, launched two initiatives (Global Implementation Accelerator, Belém Health Action Plan) to help nations develop national climate action plans and adaptation policies. Although country representatives approved financial support for climate adaptation, there were no official agreements outlining roadmaps to end deforestation or fossil fuel use. Finally, the launch of the Sentinel-6B mission, as a collaboration between the European Space Agency (ESA), European Organisation for the Exploitation of Meteorological Satellites (EUMETSAT), U.S. National Aeronautics and Space Administration (NASA), and the U.S. National Oceanic and Atmospheric Administration (NOAA), will monitor Earth's oceans and sea level and support weather forecasting for research and applications.

In this issue, Ms. Magda Mihaila summarised the WMA proceedings with adopted statements and resolutions, and Dr. Ashok Philip and Dr. Jacqueline Kitulu presented their uplifting valedictory and inaugural speeches on WMA milestones, respectively. Dr. Philip and colleagues summarised key findings of the "Impact on AI in Medical Practice" scientific session at the 76th WMA General Assembly in Porto. Dr. Jacob Mathew and Dr. Jesse Ehrenfeld commented on the five-part WMA webinar series that aimed to build AI literacy for physicians. Similarly, Dr. Pablo Requena highlighted potential benefits of using AI in primary care, and Dr. Hui Yin and Weili Zhao described the incorporation of AI into primary healthcare in China. Also, Dr. Richard Fitton shared insight on patient access to records for shared decision-making, and Dr. Edward Dove examined the health privacy law and challenges related to protecting health information.

Furthermore, Dr. Jack Resneck, Jr. and Dr. John de Jong described the WMA's and World Veterinary Association (WVA)'s commitment to One Health. Dr. Jorge Coronel reviewed the history and organisational pillars of the Medical Confederation of Latin America and the Caribbean (CONFEMEL, in Spanish), discussing the challenges facing physicians in the region. Dr. Saksham Mehra described global solidarity for climate health and resilience in Trinidad and Tobago. Dr. Marta Lomazzi and colleagues analysed the rationale and approach for implementing life-course vaccination strategies in global health systems. Dr. Koji Watanabe shared an overview of the health checkup system in Japan. Dr. Merlinda Shazellene and colleagues provided a summary report of the Junior Doctors Network (JDN)'s webinar on early-career leadership in medicine.

The WMA, representing 118 national medical associations (NMAs), prepared eight press releases that underscore the need to protect health professionals during conflicts, invest in the health workforce, and seek ethical, physician-led integration of AI and climate-smart health systems. Also, WMA members representing 15 countries of six regions emphasised their global commitment to support disability-inclusive care, community-based rehabilitation programs, and social protection for persons with disabilities. Notably, WMA members can advance their collective discussion and debate on timely topics in medical education and ethics affecting health professionals at the 232nd WMA Council Session in Belgrade, Serbia, from 23-25 April 2026.

We are excited to connect at the 232nd WMA Council Session in Serbia!

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Valedictory Speech by the WMA President, Dr. Ashok Philip

Porto, Portugal, 10 October, 2025

Ashok Philip

My dear friends and colleagues, I would like to thank you for the great honour and privilege of representing the World Medical Association (WMA) to the world. It has been an interesting year since our last General Assembly in Helsinki, and the time has flown by. I have attended many meetings, both physical and virtual, with our members and with other organisations and partners. While we may have significant differences, my feeling that doctors are by and large deeply ethical and moral has been reinforced. I guess those entering the healing profession tend to be more caring and self-sacrificing than most people.

During the year, I have seen many challenges and trials that face our field. They are perhaps too numerous to mention individually, but perhaps I could focus on two issues, one external and the other internal.

As I mentioned earlier, I was able to attend meetings of some of our constituent members. In early June, I was at the meeting of the American Medical Association (AMA) in Chicago, and I was privileged to hear “angry Bruce”. Not Bruce Banner, so there was no smashing involved. It was Bruce Scott who was angry, and in his anger, he was eloquent and passionate about interference in the work of doctors. It struck me that if we had taken him and put him in front of doctors anywhere to make the same speech, we would all have understood the issues involved. The fact that all of us, to a greater or lesser degree, face these interfering individuals and organisations should be treated as a plague or pandemic affecting the medical profession.

We do not work on some isolated Olympian plane. Healthcare needs teams. There is no arguing with that. However, teams need leaders, and those leaders must be doctors. No other healthcare professionals have the breadth and depth of training to fill this role better.

Unfortunately, it seems that everyone wants to be a doctor – without going through the studying and training needed. Maybe we make the practice of medicine look too easy. Whatever the reason, the attempted inroads are everywhere. The push to replace doctors with “physician assistants” or “physician associates” is widespread. These people are supposed to support doctors, but it seems that often they begin to believe and act as if they are the experts. They are not, and such behaviour is unacceptable. Unfortunately, administrators look only at the immediate cost savings of hiring less educated people, and do not consider the much higher long-term cost of missed and delayed diagnoses, inappropriate or wrong treatments and procedures, and complications. It is incumbent on us as doctors to push back against the dangerous aspects of these policies. This is not turf protection – it is patient care in the largest sense.

Similar impulses also seem to be at play when we seek approval for treatment from financing bodies – whether they are private insurance companies or state bodies which lay down guidelines for management. Of course, guidelines are needed, but we know that even the most detailed flow charts will not be able to encompass all clinical situations. The first impulse of administrators, whether in government bodies or in private insurance companies, must not be to deny care if guidelines are not adhered to. They should seek clarification from the doctors involved. It should go without saying that the person seeking the clarification must also be a suitably qualified doctor. In many places, we have to deal with medically illiterate people asking us the same irrelevant and often incoherent questions again and again, delaying care and promoting adverse outcomes. We need to stand up, unite, and work together to bring flexibility and rationality to this mess.

As to the internal issue – it will not have escaped your notice that there are many conflicts raging around the world. Obviously, this leads to attacks on healthcare professionals and facilities. There will be shortages of medicines and medical supplies. Civilians will be injured or killed. Food and medicines will be in short supply. These are all matters that we as doctors and as an association of doctors must address – and we have. Generally, our statements are based on facts, our expertise, and our ethical principles. They are usually uncontroversial, though not necessarily popular. In one conflict, however, we can seem to do no right. When we make statements using our usual principles, we are assailed for not saying more or being too nuanced.

I can understand this. Individuals see what is reported and are distressed, upset, and angry. However, the WMA does not make statements based on the feeling of individuals – certainly not

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my feelings. First, we have to be made aware of what is happening. Then, to the extent possible in war zones, we have to confirm the facts. For both of these, we rely on our members and partners for help. If we feel that the events occurred substantially as reported, we need to determine if they fall within our area of expertise – medicine and its ethical principles. If they do, then we can make a statement.

This rather careful process is necessary to maintain our credibility, but it does mean that sometimes it may be quite some time before we respond. Again, to some extent, it does depend on our partners and members. We have a small Secretariat, and it may not be able to keep current on everything going on.

When we make statements, some people are angered by them, or disagree vocally with what we say. This is fine – we do not expect everyone to agree with us, and we can understand emotional or angry responses. What I personally deplore, though, is what I refer to as the terrible moral certainty of some individuals. By this, I do not mean the certainty that you are right – I believe most sane people act on what they believe to be true and right. Rather, I refer to the conviction of some that those who disagree with them are wrong. This is not a logical conclusion. In such complex matters, it is quite possible for both sides to be right, because we consider different facts differently, and come to different conclusions. What is worse, though, is then deciding to stop talking to those you disagree with. I have little use for Oliver Cromwell, but I agree with his statement to the Church of Scotland – *"I beseech you, think it possible that you may be mistaken."*

If you stop talking to those with whom you disagree, you will find yourself in an echo chamber, and never learn anything new or correct old errors. Please do not cut ties with other associations. The actions of the country are not the actions of the association. In many cases, the association speaks out against the actions of their government. We should support them, not cut off contact. We belong to a profession which prioritises lifelong learning. This should apply equally to ethical matters. My appeal to you, therefore, is to talk most with those with whom you disagree most. You may convert them to your point of view, learn that you are wrong, or come to some more accurate synthesis of your viewpoints. We do not refuse to treat patients on ideological grounds. Why should we treat our colleagues worse?

Let me end my lecture here. What is left is the pleasant task of thanking the Executive Committee and Secretariat. We are truly fortunate at the WMA that we have a small but passionate, dedicated and extremely competent group working for us. It has been a great pleasure working with them – and with all of you. Of course, I cannot forget to thank the most important person here – my wife Premah. She has put up with my frequent late-night meetings and trips to other countries. Her support has been invaluable.

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Inaugural Address by the WMA President, Jacqueline Kitulu

Porto, Portugal, 10 October 2025

Jacqueline Kitulu

Distinguished colleagues, esteemed delegates, honored guests, and fellow physicians around the world,

It is with profound humility and deep gratitude that I accept the presidency of the World Medical Association (WMA).

This moment is not mine alone. It reflects the collective commitment of physicians across every continent who devote their skill, intellect, and compassion to improving human health.

I begin by honoring those who have gone before me. I pay special tribute to Dr. Margaret Mungherera, the first African woman to serve as President of the WMA. Her courage and vision lit the path that I now walk, and she remains a constant inspiration on this journey.

I extend thanksgiving to my village, my husband and sons, my parents and siblings, and my extended family who are present here today. Your love and support have carried me to this moment. I also give special thanks to the Kenya Medical Association (KMA), which nominated me, supported me, and continues to walk alongside me. And above all, I thank God–who sets all things in His time, and who has positioned me for this role, for impact, for the people of the world.

This inauguration is not ceremonial–it is a call to action. During my presidency, I will advocate for three central priorities: fostering inter-regional collaboration, strengthening mentorship and capacity building, and championing global policy advocacy for primary healthcare.

Fostering Inter-Regional Collaboration

The WMA represents 115 member associations across diverse systems and realities. Yet our challenges –pandemics, non-communicable diseases, climate change, and workforce migration – are shared.

Inter-regional collaboration is not an option… it is an ethical imperative.

When Ebola struck West Africa, the world learned that siloed responses cost lives. During COVID-19, knowledge-sharing across continents saved lives: clinical lessons from Asia informed European and American hospitals, while vaccination strategies from South America guided African programs. These examples remind us that no region holds a monopoly on wisdom.

I will advocate for:

- Global Learning Hubs to rapidly share best practices on preparedness, digital health, and resilience.
- Virtual exchange platforms connecting physicians and young doctors across continents.
- Unified advocacy at the WHO, the UN, and multilateral organisations so our voice influences global health policy.

Importantly, I will also work toward an active and operational Coalition of African National Medical Associations (CANMA). A strong, united CANMA will not only strengthen Africa's role within the WMA but also enrich global dialogue by bringing forward the lessons, innovations, and perspectives from African physicians.

Mentorship and Capacity Building

Mentorship has been transformative in my own life – from being one of only 10 women in a class of 100 medical students, to serving as the first female President of the KMA. I am here today because of the mentors who believed in me, guided me through moments of doubt, and helped me reach this apical point.

I will advocate for:

- Expanding the Junior Doctors Network so every young physician has access to structured mentorship.
- Leadership and advocacy training – in policy, negotiation, and systems thinking.
- Regional exchange fellowships to foster cross-border learning and innovation.

Mentorship is a two-way street: senior doctors share wisdom, while younger colleagues bring fresh perspectives. Together, we secure the future of medical leadership.

Global Policy Advocacy for Primary Healthcare

Primary healthcare remains the cornerstone of resilient systems, yet it is under-resourced in many countries. Policies adopted in Geneva or New York hold little value unless they translate into stronger clinics, more equitable healthcare access, and

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healthier communities.

I will advocate for:

- Investment in the health workforce – fair pay, training, and safe working conditions.
- Inclusion of physicians' voices in primary healthcare reform, ensuring policies reflect realities on the ground.
- Linking global commitments to local action, supporting member associations to hold governments accountable.

A motivated, empowered workforce is our greatest defense against the challenges of today and tomorrow.

Looking Ahead

Even as we focus on these three pillars, we must also prepare for wider challenges:

Health in conflict zones: In Gaza, Myanmar, Sudan, and Ukraine, health facilities and workers are under direct attack. These are grave violations of international humanitarian law and affronts to the principle of medical neutrality. The WMA must remain steadfast in defending this principle and amplifying the voices of colleagues who serve under fire.

Ethical leadership as artificial intelligence and digital health reshape medicine.

Climate change as a determinant of health that demands physician advocacy.

Digital innovation that must be guided by equity and privacy principles.

As physicians, our highest calling is to the art of medicine and the healing of those in need. It transcends politics and the divisions that polarise societies worldwide. In these times of uncertainty, let us remember that our strength lies in unity, collegiality, and shared purpose. Under the umbrella of the WMA, we stand together as one global community, committed not to political agendas but to the enduring values of compassion, science, and care. Let us move forward united and steadfast in our mission.

Closing Call to Action

Colleagues… we became physicians to serve humanity. The challenges before us are formidable – but so is our collective strength.

Let us:

- Build stronger regional and global collaborations, including an operational CANMA.
- Mentor the next generation generously.
- Advocate for primary healthcare as the foundation of equitable health.

History will not judge us by the offices we held – but by the lives we touched and the systems we strengthened.

Together, let us ensure that the WMA remains a beacon of ethics, solidarity, and advocacy – serving humanity with integrity and hope.

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WMA General Assembly Report

Porto, Portugal, 8–11 October 2025

Magda Mihaila

The 78th General Assembly of the World Medical Association (WMA), which took place from 8-11 October 2025, and hosted by the Portuguese Medical Association (Ordem dos Médicos), brought together delegates from 53 national medical associations (NMAs) (Photo 1).

Wednesday, 8 October

Council Session

The 230th Council Session was called to order by the Chair of Council, Dr. Jack Resneck Jr., who welcomed delegates and expressed gratitude to the Portuguese Medical Association for hosting the event.

The Secretary General, Dr. Otmar Kloiber, announced the appointment of the Credentials Committee, composed of Dr. Brian Chang (Taiwan Medical Association), Dr. Yves Louis (Association Belge des Syndicats Médicaux), and Dr. Pablo Requena (Vatican Medical Association), representing the three official WMA languages–English, French, and Spanish.

President's Report

The WMA President, Dr. Ashok Philip, reiterated the central importance of the WMA's ethical mission, noting that despite the challenges of global division and multiple armed conflicts, physicians remained united by shared professional values. He condemned ongoing violations of medical neutrality, particularly the targeting of healthcare professionals and facilities, and highlighted the WMA's continuing advocacy on these issues through public statements and resolutions.

He reflected on his presidency as a period of significant renewal for the Association, marked by the adoption of the revised Declaration of Helsinki and the publication of its 60th anniversary commemorative edition. He expressed gratitude to the Finnish Medical Association for hosting the 75th WMA General Assembly in Helsinki, Finland, and to all constituent members for their hospitality and engagement during his visits throughout the year.

During his presidency, Dr. Philip attended several national and international events on behalf of the WMA, including meetings in France, Taiwan, Austria, Indonesia, Germany, Norway, the United States, and the United Kingdom, as well as the 110th anniversary of the Chinese Medical Association. He also represented the WMA at major external events such as the Vienna Conference, the Asian Development Bank's Global Patient Safety Meeting, the World Health Assembly, and the International Federation of Medical Students' Associations Meeting, where he addressed physician well-being and psychological safety.

In closing, Dr. Philip reflected on the forthcoming retirement of the WMA Secretary General, expressing confidence in the continuity of leadership and thanking the Secretariat for its dedication.

Secretary General's Report

The WMA Secretary General, Dr. Kloiber, reported on the continuing development of the Association's work and collaboration with partner organisations. He highlighted the close cooperation between the WMA and the World Federation for Medical Education (WFME), following a highly successful joint conference held in Bangkok, Thailand, which gathered more than 1,000 participants from across the world. He also drew attention to the Bangkok Declaration on Support for Learners, adopted at the conference, calling for improved working and living conditions for medical students and trainees, including those engaged in continuing professional development.

Dr. Kloiber also provided updates on the WMA's ongoing advocacy for the protection of healthcare in conflict zones, its collaboration with the World Health Organization (WHO) and the World Health Professions Alliance (WHPA), and preparations for the First Expert Meeting on the Revision of the WMA Declaration of Taipei, to be held in Taipei, Taiwan, from 4-6 December 2025.

He concluded by expressing sincere gratitude to the Council, the Secretariat, and all members for their trust and collaboration during his tenure, and reaffirmed his commitment to ensuring a smooth transition in the leadership of the WMA Secretariat.

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Chair of Council's Report

The WMA Chair of Council, Dr. Resneck Jr., expressed his appreciation to the Council members, the Secretariat, and the Portuguese Medical Association for their commitment to ensuring that the meetings in Porto were conducted with efficiency and collegiality. He acknowledged the considerable work undertaken by all committees since the Council's last session in Montevideo, noting the breadth of issues considered–from physician well-being and scope of practice to the ethical implications of artificial intelligence and the revision of core WMA policies.

He highlighted the WMA's continuing role as the global voice for the medical profession in defending ethical practice and human rights, particularly amid growing humanitarian crises and threats to medical neutrality. The Chair commended NMAs for their constructive engagement and reaffirmed the importance of unity and respect in addressing sensitive global issues.

Dr. Resneck Jr. drew special attention to the WMA's financial stability, its progress on policy revision, and the strength of its partnerships with international bodies such as WHO, WFME, and WHPA. He also recognised the outstanding service of Dr. Kloiber, who will conclude his tenure as Secretary General with the Council Session in April 2026, and expressed the Council's gratitude for his decades of leadership and dedication to the Association.

In closing, Dr. Resneck Jr. reiterated his confidence in the WMA's capacity to meet future challenges through collaboration, transparency, and the shared ethical principles that bind physicians worldwide.

Thursday, 9 October

Committee Reports

Finance and Planning Committee

The Finance and Planning Committee, chaired by Dr. Philippe Cathala (Conseil National de l'Ordre des Médecins, France), approved the Audited Financial Statement for 2024 and the proposed WMA Budget for 2026, and both were forwarded to the General Assembly for adoption.

The WMA Treasurer, Dr. Rudolf Henke (German Medical Association), presented the financial report, noting continued fiscal stability and sound financial oversight.

WMA Strategic Plan 2026–2030

Dr. Otmar Kloiber, Secretary General, reported that the Association's activities remained aligned with the 2020–2025 plan and that the WMA Strategic Plan 2026–2030 had been finalised after extensive consultation. Dr. Henke underlined that the plan provides a strong basis for continued operational stability and growth.

WMA Statutory Meetings

Dr. Jack Resneck Jr. announced that the next Council Session will be held in Belgrade, Serbia, from 23-25 April 2026, hosted by the Serbian Medical Chamber. He also shared that the 77th WMA General Assembly will take place in Rotterdam, the Netherlands, in October 2026, hosted by the Royal Dutch Medical Association (RDMA).

WMA Special Meetings

Dr. Kloiber informed the committee that preparations are underway for the First Open Expert Meeting on the Revision of the WMA Declaration of Taipei, to be held in Taipei, Taiwan, from 4-6 December 2025. He thanked all member associations and experts who have participated in the consultation process and expressed appreciation to the Taiwan Medical Association for its support in hosting the meeting.

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The Editor-in-Chief, Dr. Helena Chapman, shared her report and thanked contributors to the most recent issues of the World Medical Journal. She highlighted three specific WMA achievements in the past two issues: article from Asia and Eastern Mediterranean Region NMA leaders (seven countries), scholarly articles from WMA members (14 countries), and two collective articles from WMA members that described national policies and activities supporting International Nurses Day and World Mental Health Day (21 countries). She encouraged members to actively share their articles and national reports to showcase the work of their Associations in future editions.

Public Relations

The WMA Communication and Information Manager, Ms. Magda Mihaila, presented the report on the Association's public relations and communications activities. She informed the committee that the Secretariat continues to disseminate press releases, newsletters, and digital updates on the WMA's policy work and statements adopted by Council and the General Assembly. She also reported on the regular publication of information through the WMA website, the *World Medical Journal,* and the Association's social media channels.

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Medical Ethics Committee

The Medical Ethics Committee (MEC), chaired by Dr. Christofer Lindholm (Swedish Medical Association), reviewed key policy documents and updates. The WMA Statement on Conflict of Interest and the WMA Statement on the Protection of Medical Neutrality in Times of Armed Conflict and Other Situations of Violence were adopted and forwarded to the General Assembly for approval. The WMA Statement on Ethical Issues Concerning Patients with Mental Illness was circulated for comments, while the Declaration of Lisbon on the Rights of the Patient was deemed to require a major revision, and a workgroup was established.

Socio-Medical Affairs Committee

The Socio-Medical Affairs Committee (SMAC), chaired by Dr. Zion Hagay (Israeli Medical Association), adopted several key policy updates reflecting global medical and public health priorities covering six areas: Scope of Practice, Task Sharing and Task Shifting, Ageing, Physician Well-Being, Trans People, and Augmented Intelligence in Medical Care. The committee also received progress reports on the revision of the WMA Declaration of Delhi on Health and Climate Change and the Statement on Divestment from Fossil Fuels, as well as updates on WMA participation in preparations for COP 30 in Belém, Brazil.

Associate Members

The meeting elected Dr. Julie Bacqué (France) as Chair of the Associate Members for the 2025–2027 term, succeeding Dr. Jacques de Haller (Switzerland), who was thanked for his service and commitment. The meeting also elected Dr. Thirunavukarasu Rajoo (Malaysia) as Independent Member-at-Large and Dr. Uchenna Ojukwu (Nigeria) as Student Member-at-Large, following the electronic ballot held in September 2025.

The Report of the Outgoing Chair, Dr. Jacques de Haller, was received, along with the reports of the Junior Doctors Network (JDN) and the Past Presidents and Chairs Network (PPCN). The meeting appointed Dr. Caline Mattar (United States) and Dr. Ankush Bansal (United States) as representatives of the Associate Members to the 2025 General Assembly, with Dr. Dersim Dagdeviren (Türkiye) and Dr. Elizabeth Gitau (Kenya) as alternates.

Rules Applicable to WMA Associate Membership

The meeting noted that the Council and General Assembly had endorsed the revision of the Rules Applicable to WMA Associate Membership, which removes the category of medical students from future Associate Membership. Existing student members will retain their membership, while future engagement will occur through collaboration with student organisations.

Scientific Session

The Scientific Session incorporated the "Impact of Artificial Intelligence (AI) on Medical Practice" theme. The session opened with welcoming remarks from Dr. Philip and the President of the Portuguese Medical Association, Dr. Carlos Cortes, who highlighted the growing importance of digital transformation in medicine and the need for strong ethical foundations to guide innovation.

The keynote lecture, "AI in Health," was delivered by Prof. António Vaz Carneiro (Portuguese Medical Association, University of Lisbon). He provided an overview of current definitions and methodologies of AI in medicine, reviewing its expanding applications in diagnostics, clinical reasoning, research, and public health. Prof. Vaz Carneiro emphasised the importance of rigorous evaluation, transparency, and ethical oversight to ensure that technological advances enhance, rather than undermine, medical professionalism and patient safety.

The first session, "Practical Aspects of Implementing AI," was moderated by Dr. Philip. Dr. Ana Ribeiro da Cunha (Portuguese Medical Association) presented on international consensus and guidelines for trustworthy and deployable AI in healthcare, outlining the frameworks that ensure safety and reliability in clinical use. Dr. Mzulungile Nodikida (South African Medical Association) shared experiences from South Africa's national digital health strategy, describing efforts to overcome challenges related to fragmented health data and equitable access. Dr. Tomás Cobo (Spanish General Medical Council) offered reflections on the professional and ethical challenges of AI in clinical practice, especially regarding its impact on the doctor–patient relationship. The session concluded with an engaging panel discussion among the speakers.

The second session, "Ethics of AI in Medicine," was moderated by Dr. Cathala. Dr. Bernardo Duque Neves (Portuguese Medical Association) discussed accountability and risk governance in AI-assisted clinical decision-making, highlighting the concept of shared responsibility between human and machine. Prof. Rui Nunes (Head, International Chair in Bioethics) examined the ethical principles that should guide AI's integration into medical care, while Dr. Ramin Parsa-Parsi (German Medical Association) analysed the evolving dynamics of trust, confidentiality, and professional

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integrity within the patient–doctor–AI relationship. The presentations were followed by a thoughtful panel debate on the ethical boundaries and opportunities presented by these emerging technologies.

The final session, "AI in Practice," was moderated by Dr. Bobby Mukkamala (American Medical Association). Dr. Ana Pina (Portuguese Medical Association) explored the notion of "collective intelligence," emphasising the value of interdisciplinary collaboration and shared accountability in AI-enabled medical teams. Dr. Pablo Requena (Vatican Medical Association) reflected on the potential of AI to enhance communication and strengthen the doctor–patient relationship in primary care settings. A concluding panel discussion gathered all speakers to reflect on how physicians can guide the responsible and human-centred integration of AI in healthcare.

The session closed with concluding remarks by Prof. Alberto Caldas Afonso (Portuguese Medical Association), who summarised the discussions and reaffirmed the need for ethical vigilance and continuous education as AI reshapes medical practice.

Friday, 10 October

Ceremonial Session

Dr. Carlos Cortes, who welcomed delegates to Porto on behalf of the Portuguese Medical Association, highlighted the unity of physicians through shared ethical values and the responsibility of the profession to promote peace and protect medical neutrality. He referred to the "Medicine for Peace: An Ethical and Professional Imperative" manifesto, endorsed by over 50 organisations, calling for empathy, professional judgment, and respect for human dignity to remain central to medical practice. He also emphasised that while innovation and technology are transforming medicine, they must always serve the physician–patient relationship.

Prof. Ana Povo (Secretary of State for Health, Portugal) underlined the importance of ethics, professionalism, and trust in medicine during an era of technological change.

Dr. Ashok Philip delivered his Valedictory Address, where he reflected on a year of global engagement with the WMA, noting the ethical dedication of doctors worldwide and the many challenges that continue to confront the profession — from threats to physician leadership roles and encroachment by non-physician practitioners, to the protection of healthcare personnel and facilities in war-zones. He emphasised that the WMA issues statements based on facts and expertise, not emotion, and called for ongoing dialogue even with those who hold opposing views: *"Talk most with those you disagree with most."* He concluded by thanking the Secretariat, the Executive Committee, his wife Premah, and all his colleagues for their support.

Installation of the New President

Dr. Jacqueline Kitulu (Kenya Medical Association) was installed as the 76th President of the WMA by Dr. Jack Resneck Jr. She delivered her Inaugural Address, where she expressed deep gratitude as she accepted the presidency of the WMA. She paid tribute to her predecessor and to pioneering leaders, especially African women physicians, and acknowledged her family and home country for their support.

She laid out three key priorities for her term: strengthening inter-regional collaboration, building mentorship and leadership capacity (especially among junior doctors), and advancing physician-led policy advocacy for primary healthcare. She further emphasised the global ethical responsibilities of the profession, including protection of healthcare professionals in conflict zones, climate-linked health challenges, and the equitable and ethical integration of digital innovation. The address concluded with a call to action: to mentor the next generation, advocate for primary care, and remain united as physicians serving humanity.

Saturday, 11 October

General Assembly

The General Assembly elected Dr. Jung Yul Park (Korean Medical Association) as President of the WMA for 2026–2027, to succeed Dr. Jacqueline Kitulu upon completion of her term.

The General Assembly adopted, without amendment, all reports and policies forwarded by the Council. The adopted policies include the revised WMA Statements on Scope of Practice, Ageing, Physician Well-Being, Physician Mental Health Care, Trans People, and Augmented Intelligence in Medical Care, as well as the Statement on Conflict of Interest and the Statement on the Protection of Medical Neutrality in Times of Armed Conflict and Other Situations of Violence.

The Assembly also adopted the Resolution on Health Workforce at the WHO, confirming the WMA's commitment to strengthening health systems through sustainable workforce investment.

Session on the Gaza Conflict and Medical Neutrality

One of the most substantive discussions of the General Assembly focused on the situation in Gaza and the broader question of medical neutrality in armed conflicts. Delegates expressed grave concern about reports of attacks on hospitals, the detention of health

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personnel, and the denial of access to essential medical services.

The General Assembly adopted the WMA Resolution Calling on the Israeli Government to Comply with the Geneva Conventions and Other Applicable Instruments of Humanitarian Law, reaffirming the fundamental principles of medical ethics, humanitarian law, and the duty of physicians to treat all patients impartially. During the discussion, several delegates underlined that physicians must be allowed to perform their professional duties without intimidation or interference. The General Assembly recalled that the protection of health personnel and facilities is a non-negotiable obligation under international humanitarian law, and urged all parties to ensure safe and unhindered access to care.

In adopting the resolution, the Assembly reiterated the WMA's longstanding commitment to the neutrality and independence of the medical profession in all conflicts.

Membership

The General Assembly confirmed the admission of the Medical Council of the Islamic Republic of Iran (IRIMC), the Lebanese Order of Physicians (LOP), and the Canadian Medical Association (CMA), with the latter as a returning Constituent Member. The Assembly received presentations from Dr. Catharina Boehme (WHO), Dr. Christian Keijzer (Standing Committee of European Doctors, CPME), and Dr. John de Jong (World Veterinary Association, WVA), highlighting international collaboration and ethical leadership.

In the Open Session, reports were shared by Dr. Pablo Estrella Porter, Dr. Caline Mattar, Dr. Uchenna Ojukwu, and Dr. Thirunavukarasu Rajoo, reflecting the growing engagement of junior physicians and Associate Members. In his closing remarks, Dr. Resneck Jr. thanked all delegates, committees, and the Secretariat for their collaboration and commitment to the WMA's mission.

The 78th WMA General Assembly in Porto was a defining moment for global medical ethics. The adoption of new and revised statements on physician well-being, mental health, ageing, and AI reaffirmed the WMA's leadership in guiding medical professionalism through rapid societal and technological change.

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Photo 1. Group photo at the Pestana Douro Riverside during the 78th General Assembly in Porto. Credit: WMA

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WMA STATEMENT ON ARTIFICIAL AND AUGMENTED INTELLIGENCE IN MEDICAL CARE

Adopted by the 76th WMA General Assembly, Porto, Portugal, October 2025

PREAMBLE

1. The World Medical Association (WMA) recognizes that artificial intelligence (AI) is rapidly transforming all sectors, including healthcare. In this statement, the WMA reaffirms its commitment to patient-centered, physician-led care by emphasizing the concept of augmented intelligence – a framing that highlights AI's role in augmenting human judgment – by strengthening rather than supplanting it, while recognizing that in specific, well-defined tasks AI may perform independently but always under human accountability. Through augmentation, AI is supporting rather than replacing human judgment, empathy, and accountability.

2. Building on lessons learned from early deployments, the WMA sets out principles that maximize AI's benefits while mitigating its risks, ensuring that its development, regulation and use remain consistent with medical ethics, international human-rights standards and the public's trust in the profession.

DEFINITIONS AND SCOPE

3. To promote clarity across jurisdictions while embedding the augmented intelligence perspective, the WMA uses the following working definitions in the healthcare ecosystem:

- Artificial Intelligence (AI): Computer systems designed to perform tasks that normally require human intelligence – such as learning, problem-solving, understanding language, and recognizing patterns.

- Augmented Intelligence: Use of artificial intelligence designed to support – not replace – human capabilities in healthcare.

- Physician-in-the-Loop (PITL): an extension of the general "human-in-the-loop" principle whereby a licensed physician – rather than any user – must review and retain final authority over all AI outputs before they shape clinical care. Where clinical care involves multidisciplinary teams, PITL implementation should ensure that all relevant licensed professionals are adequately consulted, while the physician retains ultimate clinical responsibility.

4. Emphasis on "augmented"

- The term signals a human-centered approach to AI – one that reinforces the physician's role as the final decision-maker. Rather than viewing AI as a replacement, augmented intelligence frames these tools as extensions of clinical expertise, designed to support – not replace – professional judgment, empathy, and responsibility.

- While "AI" is widely understood as artificial intelligence, emphasizing the augmented perspective helps ensure that systems are designed, validated, regulated, and trusted with the right ethical priorities.

- For the medical profession, this framing also enables more effective advocacy – especially when engaging with policymakers, regulators, and stakeholders who default to the broader term AI. It equips physicians to promote technologies that truly align with the goals of ethical, patient-centered care.

5. Scope and audience

- This statement aims to apply to all uses of AI in medicine, including clinical care and research, where AI primarily augments human decision-making. AI systems in administrative and educational contexts should be applied responsibly and with appropriate human oversight.

- Its principles address physicians, other healthcare professionals, healthcare organizations, developers, regulators, payers, academic institutions, and industry partners, each of whom shares responsibility for ensuring that AI remains a safe, equitable, transparent, and ethically-governed tool in the delivery of healthcare worldwide.

GUIDING PRINCIPLES FOR AI IN HEALTHCARE

6. **Human-centricity:** Human-centricity in AI prioritizes human needs, values, and wellbeing above technological capabilities or performance metrics. This principle includes:

- Maintaining and respecting patient dignity, autonomy, and rights through meaningful consent for AI use.

- Preserving patient health and well-being, and the human connection as the paramount considerations.

- Embedding cultural competence to ensure AI systems respect diverse patient values, clinical needs, languages, and health beliefs.

7. **Physician well-being:** The well-being of physicians and other clinicians must be safeguarded, recognizing that reducing administrative burden and avoiding unnecessary cognitive load are essential

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not only for supporting healthcare professionals but also for ensuring the quality and safety of patient care.

8. **AI is a Tool:** AI should serve as a means to support healthcare goals rather than an end in itself. Unlike traditional medical tools, AI systems may appear to learn and adapt without continuous human input, making it essential to pair their use with strong human oversight and ethical governance.

9. **Accountability:** AI integration does not diminish physician responsibility for patient welfare and advocacy. Consistent with the PITL principle, physicians must continue exercising professional judgment, and the final responsibility and accountability for diagnosis, indication, and therapy must always lie with the physician. At the same time, the growing prevalence of these tools necessitates clearly distributed accountability. Responsibility should be appropriately allocated among all stakeholders, including but not limited to developers, healthcare organizations, regulators, researchers and clinicians.

10. Transparency, Explainability, and Trustworthiness:

- AI systems must be designed and developed in ways that ensure their outputs and recommendations can be meaningfully understood by their intended end users – whether physicians, other healthcare professionals, or patients – within the relevant clinical context. Transparency extends beyond the "black box" paradigm, while explainability provides insight into the basis for specific outputs, thereby fostering trust and enabling responsible use. Transparency requirements and disclosures must be tailored to the needs of physicians and patients without adding paperwork or extra administrative tasks. Ensuring these qualities is a shared responsibility across all stakeholders, including developers, healthcare organizations, regulators, researchers, and clinicians.

- Mechanisms should exist for meaningful challenges of healthcare AI outputs, enabling patients and clinicians – including physicians – to question, review, or override AI recommendations when appropriate. This capacity is essential for building clinical trust, without which clinicians may reject valuable AI tools or overly rely on opaque systems.

- Explainability exists on a spectrum, with some complex models functioning as "black boxes" where only input/output relationships can be observed. The level of explainability required should generally be proportional to the clinical risk involved and the degree of autonomy granted to the system. In high-stakes contexts such as life-and-death decision-making, additional safeguards and oversight must be in place whenever full explainability cannot be achieved.

11. **Safe deployment:** Safe deployment of AI in healthcare requires real-world validation demonstrating consistent performance, clinical efficacy, and usability before widespread adoption. Before clinical deployment, AI systems must also undergo rigorous ethical and health equity impact assessments that are context-sensitive and adapted to the specific healthcare setting and population, with particular attention to vulnerable and underrepresented groups. Implementation must include continuous performance monitoring, feedback mechanisms, and iterative improvement protocols to ensure sustained benefit and global accessibility. Risks and harmful consequences, including bias, must be properly understood, anticipated, and mitigated.

12. **Equitable implementation:** New and beneficial AI healthcare tools must be developed and deployed equitably, with the goal of being accessible worldwide. Equitable implementation should ultimately bridge gaps in healthcare access, treatment, and outcomes., while expanding access to technology across disparate health care facilities.

13. **Data governance:** All stakeholders must maintain the highest standards of data collection, storage, processing, and sharing to protect patient privacy, and institutional trust. This principle is foundational because healthcare AI depends on data access. Transparency around data provenance – including the origin, diversity, and quality of datasets used to train AI systems – must also be ensured to build trust and verify that data appropriately represents the patients being served.

14. **Environmental impact:** Effective implementation of AI in healthcare requires careful consideration of its environmental impact and a strong commitment to sustainability. Environmental responsibility must be integrated alongside clinical validation to ensure that new technologies improve care while minimizing harm to the planet.

PHYSICIAN ROLES AND RESPONSIBILITIES

15. **Clinical Judgment and Accountability:** As emphasized in the PITL principle, physician judgment remains essential when using AI in healthcare, serving as both an ethical imperative and a practical necessity. Physicians must maintain professional autonomy and clinical independence to act in the best interests of patients, consistent with the WMA Declaration of Seoul.

16. **Patient Advocacy:** Physicians must safeguard patient health, well-being, and safety, ensuring that AI tools are only used in ways that genuinely benefit patients. Patient safety must remain a fundamental priority, whether or not augmented intelligence is applied.

17. **AI tool development:** Physicians should be involved throughout the development and implementation of AI technologies in healthcare. They must participate in decision-making processes about

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technology and its use from the outset and be empowered to scrutinize new innovations, including for usability.

18. **Maintenance of competencies:** Physicians must maintain core clinical expertise while also being educated and trained to work responsibly with AI systems. Delegation of tasks to AI must not erode the human capability required for safe, safety-critical care or for continuity when AI systems are unavailable or unreliable. Healthcare organizations should support this through ongoing education, simulation-based refreshers, periodic skills maintenance, and documented failover procedures that enable clinicians to critically appraise, override, and – when necessary – perform essential tasks independently.

19. **Incident reporting:** Physicians must be empowered to report incidents and question outcomes resulting from the use of AI in healthcare.

PATIENT RIGHTS AND ENGAGEMENT

20. While core patient rights are covered in existing WMA policies, AI introduces new risks – especially due to its reliance on data – that require focused ethical attention.

21. **Informed consent:** Given AI systems' reliance on patient health information, appropriate safeguards for data use are crucial. The principles of informed consent and transparency, building upon the WMA Declaration of Lisbon's affirmation of patients' rights to information and self-determination, must be rigorously applied in healthcare involving AI. Where possible, patients should be informed about the role AI plays in their care in ways that are understandable and meaningful, while physicians retain responsibility for ensuring safe and appropriate use of AI. In circumstances where full technical comprehension is impractical, informed consent may reasonably extend to a 'consent for governance' model, whereby patients place justified trust in physicians, healthcare institutions, and regulatory oversight to uphold their rights, safety, and welfare.

22. **Data rights:** Patients must be informed about AI systems' limitations and potential for error, as well as how physician oversight helps to ensures their protection. Patients should retain the right to request removal of their data from AI systems where feasible and legally permissible, and the right to understand how their data contributes to their care.

23. **Patient autonomy and explanation rights:** Patient autonomy must be preserved through meaningful consent processes. Patients should retain the right, where feasible, to refuse AI-mediated interventions and request human-only assessment. Where such refusal is not possible due to systemic integration of AI, safeguards must ensure that patients' data remain anonymous and non-traceable. Patients must have access to understandable and non-biased explanations of how AI contributes to their care, tailored to their information needs and preferences. They must also retain the right to dispute AI-generated recommendations they believe to be erroneous and to seek appropriate redress. This must extend to health insurer use of AI to determine patient care, payment, and coverage.

24. **Vulnerable patient population:** Vulnerable patient cohorts, such as those with reduced decision-making capabilities, must not be disadvantaged or harmed through the use of AI in healthcare. Safeguards must include proactive bias mitigation, inclusive dataset development, and tailored consent or governance procedures to protect those unable to fully exercise autonomy. Particular attention must be given to ensuring that informed consent and data rights principles are applied in ways that do not reinforce structural inequities or exclude vulnerable groups from fair access to care.

GOVERNANCE, REGULATION, AND LIABILITY

25. **Up-to-date standards:** Regulation, standards, and guidance must be suitably robust to safeguard patient safety and to ensure that the ethical rules of the medical profession are considered, with regulators empowered to stay up to date with developments and enforce legislation. Health care AI policies should be coordinated and consistent across government entities.

26. **Liability:** Clear lines of legal liability must be established, including the AI developers, as well as physicians, and healthcare organisations. Accountability should be shared and proportional, reflecting each actor's role in design, deployment, and use, rather than defaulting to a single actor alone.

27. **Continuous audit:** There should be regular reviews and audits of regulatory processes and bodies surrounding AI in healthcare, including bias audits, ethical reviews, and participatory governance with physician input.

CLINICAL INTEGRATION AND IMPLEMENTATION OF HEALTH AI

28. **Tool evaluation and governance support:** AI systems implemented in clinical settings must be validated for clinical relevance, safety, and effectiveness. Regular updates must be implemented to maintain security and ensure systems remain compatible with evolving clinical practices. In complex delivery environments, AI adoption must also be supported by appropriate governance structures that align clinical teams, leadership, and technology teams to ensure safe and responsible implementation.

29. **Workflow integration:** AI tool implementation requires seamless integration within existing workflows to enhance usability and function as supportive additions rather than disruptive elements that impede efficient care delivery. Mechanisms should be established for tracking AI recommendations and their relationship to final clinical decisions.

30. **Post-deployment monitoring:** Robust post-deployment monitoring is critical to ensure AI systems continue performing as intended. AI systems can drift from initial performance parameters when encountering new patient populations not represented in training data, as clinical practices evolve, or even within the same populations over time. Special attention should be directed toward monitoring outcomes in patient groups not adequately represented in training datasets.

DATA GOVERNANCE IMPLEMENTATION

31. **Patient data:** All patient-identifiable information used or generated by AI systems must be collected, stored, and processed in strict accordance with the WMA Declaration of Taipei on Ethical Considerations Regarding Health Databases and Biobanks, as well as all applicable laws and regulations. Security safeguards are mandatory to preserve confidentiality, prevent unauthorised access, and uphold the therapeutic trust that underpins the patient–physician relationship. Additionally, patient data use must follow the same ethical safeguards applied to clinician data, including purpose limitation, transparency and consent, protection against misuse, and, where feasible, anonymisation and minimisation of data collected.

32. **Clinician data:** AI systems are increasingly capturing granular data about clinicians (e.g., keystrokes, voice recordings, workflow metrics, prescribing patterns). Such information can support quality improvement and safety, but it also carries a risk of surveillance, punitive misuse, or erosion of professional autonomy. Therefore:

- *Purpose limitation:* Clinician-identifiable data may be used only for clearly defined clinical, educational, or quality-improvement objectives that have been disclosed to – and agreed by – those clinicians.

- *Transparency and consent:* Physicians must be informed, in advance and in comprehensible terms, what data are collected, how they will be analyzed, and who will have access. Explicit consent is required for uses beyond direct patient care or clinician-requested feedback.

- *Protection against misuse:* Data must not be repurposed to penalize clinicians, set unrealistic performance quotas, or otherwise undermine the patient-physician relationship. Any secondary use (e.g. commercial analytics, administrative oversight) requires separate ethical review and consent.

- *Anonymization and minimization:* Where feasible, clinician data should be de-identified or aggregated, and collection limited to the minimum necessary to achieve the stated purpose.

33. **Governance and oversight:** Healthcare organisations must establish independent oversight mechanisms – such as, and not limited to, data protection officers, ethics committees, and periodic external audits – to verify compliance with safeguards for both patient and clinician data. Breaches or unauthorised uses must trigger transparent disclosure, remediation, and, where appropriate, sanctions. In addition, AI system developers must implement and support robust cybersecurity policies and controls to protect the confidentiality, integrity, and availability of health data throughout the AI system's lifecycle.

MEDICAL EDUCATION AND CAPACITY BUILDING

34. **AI literacy requirements:** Physicians must maintain appropriate AI literacy in the rapidly evolving AI landscape, including the knowledge and skills to use AI tools properly and the ability to critically understand and assess AI literacy must be systematically integrated into undergraduate medical curricula to ensure all physicians acquire a foundational understanding of these technologies. In addition, AI literacy should be reinforced through mandatory continuing professional development programs, enabling physicians to keep pace with evolving tools and to ensure their safe, ethical, and informed use in practice.

35. **Global equity:** Focused attention must be directed toward bridging AI education gaps between regions, with particular emphasis on enhancing capacity in low- and middle-income countries (LMICs). Equitable distribution of educational resources and opportunities is essential to prevent widening disparities in AI implementation and ensure global benefit from these technological advances.

RESEARCH, INNOVATION AND EVALUATION

36. **Medical research standards:** Any medical research involving AI, whether as the tool or object of study, must abide by accepted international standards of medical research, including, but not limited to, Good Clinical Practice, the WMA Declaration of Helsinki, and the WMA Declaration of Taipei.

GLOBAL CONSIDERATIONS AND COLLABORATION

37. **Cross-jurisdiction applicability:** AI policies and infrastructures should, as far as possible, be aligned to have applicability across jurisdictions.

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38. **Diverse healthcare environments:** Appropriate AI solutions must be pursued across diverse healthcare environments, including low-resource settings. This requires supporting locally developed, context-sensitive innovations to ensure AI systems are responsive to local needs, realities, and resource constraints.

39. **Cultural Sensitivity:** AI policies should respect varied cultural approaches while ensuring alignment with fundamental ethical principles, such as respect for human dignity, rights, and wellbeing.

RECOMMENDATIONS

40. **For physicians and medical associations:** Medical professionals and their representative organizations should promote the development of comprehensive AI literacy programs, actively engage in AI governance structures – including contributing to the development of best practices for AI use in medicine – and uphold rigorous ethical standards to ensure quality patient care in an AI-enhanced healthcare environment. They should also consider creating educational materials for patients to support transparency and informed understanding of AI in healthcare.

41. **For healthcare facilities:** Healthcare institutions must establish robust governance frameworks for the safe adoption of AI technologies and implement continuous monitoring processes. Organizations should balance innovation with safety considerations and maintain respect for clinical judgment when deploying AI systems. Importantly, AI implementation should be pursued when it demonstrably serves patients' interests, without mandating AI use as a condition for licensure, participation, or reimbursement.

42. **For technology developers:** Technology companies and AI developers must prioritize co-design approaches with practicing physicians and provide transparency in system development, deployment and use. Sustained collaboration between clinical and technical experts throughout the entire development lifecycle is essential to create tools that enhance healthcare quality and equity and that effectively support clinical activity.

43. **For regulators and policymakers:** In consultation with medical associations (and other health professions organisations), craft physician-informed regulations and foster international cooperation.

44. **For educational institutions:** Embed AI training in curricula and support global capacity building.

45. **For researchers and innovators:** Pursue ethical, equitable, and evidence-based AI advancements.

APPENDIX

Narrow AI:

Domain-specific applications confined to clearly defined clinical or administrative objectives.

Generative AI:

Models, often large-language models, that create new clinical content – such as documentation drafts or treatment-plan suggestions – based on training data.

Foundational Models:

Broad, continuously trained models that underpin multiple healthcare applications and therefore require ongoing domain-specific oversight.

Machine learning:

A subset of artificial intelligence in which computer algorithms autonomously improve their performance at a specific task by learning complex relationships or identifying patterns in data, rather than by following explicit, pre-programmed instructions.

Patient-Physician Relationship:

Trust can be enhanced in the patient-physician relationship when:

- Physicians transparently discuss the role of AI in patient care
- AI systems demonstrably improve quality or safety outcomes
- Patients clearly understand how their data is used and protected and how data governance is organized.
- Patients are offered more time with their physician

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WMA STATEMENT ON DEMENTIA

Adopted by the 76th WMA General Assembly, Porto, Portugal, October 2025

PREAMBLE

Dementia is a syndrome caused by many different diseases, which collectively form an increasing part of non-communicable conditions globally. According to the World Health Organization (WHO), “Dementia is an umbrella term for several diseases affecting memory, other cognitive abilities and behavior that interfere significantly with a person’s ability to maintain their activities of daily living. Although age is the strongest known risk factor for dementia, it is not a normal part of ageing.”

Dementia is primarily a condition of older people but one in ten affected individuals show signs before the age of 65. As the actual number of older people is increasing steadily around the globe, there is a rising number of cases of dementia. In 2023 the WHO estimated the number of individuals with dementia to be 55 million worldwide and this is expected to rise to 139 million by 2050. Currently, 60% of people with dementia live in low and middle-income countries, but by 2050 this is predicted to rise to 71%.

Dementia incidence and outcome are influenced not only by biological factors but also by social determinants such as education, socioeconomic status, and access to healthcare, which vary widely across regions and populations.

The annual global cost of dementia was estimated in 2019 to be more than 1.3 trillion US$ and is expected to rise to 2.8 trillion US$ by 2030. This figure includes costs attributed to informal care (unpaid care provided by family and other informal caregivers) and direct costs of social and medical care.

Non-communicable diseases (NCDs), including heart disease, stroke, cancer, diabetes and chronic lung disease, are collectively responsible for 74% of all deaths worldwide according to the WHO. Dementia is not listed as a major NCD despite its major effects on individuals and families as well as its rising contribution to societal cost. However, dementia risk increases with the five major risk factors on the NCD list of WHO: tobacco use, physical inactivity, harmful use of alcohol, unhealthy diets and air pollution.

Alzheimer´s disease, the most common disease causing dementia, is the seventh most common causes of death globally, but the fourth in high-income countries. Alzheimer´s disease is the only one of the ten most prevalent causes of death with no effective prevention or cure and only limited treatment possibilities.

Women are disproportionately affected by dementia, with greater prevalence rates than men in all age groups and a higher proportion of deaths. Women are also responsible for providing roughly 70% of informal care hours globally, with the highest proportions being in low- and middle-income countries.

Dementia leads to increasing dependency in daily life and decreasing quality of life. As the burden of care increases, the quality of life of the caregiver, typically a close family member decreases as well. Individuals with moderate and severe dementia ultimately need to move to a service or nursing home but in many countries, particularly low- and middle-income countries, this possibility is not available. Nursing home costs are putting an increasing strain on economies, whether inside or outside a national health service.

There is increasing evidence that up to 45% of cases of dementia might be preventable to some extent. This has been supported by the actual decrease in dementia prevalence in the last three decades, but due to the rising number of older individuals, the total number of cases of dementia continues to rise.

Dementia does not generally belong to any one specialty of medicine but is most often the responsibility of either neurology, psychiatry (often senior psychiatry), geriatrics or family medicine. It involves a multidisciplinary approach requiring collaboration across various healthcare fields. However, individuals with dementia are more frequently admitted to hospital than those without dementia independent of physical comorbidities with generally poorer prognosis than non-demented individuals.

Research into treatment options for diseases causing dementia has been lagging compared to other major NCDs and has been mostly futile. New biological treatments for Alzheimer’s disease are very costly and most societies, even the wealthiest, are having difficulties handling the financial burden. In addition, these medications have a limited effects as they are not halting the process of increasing cognitive impairment but only slowing it.

The WHO global actions plan for dementia 2017-2025 states that countries need to develop practical and ambitious national strategies. The plan includes a set of seven global targets such as viewing dementia as a public health priority to improve diagnosis, support for dementia carers and increased funding for research.

RECOMMENDATIONS

The World Medical Association (WMA) calls on the following stakeholders to:

The World Health Organization (WHO)

1. List dementia as one of the major NCDs globally.

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2. Increase its focus on dementia and its causes, particularly in low and middle-income countries since they are expected to face the greatest increase in the number of dementia cases in coming decades.

3. Collaborate with governments, international Alzheimer´s disease bodies as well as the WMA in enhancing global awareness of dementia.

National Governments

4. View dementia as a public health priority.

5. Work along the lines of the WHO global action plan for dementia.

6. Develop comprehensive national dementia strategies including clear targets and measurable indicators, with allocated funding and a clear monitoring and evaluation process.

7. Support risk reduction programs, especially through public health initiatives. Such programs will also help countering other major NCDs.

8. Increase awareness of dementia and support dementia friendly initiatives.

9. Develop programs to support caregivers, including access to respite care, financial support, and mental health services, recognizing their critical role in dementia care.

10. Increase funding for dementia research nationally and through international partnerships with a focus on effective, accessible treatments and care.

Medical Associations and the Scientific Community

11. Promote initiatives to increase physicians´ knowledge about dementia, in order to promote early identification and accurate diagnosis of cognitive impairment, thereby enabling appropriate treatment and care to be provided.

12. Increase awareness that individuals with dementia have special needs when seeking health care for other ailments.

13. Work with other stakeholders to promote high quality care and good quality of life for individuals with dementia.

14. Increase enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.

15. Encourage studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders.

16. Make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services.

World Medical Journal

WMA STATEMENT ON OBESITY

Adopted by the 76th WMA General Assembly, Porto, Portugal, October 2025

PREAMBLE

The World Medical Association recognizes obesity as a widespread, long-term chronic disease and a global concern. The WMA notes that obesity is increasing among all age groups. Still, the rise in children including adolescents is of particular concern as earlier onset leads to worsened chronic disease burden over the life course. Obesity can affect both mental and physical health and can lead to discrimination, stigma, and bullying.

Obesity is a major health problem affecting all countries and all social and economic groups. It puts much pressure on healthcare resources. It is not an aesthetic problem, it is a medical problem that increases the risk of many other illnesses and health problems and, due to its scale and consequences, it is a public health problem of the highest priority.

Obesity's causes are complicated and relate to changes in society and the economy, including the environment that encourages obesity. The causes of obesity may be multifaceted, encompassing various factors such as environmental influences on physical activity, biological and medical conditions, psychological factors, maternal and developmental aspects, dietary habits, and economic and social elements.

The WMA acknowledges that social determinants of health significantly contribute to obesity. These determinants partially account for the disparities observed in racial and ethnic minority groups.

Physicians can be instrumental in both preventing and treating obesity. However, their potential may be hindered by insufficient education regarding obesity or subconscious and conscious biases toward patients with obesity. This may subsequently affect the quality of care offered to patients with obesity.

The WMA emphasizes the need to stimulate and support multisectoral country-level action on obesity across the globe.

The prescription of drugs for the treatment of obesity should be based on a medical diagnosis with strictly scientific criteria.

The WMA recalls its policies on Free Sugar Consumption and Sugar-sweetened Beverages, the Global Burden of Chronic Non-Communicable Disease, and Primary Health Care. These policies provide important context and guidance for addressing the obesity epidemic.

RECOMMENDATIONS

1. The WMA recommends all Medical Associations to call for policies that reduce the incidence of obesity, including:

- Learning about healthy diets in school curricula;
- Facilitating access to physical activity and sports for all parts of the population;
- Actively using consumer protection regulations to restrict marketing and raise prices of unhealthy products.

2. The WMA urges all Medical Associations to advocate for the recognition of obesity as a chronic disease requiring medical care and appropriate support, and the integration of obesity prevention, management, and treatment into national health services. All stakeholders must work together to address this global health concern.

3. The WMA calls for integrating obesity prevention, management, and treatment into Universal Health Coverage as an 'essential health service.' This includes access to evidence-based therapies and treatments for obesity, ensuring these services are universally available, accessible, affordable, and sustainable.

4. The WMA encourages physicians to use their leadership roles to push for obesity reduction to be a priority for national health authorities and to advocate for policies suitable for different cultures and ages, involving physicians and other key stakeholders.

5. The WMA acknowledges that there are various treatment options for patients with obesity. These range from lifestyle and behavioral changes to pharmacotherapy, medical devices, and metabolic and bariatric surgery.

6. Primary prevention is a crucial objective for physicians in addressing obesity, but only limited effective methods to achieve it are currently available. While progression of and complications associated with obesity can be prevented and treated, there is a need to develop and support additional effective strategies to reduce its incidence. We must promote health information and education based on sound scientific criteria that inform, help and support the population in the prevention and management of this disease.

7. Physicians need thorough education on obesity to fully understand the disease. This will enable them to treat it effectively, minimize prejudice and stigma, advocate for relevant policies, and lead treatment teams efficiently.

8. Physicians attending to pediatric patients should understand the specific details associated with childhood and adolescent obesity, especially the necessity for prevention and early intervention. They should be able to identify rare types of obesity, as failure to do so can result in detrimental health consequences.

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10. The WMA recommends a multisectoral approach, based on the principles of primary health care, to prevent, treat, and manage obesity. This approach involves various sectors, including health, education, and social services, with physicians playing a crucial role in this multisectoral approach.
11. The WMA encourages its Constituent Members and physicians to advocate for healthy diet, to promote regular physical exercise and to combat diet and nutrition misinformation spread particularly on social networks.
12. The WMA calls for firm action against self-proclaimed therapists and unproven therapies.

WMA STATEMENT ON PHYSICIAN MENTAL HEALTH CARE

Adopted by the 76th WMA General Assembly, Porto, Portugal, October 2025

PREAMBLE

Good mental health of physicians and other health and care professionals is a prerequisite for high quality medical care and patient safety.

The WHO Working for Health Action Plan 2022-2030 emphasizes that many challenges faced by health and care professionals around the world, including i.a. labor market failures and substantial underinvestment that have a “direct effect on physical and mental health and worker well-being as they undermine their health, social and economic contribution to society.”

Physicians and other health and care professionals may experience mental health conditions that are linked to burnout, long working hours, high-stakes decision-making, and emotional burdens specific to their profession. If not addressed in time, mental health conditions can become chronic and have serious consequences in all areas of life. They can even lead to an increased risk of suicidal ideation among physicians.

The prevalence of mental health conditions among physicians and other health and care professionals worldwide highlights the need for greater attention to their psychosocial well-being.

Pressure from employers, extended working hours, or experiences of violence, combined with access to drugs and medication, can also give rise to situations in which physicians require help and support. These and other factors can also contribute to an increased risk of substance abuse among medical professionals. Since the mental health of physicians impacts on the quality of health care and patient safety, ensuring the well-being of physicians is essential.

Promoting physician mental health requires comprehensive action that ensures appropriate treatment and rehabilitation without stigmatization.

Several countries have implemented specific programs that have demonstrated effectiveness in providing comprehensive care to physicians affected by mental health conditions.

A history of mental health conditions does not inherently preclude a physician from providing valuable, high-quality patient care. Physicians should be supported through return-to-work programs and reasonable workplace accommodations to ensure their successful reintegration and continued contribution to patient care.

Further research regarding mental health of physicians is needed to better understand the problem and identify best practices in terms of mental health promotion and treatment, including attention to diversity and equity among physician populations.

RECOMMENDATIONS

The World Medical Association reaffirms its Statement on Physician Well-being, calls on the relevant authorities to collaborate with healthcare professional organisations on the issue of physician mental health and urges its constituent members and physicians to:

1. Advocate for the development of effective policies that protect the mental health of physicians and ensure sufficient resources to enable appropriate care.
2. Encourage concerted efforts for the prevention and early detection of mental health conditions among physicians, ensuring confidential access to evaluation, treatment, and follow-up without fear of professional repercussions. Promote physicians’ physical and mental well-being through specific strategies, including during higher education and postgraduate training. These strategies should provide support for those experiencing mental conditions and ensure that resources to promote positive mental health are available to all clinicians, including those at risk.
3. Promote the development of specific mental health intervention programs

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and protocols for physicians that address the problem from a healthcare, social and professional point of view, with confidentiality and without stigma and encouraging physical and psychological rehabilitation. This should include programs to support physicians to overcome addictions, which could be caused by occupational psychosocial risk factors. Medical associations should promote programs helping physicians return to practice after treatment and recovery.

4. Ensure the destigmatization of mental health and substance use disorders in physicians by ensuring access to treatment and follow-up without disproportionate risk of adverse licensure or certification actions. Any restrictions on medical practice should be based on an objective, case-by-case assessment involving relevant regulatory bodies, with full consideration of patient safety, clinical recovery, and the rights of the physician.

5. Duly consider the experience acquired by physicians recovered from mental health disorders in efforts to overcome stigmatization, discrimination and to reduce inequalities.

6. Support and expand physicians' mental health research and education to identify and implement best practices.

7. Increase awareness and promote comprehensive training on physician mental health across healthcare, academic, and institutional settings and at all stages of medical education.

8. Encourage research on the prevalence and impact of psychosocial risks factors in the medical profession.

9. National medical associations should promote the establishment of mechanisms such as observatories or dedicated monitoring initiatives to recognize, assess, and track mental health challenges among physicians, and to develop evidence-based proposals for their prevention and resolution.

10. Consider and promote measures to create positive and supportive workplace cultures that foster open communication, teamwork and a sense of belonging where physicians feel valued and respected, including leadership training, peer support initiatives, and confidential channels for raising concerns without fear of retribution.

WMA STATEMENT ON THE PROTECTION OF REPRODUCTIVE HEALTH RIGHTS OF WOMEN AND GIRLS

Adopted by the 76th WMA General Assembly, Porto, Portugal, October 2025

PREAMBLE

The WMA *notes with concern* that reproductive health[1] is underprioritized in many regions of the world.

The WMA *recognizes* that access to reproductive health services may be influenced by local moral, cultural and religious beliefs, traditions and practices.

The WMA *affirms* that such beliefs, traditions and practices should not constitute a barrier to access to health services.

The WMA opposes laws, policies, and juridical practices that unreasonably restrict or criminalize the termination of pregnancy.

The WMA *underlines* that physicians are responsible for protecting their patients' privacy and maintaining physician-patient confidentiality.

The sexual and reproductive rights of women and girls are human rights that must be respected to ensure their full development in all spheres of life.

The WMA reaffirms its Statement on medically-indicated termination of pregnancy.

RECOMMENDATIONS

The WMA recommends its constituent members to:

1. Address reproductive health in public debate in order to promote greater societal knowledge and understanding of the issues at stake.

2. Consider reproductive health as an individual and public health issue in the same way as other health needs.

3. Promote universal accessibility, with a focus on affordability to health services, including reproductive health services.

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4. Oppose criminal and civil penalties for the provision of reproductive health services, including access to contraception.

5. Advocate for legal protection for physicians and patients who provide and receive reproductive health services, including contraception.

6. Oppose criminal and civil penalties for the provision of voluntary termination of pregnancy and advocate for legal protection for physicians who provide voluntary termination of pregnancy and for their patients.

7. Facilitate development of and access to knowledge related to reproductive health.

8. Promote health and sexual information and education for girls and women in order to develop adequate and healthy reproductive health.

The WMA recommends physicians to:

9. Ensure that patients' health and well-being are prioritized without discrimination.

10. Treat all patients with respect for their autonomy and dignity.

11. Ensure that where conflicts of conscience prevent the physician from providing reproductive health services, sufficient information is provided about alternative care givers and timely access to care is ensured for every patient.

12. Assist patients with information and products that support their autonomy with regard to family planning.

13. In obstetric care, always facilitate safe childbirth and post-partum care.

[1] The term "reproductive health" in this statement includes maternal and neonatal care, contraception, fertility treatments and family planning.

WMA RESOLUTION CALLING ON THE ISRAELI GOVERNMENT TO COMPLY WITH THE GENEVA CONVENTIONS AND OTHER APPLICABLE INSTRUMENTS OF HUMANITARIAN LAW

Adopted by the 76th WMA General Assembly, Porto, Portugal, October 2025

PREAMBLE

The WMA reaffirms the WMA Resolution on the Protection of Healthcare in Israel and Gaza, including the call for immediate and safe release of all hostages.

The World Medical Association (WMA) expresses its profound concern over the attacks on patients, health professionals, medical facilities, and humanitarian aid convoys in Gaza in violations of the Geneva Conventions and applicable international humanitarian law.

Gaza is facing a deepening humanitarian and public health crisis. More than half a million people in Gaza are trapped in famine, marked by widespread starvation, destitution and preventable deaths, according to an Integrated Food Security Phase Classification (IPC) analysis. Medical supplies and intervention are vital to treat the effects of malnutrition.

The opportunities for international organisations and actors providing medical humanitarian aid to operate in the region are limited.

It is imperative that all governments, armed forces, and entities in positions of authority strictly adhere to international humanitarian law, including the provisions of the Geneva Conventions, thereby guaranteeing access to humanitarian aid, and that physicians and other health professionals can safely deliver essential care to all individuals in need, particularly within contexts of armed conflict.

Furthermore, physicians must be afforded unimpeded access to patients, medical infrastructure, essential medicines, and critical equipment and must be provided with comprehensive protection to execute their professional duties without hindrance.

RECOMMENDATIONS

1. The WMA emphatically calls upon the Government of Israel to:

- Instantly halt all forms of attacks on healthcare personnel, patients, healthcare facilities, and food and medical aid logistics in accordance with the Geneva Conventions and applicable international humanitarian law.
- Ensure delivery of humanitarian aid and access to food to all in need.
- Guarantee respect for the principle of medical neutrality and proceed with the immediate and unconditional release of

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all health personnel arbitrarily detained.

- Ensure that health professionals can perform their duties safely, without obstruction or interference.
- Grant necessary permissions for the unhindered entry and distribution of medical aid and ensure the safe delivery of essential equipment and medicines to healthcare services.
- Fully honour and adhere to the principles enshrined in the Geneva Conventions and other applicable international humanitarian instruments.
- Facilitate access for independent investigators and ensure that all individuals responsible for criminal acts are held accountable under international law.

2. The WMA calls upon its Constituent Members to unequivocally condemn attacks on healthcare personnel and facilities during the ongoing conflict in line with the Geneva Conventions and international humanitarian law.

3. The WMA calls on the World Health Organization (WHO) to undertake a comprehensive study to determine the full extent of the damage caused to health services, physicians, and other health professionals in Gaza and to identify the measures necessary for their full restoration and compensation.

4. The WMA urges governments to support peace initiatives and constructive frameworks to bring an end to the hostilities in Gaza and the region.

WMA STATEMENT ON AGEING PHYSICIANS

Adopted by the 76th WMA General Assembly, Porto, Portugal, October 2025

PREAMBLE

The increasing number of physicians at or near retirement age plays a great role in contemporary medical practice. They provide competent care as well as improve patient access to medical care. This resolution supports professional autonomy, and addresses the matter of continued competency evaluation, to preserve patients' access to care, patients' right to freedom of choice, as well as patient safety and medical care standards.

The number of physicians at or near retirement age is increasing in many parts of the world, and many of these physicians still play an active and leading role in their respective fields.

Ageing physicians can play a valuable role contributing their experience and knowledge of the healthcare environment, of their patients, and of the interpersonal dynamics and the patient-physician relationship.

The World Medical Association believes that when there is concern about a physician's competence, the physician's colleagues and internal management should examine whether the concern is well-founded and if so, whether the issue can be resolved quickly and through internal processes without risk to patient safety. If such efforts do not resolve the problem, it may be necessary to report the physician to the relevant authorities in good faith and in the best interests of the physician and of their patients. It is imperative that this approach be marked by the utmost benevolence and collegiality. Appropriate personal support to the physician should be ensured.

RECOMMENDATIONS

1. The World Medical Association urges avoidance of policies that mandate age-specific retirement for physicians.

2. The World Medical Association invites its Constituent Members to:

- Foster the principles of evidence-based competency evaluation of the individual physicians and strive for professional autonomy in this matter.
- Seek to ensure appropriate and balanced evaluation of the working ability of ageing physicians that wish to continue their medical practice.
- Promote tailored continuing professional development activities to support ageing physicians and the maintenance of their professional aptitude, for them to provide high quality care throughout their practice careers.
- Promote ways for ageing physicians to remain active after retirement, including through volunteer opportunities.

3. Physicians should report to the appropriate authorities conditions or circumstances which impede a physicians from providing care of the highest standards, as set forth in the WMA's International Code of Medical Ethics.

4. The World Medical Association invites its members and health authorities to secure appropriate pathways when there

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is concern about a physician's competence or circumstances which impede a physician from providing care of the highest standards, as set forth in the WMA's International Code of Medical Ethics.

5. The World Medical Association invites its members and health authorities to secure appropriate pathways when there is concern about a physician's competence or circumstances which impede a physician from providing care of the highest standards, as set forth in the WMA's International Code of Medical Ethics.

6. In these circumstances, the physician's colleagues and internal management should examine whether the concern is well-founded and if so, whether the issue can be resolved quickly and through internal processes without risk to patient safety.

7. If such efforts do not resolve the problem, it may be necessary to report the physician to the relevant authorities in good faith and in the best interests of the physician and of the patients. It is imperative that this approach be marked by the utmost benevolence and collegiality. Appropriate personal support to the physician should be ensured.

8. The World Medical Association recommends physicians to:

- Have their health and work ability regularly evaluated by another physician.

- Maintain professional skills with appropriate continuing professional development activities, in order also to adapt to new technologies, treatments and healthcare protocols and ensure up-to-date and safe medical care.

WMA RESOLUTION ON HEALTH WORKFORCE AT THE WORLD HEALTH ORGANIZATION (WHO)

Adopted by the 76th WMA General Assembly, Porto, Portugal, October 2025

PREAMBLE

The health workforce is the backbone of health systems. Effective healthcare service delivery necessitates adequately resourced, educated, ethically recruited and employed health professionals in decent working conditions.

The world is facing an 11 million health worker shortage by 2030 to achieve universal health coverage. Now more than ever, a strong global leadership at the WHO is necessary to effectively support and strengthen the health workforce through developing evidence and normative guidance to support member states in planning, employing, and retaining their national workforce.

Member states have reiterated their support by adopting yet another resolution at the 78th World Health Assembly titled "Accelerate implementation of the Global strategy on human resources for health: Workforce 2030."

The WHO is currently undergoing a restructuring process, planning to downsize the Health Workforce Department and move its staff to the WHO Academy.

The World Medical Association expresses its concern about the currently planned restructuring process, which will significantly impede the WHO's ability to continue its leadership in accelerating global progress on the health workforce.

RECOMMENDATIONS

1. The WMA calls urgently on the World Health Organization's Director-General to prioritise the health workforce by upholding its Health Workforce Department as a separate entity, ensuring it continues to be adequately staffed with strong leadership.

2. Additionally, we request that the department remain in its headquarters in Geneva to ensure cross-collaboration, particularly with the Health Systems, Universal Health Coverage, Non-Communicable Diseases departments among others, as well as with the Health Professional Associations, which are largely headquartered in the Geneva region.

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WMA RESOLUTION ON PUBLIC HEALTH FUNDING WORLDWIDE

Adopted by the 76th WMA General Assembly, Porto, Portugal, October 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.

RECOMMENDATIONS

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.

WMA 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

and by the 76th WMA General Assembly, Porto, Portugal, October 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 RESOLUTION TO UPHOLD THE ETHICAL FRAMEWORK OF HEALTHCARE

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

and by the 76th WMA General Assembly, Porto, Portugal, October 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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Information about the 232nd WMA Council Session, Belgrade 2025

Dear colleagues of the World Medical Association,

On behalf of the Serbian Medical Chamber (Лекарска комора Србије), we cordially invite you to participate in the 232nd Council Session of the World Medical Association, which will be held on 23-25 April 2026, in Belgrade, Serbia. The Serbian Medical Chamber, founded in 1901, is pleased to serve as the host for this event and share the promotional video (https://www.youtube.com/watch?v=0aJ7vJti23w). Our team has prepared a robust agenda of key 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 Belgrade for this exciting event.

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Navigating the Dialogue on Using Artificial Intelligence in Medical Practice at the 76th WMA General Assembly


Carlos Cortes


Ashok Philip


Philippe Cathala


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Helena Chapman

With the rise of technological development, the incorporation of artificial intelligence (AI) and language model tools in medical practice is inevitable and will require that these systems are tested and validated into existing workflow related to clinical documentation, decision support, and patient communication. Physicians should be prepared to effectively use this technology to enhance diagnostics and strengthen training, while being alert for risks to patient safety, health and well-being, and autonomy [1]. Incorporating AI capabilities into health system processes, however, is constrained by established regulatory and governance frameworks that are based on traditional (not adaptive) models and algorithms, which hinder the immediate implementation of AI tools [2].

The World Health Organization (WHO) published the *Ethics and Governance of Artificial Intelligence for Health* report in 2021, as a guide to support emerging technologies for health systems and governments [3,4]. The report outlines six key ethical principles for its design and successful application: 1) protect autonomy; 2) promote human well-being, human safety, and public intertest; 3) ensure transparency, explainability, and intelligibility; 4) foster responsibility and accountability; 5) ensure inclusiveness and equity; and 6) promote AI that is responsive and sustainable [3,4]. This report catalysed the United Nations (UN) launch of the Global Initiative on AI for Health (GI-AI4H) in 2023, led by the WHO, International Telecommunication Union (ITU), and the World Intellectual Property Organization (WIPO), as a long-term structure to facilitate the ethical implementation of AI in across health systems [5].

The World Medical Association (WMA) recognises that AI has the ability to transform the healthcare sector, and advocates for physician-led incorporation of AI in medical practice [6]. To open the global dialogue, the WMA supported the five-part webinar series focusing on AI from January to May 2025 (https://www.youtube.com/worldmedassociation). The specific topics included: 1) Introduction to AI in medicine; 2) Ethical, legal, and regulatory aspects of AI in healthcare; 3) Current and future applications of AI in medicine; 4) Best practices in medical AI development; and 5) AI for health equity: Bridging the global divide [7]. This professional development series offered an opportunity to explore five dimensions of AI applications in healthcare, support the physicians' role in bridging the effective and ethical implementation to medical practice, and ensure trustworthy and transparent processes with patients and the public.

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As part of the 76th WMA General Assembly, the Portuguese Medical Association's Organizing Committee coordinated the "*Impact of AI in Medical Practice*" scientific session on 9 October 2025, in Porto, Portugal. This session aimed to raise awareness and encourage discussion on implementing AI in health systems, understanding ethical considerations of AI in fostering physician–patient rapport, and applying AI in collaborative healthcare teams in clinical practice. Navigating AI will require innovative solutions to help prepare health professionals and health systems to manage emerging technologies and recognising their strengths and challenges to clinical practice.

The Opening Session provided an opportunity to learn how AI has evolved and incorporated into medical education, training, and practice. Then, experts offered their insight and perspectives related to incorporating AI into clinical practice in three scientific sessions, entitled, *"Practical Aspects of Implementing AI"* (Session 1), *"Ethics of AI in Medicine"* (Session 2), and *"AI in Practice"* (Session 3). Finally, the WMA and Portuguese Medical Association leaders concluded with a session summary and recommendations for the collective WMA call to action.

Opening Session

As part of the Opening Session, Dr. Ashok Philip (WMA President), Dr. Carlos Cortes (President, Portuguese Medical Association), and Dr. Alberto Caldas Afonso (Immediate Past Treasurer, National Council of the Portuguese Medical Association) welcomed the members to the 76th WMA General Assembly (Photo 1). They shared their enthusiasm to organise this timely scientific session for this event, where they hoped to encourage collective dialogue with global physicians representing 53 countries in attendance. They introduced the moderators and invited speakers, who offered their perspectives related to AI in medical practice across eight countries.

Photo 1. Dr. Carlos Cortes, President of the Portuguese Medical Association, delivers welcoming remarks at the Scientific Session of the WMA 76th General Assembly. Credit: WMA

As the keynote speaker, Professor António Vaz Carneiro (Coordinator, Portuguese Medical Association's Artificial Intelligence Commission) outlined how AI has become a central force in modern healthcare. He noted that over the past five decades, computer technology has increased exponentially, especially in terms of volume, velocity, and variety of processed data. Defining AI as a *"field which combines computer science and robust datasets to enable problem solving,"* he provided key examples – clinical reasoning evaluation, pattern recognition (e.g. radiology), and clinical research (e.g. design and trial enrolment, adverse effects). Finally, he concluded that AI can facilitate predictive models and precision medicine, and caution is essential to ensuring a strict research and development approach.

Session 1: Practical Aspects of Implementing AI

> *"AI is already playing a role in diagnosis and clinical care, drug development, disease surveillance, outbreak response, and health systems management … The future of healthcare is digital, and we must do what we can to promote universal access to these innovations and prevent them from becoming another driver for inequity."*
>
> - Dr. Tedros Adhnom Ghebreyesus, WHO Director-General

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In the first session, panellists shared diverse perspectives on the implementation of AI in practical applications in Portugal and South Africa. Dr. Philip moderated the session, reiterating that AI is already being rapidly incorporated into medical education, training, and practice, and physicians should be ready to effectively apply this technology to improve patient care. He reminded participants that although this technology delivers on its promise of innovation, it remains sensitive to health system's strengths and critical vulnerabilities.

Dr. Ana Ribeiro da Cunha (Member, Portuguese Medical Association's Artificial Intelligence Commission) described the FUTURE-AI Consortium (https://future-ai.eu/), which was founded in 2021, with a total of 117 scientific experts from 50 countries, as an international consensus guideline for the trustworthy and deployable application of AI in healthcare. She stated that the underlying principles to guide its application include explainability, fairness, robustness, traceability, universality, and usability. She provided a historical overview of technological advancements, starting from Hippocratic traditional medicine, advancing to evidence-based medicine and clinical trials, following to explicit personalised medicine (visualizable algorithms), and finally with implicit personalised medicine (AI-based). She noted that health professionals remain challenged to widely implement AI technology into clinical and research practice, due to ethical considerations and limited trust.

Dr. Mzulungle Nodikida (Chief Executive Officer, South African Medical Association) highlighted examples of AI applications used in Obstetrics and Gynaecology and the wider South African health system. He described the plethora of electronic health records and health information systems in operational use across the South African provinces and in the private sector. He emphasised the need to build institutional capacity, invest in team training, and foster collaboration between clinicians and engineers. He concluded that the South African Medical Association (SAMA) has demonstrated their important role in clinical and ethical leadership across the nation, building international collaboration and partnerships and providing professional development opportunities for physicians.

Dr. Tomás Cobo (President, Spanish General Medical Council) provided a historical context behind the foundation of the WMA in 1947, following concern for medical ethics during the post-World War II period, and the drafting of key ethical documents like the Universal Declaration of 1948. He reflected on AI as a scientific, diagnostic, and learning support tool for four powerful technologies (diagnostics, therapeutics, big data, clinical logistics), noting that overreliance on AI in clinical practice can create substantial challenges and risks. He commented that some ethical dilemmas include consent, fairness and job displacement, deterioration of the physician–patient relationship, and AI model errors in unfamiliar contexts.

Session 2: Ethics of AI in Medicine

"Like all new technology, artificial intelligence holds enormous potential for improving the health of millions of people around the world, but like all technology it can also be misused and cause harm."

\- Dr. Tedros Adhnom Ghebreyesus, WHO Director-General

In the second session, panellists reflected on AI's growing role in daily medical practice, raising new questions about trust, accountability, and the physician–patient relationship. Moderated by Dr. Philippe Cathala (WMA Finance and Planning Committee Chair), he recapped that AI must be incorporated to strengthen, not replace, the array of clinical services in the health system. He also highlighted the need to ensure that technological progress is directly connected to the service of clinical expertise and human responsibility.

Dr. Bernardo Duque Neves (Portuguese Medical Association) described strategies for addressing ethics and accountability issues in superhuman AI for clinical decisions in order to prevent single-point failures. He emphasised that clear regulation and responsible implementation, coupled with advances in governance and education, are essential to preserve trust. With the expanding range of AI applications in medical practice, it is crucial to adopt adequate protections that prevent overreliance and excessive dependence on these AI-driven decision-making systems.

Professor Rui Nunes (Portuguese Medical Association) stressed that AI applications will profoundly and irreversibly transform every aspect of medicine, including medical education, clinical practice, and scientific research. He advocated for the creation of a supranational AI regulatory system that evaluates and manages AI applications and their level of risk to patient health and safety. He commented that only a high level of AI literacy among health professionals will ensure that the transformative shift driven by AI in healthcare leads to improved patient care.

Dr. Ramin Parsa-Parsi (German Medical Association) highlighted the importance of the physician–patient-AI relationship and emphasised the benefits of integrating AI into healthcare, including improved

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diagnostic accuracy, more personalised care, and reduced administrative workload for health professionals. He presented research findings showing physicians' perceptions that AI applications can enhance clinical practice by improving diagnostic accuracy and influencing physician-patient rapport. To safeguard the effective use of AI in medical practice, the design and utilisation must be guided by the ethical principles that uphold trust, empathy, and respect in medical practice, which preserve transparency and the human connection. He cautioned WMA members to be aware of the risks of overreliance on AI in healthcare, including the potential loss of patient trust, challenges related to liability and privacy, perils of bias in algorithms.

Session 3: AI in Practice

"As AI becomes more sophisticated and its health applications expand, so must our efforts to make them safe, effective, ethical, and equitable."

- Dr. Tedros Adhanom Ghebreyesus, WHO Director-General

In the third session, panellists offered concrete examples of how AI use could and should look in the day-to-day lives of physicians and patients. Dr. Bobby Mukkamala (President, American Medical Association) moderated the session, demonstrating that AI has the potential to positively impact the practice of medicine. However, the extent of AI's success in healthcare will depend largely on how physicians help implement, monitor and complement the technological tools.

Dr. Ana Pina (Portuguese Medical Association) commented that interdisciplinary health can galvanise AI technology toward collective intelligence in clinical practice. She noted three significant constraints – increased demand (e.g. non-communicable diseases represent 74% of global deaths), workforce shortage, and decreased sustainability. Managing AI tools effectively to navigate constraints is best achieved through team-based models that leverage diverse expertise to collectively oversee the monitoring and governance of AI in medical practice. She concluded that these collaborative teams, which may feature new roles and specialised skill sets, can help address AI mistrust and facilitate patient-centred care by ensuring that robust expertise guides the ethical applications of AI algorithms for health systems.

Dr. Pablo Requena (Vatican Medical Association) shared insights exploring the potential of AI technology to strengthen the physician–patient relationship in primary care by alleviating physicians' administrative burdens, supporting clinical decision-making, and improving diagnostic accuracy. He accentuated that AI can never satisfactorily replicate the human connection – such as empathy, compassion, and communication – as defining hallmarks of the physician profession. The rapid development and implementation of AI technology will require physicians to seek continuing education to ensure that they maintain relevant competencies and understand the technology's limitations toward optimised patient care.

Conclusion

As part of the Closing Session, Dr. Caldas Afonso and Dr. Otmar Kloiber (WMA Secretary General) shared their appreciation for the session organisers, expert panellists, and the audience. Dr. Caldas Afonso summarised the key point that AI applications will transform medical practice by helping translate evidence-based scientific findings into clear language, improving clinical diagnostic accuracy, supporting shared physician–patient decisions in healthcare, and reinforcing patients' autonomy and health literacy. He emphasised that AI applications in healthcare must adhere to core ethical principles, such as respect for patient autonomy, promotion of justice, protection of privacy, and increased protection for vulnerable populations. Finally, he reminded WMA members that AI technology must be human-centred and enable effective human oversight, where modern regulations must evolve alongside innovation, to prevent the violation of fundamental human rights.

As the Portuguese Medical Association's Organizing Committee successfully hosted the 76th WMA General Assembly, it reaffirmed the valuable role of national medical associations as essential leaders, learning about novel technologies, contributing their scientific expertise, and expanding regional networks and partnerships to advance health priorities and promote physician solidarity worldwide. The final proceedings of the 76th WMA General Assembly resulted in the adoption of the WMA Statement on Artificial and Augmented Intelligence in Medical Care, which outlined ethical principles to guide the safe and responsible use of AI in health systems as well as the need for continuous evaluation to ensure transparency and shared accountability [8,9]. Given the complexity of global health challenges, AI technology has the potential to support (not replace) physicians, who are uniquely positioned to lead cross-disciplinary efforts to evaluate, validate, and monitor these systems.

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Potential Gains of Using Artificial Intelligence in Primary Care Lie Beyond Technology Itself

Pablo Requena

The biomedical literature increasingly emphasises the advantages that artificial intelligence (AI) could bring to medical practice, particularly in primary care. However, significant challenges accompany its implementation, generating concerns among healthcare professionals and patients alike. In this brief essay, I argue that the benefits of AI in primary care ultimately depend on structural and human factors rather than on the technology itself. While AI can become a valuable tool in primary care, its potential can only be realised once the serious problems of staff shortages and professional burnout are adequately addressed. Furthermore, AI's potential contribution to improving the doctor–patient relationship depends on professionals continuing to prioritise training in empathy, compassion, and communication skills. These elements distinguish clinical encounters from mere service provision.

1. AI in Primary Care: Possibilities and Concerns

Wiedermann and colleagues (2023) examined perceptions of both physicians and patients regarding AI use in symptom checking within primary care in the Italian health system [1]. They used a provocative title, "Redesigning Primary Care: The Emergence of Artificial Intelligence-Driven Symptom Diagnostic Tools," suggesting that AI would bring about, if not a complete redefinition of primary care, at least a fundamental redesign. As this concept has become of particular interest to global physicians, it has been analysed in other recent publications.

Sarkar (2024) addressed AI's potential benefits in primary care by examining the added workload associated with electronic health records in the United States [2]. The literature frequently links these systems to increased physician burnout. In this context, AI could provide support in four key areas: a) managing electronic patient message inboxes, b) handling clinical documentation, c) monitoring patients between visits, and d) supporting diagnostic and therapeutic decision-making [2]. Also, Martínez (2025) argued that AI has already substantially improved several areas of medical practice, highlighting advances in diagnostic accuracy, image interpretation, and personalised medicine [3].

Concerns identified in the medical literature include risks to data privacy and security, doubts about diagnostic and therapeutic accuracy, and potential AI algorithm biases [3-5]. Allen and colleagues (2024) highlighted how primary care physicians discussed both benefits and concerns related to AI [4]. Some feared that introducing this technology might increase, rather than reduce, their workload. One participant stated clearly: *"My concern is that like everything else we have tried to do to make things better in medicine, it actually makes things harder on the physician and creates more work for us instead of less work"* [4].

This observation raises a crucial question: *does AI genuinely save physicians time?* Theoretically, the answer is affirmative [6-8]. Practically, however, the situation may differ. Allen and colleagues (2024) highlighted that another participant feared that any time saved through AI would simply result in increased patient loads [4]. Wiedermann and colleagues (2023) confirmed that neither physicians nor patients perceived significant time savings in consultations [1].

Bias in AI training represents another frequent concern, extending beyond medicine to broader technology applications, often referred to the "black box" problem. Some authors, including Chan (2023), have argued that AI tools should not be used unless their algorithms are fully understood, except when functioning as "copilots" or when diagnostic and therapeutic resources are severely limited [9]. Gordijn and Ten Have (2023) adopted a less restrictive view, suggesting that physicians themselves can be considered "black boxes" when making diagnostic and therapeutic decisions [10].

Although this open debate cannot be fully explored here, it underscores the need for continued theoretical reflection on AI use in medicine. Mache and colleagues (2025) concluded that healthcare professionals tend to adopt an attitude of "cautious optimism" [5]. As most authors point out, alongside their enthusiasm for the potential benefits of AI, they stress that the possible dangers of its application should not be underestimated.

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2. AI and the Doctor–Patient Relationship

AI's significant impact on the physician-patient relationship, particularly in primary care, is widely acknowledged in the cited literature. This relationship lies at the heart of medical anthropology and ethics, requiring careful consideration. A fundamental question emerges: *is AI simply another tool, like the stethoscope or MRI, or does it fundamentally alter the doctor–patient relationship?* Throughout medical history, discoveries such as antibiotics and X-rays revolutionised practice without changing the essential nature of the doctor–patient relationship.

AI, however, raises questions about whether the relationship itself is being reshaped. Lorenzini and colleagues (2023) argued that AI transforms the doctor–patient relationship from a dyadic to a triadic one [11]. While this view seems overly radical, it suggests that AI transcends the role of a neutral tool at the physician's disposal. In my view, AI is not merely another instrument added to the diagnostic and therapeutic arsenal. Its use will increasingly influence how medicine is practiced. However, I do not believe it necessarily changes the essential configuration of the physician-patient relationship.

Some question whether AI could replace physicians entirely. However, this seems unlikely. AI may reduce the need for physician consultations for minor health issues, but patients with moderate or severe conditions will always require medical care from a human physician. Ilan (2024) argued that physicians cannot be replaced by AI for technical reasons related to human brain complexity: *"There will always be tasks where humans are faster, more reliable, and cheaper"* [12]. Beyond these technical arguments lie deeper human dimensions. Patients are people who, in fundamental life moments such as birth, illness, and death, require the presence and care of other people [13]. While machines may offer precise diagnoses and effective treatments, they will never possess personal subjectivity, even if they can simulate it. Replacing physicians with increasingly sophisticated AI would not enrich medicine–it would impoverish it.

The doctor–patient relationship extends beyond technical outcomes. It represents an encounter between two subjectivities (two life stories) that seeks therapeutic results and carries existential meaning. Research has long demonstrated correlations between positive doctor–patient relationships and improved therapeutic outcomes [14]. Hindocha and Badea (2022) not only rejected the possibility of AI replacing physicians, but also argued that physicians must "ethically educate" algorithms [15].

Several authors highlighted empathy as a uniquely human quality that is difficult to replicate algorithmically [3,16]. Extensive literature exists on "empathetic robots" – machines capable of recognising human emotions and responding in ways that generate positive feelings [17]. However, this raises additional debates. Sirgiovanni (2025) recently questioned the clinical value placed on empathy, noting that it may sometimes conceal judgments or biases that do not actually support positive doctor–patient relationships [18]. Nonetheless, while healthcare robots may be programmed to display empathy, they are not persons. Behind these programmed responses exists no real subjectivity, no genuine "you" who truly shares the patient's suffering. Patients are acutely aware of this distinction.

Wiedermann (2023) observed little possibility of AI replacing physicians, emphasising the need to *"carefully integrate digital innovations while preserving essential human contact in healthcare"* [1]. This introduces another important dimension of the doctor–patient relationship: physical contact. Both procedural and expressive touch communicates beyond words. Studies have highlighted the importance of such nonverbal communication, though modern medicine often overlooks it. As one physician interviewed by Cocksedge (2013) noted: *"Even if it's just putting a hand out... I think touch often can say much more than words; it can be very reassuring"* [19].

3. The Real Help AI Can Offer in Primary Care

We must now return to central questions: can AI actually help primary care physicians in their work, and can it improve therapeutic outcomes in this setting? While no one doubts AI's many benefits in diagnostic and therapeutic domains, these issues must move beyond theory and be tested in the daily practice of health centres and hospitals. Studies must provide statistically supported answers within real-world contexts. The response to our original question appears to move in two directions: institutional and personal. Currently, primary care faces professional shortages and growing burnout levels. As noted earlier, the implementation of electronic health records has exacerbated this problem.

Family physician Dr. Steven Kanner, now retired, responded convincingly to Sarkar's analysis of how AI could improve primary care. He argued that no improvement would occur without structural changes to the U.S. healthcare model, which for 30 years has made each physician responsible for approximately 2,500 patients [20]. Addressing this problem requires medium and long-term primary care reorganisation aimed at increasing the

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number of physicians dedicated to this work. AI offers little assistance here without political will for structural reform.

Conversely, care quality – in both primary and specialised settings – will always depend on healthcare professionals' attitudes and virtues. From its inception, ethical reflection on AI in medicine has used principlism as its reference model. However, the four principles of bioethics – autonomy, non-maleficence, beneficence, and justice – quickly proved insufficient for addressing AI's ethical challenges [21]. An alternative model, virtue ethics, has long proposed integrating principles with personal virtues. Although research on AI and virtue ethics remains in early stages, several studies are beginning to explore this area [22]. Of particular interest is Paladino (2023)'s ethical evaluation of AI in medicine, drawing on Edmund Pellegrino's proposal, where she emphasised the need for a perspective rooted in *praxis* rather than reducing analysis to *poiesis* alone [23]. Hagendorff (2022) published a proposal for applying virtue ethics to AI in medicine, identifying four basic AI virtues: justice, honesty, responsibility, and care. He also suggested two second-order virtues – prudence and courage – which represents an interesting contribution deserving further consideration and study [24].

Conclusion

The benefits that AI could bring to primary care are undeniable, particularly in diagnostic, administrative, and decision-support contexts. However, experience demonstrates that these improvements do not automatically translate into enhanced clinical practice. AI's real impact depends on two inseparable dimensions: structural and human.

Regarding the structural dimension, as long as professional shortages and overload caused by inefficient organisational systems persist, AI cannot compensate for these deficits. Healthcare reorganisation–with increased human resources and fairer responsibility distribution–is a prerequisite for technology to function as genuine support rather than an additional burden. Regarding the human dimension, primary care quality is closely tied to the doctor–patient relationship. While AI may be a valuable tool, it will never replace subjectivity, empathy or the personal care required in clinical encounters. Training professionals in communication skills and virtues, such as responsibility, prudence, and compassion, is essential for integrating AI without undermining medical practice's essence.

Therefore, effective AI use in primary care does not depend primarily on algorithmic sophistication, but rather it depends on decisions made by governments, institutions, and professionals. Healthcare must innovate organisationally while preserving the centrality of the doctor–patient relationship. Only under these conditions can AI become a tool that serves medicine rather than represents a force of dehumanisation.

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Building Artificial Intelligence Literacy for Physicians: Lessons from the WMA Medical Technologies Working Group Webinar Series

Jacob Mathew

Jesse M. Ehrenfeld

Artificial intelligence (AI) has moved quickly from a distant concept to a daily topic in medical practice. As AI tools are already being integrated into clinics, hospitals, and health systems, clinicians around the world remain optimistic, wondering how this shift will impact patient care, professional judgment, and the future of our work. Three specific reflections remain: How safe and accurate are AI tools, and how will they fit into real-time clinical workflows? Will AI help reduce the pressures that physicians face, or will it introduce new complications? How can we make sure that AI strengthens, rather than weakens, the physician-patient relationship?

With this growing need in mind, the World Medical Association (WMA)'s Medical Technologies Working Group organised a five-part webinar series from January to May 2025 (https://www.youtube.com/worldmedassociation). The series was co-hosted by Dr. Jesse Ehrenfeld (American Medical Association) and Dr. Jacob Mathew (Kuwait Medical Association), with support from Michelle Glekin (Israeli Medical Association) and the Medical Technologies Working Group team, along with Clarisse Delorme, Magda Mihaila, and Marie Ferreira from the WMA Secretariat. The sessions began with foundation concepts and then progressed to clinical use, legal considerations, development practices, and global equity. They aimed to help clinicians build confidence as well as a grounded understanding of AI amidst a rapidly changing landscape. Notably, the Working Group invited global experts for a roundtable-style conversation, rather than comprehensive lectures, allowing experts and participants to think through the issues together and encourage questions, dialogue, and reflection on practical uses of AI in clinical practice [1].

Webinar 1: Introduction to AI in Medicine

The first session opened with remarks from Dr. Ashok Philip (WMA President), who set the tone by acknowledging both the opportunities and the responsibilities that come with incorporating AI in medical practice [2]. The discussion period focused on making AI terminology understandable for physicians, especially typically interchangeable terms of machine learning, deep learning, and large language models. It offered a comprehensive summary of each concept and offered examples of how they are being used in healthcare today. As participants raised concerns about black box systems, hallucinations, and the limits of current models, the message was clear: AI still requires clinical oversight. The session closed with a brief look at prompt engineering and why the wording of a query will shape the quality of AI's response.

Webinar 2: Ethics, Legal, and Regulatory Aspects of AI in Healthcare

The second webinar brought in Professor Barry Solaiman (Hamad Bin Khalifa University), who focused on the legal and ethical challenges of AI that are becoming increasing complex [3]. The accountability of this tool raised concerns, especially on the identification of the responsible party if an AI system contributes to a clinical error. Although physicians frequently assume the responsibility of liability, even when technology plays a direct role, this imbalance will not be sustainable. The discussion covered informed consent, bias, privacy, data security, and the pace at which regulation needs to evolve. The session finalised with the emphasis that AI should be governed across its entire lifecycle, rather than just at the point of deployment.

Webinar 3: Current and Future Applications of AI in Medicine

The third session featured Dr. Michael Krauthammer (Professor of Medical Informatics, University of Zurich), who walked through how AI is being used in areas ranging from rheumatology to radiology, and how these tools attempt to approximate expert reasoning [4]. He highlighted an example of how AlphaFold (https://alphafold.com/) has changed protein structure prediction. It demonstrated a clear case of how far-reaching AI can be, influencing beyond clinical diagnostics and expanding to biomedical research

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and drug discovery. The discussion covered digital twins, predictive analytics, and workflow automation, along with an honest look at existing gaps and the need for stronger validation and more representative datasets.

Webinar 4: Best Practices in Medical AI Development

The fourth session brought in Dr. Nathalie Bloch (ARC Innovation Center, Sheba Medical Center), who spoke candidly about AI tool development for clinicians in the workplace [5]. As her experience spans both clinical practice and innovation, she stressed that real clinical problems (not technology) should lead the conversation. She shared that AI solutions work best when clinicians are involved from the beginning, helping to shape the problem statement and the workflow integration. She underscored the importance of testing tools in real clinical environments before large-scale deployment, as promising systems may fail simply because they do not align with healthcare delivery. The discussion incorporated lessons from real-world solutions and highlighted the importance of designing AI tools that respect clinical time, cognitive load, and the realities of frontline practice.

Webinar 5: AI for Health Equity: Bridging the Global Divide

The final session featured Professor Mary-Anne Hartley (Laboratory for Intelligent Global Health & Humanitarian Response Technologies, LIGHT) who transitioned the dialogue from individual clinics to the global landscape, focusing on how AI may reduce existing healthcare disparities [6]. She introduced Meditron (https://jointhemoove.org/meditron), an open-source medical language model built for low-resource settings from MOOVE (https://jointhemoove.org/), a global platform for validating AI models in different environments. The discussion offered insight on data sovereignty, model ownership, and the need for lightweight tools that can operate with limited hardware. Dr. Philip closed the webinar series by reiterating the importance of ensuring that AI serves all health systems, not just the most advanced health systems.

Looking Ahead

Led by the WMA's Medical Technologies Working Group, this webinar series represents an early step that supports the WMA's efforts to help physicians navigate AI with clarity and confidence. By bringing together clinicians, legal experts, technologists, and global health leaders, this series created an important space for the honest discussion about the capabilities of AI technology in shaping medical practice. However, questions remain on how to guide its use to strengthen clinical judgment, protect patient safety, and support fair and equitable health systems. Hence, the WMA's Medical Technologies Working Group will continue to build on the conversations that emerged across the five sessions, which can help physicians worldwide engage with AI thoughtfully, confidently, and with their patients' best interests.

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Artificial Intelligence Empowering Quality Primary Healthcare in China

Hui Yin

Weili Zhao

Global health systems today face converging pressures, including demographic ageing, growing burden of non-communicable diseases, and persistent disparities in the distribution of medical resources. Primary Health Care (PHC)-anchored in community-based, preventive, and continuous care-has become the cornerstone for achieving universal health coverage. To enhance the performance of PHC, innovative technologies such as artificial intelligence (AI) have emerged as critical instruments in addressing these global health challenges.

In this context, many countries have initiated pilot programs to integrate AI with PHC, but they have found emerging operational, systemic, and structural challenges.In Sweden, a qualitative study of healthcare professionals found that although an AI-based triage application was introduced in PHC, it has not yet been fully embedded into routine workflows due to insufficient organisational support and misalignment with established work practices [1]. In the United Kingdom, one workshop conducted with 16 general practitioners concluded that they perceived AI's potential for aiding diagnosis and risk assessment, but shared concerns about its accountability issues and the potential to increase administrative workloads [2]. In Sub-Saharan Africa, a comprehensive review of AI in healthcare identified multiple applications in diagnostics, remote monitoring, and maternal-child health, but identified challenges in infrastructure, data ecosystems, governance, and system readiness [3].

Therefore, international organisations such as the World Health Organization (WHO) and the World Medical Association (WMA) are emphasising the importance of ethical AI integration in healthcare to ensure its effective and responsible use in healthcare. The WHO's *Ethics and Governance of Artificial Intelligence for Health* calls for the ethical use of AI to strengthen the global drive toward health for all [4]. The *WMA Statement on Artificial and Augmented Intelligence in Healthcare* also stresses that AI must empower physicians, serve patients, and advance fairness, rather than serve as a substitute for human judgement [5].

In response to global calls for ethical and effective use of AI in healthcare, China has been a pioneer in implementing community-led PHC models at all stages of socioeconomic development [6]. The health system incorporates a three-level health service network, "barefoot doctors" in rural communities, cooperative medical insurance, and integration of traditional Chinese and Western medicine. With *Healthy China 2030* Plan and ongoing health systems reform, China has further integrated AI into its healthcare system, extending from community clinics to tertiary hospitals [7]. These developments are simultaneously a domestic response to governance modernisation and an active contribution to international cooperation within the global medical community.

Five Dimensions of AI Empowerment in Quality PHC

China's experience reveals a coherent five-dimensional framework for AI empowerment in quality PHC: PHC doctors' capacity, accessibility, efficiency, integration of preventive and clinical services, and cross-sector collaboration (Figure 1). Together, these dimensions illustrate how technology, when ethically governed, can reinforce human professionalism and advance universal health coverage.

Enhancing Physician Competence. AI strengthens the cognitive and diagnostic capabilities of PHC physicians through decision-support systems, knowledge retrieval, and predictive analytics. For example, studies on diabetic retinopathy screening and conversational AI models in community clinics have shown measurable gains in diagnostic precision and patient communication [8]. Similarly, field experiments conducted in PHC settings for chest diseases have demonstrated that machine-learning assistance improved diagnostic accuracy from 72% to 96% [9]. Research has revealed that large-language models outperform average medical trainees in theoretical assessments, while experienced clinicians remain superior in empathy and contextual judgement [10]. This evidence underscores that AI functions as an augmentative, rather

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than substitutive, tool: physicians remain the ultimate decision-makers, while technology acts as a dynamic cognitive partner. It aligns with the WMA's ethical principle that AI should enhance, not replace, professional judgement [5].

Expanding Service Accessibility and Advancing Universal Health Coverage. By leveraging telemedicine, mobile diagnostics, and cloud-based platforms, AI helps bridge the urban-rural divide in access to care. For example, the Lin'an District in Hangzhou supports its Smart Mobile Hospital, which has integrated mobile clinics, remote imaging, and digital pharmacies powered by AI, expanding coverage to more than 500,000 residents across 165 previously unserved villages [11]. The initiative has demonstrated how initial investments in digital tools can evolve into stable, community-centred systems that support long-term service provision [12]. Digital connectivity and smart devices can also improve rural residents' access to timely and continuous care [13]. Hence, AI can effectively contribute to technological efficiency and promote health equity, as envisioned by the Sustainable Development Goal 3 (Goal 3.8: universal health coverage).

Improving Service Efficiency and Reducing Doctors' Administrative Burdens. AI enhances operational performance by optimising workflows and resource allocation for PHC doctors. For example, Xiji County in Ningxia used a cloud-based system and 5G connectivity to link county–township–village health facilities, which increased PHC service efficiency by over 40%, showing how digitalisation can substantially streamline rural healthcare delivery [14]. AI enhances information integration, aiding doctors in standardising clinical tasks and reporting, and supporting evidence-based resource planning. This reduces doctors' cognitive stress, allowing them to spend more time communicating with patients and making informed decisions.

Integrating Preventive and Clinical Care. AI facilitates the integration of prevention, diagnosis, treatment, and follow-up services - bridging the traditional divide between clinical medicine and public health. As an example, in the Lin'an District, the Tianmu Health Sharing Platform has unified hospitals, community centres, and village clinics through a single cloud-based network, forming a closed loop linking clinical and preventive services [11]. Smart devices and interconnected data systems have been shown to strengthen rural health networks' responsiveness and resilience [13]. Doctors can view complete patient records, receive algorithm-generated risk alerts, and coordinate cross-facility follow-up care. AI helps doctors anticipate risks, intervene earlier, and maintain continuous relationships with patients across the full spectrum of health needs.

Synergizing Health and Social Services. PHC doctors often encounter patients whose health problems are intertwined with social factors such as ageing, poverty, disability or limited access to public services. AI enables more effective cross-sector collaboration by linking medical data with social welfare, long-term care, and community service systems. In China, integrated digital health platforms connect medical, civil affairs, social security, and education databases, providing elderly and chronically ill patients with unified health records, welfare benefits, and care plans [11]. Through such systems, AI amplifies doctors' ability to act as health coordinators, helping them identify vulnerable patients, organise interdisciplinary support, and provide continuous monitoring across sectors, which aligns

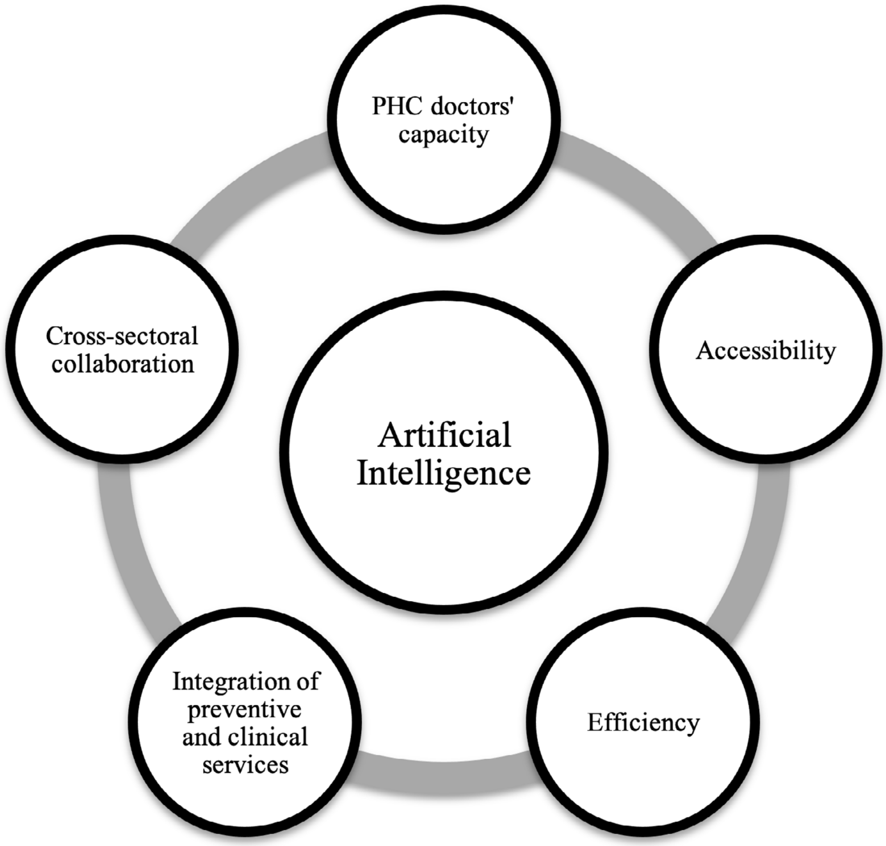

Figure 1. Five dimensions of AI empowerment in quality Primary Health Care (PHC). Credits: H. Yin and W. Zhao

with global trends toward whole-of-society health promotion.

Enabling Conditions and Ethical Mechanisms

AI can only empower quality PHC when it is supported by sound governance, trustworthy data practices, professional training, and ethical safeguards. China's experience shows that the successful adoption and use of AI depends not merely on technological capability, but similarly on institutional design and professional responsibility.

Governance and Institutional Norms. AI in healthcare operates within an emerging governance framework that blends legal, ethical, and professional accountability. Several prominent frameworks have been developed to guide the responsible deployment of AI in healthcare. First, the *EU AI Act* provides a risk-tiered approach, classifying most AI applications in healthcare as high-risk systems [15]. Second, the *AI Risk Management Framework*, by the U.S. National Institute of Standards and Technology, offers a structured approach to mapping, measuring, managing, and governing AI risks [16]. Third, the *Guidance on Promoting and Regulating the Application Development of Artificial Intelligence + Healthcare*, by the National Health Commission of China, sets clear goals for the integration of AI in healthcare by 2027 and 2030, by outlining measures to ensure the safe and ethical use of AI in healthcare. It calls for the development of standards and guidelines to govern the use of AI in clinical settings as well as regulatory frameworks for AI applications, data security protocols, and privacy protection measures [17].

Data Infrastructure and the Dual Imperative of Trust and Security. Reliable, ethically sourced data underpin every successful AI adoption in healthcare. Cross-provincial or municipal interoperability and local protection measures can enable scientific collaboration and safeguard privacy and consent. Privacy-preserving technologies (such as differential privacy) have been piloted to enable AI to analyse patient data trends without exposing individual records, thereby reducing the risk of data leakage [18]. Also, the Blockchain Service Network can be authenticated and encrypt patients' healthcare data, allowing secure sharing and circulation of medical data between healthcare institutions with patient authorisation [19]. Doctors can use this technology to gain a comprehensive understanding of patients' physical and mental health to aid in their care management.

Strengthening the Medical Workforce for the AI Era. Physicians' responsibilities in the digital age encompass four domains: clinical judgement, ethical stewardship, data oversight, and health advocacy. The World Federation for Medical Education (WFME) accreditation frameworks have increasingly encouraged medical schools to embed digital health, data governance, and AI-related competencies in curricula, and similarly, recent international consensus statements identify that AI literacy, ethics, and data governance as mandatory learning outcomes for future physicians [20]. In China, medical education reform has advanced toward interdisciplinary medical engineering integration, where universities and teaching hospitals have been integrating AI into curriculum modules on clinical reasoning, ethics, interpretation of digital tools, and interdisciplinary collaboration. Integrating medical with engineering education allows trainee doctors to use AI critically, rather than follow it passively, and AI-assisted training can improve residents' ability to frame differential diagnoses [21,22].

Ethical Foundations and the Principle of Interpretive Responsibility. The ethical challenge of AI lies in maintaining transparency, explainability, and accountability, as tools used by doctors must provide clear rationale for their outputs, enabling physicians to judge whether recommendations align with clinical evidence and patient needs. In Singapore, AI for clinical use is classified as a regulated medical device, subject to strict documentation, validation, and human-in-the-loop governance [23]. China's draft *Artificial Intelligence Science and Technology Ethics Management Service Measures (Trial)* explicitly covers high-risk uses (such as medical AI) and introduces enhanced ethical management requirements for such applications [24]. Pilot programmes in Zhejiang and Beijing now review AI projects for safety, efficacy, fairness, and interpretability. This transition from technological regulation to ethical co-governance signals a deeper moral maturity within the global medical profession.

Looking Ahead

AI will continue to reshape how PHC doctors diagnose, counsel, and care for patients. Its long-term value will depend on whether future developments deepen doctors' clinical authority, strengthen trust, and advance fairness.

Redefining the Medical Profession of PHC Doctors. The professional identity of physicians now includes ethical stewardship of digital tools, advocacy for patients' rights, and leadership in interpreting complex data. This shift will encourage doctors to see themselves as informed interpreters, responsible decision-makers, and ethical guardians, rather than passive users of technology. When AI handles repetitive analytical tasks, physicians can redirect their time toward empathy, communication, and contextual reasoning [8]. Future research should therefore explore how AI influences medical ethics, patient trust, and accountability.

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Transformation of PHC into a Community-based Integrated and Quality Care. By enabling a shift from reactive treatment to proactive health promotion, AI can advance PHC by focusing on the guiding principles of human-centredness, fairness, cooperation, transparency, and learning. Where cost and workflow efficiency are prioritised in the Global North, equitable distribution of AI innovation remains the central focus in the Global South. Future practice should focus on building systems where AI amplifies the preventive and integrative roles of PHC doctors.

Ensuring that AI Promotes Equity. The success of AI in empowering doctors depends on its ability to promote fairness, dignity, and people-centred care. The promise of AI can be achieved only if its deployment mitigates, rather than deepens, existing inequities. Therefore, future scholarship and policy must evaluate whether AI closes or widens gaps between rural and urban physicians, whether it supports vulnerable populations (e.g. older adults, disabilities, underserved), and whether doctors feel enhanced (not constrained) in their professional roles.

Conclusion

The increasing prevalence of AI in healthcare has given rise to a range of pressing legal, regulatory, and ethical challenges, including the determination of liability in AI-assisted misdiagnosis, the lack of transparency in AI algorithms, and the protection of patient rights. China's five-dimensional model and experiences provide insights and potential solutions to these governance and ethical challenges. Looking ahead, the integration of AI with PHC will continue to drive the exploration of innovative approaches in clarifying accountability mechanisms, promoting medical model transition, and establishing interdisciplinary ethical governance bodies.

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Interview with the Family Medicine Expert in Patient Access to Records and Patient Safety

Richard Fitton

Dr. Richard Fitton joins the interview with Dr. Helena Chapman, the WMJ Editor in Chief. As a family physician in the United Kingdom, he is passionate about ensuring that patients have access to their medical records, receive safe medical care with minimal errors or omissions in patient records, and are enabled with the means of patient agency. Notably, he has almost four decades of experience in clinical care and patient education and provision of the knowledge, skills, and attitudes required by patients for full participation in their healthcare decisions.

What are four ethical considerations that continue to challenge physicians with incorporating patient access to their records into digital health to enhance clinical care and shared decision making? How can they work together to address these challenges?

Firstly, *clarifying the processes of confidentiality:* Personal health data is confidential to the doctor and patient, but confidentiality should not preclude patients from seeing their own data. Patients should be able to view their personal data, albeit with a few exceptions. Secondly, *providing sufficient information to patients to explain their personal health data that physicians share with them:* Informed patients are better prepared to give consent to proposed care and health interventions, when they are provided information that is tailored to their level of literacy and linked to their patient accessed records.

Thirdly, *deciding whether to allow patients to see their personal health data during or before their medical appointment:* Physicians have traditionally shared "bad news" to patients, which requires empathy, and compassion in the delivery. However, one multi-site research study of more than 8,000 surveyed patients in the United States found that most patients preferred receiving their medical results immediately, and before physicians' formal reviews or consultations [1]. Fourthly, *finding a way for physicians to make their findings and notes available to physicians in other hospitals*: Physicians treat patients with complex medical histories from other hospitals, specialties or countries with difficulty when they have no access to the previous medical records. Physicians will minimise this difficulty when they allow their patients to share their personal health data wherever, whenever, and with whoever, they wish.

When physicians prepare their clinical notes, they should routinely include a recommendation that allows patient access to their digital records, especially in long-term health plans [2,3]. Physicians' continuing professional development should cover the etiquette of writing notes that can be shared with patients and how to work with patient data in the digital world.

Can you describe two lessons learned during the COVID-19 pandemic that prompted the need to improve healthcare practice, safety, and patient agency?

The COVID-19 pandemic challenged health systems to respond in the fastest possible time to a previously unknown, often fatal, contagious disease. As service providers and governments learned lessons in disease surveillance, care management, and response measures, two specific lessons have helped improve patient education and agency in clinical practice.

Firstly, the National Health Service (NHS) promoted the NHS App widely in response to the COVID-19 crisis. The NHS App was used to communicate with patients who were in quarantine and unable to visit health facilities (https://digital.nhs.uk/services/nhs-app). Patients learned to use the NHS App to manage medical appointments and vaccinations, order repeat prescriptions, and to present their medical histories to health professionals. They obtained health information, chose how the NHS uses their data, received instant health advice, and requested medical assistance. Notably, over one million individuals had signed up for the NHS App by December 2019, and a total of 33.6 million individuals by November 2023 [4].

Secondly, the NHS learned to engage with the public and patients using these digital channels. Patients learned to read and use their health records for work, travel, and to plan their health. They learned to grant the NHS permission to contact them for vaccinations, and to trust the NHS App with their personal health data for research, planning, and audit purposes. The government issued the *Regulation 3(4) of the Health Service (Control of Patient Information) Regulations 2002* during the COVID-19 pandemic in 2020, requiring the sharing of confidential patient information among health organisations (and other appropriate bodies) to protect public health and provide healthcare services

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during the outbreak monitoring and response.

How can physicians lead efforts to facilitate patient access to their records to effectively ensure patients' rights in clinical practice, while striving to safeguard autonomy in decision-making processes?

Clinical tutors can provide physicians-in-training with the knowledge, skills, and attitudes, to share digital health records with patients [3,4]. Physicians can advise and encourage patients to access their digital health records during consultations. They can collaborate with information technology suppliers to develop and enhance patient portals. However, the question remains: *Can physicians who support patient access effectively ensure patients' rights in clinical practice while striving to safeguard autonomy in decision making processes?*

Data access, physician-patient rapport, autonomy, and shared decision-making align directly with the World Health Organization (WHO) Patient Safety Charter, which describes 10 patient rights. 1) right to timely, effective and appropriate care; 2) right to safe health care processes and practices; 3) right to qualified and competent health workers; 4) right to safe medical products and their safe and rational use; 5) right to safe and secure health care facilities; 6) right to dignity, respect, non-discrimination, privacy and confidentiality; 7) right to information, education and supported decision making; 8) right to access to medical records; 9) right to be heard and fair resolution; and 10) right to patient and family engagement [5]. Notably, nine rights (all except 5) are linked to patient access to records, whereas three rights (rights 1, 7, and 8) support autonomy in decision-making processes. Patient access to records is a strong supporter of patient respect and dignity, leading to patients who feel more respected and dignified in clinical encounters.

How do you anticipate that the widespread use of health apps and patient access to their records will impact patient data, agency, safety, and privacy?

Over the next decade, patient data will become ubiquitous to patients. Health apps will complement and supplement healthcare structures and processes, and communities and villages with limited access to health professionals will be able to access their digital data and health services through these health apps. The promise of secure national health apps will reduce the risk of data privacy breeches currently observed with less secure apps and websites. Furthermore, patients' trust in data sharing will improve as they access their records, understand how their data are viewed by health professionals, and inspect their records for errors or omissions.

With technological advancements and globalisation, how do you envision the future of clinical practice, patient agency, patient safety, patient access to their records, and the need to protect data and privacy?

Global digital health languages, such as SNOMED CT (https://www.snomed.org/), will unify global health records. SNOMED CT has standardised the digital elements of traditional medicine and has ongoing work to incorporate the International Classification of Diseases (11th revision) (https://icd.who.int/en/). Patient access to records will be central to health system development, and a global health data governance framework, such as the UN Global Data Compact, will facilitate cross border care, international data sharing, migration, and domestic and international travel [6].

What innovative tools help physicians to learn more about patient access to digital records and increased patient agency?

Patients' personal stories are very effective for teaching physicians and administrators to share records with patients. Stories can highlight a holistic framework of patients' healthcare experience, demonstrate the benefits of patient access to health records, and outline the cultural changes of patient access to records [7]. Personalised testimonies offer additional insight on how to adapt medical education and training programs – including the "humanistic touch" – to improve patients' expectations, and autonomy, in care and decision-making, as well as strengthening global healthcare service delivery [8-11].

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Health Privacy Law: Getting the Balance of Interests Right

Edward S. Dove

In terms of scale, scope, and pace of change, health information - and the frameworks governing its protection - are daunting subjects to confront. As everyone knows, health information collected from and about us (which may be broadly defined to include our genetic relatives) is used to diagnose and treat us. The provenance and curation of this information, however, can be mystifying. The information may come from our own medical files, but it may also come indirectly from the data of hundreds of thousands, if not millions, of other people based on clinical audits, observational research, clinical trials, and data linkage studies. In England, for example, the National Health Service (NHS) holds medical records of more than 65 million people – practically the entire population in the nation – dating back for decades [1]. It is uniquely valuable in holding cradle-to-grave information on a national population, and a much-desired "treasure trove" that tech and pharma companies, unfriendly foreign governments, and others would love to access.

But that desired enhanced access is, thankfully, protected around the globe, albeit to varying degrees, by various normative frameworks, including laws. Medical confidentiality is an ancient ethical, professional, and legal obligation that health professionals and researchers alike owe to their patients and participants, respectfully. To focus on ethical codes, the Hippocratic Oath advises doctors that whatever they *"may see or hear in the course of the treatment or even outside of the treatment in regard to the life of [patients], which on no account one must spread abroad"*, they will keep to themselves, *"holding such things shameful to be spoken about"* [2]. The Declaration of Geneva obliges doctors to *"respect the secrets that are confided in [them], even after the patient has died"* [3]. Finally, the medical research-orientated Declaration of Helsinki demands that researchers take *"every precaution […] to protect the privacy of research participants and the confidentiality of their personal information"* [4].

If we also look to specific texts from the professional regulators around the globe, as well as national, regional, and international laws, there is in fact a panoply of precepts and rules governing what health professionals may do with the things they see, are told, write down, and share with others. If a health professional breaches a patient's confidentiality, we can be relatively confident that there will be, at least in principle, some form of sanction, be it from the professional's employer, a regulator, or a court of law. And yet, sometimes health professionals, employers, and governments alike fall short in respecting the reasonable expectations of patients and participants regarding the protection of their health information. Box 1 presents details about the "health privacy law," an emerging cognate area of law comprising three distinct legal frameworks.

Box 1. A Primer on Health Privacy Law [5]

Health privacy law is an emerging cognate area of law comprising three major legal frameworks: confidentiality law, privacy law, data protection law, and laws governing access to health records. Depending on the jurisdiction in question, these legal frameworks may be conjoined or separate, and in some rarer instances, non-existent (e.g. some jurisdictions still have not passed data protection laws that address health information). It is the corpus of laws and legal norms that govern 1) the collection, storage, and use of information relating to a person's or group of persons' physical or mental health, including the provision of health care services, which reveal information about one or more persons' health status, and 2) the spatial and decisional aspects concerning one or more persons' health, such as reproductive choices and end-of-life decision-making.

Confidentiality law is the legal framework that protects information disclosed by one party to another. In the health context, classically this would be medical information confided by a patient to one's doctor. Unlike privacy law and data protection law, it is primarily concerned with rules around protecting and sanctioning wrongful disclosure of health information rather than rules governing its collection.

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Privacy law, in its broadest understanding, is the corpus of laws and legal norms that govern the collection, storage, and use of personal information, as well as the dimensions of private life of individuals (what might be termed our 'intimate lives') and, more provocatively, groups and communities.

Data protection law is primarily shaped by statute. It largely comprises a set of legal rules that aims to protect the rights, freedoms, and interests of individuals whose personal data are collected, stored, processed, disseminated, or deleted. Its principal purpose is to facilitate flows of personal data across organisations and countries, while at the same time ensuring fairness in the processing of data and, to some extent, fairness in the outcomes of such processing.

In May 2023, it was reported that a "stalker" doctor at Addenbrooke's Hospital in Cambridge, England, accessed and shared highly sensitive information about a woman who had started dating her ex-boyfriend, despite not being involved in her care. The doctor first accessed the hospital's medical records system and subsequently another records system that contained detailed notes of intimate conversations (e.g. her former partner's new girlfriend with her general practitioner about a family tragedy, her child's health). The hospital initially denied that staff could access patients' records through the hospital's medical records system, but in a subsequent meeting with the victim, the deputy medical director acknowledged that her full general practitioner's records were available for staff to access [6]. Many other examples abound, such as concerns about the NHS sharing patients' details with the United Kingdom (UK)'s Home Office (interior ministry) so it could trace people breaking immigration rules, and access to the UK Biobank data from a so-called "race science" research group [7,8].

Coupled with these unfortunately not-so-infrequent instances of putative health privacy violations is a growing sense of disempowerment and bewilderment. This scenario is caused in part by increasingly sophisticated and intrusive technical devices, technological developments, and volume of data linkage activity alongside massive mixed datasets of personal and non-personal data. The vast and growing array of policies, frameworks, laws, and legal agreements that characterise data privacy also influences any confusion or negative sentiment toward the ability of state and non-state actors alike to protect and promote our health privacy.

Indeed, the scale of collection, use, and sharing of all sorts of information concerning each individual seems to be growing exponentially. Data may come from the smartphone apps that can track movement and hence trace the spread of infectious diseases (e.g. coronavirus disease 2019, COVID-19) or document vaccination status. It may come from our visits to the therapist's office for a routine appointment or the hospital for a programmed surgical procedure or outpatient treatment. Data may come from simply relaxing in our apartments, taking the tram, train or bus to work, speaking to Alexa, prompting artificial intelligence (AI) chatbots such as ChatGPT or DeepSeek with health-related queries, and going on Bluesky, X, Instagram or TikTok to post a text or "passively" scroll through reels. Few doubt that there is a daunting amount of information about our lives that is hoovered up by algorithm-powered machines, digital devices, and digital systems, which is then assembled, stored, and manipulated into various datasets, and used in ways by governments, companies, researchers (and sometimes hackers) often beyond our understanding and awareness.

Cutting across this desire for solid protection in the face of mystifying and exponential growth in health information collection and use is the powerful pull of economic growth and societal wellbeing-and as part, medical progress to enable healthy, happy lives. The collection and use of health information (e.g. assemblage into datasets, curation, and making available to others for different purposes) depends on its relatively unencumbered free flow, both within and across national borders. Health privacy law, however, may present barriers, such as strict rules preventing the sharing of vital information across international borders, for scientific research and other bona fide purposes.

The question remains: How do we achieve the balance between 1) assuring patients and participants that their health information is vigorously protected, and sanctions will be applied to professionals and other parties (including governments) who violate that trust; and 2) enabling health information to be used for the individual and public good?

In a recently edited book [9] and forthcoming book entitled Health Privacy Law [5], the author charts how the relatively simple days of easy-to-understand laws protecting medical secrets passed from patient to doctor have transitioned to an incredibly complex interplay of legal frameworks that govern the collection, use, and disclosure of health information concerning individuals and groups (as patients, consumers or research participants). For example, the European Union has complicated

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interactions between a serious of substantive laws, including the General Data Protection Regulation, the Data Governance Act, the Artificial Intelligence Act, and the European Health Data Space Regulation [10-13]. Aspects of health information impact the immediate individual (to whom the information relates) and may implicate other individuals, which raises under-addressed questions about group (or even familial) rights and interests.

In both of these recent works, the author explains how achieving the balance involves the careful drafting, interpretation, monitoring, and enforcement of legislative instruments, coupled with clear case law and policy documents, and easy-to-understand guidance for health professionals and patients. These efforts can help drive global harmonisation and consensus, and prudently shape what may be done lawfully with information concerning our health. Of course, laws and regulations only represent part of the journey to building a culture of sustained protection and promotion of health privacy. Apart from compliance with laws and regulations, health professionals must continue to act virtuously, working with health organisations to develop and practice a culture that supports privacy-promoting compliance systems. Likewise, regulators, including health professional regulators, must possess and hone sufficient skills to evaluate and ensure health privacy is respected; regulators must also have the courage and political support to hold professionals and organisations accountable when privacy violations occur [14].

Health privacy and its regulation is unquestionably a dynamic, multifaceted field that engenders deep questions about power, control, reasonable expectations, and accountability. The author encourages readers to critically consider the ways in which the ethical, legal, and professional regulatory frameworks in their home jurisdiction regulate flows of health information, whether these frameworks are fit-for-purpose, and whether regulators are robust enough in their monitoring and enforcement. In other words, readers should ask: Are these frameworks attuned sufficiently to the evolving paradigm of large-scale, global, and digital data-driven healthcare and biomedical research? Do they strike an appropriate, proportionate balance between protecting morally and legally relevant interests in our health information, and the interests of society in promoting safe, efficient, and effective data flows? Is there a relative balance of power between relevant stakeholders, or do the frameworks inadequately protect individuals (and groups) from privacy intrusions by powerful actors (e.g. private companies like Big Tech, well-funded scientists, intrusive government bodies)? Should regulators do more, are they properly resourced to do more, and is the political will there?

Fundamentally, as we reflect on the answers to these questions, we should consider how health privacy law can help protect and promote human values, serving the interests of society and furthering our ability to lead healthy, flourishing lives. It is my sincere and admittedly self-interested hope that readers find health privacy law as a matter of profound interest and importance for their practice and for sustaining trust with patients and research participants. The forthcoming book, *Health Privacy Law,* provides insight into how we can all do better to protect and promote our health privacy in our daily practice.

Special note: This opinion piece is adapted and excerpted from the author's forthcoming book [5], with permission to reprint kindly granted by Edward Elgar Publishing.

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WMA and WVA Reinforce Shared Commitment to One Health

John de Jong

Jack Resneck, Jr.

On 18 July 2025, the World Medical Association (WMA) and the World Veterinary Association (WVA) formalised the new memorandum of understanding (MOU) at the WVA General Assembly in Washington, DC [1]. Dr. John de Jong (WVA President) and Dr. Jack Resneck, Jr. (WMA Chair of Council) signed this agreement to reinforce their respective organisations' shared commitment to One Health (Photo 1). This current MOU builds on the previous MOU, which was signed by Dr. Faouzi Kechrid (WVA President) and Dr. Cecil Wilson (WMA President) at the WMA General Assembly, held in Bangkok, Thailand, in October 2012 [2].

This agreement is intended to create increased collaboration to provide for a stronger future for human, animal, and environmental health. These three areas are inextricably intertwined and co-dependent for sustainable life on Earth.

Since 2012, the idea of One Health has received significant recognition in global health, which offers a timely reason to elevate the friendly cooperation between both organisations. In October 2024, during the WMA General Assembly in Helsinki, Finland, Dr. de Jong met with the WMA leadership to foster professional networks and propose potential collaborations that integrate scientific expertise between WMA and WVA members. These multidisciplinary collaborations are essential, considering the vast amount of zoonotic and emerging diseases globally such as avian influenza, arboviruses, and parasitic diseases (e.g. Lyme disease). Specifically, he suggested writing and signing a new refreshed and more impactful MOU that would address the pathogens that affect both humans and animals. As the WMA leadership enthusiastically agreed, the drafting of the new MOU was prepared between January and June 2025, and both organisations signed the revised MOU in July 2025.

This agreement renews the pledge to focus on global development objectives aligned with the One Health concept, as a unified approach to human and veterinary medicine. Together, the WMA and the WVA can work to educate governments, regulatory bodies, and the public about the many diseases that affect various species, helping to minimise or even eradicate them in order to create a healthier world. Proactive advocacy efforts coordinated by both organisations hold the potential to increase global attention on these issues.

This document also further highlights five priority areas where both organisations can share valuable clinical and community expertise and enhance professional networks. First, the agreement aims to support joint educational efforts that expand engagement between human medical and veterinary medical schools. Second, it helps expand efforts to enhance cross-species disease surveillance and control related to zoonotic disease transmission, which aligns with ongoing collaborations with the World Health Organization (WHO) and the World Organisation for Animal Health (WOAH). Third, the document proposes to strengthen initiatives to promote the responsible use and prescribing practices of antimicrobials, which will combat the global risk and spread of antimicrobial resistance. Fourth, it intends to boost the critical partnerships between human and veterinary medical professionals in academic, clinical care, public health, and biomedical research. Finally, it helps explore collaborative initiatives that advance the interconnectedness of human and animal health disciplines with common activities (such as fellowship opportunities), including those established in previous agreements.

Over the past decade, the WMA and WVA have organised inaugural One Health events for the global community. First, using the "Drivers towards One Health: Strengthening Collaboration between Physicians and Veterinarians" theme, leaders organised the Global Conference on One Health in Madrid, Spain, on 21-22 May 2012. Second, applying the "Moving Forward from One Health Concept to One Health Approach" theme, leaders collaborated with the Japanese Medical and Veterinary Associations

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Photo 1. The agreement, signed by WMA Chair of Council Jack Resneck, Jr. (left) and WVA President Dr. John de Jong (right), reinforces the WMA's and WVA's shared commitment to One Health. Credits: WMA/WVA

to coordinate the Global Conference on One Health in Kitakyushu City, Japan, on 10-11 November 2016. These events created a collective platform to acknowledge the valuable expertise of human and animal health professions, underscore the need for cross-sector partnerships, enhance awareness of essential leadership, communication, and facilitation skills, and ultimately foster greater unity and rapport within professional networks. As emerging and reemerging global health risks transcend geographic borders and species, both organisations deem the continuation of joint One Health events as vital to engaging and empowering health leaders in scientific discussions that lead to concrete community and policy action.

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Interview with the President of CONFEMEL

Jorge Coronel

Dr. Jorge Coronel joins the interview with Dr. Helena Chapman, the WMJ Editor in Chief. As a physician specialist in intensive therapy, he is the current President (2025-2027) of the Medical Confederation of Latin America and the Caribbean (Confederación Médica Latinoamericana y del Caribe, CONFEMEL), as well as the current Vice President (2025-2026) and Immediate Past President (2015-2024) of the Medical Confederación of the Republic of Argentina (Médica de la Republica de Argentina, COMRA). He has actively contributed to national and regional initiatives, including serving as the former President of COMRA's Drug Commission, endorsed by the Argentina Ministry of Health, Pan American Health Organization, and World Health Organization, which was responsible for the implementation of health policies on the rational use of medicines by health professionals. Also, as consultant with the Health Sector of the Inter-American Development Bank, he led the preparation of the Strategic Development Plan for the Province of Salta in Argentina.

Can you share a brief history about CONFEMEL and describe the fundamental pillars of the organisation?

Between 1946 and 1973, the Pan American Medical Confederation represented the regional organisation that linked the national medical associations within the Americas region. During the 1970s, several countries experienced political turmoil (including coups d'état), which limited regular coordination of national and regional meetings. However, medical organisations continued to actively operate and coordinate key activities in their respective countries until the late 1990s. At this point, medical organisations agreed that a regional organisation was essential to unite countries and focus on how physicians can deliver quality healthcare services to the public. This movement led to the establishment of CONFEMEL in Santa Cruz de la Sierra, Bolivia, in 1997. Today, CONFEMEL is an organisation representing more than two million physicians from medical institutions from the Latin American and Caribbean countries, Spain and Portugal, and external regions (e.g. France, Israel, Italy).

As CONFEMEL represents its member medical institutions at all levels, its organisational pillars are founded on the principles of universal, comprehensive, and equally accessible healthcare. CONFEMEL aims to uphold the dignity of the medical profession by promoting ethical and professional standards, creating and fostering initiatives that strengthen physicians' education and training, and defending physicians' working rights and conditions. CONFEMEL actively collaborates with universities and other institutions, states, and governments to accelerate the scientific, technological and social development of medicine as well as ensure physicians' well-being and safe workplace environment.

How has your medical training and professional experiences as former president and current vice president of COMRA helped prepare you for your new role as president of CONFEMEL?

I began my career as a primary care physician in an indigenous community in northern Argentina, which allowed me to learn about social medicine and community health. Later, I specialised in intensive care, and then received training in health systems management and health economics. Before my recent COMRA leadership role as President (2015-2024), I had previously served as the Secretary of Scientific and University Affairs (2000-2009) and Union (Gremial) Secretary (2009-2015), where I acquired valuable experience in institutional management that represented the interests of the Argentinian medical community. During my tenure as COMRA President (2023-2024), I led the Association in defending medical work and to represent its voice in international forums, where I understood the importance of collaborative work, the exchange of experiences, and debate based on ethical and philosophical values.

Also, I have regularly attended CONFEMEL conferences, where I contributed to panel discussions for the collective exchange with regional members on scientific topics, including pharmaceutical policies, biomedical research, and physicians' working conditions. This scientific dialogue has allowed me to acquire a deeper understanding of the real-time needs, priorities, and challenges faced by physicians in the Americas region. Through my COMRA leadership, we have continued to support CONFEMEL's efforts and strengthen cooperation between national medical associations (like COMRA) and CONFEMEL. I am honoured to serve

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as the CONFEMEL President, where I continue to support CONFEMEL's mission and promote organisational growth, established goals, and expansion to local, regional, and international levels.

What are two challenges related to defending medical practice in Latin America and the Caribbean? Regarding the challenges, what are two actions or interventions that CONFEMEL is proposing for the next two years?

First, professional standards in medicine have been difficult to standardise and validate across Latin America and the Caribbean institutions, especially in low-resource settings. Many physicians experience significant barriers in their daily workplace, such as job insecurity, unstable working conditions, workplace violence, excessive workloads, and limited infrastructure and supplies, which deteriorates the quality of professional practice and undermines the dignity of physicians. CONFEMEL has articulated their quality care must be delivered with decent working conditions, and that defending physicians is key to protecting patients and the healthcare system.

Second, maintaining continued medical education, while preserving the human dimension of medical practice, has been difficult in the face of rapid scientific and technological advancements (e.g. artificial intelligence). Recertification and periodic professional accreditation are key tools to confirm competence and ethical behaviors, leading to diagnostic precision and patient safety. Since CONFEMEL has highlighted that technology cannot replace physicians' compassion, empathy, and ethical judgment, it is essential to promote comprehensive medical education that combines scientific excellence with humanistic values.

To address these two challenges, CONFEMEL has outlined two priority actions for the next decade. First, CONFEMEL aims to promote public policies and regulatory frameworks that guarantee decent and safe working conditions for physicians. By working with governments and national medical organisations, they can develop timely strategies to ensure job security, prevent workplace violence in health institutions, and strengthen legal and institutional protections of healthcare professionals. Second, CONFEMEL intends to strengthen continuing medical education and professional accreditation by working on harmonising recertification processes, promoting lifelong medical education, and incorporating evidence-based content on ethics, public health, and environmental sustainability. As a result, CONFEMEL can lead efforts to prepare physicians to manage emerging and reemerging global health challenges and how to effectively use new technologies (like artificial intelligence and digital platforms) for quality healthcare service delivery to patients.

How can physicians lead efforts to effectively use artificial intelligence in the clinical workplace?

As artificial intelligence represents a significant tool that can help physicians improve clinical and administrative processes in health systems, the effective incorporation of these novel technologies will require ethical medical leadership and technical expertise. CONFEMEL members believe that physicians must lead this transformational process from two perspectives. First, physicians should actively participate in the design, evaluation, and application of these technologies to ensure that their operational use is based on clinical (not commercial) criteria. Second, they must ensure that artificial intelligence does not hinder the physician–patient relationship as the heart of medical practice. We understand that training new generations of physicians to acquire digital skills and reinforce critical and ethical analyses can help leverage these technological advantages without losing the humanistic touch in clinical care. Artificial intelligence can expand physicians' clinical capabilities, but it can never replace their judgment, empathy or moral commitment to patient-centred care.

How can physicians contribute to applying the One Health concept to clinical and community practice?

Physicians have a fundamental role in operationalising the One Health concept in clinical and community practice. We must broaden the perspective of medical practice, by recognising how economic, environmental, and social determinants influence well-being and illness. In our daily practice, we can promote sustainable health behaviors, participate in vaccination campaigns, and organise educational seminars on emerging diseases risks (including zoonoses). Physicians can also collaborate with other professionals (e.g. veterinarians, ecologists, laboratory specialists) to educate local communities about the importance of environmental stewardship, responsible resource management, and the prevention of emerging diseases linked to climate change.

CONFEMEL members understand the direct links among human, animal, and environmental health, and by applying the One Health concept in our practice, we can move toward a more preventive and collaborative healthcare model. Together, we can promote sustainable health habits and environmental practices, contribute to research that examines emerging disease risks (like deforestation or extreme heat), and

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develop relevant policies and guidelines to protect human, animal, and environmental health. As physicians, our medical expertise will help guide the formation of a comprehensive and sustainable health model to safeguard health and well-being for future generations.

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Trinidad and Tobago Medical Association's Global Solidarity in Climate Health and Resilience: A Small Island Perspective

Saksham Mehra

In an era defined by accelerating climate change and its cascading effects on human health, physicians and national medical associations stand at a defining crossroad. The climate crisis is not an abstract environmental issue – it is a lived public health emergency that tests the resilience of our health systems, the principles of our profession, and the unity of our global community. Within this shifting landscape, the Trinidad and Tobago Medical Association (T&TMA) has positioned itself as a steward of planetary health, an advocate for resilient health systems, and a partner in global solidarity.

From Observation to Action

The 21st century demands a broader understanding of medicine - one in which those who care for patients also engage with the policies that shape their health and the systems that sustain their care. Rising temperatures, extreme weather events, and emerging vector-borne diseases are no longer theoretical concerns; they shape the daily realities of healthcare delivery, particularly within small island developing states (SIDS) [1]. SIDS in the Caribbean face heightened health risks from climate change, as their populations are simultaneously exposed to multiple climate-driven hazards while being constrained by limited adaptive capacity and a smaller regional evidence base [2].

Physicians on the frontlines witness these impacts firsthand- disrupted care, health facility vulnerabilities, and increasing burdens on already stretched systems. Recognising this convergence, the T&TMA has advanced a structured policy framework that positions climate resilience as both a health priority and a professional duty. This initiative – one of the first of its kind by a national medical association in Trinidad and Tobago – seeks to embed climate-health action into the ethical and operational fabric of medical professionalism.

A Framework for National and Professional Collaboration

The T&TMA's climate-health policy framework, adopted as a formal institutional position, establishes the following central priorities: building climate resilience in health facilities, equipping physicians with knowledge and tools to address climate-sensitive health risks, and promoting sustainability in healthcare delivery [3]. This development is intended to encourage broad-based engagement among national stakeholders – bridging the health, environment, and policy sectors – to address the challenges of climate change and health collectively at the local level. It reflects a commitment, not only to professional leadership but also to partnership: strengthening the country's capacity to adapt and ensuring that healthcare remains responsive and resilient amid environmental change.

A Voice in Global Dialogue

The T&TMA's leadership extends beyond the national sphere, with significant contributions to the collective discussion at the 76th General Assembly of the World Medical Association (WMA) in Porto, Portugal. Through the "Global Solidarity in Climate Health and Resilience" presentation, the T&TMA shared its experiences and perspectives, understanding that the lessons drawn from small and vulnerable states may hold value for others across the world (Photo 1). The T&TMA underscored the need for deeper collaboration among national medical associations, particularly those representing small islands and other climate-vulnerable settings. Equally, the Association expressed its openness to learning from the diverse approaches pioneered by colleagues within the WMA community. This exchange of experiences and strategies exemplifies the essence of professional solidarity – rooted in shared purpose and mutual respect. The T&TMA reaffirmed its readiness to share findings, collaborate internationally, and contribute to the collective development of guidance for climate-resilient and sustainable healthcare systems.

Photo 1. Dr. Saksham Mehra delivered the T&TMA's presentation at the 76th WMA General Assembly in Porto, Portugal, in October 2025. Credit: WMA

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A Call for Solidarity and Leadership

No island stands alone. The future of global health security depends on cooperation that transcends borders and hierarchies [4]. The T&TMA envisions a collaborative approach in which national medical associations share insights toward climate-smart, adaptive health systems. Through its participation in global forums, the Association continues to advocate for inclusion, partnership, and shared learning - ensuring that small nations have a voice in shaping global resilience strategies (Photo 2).

In 2023, a landmark regional collaboration was established to strengthen the Caribbean health sector's unified response to the escalating challenges of climate change. This alliance, comprising national medical associations from Trinidad and Tobago, Jamaica, Barbados, St. Lucia, Suriname, and other Caribbean nations, in addition to EarthMedic and EarthNurse Foundation for Planetary Health, led to the formation of the Caribbean Health Alliance for Climate Action (CARHACA). [5]. Through a collective statement, the region articulated a shared commitment to addressing climate change as an urgent public health priority, underscoring the critical importance of coordinated regional action to mitigate its health impacts and enhance the resilience and sustainability of Caribbean health systems.

As the world edges deeper into the age of climate disruption, the physician's role must evolve. Leadership in this context builds upon clinical expertise – extending it through foresight, collaboration, and an enduring ethical commitment to the future of care. Rather than prescribing a single path, the T&TMA hopes to contribute to a collective professional movement – where medical associations worldwide, guided by shared values, work together to advance sustainable, evidence-informed health systems.

The T&TMA embraces this responsibility with humility and purpose. It stands as both participant and partner in a broader movement– uniting professional leadership, public purpose, and planetary stewardship. The journey toward climate-resilient healthcare is not merely about adaptation; it is about moral clarity and collective will. In this shared endeavour, physicians are not passive witnesses to climate change – they are architects of health-secure futures, building systems that protect both people and the planet.

Photo 2. Group photo of T&TMA members in Claxton Bay, Trinidad and Tobago, in January 2025. Credit: T&TMA

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Life-Course Vaccination: A Global Call to Action for Equity, Resilience, and Strong Health Systems

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Vaccination has long been recognised as one of the most successful and cost-effective public health interventions in human history. This preventive medicine approach has eradicated smallpox, nearly eliminated polio, and significantly reduced the burden of infectious diseases worldwide [1]. Yet despite this progress, inequities in access, insufficient investment, and under-recognition of the importance of immunization across the life course continue to hinder the realisation of its full potential [2]. On 4-5 November 2024, a coalition of international health and community-based non-government organisations (NGOs) gathered in Geneva, Switzerland, to reaffirm a shared commitment: to strengthen advocacy for life-course vaccination. The resulting call to action, endorsed by leading global associations representing physicians, nurses, pharmacists, social workers, ageing networks, students, and patient advocates, urges policymakers and health systems to view vaccination not merely as a childhood intervention, but rather as a lifelong necessity that safeguards individuals, health systems, and societies [3].

This article will explore the rationale, scientific evidence, and pathways for implementing life-course vaccination strategies in global health systems. It will emphasise the vital role of health and social care professionals as both beneficiaries and advocates and situate vaccination within the broader fight against inequity and non-communicable diseases. Finally, it will outline concrete actions for governments, international organisations, and communities to advocate for making vaccination accessible to everyone, at every stage of life.

Vaccination Beyond Childhood: Why the Life-Course Approach Matters

Historically, immunization has been framed largely as a paediatric intervention. Childhood vaccination programs have been remarkably effective, achieving high coverage rates for diseases such as measles, diphtheria, and pertussis. However, focusing exclusively on children fails to recognise the complex epidemiology of infectious diseases and the vulnerabilities that arise at every stage of life. For example, adolescents and young adults require protection against human papillomavirus (HPV), meningococcal disease, and hepatitis B, which carry long-term health risks if left unchecked [4]. Adults benefit from vaccines against influenza, pneumococcal disease, coronavirus disease (COVID-19), and pertussis boosters, which can reduce absenteeism, maintain workforce productivity, prevent transmission to vulnerable groups, and protect during pregnancy [5]. Older adults, particularly those with frailty or chronic conditions, face a heightened risk of severe outcomes from influenza, pneumonia, shingles, and respiratory syncytial virus (RSV); vaccination at this stage helps maintain independence, reduce healthcare utilisation, and extend healthy life expectancy [6-8]. Since a life-course approach recognises that immunity wanes, exposures change, and comorbidities accumulate, vaccination must therefore be continuous, adaptive, and equitable to ensure protection for all [9].

The Burden of Vaccine-Preventable Diseases in Adults

Global data highlight a pressing need to expand immunization beyond children. Influenza alone causes up to 650,000 respiratory deaths annually,

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with disproportionate impacts on older adults, pregnant women, and people living with chronic conditions [10]. Pneumococcal disease contributes significantly to morbidity and mortality in adults over age 65, while pertussis outbreaks continue to threaten both adults and infants [11,12]. Moreover, the COVID-19 pandemic underscored the vulnerability of health and social care professionals, where frontline workers were exposed daily to pathogens, not only risking their own health but also becoming potential vectors of disease transmission. Hence, vaccination has a dual importance: safeguarding essential workers and protecting the patients and communities they serve [13].

Infectious Diseases and the Cascade of Non-Communicable Diseases

Immunization is not only critical for preventing communicable diseases, but also plays a major role in preventing or limiting the progression of non-communicable diseases (NCDs). Infections can trigger or worsen chronic conditions, creating a cycle of health decline. For instance, influenza and pneumonia increase the risk of cardiovascular events, including myocardial infarction and stroke [14]. Chronic respiratory diseases, such as chronic obstructive pulmonary disease, are exacerbated by recurrent infections, often resulting in hospitalisations [15]. Also, HPV infections are directly linked to cancers, including cervical, oropharyngeal, and anal cancers [16]. Finally, new vaccines are being researched and developed to target other chronic conditions, including hypertension, diabetes, and obesity [17]. Protecting populations against infectious diseases is dually a matter of acute prevention and a vital strategy for reducing the global burden of NCDs.

Equity as a Central Principle

Access to vaccines remains profoundly inequitable. The World Health Organization reports that millions of adults worldwide lack access to basic immunizations. Low- and middle-income countries (LMICs) face particular challenges, including limited supply chains, under-resourced health systems, and competing health priorities. Within high-income countries, marginalised groups – such as migrants, ethnic minorities, and persons in precarious employment – also face barriers in accessing vaccination [18]. Equity must be at the heart of any life-course immunization agenda, including ensuring that health and social care professionals in all contexts can access recommended vaccines, recognising their right to protection and their role as trusted advocates for immunization.

Health and Social Care Professionals: Protectors and Advocates

Health and social care professionals occupy a unique position at the intersection of personal vulnerability and community responsibility, and evidence consistently shows that their attitudes toward vaccines strongly influence patient uptake. Empowering these professionals to advocate for immunization requires ensuring they are fully protected through comprehensive vaccine access, providing training and resources to communicate effectively with hesitant populations, and embedding vaccination into occupational health programs. Prioritizing the health workforce in this way safeguards their own health, strengthens the resilience of health systems, and fosters greater confidence in the communities they serve [19].

The Ten Action Points

The Call to Action outlines ten concrete steps for advancing life-course vaccination, providing a clear roadmap for operationalizing immunization in diverse contexts [3]:

1. Ensuring full access to recommended vaccines to protect health and social care professionals: Mandatory occupational health programs, workplace vaccination campaigns, and subsidised or free access to vaccines can safeguard the workforce and reduce risks of disease transmission to patients and the wider community.

2. Guaranteeing equitable access to vaccines throughout all stages of life: Governments and health systems can implement policies that remove financial, geographic, and social barriers, such as offering vaccines at community clinics, mobile health units, at pharmacies, and through school - and workplace-based programs. Ensuring affordability, particularly in LMICs, is essential for reducing disparities and achieving broad coverage.

3. Mobilising the health workforce for vaccine delivery: Health systems can provide healthcare professionals with up-to-date guidance, communication training, and resources for addressing vaccine hesitancy, and logistical support, such as cold-chain infrastructure and mobile vaccination units.

4. Establishing comprehensive adult vaccination schedules for life-course protection: National immunization programs can define standardised schedules and integrate immunizations relevant to adult populations into routine primary care visits, including influenza, pneumococcal disease, HPV, and COVID-19 boosters.

5. Developing interoperable immunization registries: Digital platforms that link primary care, pharmacies, hospitals, and public health authorities can identify gaps, support timely reminders, enable

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real-time monitoring of vaccine uptake and coverage, and facilitate targeted interventions.

6. Integrating vaccination into multi-sectoral health priorities and strategies: Collaboration between ministries of health, education, labor, and social protection can position vaccines as essential tools for its broader public health value, including healthy ageing, maternal and child health, non-communicable disease prevention, and workforce productivity.

7. Expanding and simplifying vaccination pathways: Strategies, such as walk-in clinics, community pharmacies, outreach campaigns, and telehealth scheduling, can make vaccines more accessible, particularly for professionals working in underserved areas.

8. Raising awareness and building vaccine confidence: Increasing health literacy and awareness requires culturally sensitive communication, educational campaigns, and leveraging trusted community leaders. Tailored messaging that addresses misinformation and emphasises the benefits of vaccination across the life course can strengthen public trust.

9. Embedding community engagement into vaccine development and delivery: Participatory approaches, including focus groups, community advisory boards, and co-design of vaccination campaigns, can be responsive to local needs and priorities and ultimately enhance uptake and relevance.

10. Leveraging youth and ageing organizations to champion vaccination: Engaging student networks, professional associations, and senior advocacy groups can amplify advocacy, mentor future health leaders, and create community-based champions who promote immunization at every stage of life. It can build capacity and influence across generations.

The Time for Integrated Action is Now

Vaccination saves lives, reduces inequities, strengthens health systems, and contributes to social and economic resilience. Life-course vaccination is not optional, but rather a necessity. Investment, integration, and innovation, guided by equity and solidarity, are essential to build resilient health systems, ensure universal access to vaccination, and protect people's health across all stages of life. Implementing the ten action points outlined in the Call to Action will ensure protection at all stages of life and contribute decisively to global health resilience, starting with health and social care professionals.

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World Medical Journal

Review of the Health Checkup System in Japan

Koji Watanabe

Today, Japan represents a model where economic growth since World War II has resulted in high average and healthy life expectancy rates. Specifically, the average life expectancy at birth is estimated at 84.5 years (87.2 years in female, 81.7 years in males), as compared to 77.4 years in the Western Pacific and 71.4 years worldwide [1]. Also, the average healthy life expectancy at birth (e.g. years lived in “full health”) was approximately 73.4 years (74.8 years in females, 71.9 years in males), as compared to 68.2 years in the Western Pacific and 61.9 years worldwide [1].

The Japanese health system supports an estimated 124 million residents, with universal healthcare with its lifelong health checkup system and emphasises disease prevention and primary healthcare. This health checkup system, which was established after World War II, has undoubtedly contributed to promoting health in Japan however, has faced challenges due to the declining birthrate, aging population, and ongoing digital transformation of healthcare. In this article, the author will discuss the structure of Japan’s health checkup system, specifically focusing on four phases – infant and child, school-aged children, working adults, and elderly – and share general views on its challenges.

Components of the Health Checkup System

Japan’s health checkups system is entirely conducted by physicians and is stratified by age group according to the type and competent authority. For example, health checkups are implemented by the Children and Families Agency and the Ministry of Education, Culture, Sports, Science and Technology (MEXT) in infants and children (0 to 6 years) and school-aged children (6 to 18 years), and by the Ministry of Health, Labour and Welfare (MHLW) in adults and the elderly. The MHLW launched the National Health Promotion Movement in 2000 – recognised as Health Japan 21 – as the national policy of reducing risk of non-communicable diseases and promoting the healthy life expectancy beyond the 72-75 age range [2]. The third term (2024-2035), will build upon successes of the first term (2000-2012) and second term (2013-2023), including the further enhancement of health screening programs across the country.

Infant and Child Health Checkup (0 - 6 years)

By law, municipalities are required to provide infant health checkups for children aged 18 months and 3 years, and the participation rate is over 90%. From FY 2023, health checkups for infants of 1 month, 3 months, and 9 months, as well as children of 5 years of age have been implemented under the subsidy program of the Children and Families Agency. Results are kept by each municipality and recorded in the mothers’ paper-based maternal and child health handbooks. A digital version of the maternal and child health handbook is currently being introduced, allowing mothers to manage checkup results via digital devices (e.g. smartphones).

In addition to the infant health checkups, regular health checkups from infants to children of 6 years are provided annually at kindergartens and biannually at nurseries and certified daycare centers. The enrollment rate of children is approximately 90%, and the health checkup participation rate is approximately 100%. Checkup data are managed separately by each facility, and results are provided to parents with recommendations to undergo further medical tests as necessary.

School Health Checkup

Under the jurisdiction of MEXT, the school health checkup is defined as *“screening for diseases to detect any problems that may affect a child’s school life,”* and *“identifying health issues at school and utilising such information for health education.”* Stipulated by the School Health and Safety Act, school health checkups, which are conducted from April to June each year, cover primary, junior high, and high school grades [3]. The checkup results (11 checkup items) are managed separately by each school, and results are provided to parents with recommendations. Schools utilise these results to provide health education on lifestyle-related diseases in children. Additionally, health education at school includes topics such as cancer, smoking cessation, and preconception care, which are implemented on a voluntary basis. Notably, one major issue concerning the school health checkup system is the lack of effective collaboration between MEXT and MHLW to integrate health checkup data after adolescents graduate from high school.

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Health Checkup System from Working Adults to Elderly

Health checkups for working adults include workplace checkups implemented by employers and regional checkups implemented by municipalities. Workplace health checkups include the regular health checkup with the physical examination and blood tests (e.g. hepatic function, lipid levels, cardiac function tests), and specific health checkups by business type, such as radiation exposure tests (if handling radiation) or organic solvent exposure tests (if in the printing industry). Regional health checkups include screenings for cancer (e.g. gastric, lung, colon, breast, cervical) and other diseases (e.g. hepatitis virus, osteoporosis, periodontal disease).

Specific Health Checkup and Health Guidance

Since 2008, the Specific Health Checkup and Health Guidance program has been implemented to prevent lifestyle-related diseases with a focus on visceral fat obesity in individuals aged 40 years and older. This program is mandatory for those individuals covered by the National Health Insurance and the employee health insurance. Individuals who meet certain criteria based on the health checkups are selected, and an estimated 25% of checkup participants currently fall into this group and receive health guidance. For participants with a particularly high risk, motivational or more proactive health guidance and consultations are provided depending on the degree of risk (Figure 1). To maintain the evidence-based guidelines, the Specific Health Checkup and Health Guidance program is reviewed every five years at MHLW review meetings, with medical expertise provided by the Japan Medical Association (JMA).

Encountered Challenges in the Health Checkup System

While this health checkup system may have contributed to Japan's high average and healthy life expectancy today, it does not include a unified standard for health checkup results. Since checkup results of infants and children (0 to 6 years) and school-aged children (6 to 18 years) are managed by the MEXT, data cannot be combined with health checkup data from adults and the elderly, which are managed by the MHLW. Hence, the implementation of health information management and health education is limited across the lifespan.

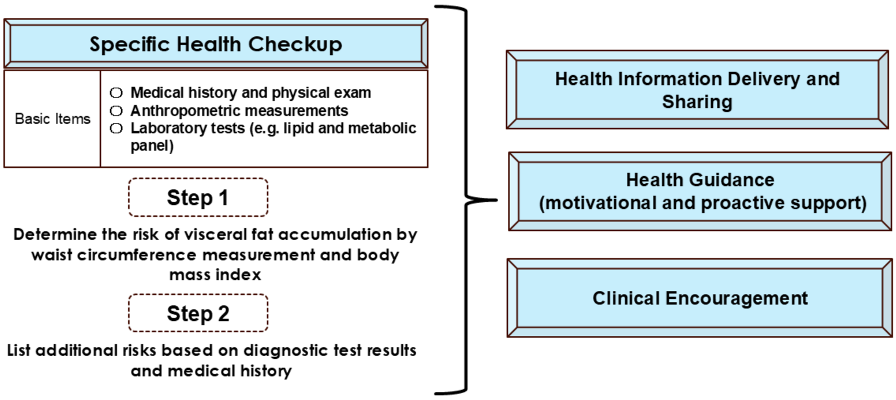

Figure 1. The Specific Health Checkup and Health Guidance program is administered by health insurance providers. The insurers encourage members to participate in this program, expecting that this will reduce the number of patients who require medical care for lifestyle-related diseases (like diabetes), and thereby helping to control future healthcare expenditures. Credit: K. Watanabe

To address this challenge, the health system is identifying opportunities to incorporate novel digital technologies in health service delivery, especially for the management of health checkup information throughout the lifespan. First, the MHLW is developing the Nationwide Healthcare Information Platform, to serve as a foundation for the collection, external provision and reception, storage, and sharing of health information. Second, a Public Medical Hub (PMH) serves as a foundation for managing local health checkup information in a municipal-level database, allowing each individual to access their own health information via the government-managed Mynaportal [4]. Finally, basic guidelines for Personal Health Records (PHRs) have been established to enable individuals to securely review and manage their health records [5].

Conclusion

In response to these government-led initiatives, the JMA has actively consulted with the relevant ministries, agencies, and other organisations to establish a robust foundation for health checkup information in the nation. Moving forward, the JMA aims to develop and sustain the foundation of a universal health checkup system, whereby each citizen can centrally manage their lifelong health checkup data and use information to maintain and improve their physical and mental health and well-being.

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World Medical
Journal

Leading from the Frontline: A Junior Doctor's Guide to Everyday Leadership

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For many junior doctors, the view on leadership is seen as a distant concept or formal, hierarchical title-something reserved for department heads, hospital directors or those professionals with decades of experience. It is erroneously perceived as a final destination (a position you *get*) rather than a daily practice (something you do). From the moment they first lead a ward round, manage an emergency scenario or guide a medical student in a clinical task, junior doctors are *already* in leadership roles as frontline decision-makers. The gap, therefore, is that traditional medical education excels at teaching clinical skills, but often fails to provide a framework for the influence, vision, and action required of these daily leadership responsibilities. Junior doctors are often thrust into these roles without the tools, confidence or supportive definition of what leadership *at their level* looks like.

The Medical Education Working Group, a key component of the World Medical Association (WMA)'s Junior Doctors Network (JDN), has identified this critical gap. They recognised that junior doctors were struggling with a definition of leadership that was intimidating and inaccessible, causing them to overlook the leadership opportunities and responsibilities that they already held. This observation prompted the organisation of the "Leading from the Frontline: A Junior Doctor's Guide to Everyday Leadership" webinar in October 2025. This title has a two-fold meaning: "Leading from the Frontline" shifts the focus away from the executive suite and onto the ward, and "Everyday Leadership" reframes the idea of leadership from a final destination to a daily practice.

This webinar, moderated by Dr. Merlinda Shazellenne (WMA JDN Medical Education Director and Medical Education Working Group Chair), featured two global medicine leaders: Dr. Jacqueline Kitulu (WMA President) and Dr. Ashok Philip (WMA Immediate Past President). The discussion dismantled old hierarchies and offered a new, accessible framework for leadership. Their collective message highlighted that leadership is about influence, vision, and action, starting in the hospital ward on day one. The shared insights provided a practical guide based on five key pillars: redefining leadership, fostering effective communication, engaging in advocacy, building a legacy through mentorship, and navigating resilience to prevent burnout.

Redefining Leadership: Influence Without a Title

As Dr. Kitulu shared her personal journey to medicine, she emphasised the simple "stumble" early in her career as she wandered into a meeting of the Kenyan Medical Women's Association. She recognised senior doctors who had served as lecturers, and she enthusiastically signed up to volunteer. She recalled, *"I just jumped into volunteering as Assistant Treasurer. There I am, a young doctor, unfamiliar with the organisation, and now I will serve as the Assistant Treasurer for a big organisation"*. This single act of volunteering – of simply observing and filling this organisational need – motivated her to apply for and be elected as Chair of the Association just three months later. She encouraged junior doctors to be proactive and find relevant leadership opportunities to join, contribute expertise, learn from colleagues, and make a positive difference in the community.

During his medical education, Dr. Philip said that bullying was common, and junior doctors were frequently scolded or had physical clinical notes tossed at them. His leadership moment presented itself when he gained seniority in the workplace. He said,

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"I realised that you can protect them by standing between them and the bully". For Dr. Philip, his leadership began as an act of passion for his patients and fellowship with his colleagues.

To combat junior doctors' fears of leadership, Dr. Philip stated unequivocally that as a doctor in the ward, they are already a leader of the healthcare team of interns, nurses, physiotherapist, and other health professionals. Likewise, Dr. Kitulu advised junior doctors to reframe leadership to making a change where you are, and become "changemakers" not "keyboard warriors" – a term she uses for those in Kenya who complain on X (formerly Twitter) but never act. She encouraged junior doctors to identify the challenge and develop a novel solution, noting that *"they can just start somewhere where they can make a change".* The fulfillment, she argued, comes from the change and impact, not the formal leadership title.

Effective Communication: The Conductor's Baton

If leadership is action, then effective communication is the tool that makes it possible. As the core function of any doctor remains in leading interprofessional teams with mutual respect, communication skills, and diplomacy, the concept of a team should be visualised as a collaborative ensemble rather than a pyramid shape. Since "hierarchical leadership" and "inter-cadre wars" are potential challenges, Dr. Kitulu encouraged junior doctors to view the health system as an orchestra. *"You cannot have an orchestra of one instrument, as you need flutes, clarinets, and violins. The health system works in a similar manner, as you work with many health professionals, such as nurses, pharmacists, and nutritionists, who complete their specific role to complete the system".*

Echoing these sentiments, Dr. Philip highlighted that collaborative communication extends to training and the need for engagement (not by confrontation) when dealing with other professionals (e.g. pharmacists). He shared how he changed his communication approach in teaching, by shifting from a more direct or confrontational style to a Socratic method of asking questions, trusting that junior doctors already knew the answers. This technique enabled confidence (rather than fear), which ultimately improved team dynamics and patient outcomes.

Advocacy: From Patient to Peer

Junior doctors are uniquely positioned to advocate for their working conditions and their patients. This new framework for leadership – acting as a changemaker and a respectful collaborator – is the foundation for advocacy to protect patients, improve systems, and support colleagues. Dr. Philip shared his personal story of *"standing between them and the bully"* when advocating for safe working conditions and culture. Similarly, Dr. Kitulu stressed that rather than simply accepting a flawed system, junior doctors are changemakers who can identify the problem, develop timely solutions, and create positive change.

Mentorship and Legacy: The Cross-Directional Path

Leadership is a journey of continuous learning, making mentorship a critical component in medical education and training. Dr. Philip urged junior doctors to not be intimidated by senior-level leadership and the classic internship mantra (*"see one, do one, teach one"*), but instead focus on finding a mentor and becoming a mentor. Expanding upon this insight, Dr. Kitulu described mentorship as a cross-directional process, where senior-level leadership can learn vital new skills from their junior colleagues, ultimately breaking down traditional hierarchies. She underscored the core professional duty of finding a mentor and serving as a mentor, noting that legacies are built by passing on knowledge, skill, and confidence, not by individual achievement.

Resilience and Burnout: The Armor of Passion

In a demanding career, junior doctors can be challenged to maintain the passion to lead, advocate, and mentor without succumbing to burnout. Dr. Philip said firmly that passion is the most critical layer of armor to protect against burnout in the workplace. He lamented the trend of students being forced by their families to study medicine, only to find that they cannot manage the relentless demands of the job. Complementary to passion, Dr. Kitulu emphasised the importance of "work-life integration" (not balance) and established priorities. As a personal example, during her tenure as president of the Kenya Medical Association, her frequent travel plans meant that she would be accompanied by her husband and sons. She illustrated how professional and personal lives can coexist, rather than compete, and stressed that building personal resilience through active self-care (e.g. walking groups) can inspire our purpose to make an impact in the world.

A Call to Action: Your Leadership Starts Now

The webinar concluded with a powerful, unified call to action. Dr. Philip affirmed the value that junior doctors bring to the workplace by stating, *"Stick with the junior doctors, and you are already leaders".* Similarly, Dr. Kitulu shared inspiring words that encapsulated the webinar:

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"You are not leaders of tomorrow; you are leaders of today. It starts right now. Step into those spaces, volunteer in spaces that allow you to grow. Find a mentor, and mentor someone. Be the changemaker". These personal journeys underscore that true medical leadership is a present action, daily choice, and responsibility that belongs to every doctor on the frontline.

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World Medical Journal

WMA Members Promote Disability-Inclusive Care for Global Health Systems

Credit: Drazen Zigic / shutterstock.com

According to the World Health Organization (WHO), an estimated 1.3 billion people (16% of global population) have experienced living with a significant disability [1]. The global disability burden continues to rise, especially with an ageing population and increasing prevalence of non-communicable diseases. Disability is defined across three dimensions: impairment (e.g. physical or mental functional limitations), activity limitation (e.g. reduced vision, hearing or mobility), and participation restrictions (e.g. challenges in work, social, leisure, health services) [2]. It can occur at any point in the lifespan, and may result from a range of factors, including genetics, in utero exposures (e.g. infections), developmental abnormalities, and injury.

Persons with disabilities frequently face social and systemic barriers across their communities and health systems, suggesting that their environment can directly influence their lived experiences and extent of disability [3]. Frequent barriers include attitudinal (e.g. discrimination, stigma, stereotyping), communication (e.g. inability to understand verbal or written messaging), physical (e.g. structural impediments that block mobility), policy (e.g. insufficient enforcement of current laws and regulations, lack of workplace accommodations), programmatic (e.g. insufficient time or scheduling), social (challenges in seeking employment, completing academic programs or experiencing violence), and transportation (e.g. limited access, inconvenient schedules or distances) [3]. Specifically, this hardship can be further exacerbated by rising healthcare costs, limited or lack of coordinated health services (e.g. rehabilitation, assistive technology, telemedicine), and inadequate training of health professionals to manage disability care [4]. Addressing these barriers will require sustainable political commitment to adopt disability-inclusive policies and frameworks that promote equitable access to essential healthcare services and ensure appropriate funding mechanisms and community-based resources, helping persons with disabilities achieve their highest attainable standard of health [4].

Notably, three landmark World Health Assembly (WHA) frameworks, which relate to health equity for persons with disabilities, have been adopted and incorporated into global health systems. First, the *Resolution WHA 54.21 (International Classification of Functioning, Disability and Health,* ICF) was approved in 2001, which aligned international standards for defining and measuring health and disability [5]. Second, the *Resolution A/RES/61/106 (Convention on the Rights of Persons with Disabilities),* adopted in 2006, mandates that Member States safeguard equal

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access, quality, and standards of healthcare services and protections for persons living with disabilities [6]. Third, *Resolution WHA 74.8 (The highest attainable standard of health for persons with disabilities)* in 2022, to guarantee that persons with disabilities receive effective health services, equal protection during emergencies, and equal access to health interventions [7].

Similarly, the WHO published the *WHO Global Disability Action Plan 2014-2021* in 2014, setting a comprehensive framework for national policies and plans that remove structural barriers and strengthen disability care (including rehabilitation and assistive tools) [8]. Next, the *WHO Global Report on Health Equity for Persons with Disabilities* was published in 2022, offering evidence-based findings on the burden of disability, capturing national examples of health inequities, and providing recommendations to drive national action [9]. This global report led to the subsequent launch of the *WHO Health Equity for Persons with Disabilities: Guide for Action* in 2024, as practical guidance for ministries of health and stakeholders to implement these evidence-based findings across health systems and "leave no one behind" [10]. Finally, the WHO Disability Health Equity Initiative was publicised in 2025, as an approach to promote health equity for persons living with disabilities based on four priorities: 1) building leadership with persons with disabilities and stakeholders; 2) prioritising disability-inclusive health as a political priority; 3) developing a disability-inclusive health sector; and 4) establishing key indicators, evidence, and monitoring [11].

The International Day of Persons with Disabilities, implemented by the United Nations (UN) General Assembly in 1992, is observed annually on 3 December [12]. The *"Fostering disability-inclusive societies for advancing social progress"* theme aligns with two recent global events – Global Disability Summit 2025 in April 2025, and Second World Summit for Social Development in November 2025 – where global leaders discussed and confirmed their commitment to promoting an inclusive and equitable world. With one in six persons living with a disability worldwide, understanding the interconnectedness of the UN Sustainable Development Goals (SDGs) associated with disability-inclusive care, services, and quality of life – like SDG4 (quality education), SDG8 (decent work and economic growth), SDG10 (reduced inequalities), and SDG11 (sustainable cities and communities) – serves as a call to action for all nations to assess health system leadership and governance, strengthen health surveillance systems, support timely research initiatives, and implement novel initiatives that meet the diverse needs and provide social protection for all persons with disabilities.

In this article, physicians from 15 countries – Canada, Ethiopia, Hong Kong, India, Italy, Ivory Coast, Kenya, Latvia, Malaysia, Myanmar, Philippines, Portugal, South Africa, Tunisia, and United Kingdom – described statistics of the national disability burden, existing challenges to support disability-inclusive care, national policies that protect dignity and health and employment rights and health professions' training programs. They shared community-based initiatives that support efforts to promote inclusivity and reduce stigma and discrimination related to persons living with disabilities in their countries.

Canada

Canada's population is aging, where an estimated 27% of the adult population in Canada is living with a disability, and this number is expected to increase. Currently, one in five Canadians does not have access to a family doctor, and people with disabilities face larger barriers to care than the general population, demonstrating a monumental healthcare access problem for Canadians living with disabilities. Over the past decade, significant strides have been made in Canada to improve accessibility for people with disabilities, including clear accessibility requirements in building codes, workplace accommodation legislation, and funding support for accessibility aids.

However, an unrecognised policy approach is the support for health professionals who themselves have disabilities. According to the 2021 Canadian Medical Association National Physician Health Survey, data show that 23% of Canadian physicians report living with a disability, impairment or long-term condition. As Canada is currently experiencing a severe physician shortage, ensuring that physicians with disabilities can thrive in the workplace has a two-fold benefit for patients with disabilities. By creating supportive workplace policies, physicians with disabilities are able to increase their contributions to the workforce and directly have a positive impact on the physician shortage. Equally important, data show that patients tend to have better outcomes when the physician workforce better represents the population it serves.

Programs, policies and initiatives to advance disability inclusion in medicine are growing in number across Canada. The Ottawa Hospital (TOH) implemented the first hospital position statement on the inclusion of physicians with disabilities in 2021, followed by the Department of Medicine accessibility and accommodations policy for physicians with disabilities in 2022 [13,14]. Today, other healthcare institutions are taking similar steps, including Montreal's Jewish General Hospital position statement

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and the TOH Department of Emergency Medicine accommodations policy. Drawing from the TOH policy lead, the Ontario Medical Association implemented an educational resource, which outlines legal protections for physicians with disabilities and the process for requesting workplace accommodations [15].

Defined institutional standards, leadership roles, and strategic planning are growing to improve accessibility in medical education and practice. First, the Association of Faculties of Medicine of Canada (AFMC) adopted functional Core Competencies, a significant step toward inclusion and support for learners with disabilities in Canadian medical education and has created a "Physicians with Disabilities" network to lead further efforts in inclusion in medical training [16]. Second, Toronto Metropolitan University created dedicated leadership positions with a disability health lead and special advisor to the dean, and McMaster University opened the position of Postgraduate Medical Education (PGME) accessibility advisor with disability to provide support and coaching. Finally, national health leaders are implementing further progress across Canada by advancing accessibility within the development of the *Canadian National Health Worker Well-Being Plan.*

Improving disability inclusion in medicine is important not only to improve equity, but also to preserve the medical workforce in a health human resource crisis in Canada. All medical organisations should find opportunities to advance accessibility within strategic planning, leadership, initiatives, and resources for physicians and learners across Canada [17]. Medical associations can play an important role by advancing awareness of and advocating for the protection of physicians' employment rights. Likewise, hospitals can implement accommodation policies informed by best practices. Medical education institutions can update their admissions, accommodation, and accessibility processes, while supporting informed voices in leadership and practices for learners with disabilities. The movement to improve accessibility in medicine in Canada is accelerating, and organisations and institutions should act now to position themselves as leaders, rather than sitting on the sidelines of progress.

Ethiopia

Ethiopia has the second-largest population in Africa and carries a high burden of disability. According to a national survey conducted in 2024, the number of persons over 2 years of age living with severe and some disabilities was 6 million (5.8% of the population) and 20.6 million (19.7% of the population) individuals, respectively [18]. The most common disabilities were mobility difficulties for children 2 to 4 years of age, anxiety and depression for children 5 to 17 years of age, and mobility, visual and memory difficulties for adults. The survey further indicated that persons with disabilities in Ethiopia experienced significantly reduced access to basic services like healthcare and education, as well as limited employment opportunities and restricted participation in society [18].

As steps to address this national burden, Ethiopia ratified the UN Convention on the Rights of Persons with Disabilities in 2010 [6]. Ethiopia's constitution, laws, and policies also aim to guarantee equality, non-discrimination, and reasonable accommodation as well as education and employment opportunities for persons with disabilities. First, *Proclamation No. 568/2008* prohibits all forms of discrimination in employment based on disability, unless the nature of the work dictates otherwise, and requires employers to provide appropriate working and training conditions for the workforce [19]. Second, the Ministry of Labour and Social Affairs launched the *National Plan of Action on Disability (2012–2021)* in 2012, which aimed at creating an inclusive society through education, health services and employment opportunities [20].

The Ethiopian Medical Association continues to advocate for promoting inclusive medical care, education, and research across the nation. As one example, after learning about a medical school that suspended two individuals (medical student and resident) because of their disability in April 2022, members engaged with the university, Ministry of Health, Ethiopian Human Rights Commission, and Ethiopian Federation of Associations of Persons with Disabilities. Subsequently, the Ethiopian Medical Association released a statement calling for the reversal of the decision and robust academic support measures for both students to succeed in their training programs [21]. As the Association recommended that healthcare professions be fully inclusive of persons with disabilities, the call to action was two-fold. First, it established an ad hoc committee as well as developed a concept note outlining mechanisms for providing reasonable accommodation for persons with disabilities in healthcare professions, while ensuring standards for safe and effective practice. Second, it reaffirmed its readiness to work with medical schools, Ministry of Education, and Ministry of Health to update admission criteria for medical and residency training programs and create a disability-inclusive healthcare system. As we observe the International Day of Persons with Disabilities, the Ethiopian Medical Association reaffirms its readiness to foster disability-inclusive society.

Hong Kong

As a result of rapid socioeconomic development and medical innovation, Hong Kong now leads the world in life expectancy at birth. Nonetheless, an increased *life expectancy* does not necessarily correspond to a healthier society, and the WHO and public health experts are increasingly emphasising health expectancy. Since 2000, disability has emerged as a significant public health challenge in Hong Kong, where the Hong Kong government's Census and Statistics Department has regularly conducted thematic surveys on the disability burden. The latest report revealed a 7.1% overall disability prevalence in 2020, as well as an increased proportion of individuals with physical disabilities (38.4% in 2013 to 55.3% in 2020), primarily attributed to the ageing population [22]. Public health researchers from the Chinese University of Hong Kong published findings that demonstrated that the disability-free life expectancy at 65 years of age increased more slowly by 1.8 years (from 14.6 to 16.3) in men and by 0.1 year (from 16.4 to 16.5) in women between 2007 and 2020, when compared with the increase of life expectancy by 3.7 years (from 18.3 to 22.0) in men and by 2.1 years (from 22.7 to 24.8) in women, highlighting an expansion of disability burden among the elderly with male-female health-survival paradox [23]. Comprehensive policy approaches to promoting healthy ageing for all and addressing underlying social determinants of health with an equity focus are urgently needed to address the substantial caregiving demand and significant cost on health and social care costs for the future secondary to the rapidly ageing population with rising dependency ratio [23].

Over the past two decades, the Hong Kong government and the organisations under the Joint Council for People with Disabilities (https://www.jointcouncil.org.hk/en/) have made tremendous efforts to promote the rights and freedoms of persons with disabilities. At the government level, recognising the increasing number of elderly persons with disabilities and risk of caregiver stress or burnout, it recently unveiled relevant strategies in its 2025 Policy Address. The primary initiatives include increasing the provision of day rehabilitation training for elderly persons with disabilities to alleviate caregiver burden, launching the cross-departmental Carer Support Data Platform to enable timely recognition and support for high-risk caregivers (e.g. when caregivers are admitted for hospital care), and installing intelligent accident-detection systems for high-risk households [24]. At the community level, increased awareness of the extended needs of ageing persons with disabilities has led to the launch of the five-year Jockey Club End-of-Life Community Care Project's "Unison Project," inaugurated in June 2025, to provide personalised palliative and end-of-life care specifically for persons with disabilities and caregiver support [25].

Driven by the "Safeguarding the Health of the People" mission statement, the Hong Kong Medical Association (HKMA) launched the Community Service Committee (CSC) in 2014, and has established various Community Elderly Health Management Programmes since 2016. Currently, the CSC is running several community projects to support the elderly and caregivers in districts with the highest proportion of residents over 65 years of age, namely Siu Sai Wan, Chai Wan, and Kwai Chung districts. With over 5,000 service hours per year, our Volunteer Outreach Team for the Elderly received the "Outstanding Volunteer Group" award at the Hong Kong Volunteer Award 2023. Recently, a new "Boardgame Training for Elderly with Dementia," curated by physicians and experienced community volunteers as a 2023 pilot programme and 2024 in-home training programme, demonstrated significant improvement in participants' performance in overall contribution, emotion, and communication. The programme now collaborates with several elderly community centres (as non-government organisations) in providing "Training for Carers" and "Train the Trainer" programmes, and the HKMA is developing "Boardgame Training Tools" to ensure future successful implementation with community providers [26]. In observance of the International Day of Persons with Disabilities, the HKMA urges communities and governments around the world to collaborate with physicians in delivering evidence-based innovative solutions to address the numerous challenges faced by persons with disabilities in today's advancing society.

India

Persons with disabilities represent a significant health and social priority in India, with profound implications for physicians and the healthcare system. According to recent epidemiological data, almost 1% of the Indian population lives with a disability, and 5.1% of households include at least one person with a disability, a proportion that represents a numerically substantial and vulnerable group in a country of 1.4 billion [27]. Over the past two decades, the burden of disability has intensified with India's demographic transition, including reported locomotor (44.7%) and mental disabilities (20.1%), which place considerable demands on the healthcare workforce [27]. Furthermore, the economic burden is staggering, where estimates show that India loses Rs. 4.5 lakh crore (equivalent of US $54.88 billion) annually due to the exclusion of persons with disabilities from productive participation in society [28]. For Indian physicians, this reality underscores the need to move beyond fragmented care approaches toward integrated, equitable, and inclusive

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healthcare delivery that recognises disability not merely as a medical challenge, but rather as a fundamental human rights imperative.

India has established a robust legislative and programmatic framework to advance disability inclusion and healthcare access. First, the *Rights of Persons with Disabilities Act of 2016*, enacted to give effect to the UN Convention on the Rights of Persons with Disabilities, guarantees equal rights, non-discrimination, protection from abuse, accessibility, and full participation in community life [29]. Second, several transformative initiatives demonstrate physicians' and government commitment to disability-inclusive healthcare. The Accessible India Campaign (Sugamya Bharat Abhiyan), launched in 2015, aims to ensure universal accessibility across built infrastructure, transport systems and the information and communication technology ecosystem [30]. The Niramaya Health Insurance Scheme (https://nationaltrust.nic.in/niramaya/), adopted in 2008, provides affordable coverage up to Rs. 1 lakh (equivalent of US $1,129) for individuals with disability, with no pre-insurance medical examination requirements. These multisectoral initiatives – spanning legislative protections, infrastructure accessibility, and financial protection mechanisms – collectively demonstrate India's commitment to creating an inclusive healthcare ecosystem where persons with disabilities can access equitable and dignified care. Beyond these flagship programs, other policies addressing workplace accommodation and assistive technology provision further reinforce this commitment, positioning disability-inclusive healthcare as a cornerstone of India's broader public health agenda.

As physicians and healthcare leaders in India, our collective call to action must transcend conventional medical management to embrace disability as an equity and social justice imperative. Firstly, they must strengthen disability care related competencies through continued professional education. Health professions educators bear the responsibility for cultivating inclusivity by supporting persons with disabilities in entering and progressing through medical training. Secondly, they must engage persons with disabilities as partners (versus passive recipients) in health program design, implementation, and evaluation. Finally, they must ensure that disability screening, early intervention, and rehabilitation services are integrated into routine healthcare delivery. India's vision of inclusive development and sustainable health for all (Sabka Saath, Sabka Vikas) cannot be realised without physicians stepping forward as advocates in fighting barriers and ensuring that persons with disabilities receive dignified, equitable, and quality healthcare.

Italy

The International Day of Persons with Disabilities, celebrated on 3 December, represents a symbolically significant occasion and practical opportunity for Italian health professionals. This day calls upon physicians and institutions to promote inclusive policies, continuity of care, and healthcare pathways that remove the physical, cultural, and social barriers that hinder the full participation of persons with disabilities in society. According to PASSI d'Argento, the National Health Institute's (Istituto Superiore di Sanità) surveillance system focusing on the elder population, three of 10 Italian adults over 65 years of age have partially or completely lost their autonomy, where 14% live with disabilities, and 16% are classified as frail [31]. After 85 years of age, these proportions rise to 40% and 30%, respectively. With care responsibilities falling almost entirely on families (providing 95% of the support), while only a minority receive public assistance, this burden on the National Health Service (Servizio Sanitario Nazionale, SSN) and family caregivers highlights the need for integrated social and healthcare models and continuous rehabilitative pathways. Economic and territorial inequalities remain profound, where disability risk is tripled by poverty and quadrupled by low educational attainment, and the proportion of older adults living with disabilities in southern Italy is markedly higher than in northern Italy.

Against this backdrop, Italy has strengthened its legislative framework by updating *Law 104/1992* through structural reforms. First, the *Legislative Decree No. 62 of 2024* introduced a basic disability evaluation system, managed by the National Social Security Institute (INPS) and the Individual Life Project (pilot initiative across nine provinces during 2025) [32,33]. Supportive measures have included the establishment of a National Supervisory Authority, the updating of Essential Levels of Care (Livelli Essenziali di Assistenza, LEA) and prosthetic nomenclature, and the launch of the Disability Portal that consolidates diagnostic recognition and administrative procedures. Furthermore, several public and Third Sector initiatives contribute substantially to the provision of support services for persons with disabilities. In Sicily, Sportello D- established by the National Agency for the Protection of Disabilities (Agenzia Nazionale per la Protezione delle Disabilità, APS) – operates the country's only national telephone helpline dedicated to individuals with disabilities and their families, offering timely guidance and assistance in navigating available resources. Likewise, Lega del Filo d'Oro, one of Italy's longest-standing non-profit organisations, has for more than six decades played a pivotal role through its regional centres in supporting individuals who are deaf,

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blind or affected by multiple sensory impairments, ensuring continuity of care and specialised rehabilitative services.

These initiatives are accompanied by a growing demand for health professionals' training based on the bio-psycho-social model, reasonable accommodation, and integration of social and healthcare pathways. In 2024, as the Integrated Home Care (Assistenza Domiciliare Integrata, ADI) services reported that Italian adults living with disabilities represent 239,000 of 625,000 total households served, the Alliance against Poverty report (https://alleanzacontrolapoverta.it/) noted that information campaigns and services remain fragmented [34]. Hence, strengthening continuous care pathways will be imperative, and physicians can lead efforts with multidisciplinary teams, social services, and non-governmental organisations and serve as facilitators of the Individual Life Project. Ensuring equitable access to services (especially in southern regions in Italy) and investing in education and training are vital so that health professionals can advocate for disability rights and inclusion. Protecting persons with disabilities means not only providing care, but also fostering participation, upholding dignity, and enabling joint health decisions. These robust efforts will transform 3 December from a formal commemoration day into a call for collective responsibility for all communities.

Ivory Coast

For doctors in Ivory Coast, the International Day of Persons with Disabilities is not only a symbol of solidarity, but also a call for professional and civic responsibility. According to the National Institute of Statistics (L'Institut National de la Statistique, INS), the National Survey on the Situation of Persons with Disabilities 2021 reported that approximately 600,000 Ivorians (2.4% of the population) live with a disability, and the most common disabilities are physical and hearing (deaf-mute) impairments [35]. Today, national disparities are driven by health system challenges (e.g. weak infrastructure, limited rehabilitation equipment, insufficient health professionals' training in the specific care of people with disabilities), social stigma, and limited access to employment and educational opportunities. The International Labour Organization reported that only 2% of people with disabilities have formal employment in Ivory Coast, compared to the 20% national average, in 2025 [36]. This reality challenges the medical community to find opportunities to strengthen public awareness, promote clinical compassion, and defend the right to health for all.

Over the past three decades, the Ivory Coast has undertaken several concrete actions to improve the situation of persons with disabilities. First, *Law No. 98-594* (10 November 1998) constitutes the foundational legal framework for the protection of civic, social, and economic rights of persons with disabilities [37]. Second, the Ministry of Women, Family, and Children and the Ministry of Health, Public Hygiene launched the *National Action Plan 2021–2025* for the promotion and protection of the rights of persons with disabilities [38]. Third, the national community-based rehabilitation programs, supported by the WHO, focuses on community participation, socioeconomic reintegration of persons with disabilities through primary health centres, and health professionals' training in disability care [39]. Fourth, the Ministry of Employment and Social Protection regularly conducts national campaigns (via media and digital platforms) to share information about community programs, reserved employment quotas, and workplace adjustments. Leaders adopted the Vocational Guidance and Rehabilitation Commissions (through two decrees) in 2021, aimed at promoting the social inclusion of people with disabilities in public and private sectors.

The international campaign offers a call for inclusion and equity for persons with disabilities, where health professionals can further humanise medical practice, strengthen the patient-provider relationship, and integrate the universal values of respect, dignity, and social justice into every act of care. Specifically, Ivorian doctors affirm their commitment to working towards inclusive medicine, by supporting health professionals' training on disability care (e.g. physical, sensory, and cognitive needs of patients) and empathetic communication. They can advocate for strengthened disability governance within public health policies, improved intersectoral coordination, and increased participation of people with disabilities in decision-making processes that affect them. Professional associations, like the Federation of Associations of People with Disabilities of Ivory Coast (FAHCI), continue to play a crucial role in advocating for accessibility, education, and economic empowerment of persons with disabilities. International medical solidarity through shared practices, research, and advocacy will energise a regional and global dynamic that collectively accelerates progress toward a more inclusive world.

Kenya

According to the Kenya Government's 2019 Population and Housing Census, the number of persons living with a disability was 0.9 million (2.2% of the population), with significant geographic disparities between rural (0.7 million people) and urban (0.2 million people) [40]. The most common disability affected mobility (42% of persons with disabilities), followed by visual (36.4%), cognitive

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(23.2%), hearing (16.7%), self-care (15.3%), and communication (12.1%). Recent national analyses have identified several recurrent gaps, such as limited availability and geographic coverage of rehabilitation and assistive-technology services, deficiencies in routine surveillances systems to capture disability data, and shortage of health professionals trained in disability-inclusive clinical care and rehabilitation [41]. These gaps are compounded by the variable implementation of national policies at the county level as well as social (e.g. stigma, affordability) and physical (e.g. transportation) barriers to care.

In Kenya, several key initiatives have provided evidence-based frameworks for policy reform, service integration, and societal inclusion of persons living with disability. To support these advocacy efforts, the National Council of Persons with Disabilities (NCPWD) (https://ncpwd.go.ke/) has served as a key voice for ensuring that existing policy is translated into consistent, county-level service delivery. First, the *NCPWD Strategic Plan 2023–2027* provides the NCPWD's direction in promoting disability inclusion through research, socio-economic empowerment, and institutional capacity and coordination [42]. Second, the Disability Landscape in Kenya report, based on findings from a NCPWD study that was published in 2024, highlighted insight on policies, programmes, and emerging challenges that affect persons with disabilities at national and county levels in Kenya [43]. Third, the NCPWD Status Report on Disability Inclusion report, published 2024, provided a detailed account of Kenya's achievements in disability inclusion in the public sector after the implementation of the Disability Mainstreaming Performance Indicator in 2022-2023 [41].

Legislative and policy efforts, alongside community-based rehabilitation programmes and disability mainstreaming guidelines, continue to strengthen the national response. Notably, the Kenya National Assembly passed the *Persons with Disabilities Act 2025* in 2025, which aimed to reorganise the NCPWD's functional mandate and leadership structure for protecting, promoting, and monitoring the rights of persons with disabilities, including incentives and reliefs [44]. Also, this policy strengthened *Article 54* of the Kenyan Constitution, which guarantees the rights of people with disabilities, including the right to be treated with dignity, access to education and public places, and the use of appropriate communication methods [45]. Notably, these national policy reforms have been spearheaded by Senator Crystal Asige, a visually impaired leader who lost her sight to glaucoma during childhood [46].

The Kenya Medical Association reaffirms its role in ensuring that persons with disabilities are both recipients of care and empowered partners in shaping a health system that truly leaves no one behind. Clinicians encounter disability across every specialty – congenital, acquired, physical, sensory, intellectual, and psychosocial – and health professionals must reaffirm their clinical responsibility for the early identification, reasonable accommodation in clinical settings, multidisciplinary rehabilitation, assistive-technology prescription, and advocacy for patients' rights to education, work, and social participation. For doctors in Kenya, the International Day of Persons with Disabilities is a critical reminder that healthcare must be inclusive, equitable and responsive to the needs of persons living with disabilities. The day underscores that health systems must integrate disability into public-health programming, primary care and emergency planning so that people with disabilities are not left behind.

Latvia

Commemorated on 3 December, the International Day of Persons with Disabilities is an important reminder for Latvian physicians that the global burden of disability is a significant concern for our patients and their families. According to 2023 Eurostat data from the European Union (EU)'s Statistics on Income and Living Conditions survey, Latvia has the highest self-reported level of disability in the EU, where an estimated 40.7% of people older than 16 years of age self-reported moderate or severe long-term limitations in performing their usual activities due to health problems, compared with an EU average of 26.8% [47]. According to the Latvia Ministry of Welfare and the Central Statistical Bureau, approximately 213,500 people (11.3% of the population) had a diagnosed disability in 2023, and 9,700 children (28 per 1,000 children) were diagnosed with disabilities in 2024. Specifically, 114,675 adults (18-64 years) had a diagnosed disability in 2024, with functional limitations categorised as very severe (9,620 people), severe (45,197 people), and moderate (59,858 people). Taken together, these self-reported and administrative data underline both the scale of disability in Latvia and the importance for physicians to understand disability as a spectrum of lived experience, from self-perceived limitations to formally assessed long-term functional impairments.

Latvia's progress in disability rights and healthcare is anchored in a comprehensive legal framework and recent social policy reforms. The *Disability Law* defines disability as a long-term or non-transitional very severe, severe or moderate level of functional limitation that affects a person's mental or physical abilities, ability to work, self-care and integration into society, in line with

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the UN Convention on the Rights of Persons with Disabilities [48]. Under the *Health Care Financing Law* and related regulations, persons with disabilities are exempt from patient co-payments, are entitled to social, psychosocial, and vocational rehabilitation, and provided an individual rehabilitation plan and priority access to state-funded healthcare services [48]. These provisions shape physicians' daily practice, encouraging early identification of foreseeable disability, multidisciplinary rehabilitation planning, and closer cooperation with social services. In parallel, the *Social Protection and Labour Market Policy Guidelines 2021–2027* and the *Social Services Improvement and Development Plan 2022–2024* set out a vision for a modern, accessible social services system that prioritises deinstitutionalisation, independent living, and community participation for people with disabilities [49]. Amendments to the *Law on Social Services and Social Assistance* adopted in December 2024, introduce a mandatory minimum package of municipal services starting in 2025 (e.g. home care for people with severe functional impairments, crisis centres, group homes for people with mental health conditions, social care centres for people and children with severe functional disorders, shelters) and between 2026 and 2028 (e.g. day care, respite services, and specialised workshops) [50].

As a complement to these structural reforms, the Latvia Ministry of Welfare has launched national awareness initiatives, such as the "Step into Another's Shoes" campaign and the annual "Mismatched Shoes Day" (https://cilveksnevisdiagnoze.lv/en/mismatched-shoes-day/). These events invite schools, workplaces, and communities to wear mismatched shoes annually on 26 September, as an opportunity to coordinate public events, share stories on social media, and promote empathy and inclusive attitudes towards people with functional impairments and mental health disorders [4]. These measures create a more supportive environment for physicians to discuss disability openly, reduce stigma, and connect patients with available community-based services.

For Latvian physicians, the call to action on the International Day of Persons with Disabilities is to make disability inclusion an integral part of everyday practice, education, and advocacy. As systematic clinical evaluations detect functional difficulties, health professionals can advocate for disability as an interaction between health conditions and environmental barriers, and adapt personalised care pathways with reasonable accommodation. These efforts can include ensuring barrier-free access to facilities and diagnostic equipment, flexible appointment scheduling, accessible information (e.g. easy-to-read materials, sign language interpretation, augmentative and alternative communication), and home visits or telemedicine consultations. Closer cooperation with municipal social services, personal assistants, rehabilitation teams, and long-term care providers will be essential to align treatment plans with available community-based support and caregiver needs. Medical education should incorporate didactic and practical content on disability rights and communication skills, by inviting people with disabilities and professors who have directly worked with communities with disabilities to serve as partners in training and research. Through the Latvian Medical Association and other professional bodies, physicians can advocate nationally, regionally, and internationally for adequate financing of accessible health services, data systems that capture disability respectfully, and full implementation of the UN Convention on the Rights of Persons with Disabilities across all sectors. By doing so, we help ensure that in Latvia and beyond, no one is left behind in the health system.

Malaysia

In Malaysia, the International Day of Persons with Disabilities reminds health professionals that inclusion must be central to how we deliver healthcare services. According to the Malaysia Department of Social Welfare (Jabatan Kebajikan Masyarakat, JKM), the Persons with Disabilities (OKU) registry reported an increased number of persons with disabilities from 637,537 individuals in January 2023 to 767,243 individuals in March 2025 [51]. However, community-level surveys suggest that over 11% of adults may be living with functional limitations, as a clear indication of underrepresentation in official records [51]. As the burden of disability increases with age, nearly 1.7 million older Malaysians (over 65 years of age) are expected to require disability-related support, with women comprising the majority, by 2040 [51]. Despite progress, challenges remain in ensuring access to quality care, rehabilitation, education, and employment across all settings.

Over the past two decades, Malaysia health leaders have continued to advocate for and strengthen its disability care ecosystem. First, the Government adopted the *Persons with Disabilities Act 2008* (Act 685), which established the National Council for Persons with Disabilities, providing a legal foundation for health and social protection and rights of persons with disabilities [52]. Second, the Ministry of Health has collaborated with public and private sectors to expand Community-Based Rehabilitation programs, now operating in over 550 locations nationwide. For example, national campaigns on vision screenings (including screening for diabetic retinopathy) and cataract surgeries have led to a decline – from 1.5% in

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2014 to 0.7% in 2023 – in preventable blindness among older adults [53]. Third, the Social Security Organisation (SOCSO) runs an exemplary Return to Work (RTW) programme, supporting thousands annually by integrating medical, vocational, and psychosocial rehabilitation services [54]. Furthermore, private sector organisations have stepped up, including FWD Takaful offering insurance products tailored for persons with disabilities, and Malaysia Airports' Butterfly Effect initiative supporting inclusive environments for neurodivergent travellers (e.g. autism).

As physicians, we play a critical role in dismantling systemic and social barriers and creating supportive environments across communities and workplaces. We must champion disability-inclusive education and training, integrate services within primary care, and leverage technologies that ensure no one is left behind. The Malaysian Medical Association is strengthening disability-inclusive healthcare by initiating continued medical education modules on disability care, engaging in policy advocacy under its National Health Policy Committee, and supporting rehabilitation and reintegration efforts in alignment with SOCSO's Return to Work Programme.

Myanmar

The International Day of Persons with Disabilities has special significance for Myanmar physicians, particularly those working on the frontlines, observing the increased burden of disability during the military coup. According to the Myanmar's Ministry of Labour, Immigration and Population's 2019 Inter-censal Survey of the Union Report, an estimated six million persons over 5 years of age (12.8% national prevalence) reported living with a disability [55]. Although prevalence rates were similar across residence types (12.4% among 13.5 million urban residents and 13.1% among 32.8 million rural residents), geographic disparities remain with higher prevalence rates in Chin (20.6%), Rakhine and Ayeyawady (17.3%), and Magway (17.0%), when compared to lower prevalence in Shan (8.6%) [55]. Also, the International Campaign to Ban Landmines announced that Myanmar had the highest number of casualties from landmines and explosive ordinances in 2024, resulting in thousands with severe injuries (including amputations and long-term impairments) [56]. This national crisis has revealed major shortcomings in disability data, healthcare coverage (including rehabilitation services and social and community support), challenges that are likely to worsen amid the ongoing military coup, increasing landmine casualties, and rising healthcare needs from non-communicable diseases like diabetes and cardiovascular conditions.

Under the leadership of State Counsellor Daw Aung San Suu Kyi, the democratically elected civilian government actively pursued reforms to support disability care and inclusion [57,58]. First, the National League for Democracy (NLD) government and stakeholders established the Myanmar Federation of Persons with Disabilities (MFPD) in March 2016, which provided employment and vocational training for individuals with disabilities. Second, the Government of Myanmar adopted the *2015 Law Protecting the Rights of People with Disabilities* in 2017, following its ratification of the UN Convention on the Rights of Persons with Disabilities in 2011 [57,58]. This law was complemented by the launch of the *Employing Persons with Disabilities Handbook* in 2018, and adoption of a national disability policy in 2019, guaranteeing access to healthcare, education, employment, social welfare, and emergency support for all people with disabilities by December 2023 [57,59]. Furthermore, the NLD government actively participated in the Association of Southeast Asian Nations (ASEAN) Enabling Masterplan 2025, which demonstrated regional commitment to disability-inclusive development [59].

However, the latest military takeover has severely disrupted the NLD government's progress on these policies and initiatives. The military operations have resulted in increased sexual harassment and assault on women and children with disabilities, abandonment of mobility devices and prosthetics (to avoid air strikes), and restricted access to critical medical treatment and prosthetic care (to avoid landmines) [60,61]. Amnesty International has documented cases where individuals with psychosocial and intellectual impairments are subjected to arbitrary detention and torture, due to perceived noncompliance with soldiers' orders [61]. These operations directly violate Article 11 of the Convention on the Rights of Persons with Disabilities and the *UN Security Council Resolution No. 2475.*

Physicians in Myanmar and worldwide are responsible for raising awareness, educating the public and decision-makers alike, and collaborating with disability groups to improve access to community-based services and ensure the rights and dignity for persons living with disabilities. Myanmar health leaders should prioritise funding local organisations with the expertise and trust to support medical treatment, rehabilitation, prosthetics, and psychosocial services for persons living with disabilities in the nation. International organisations, such as the UN, World Medical Association (WMA), and Junior Doctors Network (JDN), can advocate for health professionals' training in disability medicine, mental health, and trauma rehabilitation, especially in conflict-affected areas like Myanmar. As they help restore and improve community-based services and inclusive education, they can advocate for greater solidarity sustainable action to guarantee that persons with disabilities are not left behind.

Philippines

The International Day of Persons with Disabilities (IDPD), observed annually on 3 December, resonates deeply in the Philippines, a country with a strong cultural emphasis on family and community support. For the Filipino medical community, the day is a potent reminder of the social model of disability—shifting focus from individual impairment to the societal barriers that hinder full participation. It underscores our ethical and professional responsibility to dismantle these barriers within the healthcare system and beyond. It represents a call for active engagement in advocacy, policy-making, and the provision of truly accessible and inclusive health services, moving beyond mere curative care to comprehensive rehabilitation and social integration.

Philippine health leaders have observed a vast underreporting in official registry systems, where this disparity points to a major gap: the invisibility of persons with disabilities and their exclusion from essential government benefits and services. First, the 2016 National Disability Prevalence Survey found 12% of respondents older than 15 years of age reported severe disability, whereas the Philippine Statistics Authority (PSA) concluded that 4.1% and 22.9% of individuals older than 15 years of age and over 65 years of age, respectively, reported living with any functional difficulty [62,63]. Second, a critical gap in care is the lack of accessible and affordable rehabilitation services, as only a small percentage of health facilities nationwide have complete rehabilitation services (physical therapy, occupational therapy, speech therapy), with the majority as private ownership and costly [64]. Furthermore, persons with disabilities face significantly higher rates of multidimensional poverty compared to those without disabilities, highlighting a socio-economic gap that directly impacts health outcomes and access to care [62,63].

Over the years, the Philippines has enacted several landmark laws advancing disability rights and inclusion. The *Magna Carta for Persons with Disabilities (Republic Act No. 7277*, as amended) serves as the cornerstone of this framework, mandating State support in health, education, and employment, granting persons with disabilities a 20% discount on key goods and services, VAT exemption, and requiring at least 1% of positions in public and private institutions to be reserved for persons with disabilities [65,66]. The *Universal Health Care Act (Republic Act No. 11223)* and *Republic Act No. 10754* expanded these protections by ensuring mandatory PhilHealth coverage for all persons with disabilities and directing the Department of Health to develop specialised benefit packages, such as the Z-benefit program for children with disabilities [64,66,67]. Complementing these efforts, the *Inclusive Education Act (Republic Act No. 11650)* institutionalises inclusive learning through Inclusive Learning Resource Centres in every district and mandates individualised education plans and workforce training to support learners with disabilities [68]. At the local level, *Republic Act No. 10070* requires the establishment of Persons with Disability Affairs Offices (PDAOs) in all provinces, cities, and municipalities to coordinate programs and services. Collectively, these policies reflect the Philippines' continuing commitment to disability-inclusive governance, equitable healthcare, and accessible education.

Our call to action for Filipino physicians is a commitment to disability-competent care and transformative advocacy. In practice, we must dismantle physical barriers and negative attitudes to ensure fully accessible diagnostic and therapeutic environments, including effective communication (e.g. Filipino Sign Language interpreters), while simultaneously advocating for the expansion of affordable, decentralised community-based rehabilitation to bridge the rural-urban service gap. Professionally, medical and allied health institutions must integrate rights-based disability studies into core curricula and continuing medical education, with training on screening tools, legal mandates (like the 20% discount and VAT exemption for persons with disabilities), and invisible disabilities. Finally, as policy advocates, we must leverage our influence to ensure the full implementation and funding of existing laws (like PhilHealth's Z-benefit packages and operationalisation of local PDAOs) to accurately capture the needs of persons with disabilities and ensure their inclusion in the promise of universal healthcare.

Portugal

The International Day of Persons with Disabilities allows us to hold up a mirror to medicine with an essential question: who is left out when we design, fund, and deliver healthcare services? Disability cannot be treated as an external social issue, as it is a determinant of risk, outcomes, and care experience, with clear implications for triage, diagnosis, therapy, rehabilitation, health literacy, and governance. In Portugal, the 2021 Census identified an estimated 1.1 million persons (10.9% of the population) living with at least one significant limitation in the activities of daily living, where 65.6% of persons with disabilities are 65 or older, with a higher prevalence of multimorbidity, frailty, polypharmacy, and functional risk [69]. Persons with disabilities face daily challenges, including buildings and equipment that lack universal accessibility, rehabilitation programs (onset and maintenance) that are insufficient for complex needs, and

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communication modalities without plain language or alternative formats (e.g. sign language interpreter). Since digital systems often do not comply with accessibility standards, rehabilitation goals, needs, metric assessment, and outcomes evaluation, physicians can lead clinical and advocacy efforts in each consultation, discharge, and reassessment.

In recent years, Portugal adopted the *Resolution of the Council of Ministers No. 119/2021,* which launched the *National Strategy for the Inclusion of Persons with Disabilities 2021–2025 (Estratégia Nacional para a Inclusão das Pessoas com Deficiência, ENIPD 2021–2025)* in 2021 [70]. The guiding themes (e.g. education, employment, culture and sport) translate into operational requirements for hospitals and primary care and outpatient community care, focusing on patient safety (e.g. architectural and communication accessibility), care quality (e.g. easy-to-read materials, informed consent). These integrated pathways that link rehabilitation, long-term care, and social protection are essential elements of continuity of inclusive disability care. Second, the Independent Living Support Model (Modelo de Apoio à Vida Independente, MAVI), organised through Independent Living Support Centres (CAVI), shifts the axis of care towards autonomy and participation, where persons with disabilities can live in the community with daily support for mobility, self-care, study, work, and civic involvement [71]. Treatment plans include functional goals (e.g. walking, communicating, self-care, work), resulting in optimal rehabilitation outcomes and reduced hospitalisations. Third, awareness campaigns have expanded to combat stigma and improve literacy in rights and health. Continuing education programmes for health professionals emphasise inclusive communication, functional assessment, adapted screenings (e.g. mammography, colonoscopy, oral health), and prevention of adverse events linked to inaccessibility. Telehealth tools and patient portals can extend service coverage and meet accessibility requirements, such as adequate contrast, screen reader compatibility, keyboard navigation and captioning.

The International Day of Persons with Disabilities reminds us that equity is a clinical method, organisational design, and daily decision-making process, and health systems must leave no one behind in access, quality, and health outcomes. Disability should be considered a determinant of health, where clinical practice is connected with community resources and policy, reasonable accommodation, and health professionals who are trained to offer disability inclusive care. In Portugal, the combination of public strategy, operational instruments (like MAVI and CAVI), awareness campaigns, and professional training serve as robust actions to ensure fair practice. Each physician, service, and health system should ask what needs to change tomorrow so that persons with a disability receive safe, effective, and respectful care that is shaped by scientific knowledge and clinical humility.

South Africa

The International Day of Persons with Disabilities serves as a reminder to healthcare practitioners to advance dignity, equity, and meaningful participation for more than 3.3 million South Africans living with disabilities [72]. Recent national data illustrate that South Africans have reported broad disability (any degree of difficulty in at least one functional domain) (15.7%) and severe functional limitations (3.4%), which disproportionately affects women and older adults, reflecting both biological vulnerability and social determinants [72]. Since these statistics do not include people living in institutions, where disability is more common, the true burden is likely underestimated [72]. Clinicians continue to witness the consequences of longstanding structural inequities within this vulnerable group, including lower education, reduced access to basic services, and limited accessibility of assistive devices (12% of the population) [72]. These multidimensional challenges translate to poorer health-seeking behaviours, poorer health outcomes, and significantly reduced quality of life.

In response to these ongoing inequities, South Africa has introduced integrated policies and system-wide reforms aimed at strengthening disability inclusion across health and social sectors. The Government of South Africa adopted the *White Paper on the Rights of Persons with Disabilities* in 2015, which reflects the need for sustained political commitment to coordinated disability care and accessibility [73,74]. Also, recent innovations in science and technology have further expanded access to communication and assistive devices through the Department of Science, Technology, and Innovation (DSTI). Furthermore, South Africa has prioritised disability-inclusive approaches to the growing concern of gender-based violence (GBV), where the national GBV accessibility checklist promotes inclusive communication, staff sensitisation, safe infrastructure, and supportive policies [73]. Together, these initiatives demonstrate a multisectoral commitment to advancing rights, protection, and equitable service access for persons living with disabilities.

As physicians in South Africa, we call for collective, multidisciplinary and multi-sectoral action to advance disability inclusion as a core component of health systems strengthening. We advocate for inclusive policies based on key global documents, like the Missing Billion framework (https://www.themissingbillion.org/) and the *WHO Health Equity for Persons with*

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Disabilities, and integrated service delivery with investments in timely multidisciplinary care (e.g. high-quality surgical care, rehabilitation, assistive technologies, palliative care) [10,75]. Health professionals can champion disability-inclusive policies, improve equitable access, identify functional disabilities early, ensure timely referrals, and support coordinated rehabilitation and community reintegration. Partnership with communities, caregivers, and persons living with disabilities is key to co-design services that ensure access, affordability, acceptability, and dignity [10]. Collectively, our leadership, advocacy and commitment towards disability-inclusive care will shape meaningful health systems reform and advance health for all.

Tunisia

Tunisia is a country located in the Maghreb region of North Africa, with borders to the Mediterranean Sea (north), Algeria (west and southwest), and Libya (southeast). According to the Tunisia National Institute of Statistics (L'Institut National de la Statistique, INS)'s 2024 General Population and Housing Census (RGPH-2024), a total of 12 million residents (over 5 years of age) are living with a disability, including 375,600 persons (3.3%) with a severe disability and 1.3 million persons (12.2%) with moderate or minor disabilities with functional limitations [76]. Although the survey did not emphasise the cognitive domain, most disabilities were reported as visual (7.1%), mobility (6.4%), and hearing limitations (3.7%), and the prevalence of functional limitations increases significantly with age (4.2% for 5-14 years of age and 65.5% for over 80 years of age). Notably, post-traumatic disability was estimated at 23.6% for road traffic accidents and 30.9% for other types of accidents. Data remain sparse and inconclusive, however, as the Tunisian Health Examination Survey (THES-2016) reported a 2.8% prevalence of a physical or mental disability in the Tunisian population (3.3-4.0% in Tunis District), yet the Ministry of Social Affairs concluded a 14.1% disability prevalence [77,78].

The Government of Tunisia has demonstrated sustained commitment to protecting the rights of persons living with disabilities since 1981, adopting a general law on the protection and promotion of the rights of persons living with disabilities. First, leaders signed the Convention on the Rights of Persons with Disabilities, which was adopted in 2006 (*Resolution A/RES/61/106*). Second, the *Framework Law No 2005-83* (2005) establishes the protection to persons living with disabilities as a national obligation, which was later reinforced by *Law 41* (2016) that allocated 2% of annual recruitment to persons with disabilities in the public sector and set a 2% quota for employees in all public and private companies with more than 100 employees. Third, *Article 54* of the Constitution (2022) states: *"The State shall protect persons with disabilities against all forms of discrimination and shall take all measures necessary to guarantee their full integration into society."* Fourth, the Committee on the Rights of Persons with Disabilities evaluated the disaster response plans and services for persons with disabilities in 2023, concluding the need to revise the "disability" definition and implement a deinstitutionalisation strategy (transform long-term care and support comprehensive community-based services) [79].

Moreover, the Government of Tunisia has continued to support sports and education programs for individuals with special needs, including sustained investment in Paralympic athletes (since 1988) [80]. According to the Ministry of Education, a total of 22,000 children with special needs were attending public schools for the 2025-2026 academic year, noting that the increasing number of students with disability cards (including autism) over the past few years. Although the specialised national health surveillance system can monitor school and university health in Tunisia, challenges have arisen highlighting vulnerable scenarios faced by children and women who are victims of violence [81-83].

In Tunisia and worldwide, physicians and other healthcare professionals are key leaders to advocate for primary, secondary, and tertiary prevention and disability inclusion and care across their health systems. Collective efforts should focus on reducing stigma and discrimination related to mental health disorders and physical disabilities (like mobility limitations and visual impairments) across health institutions, schools, and communities. Together, they can commemorate International Day of Persons with Disabilities as an opportunity to mobilize all communities, increase awareness of the health and social challenges associated with disabilities, and ensure the protection of rights and dignity of people living with disabilities.

United Kingdom

The British Medical Association (BMA) sees International Day of Persons with Disabilities as an opportunity to recognise and celebrate our disabled medical workforce, highlight how disability-inclusive care benefits patients, and share how ableism affects people's health and employment. According to the Family Resources Survey, the estimated number of disabled persons in the United Kingdom (UK) was 16.8 million people (25% of the total population) in 2023/2024, increased from 12.2 million (19% of the total population) in 2012/2013 [84]. Furthermore, a 2025 UK-wide BMA survey of 801 disabled doctors and medical students found that an estimated 70% believed that

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ableism was a notable challenge in their place of work or study [85]. The survey also concluded that additional barriers include delays in accessing workplace adjustments (a legal entitlement in the UK), inadequate routes to report disability-related bullying and harassment, poor understanding of neurodiversity, and deferred specialist treatment for neurodivergence (such as attention-deficit/hyperactivity disorder, ADHD) [86].

In England, data on the experiences of disabled health professionals are collated in the annual NHS England Workforce Disability Equality Standard, which can help inform lobbying for policy improvements [87]. As an organisation, the BMA is also lobbying the Government to introduce mandatory disability pay gap reporting for all organisations with over 250 employees. Members have called for this policy to be accompanied by a requirement for employers to publish gap action plans, as it would likely increase transparency and galvanise employers. The BMA recognises that the economic security of individuals is fundamental to public health and is a signatory to the Disability Employment Charter (https://www.disabilityemploymentcharter.org/), which mandates the Government to improve employment opportunities and experiences for disabled people.

The BMA acknowledges that doctors worldwide play a crucial role in reducing health inequalities for disabled people. They call on all physicians and medical bodies in the UK to champion the rights and inclusion of disabled people. These efforts can include acting as allies to disabled peers and colleagues, challenging ableism, providing adjustments and paid disability leave, and using evidence-based data to ensure that local and national policies and practices are informed by the voices of disabled people. Furthermore, by strengthening medical education and training bodies, doctors can acquire a robust understanding of how to meet the individual accessibility and communication needs of disabled patients in their care management plans.

Conclusion

"Addressing health inequities for persons with disabilities benefits everyone. Older persons, people with noncommunicable diseases, migrants and refugees, or other frequently unreached populations, can benefit from approaches that target the persistent challenges to disability inclusion in the health sector."

- Dr. Bente Mikkelsen, WHO Director for Noncommunicable Diseases

The commemoration of International Day of Persons with Disabilities underscores the need to holistically understand health and social inequities experienced by persons with disabilities, design and enforce policies and programs that meet their health and social needs, and advocate for political commitment for sustainable health financing. Since disability may involve an impairment (e.g. reduced vision, hearing or mobility) coupled with environmental, social, structural or individual challenges, expanding research capacity across academic, public and private sectors will be crucial to accelerate evidence-based findings that can reinforce more inclusive and equitable policies and practices [75,88]. Applying the One Health concept (human-animal-environment nexus) will offer a unique perspective on the risks (e.g. socioeconomic or environmental condition), lived experiences (e.g. stigma or economic hardships), and care management (including the rehabilitation framework) associated with disabilities [89]. Specifically, the 4C's (communication, collaboration, coordination, capacity building) can guide community-based collaborations, build rapport among researchers and stakeholders, promote targeted health messaging, and strengthen health professionals' training in disability-related care.

The global medical community holds a powerful voice to advocate for an inclusive and equitable society that "leaves no one behind" and ensures social support and protection for patients with disabilities, families, and caregivers. As clinical and surgical experts in multiple specialties, WMA members can focus on promoting disability-inclusive care and services (including telehealth) within their health systems, partner with local organisations to coordinate health campaigns, design and incorporate disability-focused content for health professionals' education and training programs, and develop relevant epidemiological and participatory research initiatives to understand individual- and systems-level factors affecting disability. This collective article highlights how physicians can lead policy development, engage health system leadership and governance, support health professions' training, and organise community educational campaigns across the Africa, Asia, East Mediterranean, Europe, North America, and Pacific regions.

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