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Junior Doctors Network

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ABOUT WMA JDN

What is the JDN?

The Junior Doctors Network (JDN) serves as an international platform for junior doctors to facilitate an open dialogue of global events and activities that are relevant to their postgraduate training and the World Medical Association (WMA).

It was created at the 61st WMA General Assembly (October 2010) in Vancouver, Canada and the inaugural JDN meeting was held at the 62nd WMA General Assembly (October 2011) in Montevideo, Uruguay. The network, which started from a few motivated junior doctors, now has a total of over 1300 members from more than 118 countries from all regions of the world.

Junior doctors are defined as physicians, within 10 years after their medical graduation.

What is the mission?

The purpose of the JDN is to empower young physicians to work together towards a healthier world through advocacy, education, and international collaboration.

What do we do?

Networking:
During the regular JDN meetings, members get to know each other, discuss global health issues, share challenges, and start collaborations on global health issues. The JDN meets on several occasions during the year, both in-person and via online teleconferences:

- Biannual meetings in conjunction with the Council Meeting and the General Assembly of the WMA (April & October).
- Monthly general membership and management team teleconferences
- Ad-hoc online and webinars organized by the JDN

MEET THE WMA JDN MANAGEMENT TEAM

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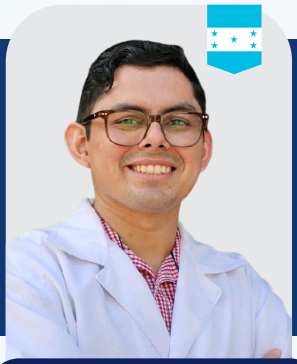

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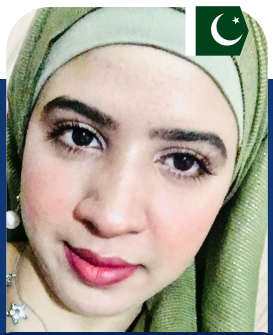

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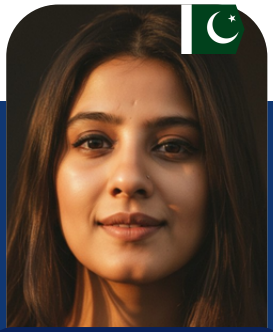

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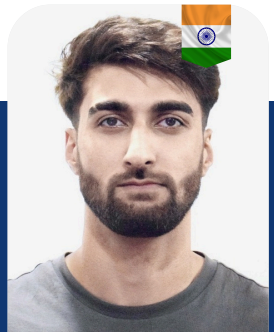

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We acknowledge the contributions by our previous Publications Team members Dr Abhishek Kashyap, Dr Douaa Roufia Attabi, Dr LV Simhachalam, Dr Liban Hassan and Dr Maha Awan.

FOREWORD BY
CHAIR

Dear Junior Doctor colleagues,

It is a pleasure to introduce the 32nd edition of the WMA Junior Doctors Network Bulletin. This has been an exceptionally active and rewarding year for the JDN. Our members have demonstrated remarkable participation and engagement, strengthening our presence in the global health arena and contributing meaningfully to numerous external events, hybrid participation, and collaborative initiatives.

Having dedicated spaces such as this Bulletin is essential. They allow JDN members from around the world to share their experiences, achievements, and milestones, while fostering a sense of community that continues to elevate the network's impact.

I would like to express my sincere appreciation to the Publications Team for their commitment and dedication throughout the term. Their work has ensured that the voices and contributions of junior doctors are highlighted, celebrated, and shared widely.

Warm regards,
Dr Pablo Estrella Porter,
Chair - Junior Doctors Network ,
World Medical Association.

FOREWORD BY
SECRETARY

Dear colleagues,

It is a privilege to introduce the 32nd edition of the WMA Junior Doctors Network (JDN) Bulletin, a testament to the passion, resilience, and global solidarity that define our community. This issue captures the lived realities of junior doctors across regions and specialties, while reaffirming our shared commitment to ethical practice, advocacy, and innovation in times of profound challenge.

This edition spans a remarkable breadth of themes that sit at the heart of junior doctors' professional and personal lives. From the courageous stance taken in support of French junior doctors advocating for fair working conditions and professional autonomy, to powerful reflections on war, disasters, and the duty of medical neutrality, the Bulletin highlights how early-career physicians are navigating some of the most difficult moral and operational terrains in modern medicine. Articles on the economics of burnout, planetary health, telehealth in underserved regions, rational antibiotic use, and universal health coverage underscore that our work is inseparable from broader social justice, climate, and health-systems debates.

What stands out throughout this edition is the central role of junior doctors as changemakers. Working groups such as the Planetary Health Working Group and others have demonstrated how coordinated youth leadership can influence WMA policy, engage multilateral processes like COP and WHO forums, and translate global frameworks into concrete local action. Similarly,

FOREWORD BY
SECRETARY

narratives from conflict zones, disaster-prone settings, and resource-limited health systems show junior doctors not only as responders, but as advocates for humane policies, evidence-based preparedness, and the protection of health workers and patients alike.

This Bulletin also shines a light on the future of our professions and training environments. Contributions on undergraduate research culture, digital health, and innovative approaches such as telehealth and “exercise snacking” emphasize that the next generation of clinicians must also be researchers, educators, and system designers. The stories of early-career colleagues who are building research ecosystems, strengthening mentorship, and championing equity in education offer a roadmap for how we can collectively transform learning and work conditions for those who come after us.

Gratitude is due to all authors, reviewers, and the Publications Team, whose meticulous work and dedication have made this edition possible, as well as to the JDN Management Team and WMA leadership for their continued support of junior doctors’ voices. May this 32nd edition inspire you to reflect, connect, and act, whether by engaging in advocacy, joining a working group, mentoring a colleague, or simply sharing these insights within your local networks. Together, as a global community of junior doctors, we continue to uphold our ethical responsibilities and strengthen health systems, even in the most uncertain times.

Dr Shiv Joshi,
Secretary - Junior Doctors Network,
World Medical Association.

FOREWORD BY

PUBLICATIONS DIRECTOR

Dear Junior Doctors Worldwide,

It is a profound honor to present the 32nd Edition of the WMA Junior Doctors Network (JDN) Bulletin. As our network expands to represent thousands of colleagues across more than 118 countries, this publication stands as a testament to our collective resilience and burgeoning influence in global health diplomacy.

This edition captures the extraordinary breadth of our members' contributions. From the vigorous defense of professional autonomy in France to the harrowing accounts of "training under fire" in conflict zones, these pages reflect the steep moral and clinical terrains we navigate. We move beyond clinical updates to address the systemic "economics of burnout" in Nigeria, the urgent call for planetary health advocacy at COP30, and the essential duty of medical neutrality.

Innovation remains our cornerstone. We explore how AI-driven telehealth is bridging healthcare deserts in North Africa and how "exercise snacking" provides a scalable tool for non-communicable disease prevention in Myanmar. Our commitment to fostering a global research culture—highlighted by pathways for undergraduate medical education in India—ensures that junior doctors are not merely practitioners, but scientific leaders.

FOREWORD BY

PUBLICATIONS DIRECTOR

As we align with the WMA's 2026–2030 Strategic Plan, our focus remains steadfast on physician-led care, ethical technology integration, and health equity. I extend my deepest gratitude to the Publications Team and every contributor for translating frontline clinical realities into this definitive record of advocacy.

May this edition inspire you to reflect, connect, and lead. Though the global health landscape is fraught with challenge, our professional purpose remains unshaken. Together, we are building the resilient, ethical healthcare systems of tomorrow.

Dr Venkatesh Karthikeyan,
Publications Director - Junior Doctors Network,
World Medical Association.

STATEMENT OF SUPPORT FOR FRENCH JUNIOR DOCTORS

APRIL 2025

Context

The Junior Doctors Network (JDN) of the World Medical Association (WMA) is closely monitoring the ongoing debate surrounding a motion from the French Parliament which seeks to better serve medically underserved areas ("medical deserts") in the country. The proposed legislative reform aims to address regional disparities in healthcare access by mandating certain professional obligations for junior doctors, including compulsory establishment of physicians in designated under-served areas and the mandatory participation of doctors in the national on-call duty system ("permanence des soins").

While the intention to strengthen healthcare delivery in underserved regions is understood and applauded, the affected doctors across the country have expressed their opposition, calling for a model that respects their freedom of career choice as physicians; one that safe-guards their well-being while balancing service delivery to the population and protects the individual doctors' autonomy.

Key Concerns and International Best Practices

1. The proposed restriction on the freedom of establishment violates the civil rights of physicians: their ability to choose their area/region of practice. International standards, including the WMA Statement on Physicians Well-Being (2015), emphasizes that autonomy in career decisions is critical for professional satisfaction, workforce stability, and ultimately, the quality of patient care.

2. The implementation of mandatory on-call duty should take into account compliance with the European Working Time Directive (EWTD). This is important to prevent burnout among doctors and to ensure patient safety. Long shifts contribute to fatigue-related errors.

3. The combination of mandatory geographical assignments and compulsory on-call duties may exacerbate poor working conditions in already pressured settings. Rather than enhancing service provision, these constraints have the potential to discourage new graduates from entering or remaining in the profession especially in the field of primary care, more specifically in the areas that are of the greatest unmet need.

Support for Collective Action

When physicians' working conditions deteriorate, collective action—including protests—is a legitimate means of advocacy (WMA Statement on the Ethical Implications of Collective Action by Physicians, 2012; reaffirmed 2022). The WMA JDN stands in solidarity with French junior doctors in their call for fair employment conditions, just remuneration and professional autonomy. We affirm that healthcare reforms must be developed in partnership with those directly affected and grounded in respect for the rights and contributions of medical professionals.

The WMA JDN, together with French junior doctors, call on the French government to engage in meaningful bilaterals with junior doctor representatives to consider alternative models that align with both healthcare equity goals and physician well-being, with the ultimate objective of enhancing patient care.

WMA JDN PLANETARY HEALTH WORKING GROUP REPORT

Dr Lekha Rathod

Dr Laura Jung

Co-Chairs of WMA JDN Planetary Health Working Group

Introduction

Planetary Health is a field of study and a global movement based on a fundamental concept: Human health and the health of our natural ecosystems are inextricably linked.

The official definition from the Lancet Commission on Planetary Health is:

"The health of human civilization and the state of the natural systems on which it depends."

Planetary health therefore moves beyond traditional environmentalism by making an explicit and undeniable connection to human wellbeing. It's not just about saving bees or polar bears; but rather recognising the complex connections within ecosystems and the processes which are creating health threats for human populations.

Junior Doctors are among the first to see the health impacts of environmental degradation as front-liners of the healthcare system, alongside other health professionals and may develop a strong political voice to influence change as respected members of the community. Moreover, youth have a unique position of legitimacy when speaking about long term impacts of human activity on the environment given that they will experience the most serious of those impacts within their lifetime. Doctors are among the most trusted voices in society and have a unique platform and an ethical duty, as outlined in the Declaration of Geneva ("first, do no harm"), to address the greatest threat to human health in the 21st century.

Planetary health is not a distant, abstract concept; it is directly relevant to our daily clinical practice, our career trajectories, and our ethical responsibilities. In daily clinical practice, one may see direct health impacts on patients, for example respiratory diseases and cardiovascular events due to air pollution, heat-related illnesses, infectious diseases, mental health deterioration, and malnutrition & food insecurity. In preventive medicine and patient counseling, a junior doctor is a trusted source of health information. In the wider healthcare system a junior doctor may be curious about sustainability, reducing waste, and rational prescribing.

The JDN Planetary Health Working Group (PHWG), established in 2022, succeeded and expanded on previous work done by the Climate Change & Health Working Group, broadening its scope of activities.

Aims

The group brings together health professionals and emphasizes their unique frontline perspective on Planetary Health and creates a Community of Practice. The PHWG aims to increase engagement of junior doctors at the intersection of human health and the environment, taking a holistic approach which considers the climate crisis, global environmental changes, and health equity.

Events and Collaboration

- In 2025, the working group has so far held 4 membership meetings and workshops at JDN's biannual meetings. The PHWG collaborated with the Primary Healthcare Working Group for a Workshop during the Spring 2025 JDN Meeting.
- The PHWG alongside the Environment WG will also collaborate with MyGreenDoctor to organize a webinar in the coming months.
- The Fall Meeting Workshop, a Policy Hackathon at Porto/Virtual, culminated into a mini policy brief, building capacity and encouraging development of health policy skills.

Advocacy Efforts and Ongoing Projects

In October 2024, the WMA Socio-Medical Affairs Committee renewed the Environment WG of the WMA for 2 years and nominated JDN as chair. Dr Laura Jung has the honor of chairing the Environment working group of the WMA (seconded by Dr Lekha Rathod) until October 2027. In this role, the Environment working group has undertaken revisions of important policies - the Delhi Declaration and the Policy on Divestment from Fossil Fuels. The revisions are currently under circulation with WMA member organizations.

The Environment WG of the WMA holds regular meetings and plans advocacy activities and interventions. In November 2025, Dr Lekha Rathod supported Dr Lujain AlQodmani in drafting a press release that was shared on behalf of the WHPA, as part of the WG's activities: WHPA Urges COP30 to Build Climate-Smart, Health Professional-Led Health Systems under the Belém Health Action Plan.

JDN-WMA representation's updates at the UNFCCC COP and SBs were presented to members of the group at the last membership meeting. JDN-WMA was also represented at COP30 Belem, Brazil in-person by Dr Mohamed Osman Gafar Abdalla and virtually by Dr Lekha Rathod.

The Working Group nominated Dr Muha Hassan as its representative to the WHO Youth Council's Planetary Health working group. She has regularly reported back to both the JDN and PHWG and more recently co-led the Youth Council delegation to the Vatican Pan-European Climate Resilience Summit in Vienna. She spoke at the climate and health panel, highlighting the impacts of air pollution and heatwaves, and outlined practical solutions at local level in line with WMA policy recommendations.

The group also followed the Plastic Treaty Negotiations which happened in December (unfortunately without an agreement) and planned to follow up on this topic throughout through two online workshops with MyGreenDoctor and an external expert on the Treaty.

The working group has engaged in helping the management team prepare for external representations - e.g. the EB and WHA meeting and grown a wide net of contacts, making JDN's voice present and known at important Climate Change & Health Forums, including UNFCCC and WHA events.

Future Activities

In the upcoming term, the group will continue their engagement together with the WMA Environment Working Group and at external events. The group will continue their ongoing activities and invite ideas for new activities from members and the wider JDN.

The group invites members (both existing and prospective) to actively share experiences from their real-world setting in our PHWG's Community of Practice.

For any further information or requests to engage, please don't hesitate to reach out to us - Dr Lekha Rathod (lekha.r91@gmail.com) and Dr Laura Jung (laurajung.gh@gmail.com)

JUNIOR DOCTORS IN WAR: TRAINING UNDER FIRE AND THE DUTY OF MEDICAL NEUTRALITY

Shiv Joshi[1], Damilola Ayowole[2] , Francesco Rosiello[3]

1 Shiv Joshi, Former Medical Ethics Officer, WMA JDN.

2 Damilola Ayowole, Department of Community Medicine and Primary Care, Federal Medical Centre, Abeokuta, Ogun State, Nigeria.

3 Francesco Rosiello, Dept. of Infectious Disease and Public Health, Sapienza-Università di Roma, Italy.

Introduction

From the post-World War II period until the 21st century, healthcare personnel have been recognized as personnel to be protected ("ghost personnel") both by customary international law (published more than 50 years ago, such as the Geneva Conventions) and by treaty law (less than 50 years ago, such as the two Additional Protocols to the Geneva Conventions). The difference is as follows: while all states must comply with customary law, treaty law applies only to states that have signed and ratified it, integrating it into their national law. For the first time, therefore, we are witnessing not only a relativism of international law but also of its sanctioning body - The International Court of Justice settles disputes between states, while the International Criminal Court investigates and tries individuals accused of international crimes.

Armed conflict reshapes health systems overnight, collapsing the boundaries between training and service for junior doctors who must shoulder responsibility amid chaos. From Gaza to Ukraine and Sudan, wars expose how fragile medical training and neutrality become under fire. For those in the steepest phase of professional formation, war compresses risk, responsibility, and moral pressure into daily practice. Training pathways fragment as rotations are suspended, supervision thins, and case-mix skews toward trauma. Yet these same doctors become indispensable providers for overwhelming needs, often without protection or recognition.

This Viewpoint examines how conflict distorts training and service delivery for junior doctors, and the roles they must play to uphold medical neutrality, sustain resilient care, and advocate ethically in the context of war.

HOW WARS AFFECT JUNIOR DOCTORS' TRAINING AND SERVICE DELIVERY

I) Training Disruption and Skill Dilution

Conflict interrupts structured rotations, examinations, and accreditation timelines. Exposure narrows to emergency, orthopaedic, surgical, and critical care trauma, reducing breadth in paediatrics, obstetrics, psychiatry, geriatrics, and primary care. Supervision becomes sporadic as seniors are redeployed, displaced, or fatigued, undermining formative feedback and procedural safety. Competency-based progression becomes opaque when portfolios cannot be completed, simulation is unavailable, and logbooks are replaced by ad hoc tasking[1,2].

Furthermore, breaking research agreements and destroying laboratories not only hinders progress in research, but also wastes the resources (in terms of money, time, etc.) invested in them.

II) Moral Injury and Safety Risks

Junior doctors confront ethically impossible triage decisions, treating under bombardment and scarcity, often caring for colleagues and family members. Repeated exposure to preventable deaths and violations of medical neutrality inflicts moral injury, burnout, and attrition. Direct attacks on facilities, arrests at checkpoints, and intimidation heighten the danger for early-career staff[1,3].

III) System Overload and Degraded Quality

Mass-casualty surges force task-shifting without

adequate training. Maternal health, TB, HIV, and NCD services collapse as supply chains fail and staff flee. Documentation, infection control, and continuity of care degrade, widening inequities for women, children, older adults, and people with disabilities[4]. The result is a silent erosion of quality that endangers populations and the moral fabric of medical professionalism.

IV) Education by Crisis

Necessity accelerated the emergence of damage-control surgery, field anaesthesia, point-of-care ultrasound, and tele-supervision, which initially arose from improvisation. While adaptive, this "education-by-crisis" risks entrenching unsafe norms without structured mentorship or reflective debriefs. The question is not only how junior doctors survive conflict, but also how they maintain their ethical and educational integrity within it[5].

WHAT IS THE ROLE OF JUNIOR DOCTORS IN CONFLICT?

I) Upholding Medical Neutrality

Junior doctors must uphold medical neutrality, treating patients' needs, not their affiliation, maintaining confidentiality, refusing to be complicit in ill-treatment, and documenting violations through lawful channels. Neutrality demands institutional support, legal literacy, and protection for conscientious practice[6,7].

Furthermore, doctors from all sides should act as a single voice to exert moral suasion on the governments of the warring parties (not necessarily state entities) in order to have not only its neutrality but even its independence and value recognized.

II) Building Resilient Services

Operational resilience is a professional competency under fire. Junior doctors can standardise triage protocols, create low-resource airway carts, steward antibiotics during scarcity, protect continuity for chronic diseases, and embed psychological first aid and structured debriefs to mitigate cumulative stress injury[4,8].

III) Documentation and Accountability

Secure, de-identified records of attacks, supply gaps, and outcomes can transform clinical data into tools for coordination and justice. Junior doctors should maintain a chain of custody for medicolegal injuries, adhere to minimum datasets, and liaise with impartial agencies while protecting patient privacy[2,9].

IV) Education, Mentorship, and Peer Support

When formal teaching breaks down, peer-led tutorials, case reviews, and tele-mentoring networks help sustain learning. Rotation of high-stress duties, "recovery shifts," and access to counselling reduce burnout. In war, teaching becomes a moral act, keeping knowledge alive when systems collapse[2].

V) Ethical Advocacy, Not Politics

Junior doctors can advocate for protected health corridors, safe passage for ambulances, and accountability for attacks on health care. Advocacy grounded in ethics, not partisanship, should cite humanitarian law and coordinate through professional associations to amplify impact and protect individuals[7,10].

SAFEGUARDS FOR LEARNING AND SAFETY

Practical safeguards must be institutionalised: carry professional identification and adhere to ethical codes; use neutral signage; encrypt patient data; prepare personal safety plans; and document training interruptions to preserve future accreditation[2,9]. Facilities should schedule micro-teaching, tele-supervision, and rest periods; embed mental health first aid; rotate high-exposure shifts; and standardise reporting on attacks against healthcare[2,7,9,10].

Healthcare personnel and facilities are marked with special distinctive signs and communicated to all parties (both those involved in the conflict and those not involved) for immediate recognition (principle of distinction in international humanitarian law).

CONCLUSION

War assaults both patients and the apprenticeship of medicine. Junior doctors stand at the intersection of disrupted training and surging need. Their response must preserve medical neutrality, well-being, and service continuity, the foundations of ethical practice under fire. With institutional backing, legal protection,

and structured advocacy, these early-career physicians can transform crisis into principled leadership, upholding the covenant of medical ethics when it is most threatened.

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Bridging the Gap: How Telehealth Can Transform Healthcare Access in North Africa

Douaa Roufia Attabi

Douaa Roufia Attabi, Former student researcher at San José State University; Incoming student, Johns Hopkins Bloomberg School of Public Health, USA.

The Hidden Crisis in Access to Care

Healthcare access in North Africa faces unique geographic challenges, particularly in underserved and remote regions. Millions of people must travel long distances–often in harsh desert conditions–just to see a doctor (1). Healthcare deserts persist in rural areas, leaving communities without nearby access to medical services (2). These barriers prevent timely care and highlight the urgent need for innovative, scalable solutions that can reach people where they are.

Personal Perspective– Why Telehealth Matters

Telehealth has the power to make a real difference in how people receive medical care. It removes many of the barriers caused by distance and helps connect patients to doctors more easily. With online consultations, regular follow-ups, and access to reliable health information, people can get the help they need without having to travel long distances. In this way, telehealth turns healthcare from something that feels out of reach for many into something fairer and more accessible for everyone.

The Dawini Approach – A Culturally Grounded Solution

Dawini, which means “Heal me” in Arabic, is a proposed AI-driven telehealth platform designed for underserved communities. It aims to connect patients with licensed doctors through a secure mobile and web app, offering consultations via video, voice, or chat.

What makes Dawini unique is how it respects the region’s culture and languages–supporting Arabic, French and English. Studies show that many healthcare professionals and patients in North Africa are already open to using digital health tools, with 40% of doctors active in digital media and almost one-third of patients using health apps (3). The platform addresses critical barriers to healthcare access by reducing long wait times and transportation costs. Patients can receive medical consultations from their homes, while doctors can manage larger patient volumes more efficiently. The multilingual interface ensures that language is not a barrier to care, particularly important in a region where Arabic, and French languages coexist.

This app also includes an AI symptom checker that helps patients understand their condition before meeting a doctor, and triage tools that highlight urgent cases so care can be given faster. These tools reflect a growing shift across Africa, telemedicine platforms have experienced significant growth across Africa in recent years (4).

Transforming Health Systems – Beyond Individual Care

Telehealth is more than just a way to offer online consultations; it can help expand access to specialist care, reach people in areas with few medical workers, and make preventive health education a regular part of care. In many parts of sub-Saharan Africa, the number of health workers is still very low, so telehealth can be a practical way to fill this gap and make care more accessible (5).

Through partnership with clinics and public health programs, Dawini aims to support community outreach, run health awareness

campaigns, and provide continuous patient education. These efforts show how telehealth can strengthen healthcare systems and bring more equality in access to care, especially in areas where telehealth can complement existing healthcare services.

Conclusion- A Call to Action for Junior Doctors

As junior doctors, we are part of a new generation that can use technology to make healthcare better and fairer. We have the creativity and skills to find new ways to reach people who struggle to get care.

Dawini is one example of how technology can help close the gap in access to healthcare. More importantly, it is a call to action: to build solutions that ensure healthcare is accessible, affordable and inclusive for everyone. Junior doctors can champion telehealth adoption by advocating for integration in their hospitals, participating in digital health training, and educating communities about telemedicine benefits. By embracing innovation while addressing implementation barriers, we can lead the transformation toward truly equitable healthcare delivery.

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The Economics of Burnout among Early Career Doctors in Nigeria: Inflation, Unpaid Arrears, and Eroded Allowances as Drivers of Poor Work–Life Balance

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Introduction

Early Career Doctors (ECDs) in Nigeria, comprising house officers, medical officers, and resident doctors, form the indispensable workforce that sustains tertiary, secondary, and emergency healthcare delivery across the country. They are often the first responders in under-resourced hospitals, working long hours in facilities plagued by staff shortages, inadequate remuneration, and fragile health financing structures(1). While the global discourse on physician burnout has expanded, little emphasis has been placed on its economic antecedents in low- and middle-income countries (LMICs), where inflation, delayed remuneration, and poor welfare policies compound psychosocial stress(2). The Nigerian context offers an archetype of how structural economic inequities intersect with professional exhaustion to erode doctors' well-being and trigger migration intentions.

The Economics of Burnout in Context

Burnout, characterised by emotional exhaustion, depersonalisation, and reduced sense of personal accomplishment, has been widely documented among ECDs in Nigeria(2). The CHARTING II study revealed that over 60% of Nigerian ECDs experience high emotional exhaustion and poor work–life balance, linked mainly to workload, lack of rest, and unmet financial expectations(1). However, while working hours and organisational culture have been repeatedly studied, the economic stressors underlying burnout, including unpaid arrears, stagnant salaries, and inflationary pressures, remain under-examined(3,4).

In Nigeria, the Nigerian Association of Resident Doctors (NARD) has persistently decried unpaid salary arrears and delayed payment of the Medical Residency Training Fund(5). Recent national reports show that health workers, including ECDs, are owed approximately ₦38 billion in salary and allowance arrears(6). These delays, sometimes spanning several months, occur within an economy where annual inflation has exceeded 20% since 2022(7). For ECDs whose basic pay has remained essentially unchanged for more than a decade, the mismatch between income and the cost of living results in chronic financial stress, a recognised precipitant of burnout(8).

Work–Life Imbalance and the Vicious Cycle of Economic Strain

Work–life balance, a vital determinant of physician wellbeing, represents the equilibrium between professional duties and personal life. Globally, early-career physicians report higher burnout prevalence than senior colleagues, partly due to unstable incomes, debt, and limited control over work schedules(8). In Nigeria, many ECDs engage in moonlighting, locum shifts, or private practice after regular duty hours to offset financial deficits(3). This coping mechanism further truncates rest periods, promotes sleep deprivation, and heightens emotional exhaustion.

The interplay between financial insecurity and excessive workload thus creates a self-reinforcing cycle: underpayment prompts longer hours, which in turn heighten fatigue, and fatigue diminishes productivity and empathy(4,8). The cumulative effect manifests as depersonalisation, irritability, and declining clinical performance, outcomes with potential implications for patient safety and public trust in the health system(1).

A Global Lens on Economic Burnout

The economic factors contributing to burnout are not unique to Nigeria. In the United States, educational debt and reimbursement disparities are leading causes of burnout among younger physicians(8). In the United Kingdom, a 2024 British Medical Association (BMA) survey found that 62 % of junior doctors were considering leaving the National Health Service due to pay erosion and inflation(9). Similarly, recent research from Ghana demonstrates that poor remuneration, limited career progression, and unfavourable working conditions significantly influence the intention of doctors to emigrate in search of better opportunities(10).

What sets Nigeria apart is the convergence of macroeconomic instability and weak institutional accountability. Inflation remains among the highest in sub-Saharan Africa (7), yet wage adjustments lag behind living costs. Unlike South Africa, where collective bargaining and inflation-linked salary reviews are institutionalised, Nigerian ECDs rely on intermittent industrial action to secure temporary concessions (5, 6). Such instability fosters uncertainty, undermines morale, and accelerates the brain drain of young professionals(10).

Policy Context and Missed Opportunities

Under NARD's leadership, ECDs have consistently advocated for welfare reform through structured dialogue and industrial action. Their communications to the government focus on clearing arrears, reviewing the Consolidated Medical Salary Structure (CONMESS), and implementing the Medical Residency Training Fund fully. Although authorities sometimes announce wage adjustments, partial implementation and delays in disbursement are frequent, resulting in a discrepancy between policy goals and the realities faced by frontline workers.

Furthermore, Nigeria lacks a formal physician wellbeing policy or duty-hour regulations, similar to the standards set by the Accreditation Council for Graduate Medical Education (ACGME) observed in high-income countries(8). Without institutional safeguards for rest, fair pay, and psychosocial support, ECDs bear the cumulative burden of system inefficiencies, both financially and emotionally.

Reframing the Solution: Economic Justice as a Burnout Intervention

Addressing burnout among Nigerian ECDs requires shifting the focus from personal resilience to systemic economic justice and institutional accountability. Evidence shows that effective burnout-prevention strategies must include fair remuneration, predictable income, and organisational respect for labour.[8] Timely and transparent salary disbursement should be a mandatory standard, supported by automated payroll systems that prevent arrears and rebuild trust between doctors and government employers.[5] Regular inflation-indexed salary reviews are equally vital to preserve purchasing power and mitigate wage erosion in a volatile economy(7).

Beyond salary, welfare interventions such as subsidised housing, comprehensive health insurance and debt-relief programmes are vital to shield early-career professionals from financial hardship(10). Institutional enforcement of duty-hour limits, recovery time and structured rotations is also essential to guarantee proper rest and prevent fatigue-related burnout. Embedding physician well-being indicators into national workforce dashboards will further support evidence-based policymaking. Economic justice, therefore, stands as a tangible and transformative strategy for sustaining Nigeria's medical workforce.

Conclusion

The burnout crisis among Nigerian ECDs is linked to macroeconomic issues like unpaid arrears, inflation, and stagnant wages. These factors promote a culture of overwork, financial insecurity, and moral distress, risking both doctor retention and patient safety. International experiences demonstrate that countries prioritising fair pay and wellbeing policies achieve a more stable workforce and lower attrition rates. Nigeria must therefore see burnout not as a personal failing to cope, but as a systemic failure of economic justice. For its youngest doctors, financial fairness is not just a welfare issue; it is essential for sustainable healthcare delivery.

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Rational Use of Antibiotics in Pediatric Care: Observations from Yemen

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During my internship as a junior doctor in Yemen, I observed a concerning pattern in the management of pneumonia and other infectious diseases in children: the routine use of broad-spectrum antibiotics such as Meropenem, Cefepime, and Linezolid as first-line treatment, often before any definitive diagnostic confirmation (1,2).

In many hospitals, physicians face limited access to accurate laboratory tests, such as bacterial cultures and sensitivity testing. The cost of these tests often exceeds that of the antibiotics themselves, making them unaffordable for most families (3,4). As a result, doctors rely on empirical treatment with the strongest antibiotics to cover all potential pathogens. Traditional antibiotics, like Ceftriaxone, are often perceived as "ineffective," pushing clinicians directly toward more potent options (4,5).

This pattern creates a vicious cycle: overuse of common antibiotics increases resistance, which drives the prescription of stronger drugs (1,3,5). Limited diagnostics and high costs further reinforce empirical overuse, eventually putting last-resort antibiotics at risk of losing effectiveness. The outcome is alarming: widespread antimicrobial resistance, increased costs, higher risk of side effects, and fewer future treatment options (6,7).

Addressing this issue requires a multi-faceted approach:

1. Financial support for diagnostic testing to make it more affordable than empirical treatment with broad-spectrum antibiotics (2,4).

2. Local antimicrobial stewardship programs to review prescriptions, guide empirical therapy, and encourage dose de-escalation when possible (4,5).

3. Regulation of antibiotic sales to prevent dispensing strong or injectable antibiotics without prescriptions (3,5).

4. Ongoing education and community awareness to reduce pressure on physicians and preserve antibiotic effectiveness (2,4).

5. Development of local guidelines based on actual bacterial resistance patterns to standardize treatment and minimize unnecessary escalation (6,7).

As junior doctors, we experience daily the tension between clinical ideals and practical realities—diagnostic limitations, economic pressures, and supply shortages. Acknowledging these challenges is the first step toward meaningful change (2,4).

Antibiotics are invaluable allies, but misuse threatens to turn them into liabilities. Rational use is not only a clinical responsibility but an ethical obligation to safeguard the future of medicine in Yemen (1,2,5).

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The 70th International Pharmaceutical Students' Federation (IPSF) World Congress

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Introduction

The 70th International Pharmaceutical Students' Federation (IPSF) World Congress brought together pharmacy students and young professionals from across the globe to accelerate progress in pharmacy education, practice, and global health innovation. This milestone gathering in Nairobi, Kenya, marked a powerful moment of reflection and reimagination for the future of pharmacy, driven by the congress theme, "Advancing Pharmacy Education and Practice for Global Health Impact." Over several inspiring days, participants examined how the pharmaceutical workforce of tomorrow can better respond to the most urgent health priorities of today —from health equity and digital transformation to medicines access and planetary health.

A Global Community with a Shared Purpose

The IPSF World Congress is more than an academic convening—it is a platform where passion meets expertise, where future pharmacists connect to amplify their voice in global health advocacy. This year's congress welcomed delegates from more than 90 countries, representing diverse health systems, cultures, research specialities, and practice environments. Together, they engaged in an agenda rich with scientific sessions, skills-building workshops, exciting fireside chats, leadership forums, public health campaigns, and networking and cultural exchanges.

Beyond the formal program, the congress nurtured a sense of community and professional identity. Students and recent graduates found opportunities to share innovations developed in their own contexts, learn from high-level experts, and build collaborations that will shape careers and strengthen national health ecosystems.

Elevating Pharmacy Education for the Future

One of the Congress's core priorities was strengthening pharmacy education to keep pace with the rapidly evolving health landscape. Speakers and panelists emphasized the role of pharmacists as accessible primary healthcare providers, medicine experts, and champions of patient-centered care.

Key discussions focused on:

- **Transforming curricula for real-world readiness -** Curriculum reform that integrates interdisciplinary learning, clinical competencies, public health, pharmaceutical policy, supply chain management, and digital health.
- **Competency-based learning and lifelong upskilling -** Ensuring future pharmacists are equipped with dynamic skills aligned to global standards and emerging health challenges.
- **Research and academic mentorship -** Expanding research capacity and encouraging innovation at early career stages.
- **Cultural competence and equity in education -** Embedding approaches that promote inclusive practice and eliminate structural bias.

Pharmacy students were urged to take agency in shaping their own learning experiences and advocating for change within their institutions.

Driving Innovation in Practice

Pharmacy practice has evolved far beyond the traditional dispensary role. Congress sessions showcased how pharmacists are

- Telepharmacy and remote pharmaceutical care to expand access in underserved areas
- Digital medication adherence technologies improving chronic disease management
- Artificial Intelligence in drug discovery and clinical decision support
- Data-driven health systems enabling stronger surveillance and pharmacovigilance for optimal patient safety

Speakers stressed that while technology offers profound opportunities, human-centered service remains the foundation of trust in pharmacy practice.

Strengthening Advocacy for Medicine Access and Universal Health Coverage

Pharmacists hold an influential role in promoting Universal Health Coverage (UHC) and addressing systemic barriers to essential medicines. Delegates explored global challenges including supply chain disruptions, rising antimicrobial resistance, counterfeit medicines, and economic inequities affecting care delivery.

IPSF reaffirmed its commitment to:

- Supporting global policy efforts that enhance affordability and access to safe, quality medicines
- Empowering youth advocates to shape national health agendas
- Advancing pharmaceutical systems that protect vulnerable populations

Discussions highlighted successful models from around the world, demonstrating how student-led initiatives—such as vaccination outreach, harm reduction programs, and health literacy campaigns—are making tangible community impact.

Spotlight on Gender Equity, Climate Health, and Emerging Global Priorities

Three cross-cutting issues gained significant attention throughout the congress:

1.The Gender Health Gap

According to the World Economic Forum's Gender Gap Report, the gender gap index in 2025 closed at 68.8%. Despite this, alongside near parity reached in health and survival metrics, there still exist disparities in economic participation, political empowerment and healthcare access. Women and girls face unique health challenges across their lifespan, including reproductive health, non-communicable diseases and higher morbidity in older age, often exacerbated by systemic barriers in low and middle-income countries. Sessions emphasized persistent inequities in research representation, diagnostics, and care delivery for women and gender-diverse populations. Pharmacists were urged to address these gaps through patient advocacy, equitable clinical guidelines, and gender-inclusive and responsive medicine access.

2.Climate Change and Planetary Health

Future pharmacists must be prepared to respond to climate-driven disease burdens, pharmaceutical waste management, and resilience in medicine supply chains. Sustainability was positioned as a professional obligation—not an optional pursuit.

3.Mental Health and Well-being

Across many countries, pharmacists are often the first point of contact for patients experiencing psychological distress. Strengthening training in mental health support and safe counseling practices emerged as a critical area of action.

Youth Leadership and Global Solidarity

A defining feature of both IPSF and this congress is bold youth leadership. Young pharmacists are no longer passive learners but influential changemakers at national and global levels. Leadership forums at the congress focused on empowering delegates to step confidently into roles that shape policy, governance, and practice transformation.

Students were encouraged to strengthen solidarity across borders—recognizing that the path to health equity requires collective action, shared knowledge, and intentional collaboration. Whether advocating for antibiotic stewardship in hospitals or participating in the global fight for reproductive health rights, pharmacy students affirmed their readiness to contribute to a healthier world.

A Renewed Vision for the Profession

As the congress concluded, one message resounded clearly: The future of global health depends on a skilled, adaptable, compassionate, and equity-driven pharmaceutical workforce. The 70th IPSF World Congress reinforced that pharmacists are uniquely positioned to bridge gaps in care and extend the reach of health systems.

Key commitments emerging from the event include:

- Advancing pharmacy education aligned to global health needs
- Driving innovation while safeguarding human dignity
- Championing universal access to quality medicines
- Advocating for sustainability and resilience in healthcare
- Amplifying the youth voice in policy and leadership
- Strengthening global partnerships and community trust

The spirit of unity and purpose displayed throughout the congress reflects the extraordinary potential of this global network of young professionals. Delegates return home not only with new knowledge but with renewed energy to act, influence, and transform.

Looking Ahead

As IPSF celebrates this milestone 70th edition, the Federation stands at the forefront of shaping the next era of pharmacy practice. With every congress, the momentum grows—future pharmacists are becoming bolder advocates, sharper innovators, and stronger leaders.

In advancing pharmacy education and practice, this generation is not waiting for the world to change. They are building the systems, solutions, and collaborations that will define global health for decades to come.

The legacy of this congress will be measured not only by what was discussed in its halls but also by the impact participants will make in their communities, institutions, and countries. And with the passion shown in this gathering, the future of pharmacy—and global health—is brighter than ever.

Figure 1: Dr. Marie-Claire Wangari taking part in the Gender Equality Panel

Figure 2: Participants of the 70th International Pharmaceutical Students' Federation (IPSF) World Congress

Barriers and Enablers of Undergraduate Research in India: Challenges, Opportunities, and Pathways to Cultivating a Research Culture

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Introduction

Undergraduate research serves as the essential foundation that trains scientists and clinicians, and innovators who will lead the future. Research on culture among Indian undergraduates and medical students continues to develop at a slow pace, even though its value is receiving growing acknowledgement. Students show positive attitudes about research, yet their actual involvement and project completion and publication success rates remain at disappointing levels (1,2). The study investigates Indian undergraduate research obstacles that stem from institutional factors and cultural and systemic elements, while showing essential supporting elements and suggesting practical solutions to build a lasting research environment.

BARRIERS TO UNDERGRADUATE RESEARCH

Academic Pressure and Exam-Centric Culture

The Indian higher education system depends mainly on exams to assess students through grades and position rather than encouraging students to develop critical thinking abilities or innovative skills. The cultural environment prevents researchers from conducting exploration because it needs dedicated time and intellectual curiosity and acceptance of unclear situations. The academic community tends to view research activities as suitable for graduate students and faculty members instead of recognising them as essential components of undergraduate education (3,4).

Lack of Awareness and Knowledge

Research indicates students show limited knowledge about available research projects and scientific methods and the value of scientific exploration (1,5,6). Research receives positive support from students because 96% of them recognise its significance yet only a few students actually finish projects or achieve publication success (2). Students show different views about science education in comparison to their actual classroom activities because they received little research training during their school years.

Insufficient Mentorship and Guidance

Most Indian research institutions lack essential mentorship programs which stop undergraduate researchers from receiving proper guidance. Faculty members must handle substantial teaching responsibilities and administrative tasks while receiving insufficient motivation to guide student research activities. Students fail to produce valuable research results when they do not receive proper guidance about project design and data analysis and dissemination methods (2,7).

Resource and Funding Constraints

The financial resources available for undergraduate research remain extremely limited because they must cover laboratory access and consumables and stipends and conference travel expenses. The Indian Council of Medical Research Short Term Studentship (ICMR-STS) operates through national programs but insufficient institutional backing together with poor awareness limits its effectiveness. The research environment at state universities together with smaller institutions gets worse because their infrastructure systems lack necessary facilities (4).

Rigid Curriculum and Time Constraints

Medical training programs give priority to clinical education instead of research training because they view research as something extra that students should learn on their own time. Students report severe time constraints due to overloaded schedules, leaving little room for research engagement(2,8). Research training enters the curriculum at a late point which prevents students from developing essential skills and maintaining their interest in research activities.

Socio-Cultural Attitudes

Society sets expectations for people to follow a traditional career route which starts with academic success and continues through challenging postgraduate studies and clinical work. Research activities encounter skepticism because people view them as having limited financial value and practical applicability. Family members support these beliefs by making students spend more time away from research activities(7).

Lack of Recognition and Career Incentives

Research accomplishments fail to achieve the same institutional acknowledgment which academic grades and clinical performance achieve. The selection process for scholarships and awards and postgraduate admissions heavily depends on exam scores which discourages students from participating in research activities because it does not reward innovative scientific work.

ENABLERS AND PATHWAYS FORWARD

Curricular Integration of Research Training

The implementation of structured research methodology courses together with project-based learning during undergraduate education establishes research as a fundamental concept instead of an optional one. The competency-based medical education system in India enables research electives and practical training to become part of the core educational structure.

Robust Mentorship Networks

Institutions need to provide time protection and research supervision training and mentorship acknowledgment to support faculty members who mentor undergraduate researchers. Research-active alumni working with peer mentorship programs will create additional networks which students can access for guidance (2,7).

Funding and Infrastructure Enhancement

Research funding accessibility will improve because institutions will establish new grant programs and industry collaborations and philanthropic backing. Students will perform meaningful projects because they will have access to better laboratory facilities and digital libraries and research software (6).

Research Skill-Building Platforms

Students can develop practical skills and teamwork abilities through their participation in regular workshops and hackathons and student research clubs and online training modules. Student-led conferences provide essential opportunities for students to develop self-assurance and establish academic networks through their ability to present and publish work (5).

Institutional Recognition and Career Integration

Research output evaluation for scholarship awards and internship placements and postgraduate admissions will motivate students to participate in these activities. Academic institutions gain elevated research prestige through the combination of awards and featured presentations and public recognition of research achievements (2).

National Policy Support

The National Education Policy 2020 from the Government includes research integration as its main focus for higher education institutions. Programs like ICMR-STS and Clinical Research Training Programme and university research fellowships require improved institutional backing and public awareness to reach their full potential (6).

Cultural Transformation

Broad awareness campaigns highlighting successful student researchers and emphasizing research impact on healthcare and society can gradually shift entrenched mindsets. Showcasing diverse career pathways in research, academia, and industry will help students and families recognize research as a viable and rewarding pursuit (7).

Conclusion

The large number of undergraduate students in India presents an opportunity to create groundbreaking research outcomes. Research culture development faces obstacles from academic structures, mentorship support, and resource availability, as well as cultural attitudes; yet, specific solutions exist to build a thriving research environment. India needs to establish research training within its educational system while providing better mentorship and funding and recognition systems and cultural transformations to develop professionals who will serve as both skilled practitioners and innovative scientific leaders and social progressors.

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Bridging the Gap: Why Exercise Snacking Could Transform Health in Myanmar and Beyond

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Introduction

When I began working as a community doctor in Myanmar, I expected to see mostly infectious diseases. What I actually faced every day were the long shadows of non-communicable diseases (NCDs)—patients with uncontrolled diabetes, hypertension, and strokes that devastated not only individuals but entire families. Later, in a neuromedical clinic under a WHO-supported project, I saw firsthand how these conditions left people disabled and dependent, overwhelming fragile health systems that were already stretched thin.

As doctors, we know the guidelines: at least 150 minutes of moderate physical activity a week. But when I asked patients about exercise, the answers were painfully consistent: "*I don't have time. I can't afford a gym. I'm too tired after work*." Apart from telling them to "*try regular exercise*," I often felt powerless. Patients who did make the effort often signed up at gyms, only to quit after a few weeks—held back by cost, long commutes, lack of support, or simply the exhaustion of surviving daily life in a developing country.

That helplessness stayed with me. I realised the problem wasn't that people didn't understand the benefits of exercise as it was that exercise, as currently prescribed, was not accessible or realistic. That realisation became the spark for my journey into research.

The Problem of NCDs in Developing Countries

In Myanmar and many developing countries, the burden of NCDs is rising fast. Economic growth, urbanisation, and longer working hours mean people move less, eat more processed food, and face higher stress levels. Yet health systems remain designed around infectious diseases and acute care.

Unlike high-income countries, where gyms, parks, and structured health programs are more available, in Myanmar access to facilities is limited, and preventive healthcare is underdeveloped. Patients often live in crowded housing, work multiple jobs, and prioritise income over health. The idea of spending an hour at the gym three times a week is simply unrealistic.

This mismatch between global exercise guidelines and local realities convinced me that we need a new approach—one that meets people where they are, instead of expecting them to change their entire lifestyle overnight.

My Journey into Exercise Science

I pursued a Master's Clinical Exercise Physiology at Liverpool John Moores University in the UK, supported by the British Council Women in STEM Scholarship. For the first time, I learned how to prescribe exercise not only as a preventive measure but also as a supportive intervention for conditions like diabetes, cardiovascular disease, and neurological disorders.

It was empowering to know I could design programs that improved blood sugar control, reduced blood pressure, or supported rehabilitation. But still, something was missing. Even with these skills, I felt that prescribing exercise one patient at a time was not enough.That realisation brought me to continue my PhD research at Heriot-Watt University, where I could step back and ask bigger questions: *How do we create solutions that work not just for individuals, but for entire communities? How can we design exercise that is simple, scalable, and accessible even in resource-limited settings like Myanmar?*

The Promise of Exercise Snacking

My current research focuses on exercise snacking, whereby short, frequent bouts of activity are integrated into daily routines. Instead of expecting people to carve out an hour for the gym, exercise snacking requires only a few minutes of stair climbing, brisk walking, or bodyweight movements done several times a day.

The idea is simple, but the science is promising. Randomised controlled trials show that exercise snacking improves glucose regulation, blood pressure, and aerobic fitness (1–3). Some studies also suggest benefits for cognitive function and mood (4). Importantly, adherence rates are high because these small bouts are realistic and easy to sustain (5).

In my ongoing systematic review of exercise snacking trials, I found consistent evidence of improvements in blood pressure, with reductions of approximately 4–5 mmHg compared with control groups. While the evidence base is still growing, the direction is clear: this approach can succeed where traditional exercise prescriptions often fail.

Bridging the Gap: From Evidence to Real Lives

For me, exercise snacking is more than an academic interest—it is a response to the realities I saw in my patients. In Myanmar, where gyms are expensive, public spaces are limited, and time is consumed by survival, people need solutions that fit their lives.

A mother who cannot leave her children to exercise can still climb the stairs at home. A man working long hours can still manage two minutes of brisk activity between shifts. Even in small, crowded apartments, simple bodyweight movements can make a difference.

The gap I want to bridge is the one between evidence and everyday life. Too often, research stays locked in journals while patients continue to struggle. My mission is to bring these findings into real-world settings—schools, workplaces, and communities—so that exercise becomes not just a guideline, but a lived practice.

Conclusion

Working in a developing country taught me a truth I carry into my research: health interventions must be practical, affordable, and sustainable. Exercise snacking offers exactly what I needed. It doesn't require gyms, equipment, or long blocks of time. It requires only willingness, creativity, and a shift in how we view movement.

As a doctor and now a researcher, my hope is to help shape strategies that give people realistic tools to protect their health. If exercise snacking can be integrated into health promotion in both high-income and low-resource settings, it has the potential to ease the growing burden of NCDs worldwide.

In Myanmar, I have seen the cost of inactivity. Through my PhD, I now see the possibilities of innovation. Bridging the gap between evidence and practice is not just an academic challenge—it is a necessity. Because in the fight against NCDs, sometimes it is the smallest steps that make the biggest difference.

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The Unshaken Purpose: Resilience and Response of Junior Doctors in the Face of Philippine Disasters

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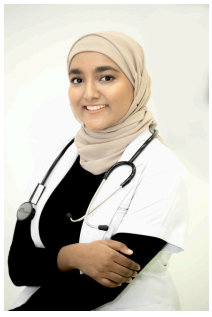

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The Philippines, an archipelago positioned along the Pacific Ring of Fire and within the primary typhoon belt, is globally recognized as one of the nations most vulnerable to natural calamities (1). The country consistently ranks as the world's most at-risk nation on the World Risk Index due to high exposure to phenomena like annual super typhoons, torrential floods, and severe seismic events (2,3). These recurrent disasters impose immense strain on the nation's fragile healthcare system, often leading to immediate infrastructure failure, mass casualty events, and the prolonged psychological distress of both the population and healthcare workers. For junior doctors and medical students training in this environment, disaster response is not an abstract concept but a critical, hands-on component of their professional development.

Personal Narratives of a Foreign Medical Student:

Nashrah Ahsan, an Indian 2nd year medical student from a private university in Cebu City accounts her experience during the recent 6.9 magnitude earthquake that struck the island of Cebu. What began as a routine clinical afternoon was instantly transformed into a moment of pure survival. For medical trainees—particularly foreign medical students thousands of miles from their primary support systems—the experience was doubly profound. The ground motion did not merely shake buildings; it fundamentally destabilized the core feeling of safety, replacing academic deadlines and examinations with the primal instinct to survive and the professional urge to serve.

The hours that followed the main tremor were characterized by logistical chaos, continuous aftershocks, and a deep sense of isolation. Sleep was impossible; every creak became a phantom tremor, an enduring somatic memory of the crisis. Yet, in the absence of official coordination, a crucial instinct emerged. The inherent professional commitment of a medical student—the oath of duty—began to whisper amidst the fear. Discussions immediately shifted from personal safety to professional readiness: organizing emergency kits, reviewing first-aid protocols, and forming ad-hoc rapid response groups aimed at assisting the affected areas.

My attempt to join a coordinated medical mission with a local Rapid Response Team, though ultimately denied due to the urgent need for centralized regulation and safety management by the provincial capitol, was not a failure of will, but a testament to this inherent impulse. It highlighted the immediate, uncoordinated surge of medical personnel seeking to deploy, and the subsequent necessary realization that effective disaster response demands highly coordinated logistics and established channels of command. This dual experience —the terror of being an individual victim and the activation of being a future healer— crystallized the meaning of professional resilience. We learned to manage the cognitive dissonance of studying for an anatomy exam one moment and being ready to evacuate the next, demonstrating that true medical training extends far beyond textbooks and into the cultivation of composure under extreme duress.

The Collective Response and Trans-Border Solidarity

The most profound realization during this crisis was the immediate, unprompted unity of the healthcare community. As the environment became volatile, the internal

solidarity of junior doctors and medical students transcended cultural backgrounds and nationalities. This was not merely survival; it was the activation of a professional community. Faculty, residents, and students rallied to ensure the physical and mental well-being of their peers before considering their own immediate needs.

In a disaster scenario, healthcare professionals rapidly coalesce, moving from individual practitioners to an organized, collective resource. This collective response often begins at the smallest scale: checking on colleagues, providing psychological first aid, and quickly assessing the integrity of essential hospital and school services. The post-disaster phase mandates a holistic approach—from surgical intervention in collapsed structures to managing the ensuing public health risks (e.g., sanitation, vector-borne diseases) and addressing the widespread mental health crisis. This phase proves that the true strength of medicine lies in its social contract and the ability of its practitioners to coordinate seamlessly under pressure.

The challenges faced—such as the breakdown of supply chains, the lack of immediate trauma resources, and the need for surge capacity—underscore the vital role of global networks like the WMA Junior Doctors' Network. These international platforms are essential for facilitating resource sharing, standardizing disaster medicine training, and establishing pre-authorized rapid deployment protocols to ensure that the initial instinct to help is channeled into effective, coordinated, and safe clinical action.

Call to Action

The lessons learned during a natural disaster are indispensable to global medical training. They illuminate that the practice of medicine requires not just clinical acumen, but deep empathy, critical resilience, and the capacity for crisis leadership. Disasters remind us that while the earth can tremble, our professional purpose must remain firm.The Junior Doctors' Network represents a global cohort facing unprecedented climate and geopolitical crises. We call upon all junior doctors and medical students worldwide to take three decisive actions:

1. Advocate for Preparedness: Lobby your local health systems to develop robust, well-funded disaster protocols that specifically integrate the training and deployment of junior medical staff.
2. Train for Adaptability: Actively participate in simulation exercises that test your capacity to practice medicine in resource-scarce and psychologically challenging environments.
3. Foster Global Solidarity: Use platforms like this Bulletin to share insights and best practices from your region/country, ensuring that the collective knowledge of disaster response is accessible to every healthcare system globally.

In the face of crisis, we are not just students or trainees; we are essential pillars of community resilience. The compassion we hold, the resilience we build, and the humanity we share are the most crucial tools we possess against the inevitability of disaster.

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MEMBERSHIP
BECOME A JDN MEMBER

WHO CAN BECOME A JDN MEMBER?

To join the JDN you:

- Must be within 10 years of graduation from medical school
- Must be an associate member of the WMA*

Note: Associate membership of the WMA is free for all doctors for the first five years after graduation. To join the JDN, please follow the links and complete:

How to become a JDN member?

1. ASSOCIATE MEMBERSHIP REGISTRATION (AND SELECT THE JUNIOR DOCTOR FORM):

CLICK HERE

2. **JDN REGISTRATION:**

CLICK HERE

Registration requires validations of the associated documents, there may be a delay of a few weeks from the time of registration to the time you are added to the mailing lists. All registrants who have submitted a completed application will receive an email confirming that they have been added and an invitation to be added to the mailing list; others will be informed how to adequately complete their application.

For more information, please contact membership.jdn@wma.net.