

WORLD MEDICAL ASSOCIATION JUNIOR DOCTORS NETWORK



33rd

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WMA JDN



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2026

TABLE OF CONTENTS

S.No	Table of Contents	Pg. No.
1	<u>About WMA JDN</u>	3
2	<u>Meet the WMA JDN Management team</u>	4
3	<u>Meet the Publications team</u>	5
4	<u>Special Foreword by The President of Commonwealth Medical Association</u>	6
5	<u>Foreword by Chair</u>	7
6	<u>Foreword by Secretary.</u>	8
7	<u>Foreword by Publications Director</u>	9
8	<u>Speaking Up Safely: The Ethical Perspective of Whistleblowing in Medicine</u>	10
9	<u>Safeguarding Health in the Face of Climate Disasters: Ensuring Service Continuity for All</u>	13
10	<u>Empowering the Next Generation of Medical Leaders: Insights from the WMA JDN Medical Education Survey to transform JDN Webinars Together</u>	16
11	<u>Report on Participation in “Youth Voices for Action: Shaping Sexual and Reproductive Health and Rights (SRHR) Priorities”</u>	19
12	<u>From Prevention to Preparedness: Why One Health Matters in Pandemic Response</u>	21
13	<u>Walking Toward Death Each Day: A Frontline Physician’s Experience During Ethiopia’s First Marburg Virus Disease Outbreak</u>	23
14	<u>When False Information Harms: The Ethical Responsibility of Doctors in the Misinformation Era</u>	25
15	<u>Health Equity Cannot Wait: Ethical Duties of Junior Doctors in Resource-Limited Care</u>	28
16	<u>How Junior Doctors Network from National Medical Associations Can Ensure Ethical Governance of AI in Clinical Training and Patient Care</u>	30
17	<u>Confidentiality Beyond the Clinic: Ethical Duties in a Digitized Health System</u>	32

TABLE OF CONTENTS

S.No	Table of Contents	Pg. No.
18	<u>Between Faith and Medical Emergency: Impact of Spiritual Beliefs on Healthcare-Seeking Behavior in the Democratic Republic of Congo</u>	35
19	<u>Shipping Lanes and Survival: When Supply Chains Become Health Risks in the Philippines</u>	38
20	<u>Prescribing Intelligence: The Case for AI-Assisted Clinical Decision Support in Antibiotic Stewardship Across Resource-Limited Health Systems</u>	40
21	<u>When Training Becomes a Bottleneck: Brain Drain, Induction Inequities, and the Future of Young Doctors in Pakistan</u>	43
22	<u>Is the Juice Worth the Squeeze?</u>	45
23	<u>The West African College of Physicians at 50: Building a Future Young Doctors Still Want to Choose</u>	46
24	<u>Mental Health Literacy: A Foundation for Global Mental Health Equity</u>	49
25	<u>How to become a WMA JDN Member?</u>	51



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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SPECIAL FOREWORD

BY THE PRESIDENT OF

COMMONWEALTH

MEDICAL ASSOCIATION



Dear Young Doctors,

It is with profound joy and deep esteem that I offer these reflections on the occasion of the 33rd edition of the WMA JDN Bulletin. Each time I witness junior doctors serving with quiet excellence in wards, emergency departments, and rural clinics across the world, I am reinvigorated with hope. You are not merely the leaders of tomorrow—you are the vital force propelling healthcare today. Your courage, originality of thought, and unwavering dedication constitute a genuine superpower for our profession.

We stand at a pivotal moment. The health consequences of climate change, the recurrence of emerging outbreaks, the relentless advance of antimicrobial resistance, and the rapid integration of artificial intelligence into clinical care are reshaping our practice. Meeting these challenges requires more than mastery of textbooks. I urge you to cultivate lifelong learning in health diplomacy, bioethics, and evidence-based communication, so that you can counter misinformation with clarity and integrity. Pursue your aspirations boldly, but let patient welfare, ethical conduct, and scientific rigor remain the unshakable centre of all you do.

Equally, resist the temptation to remain enclosed within the routines of academic study and clinical service. From the very start of your careers, give yourselves to purposeful volunteerism. Through your National Medical Associations, the Commonwealth Medical Association, and the WMA Junior Doctors Network, your collective engagement has transformative power. A single voice may fade; a united profession can shape policy, safeguard the wellbeing of doctors, and advance health equity for the most vulnerable.

Never underestimate your worth. Within each of you lies a boundless capacity - to heal, to lead, and to change the world for the better.

With my warmest wishes for every step of your journey,

Prof. Dr. J. A. Jayalal
President
Commonwealth Medical Association (CMA)

FOREWORD BY

CHAIR



Dear Colleagues,

Being a junior doctor means caring for patients while helping shape the systems in which that care is delivered. The 33rd Edition of the WMA JDN Bulletin brings this responsibility into focus through experiences, research, and reflection from across our network.

Contributors explore ethical practice under pressure: speaking up safely, responding to misinformation, protecting confidentiality, and advancing equity when resources are limited. Reflections on outbreak response and climate preparedness sit alongside discussions of artificial intelligence, mental health literacy, and the future of medical training.

These pages also remind us that professional development is a collective undertaking. The medical education survey and the policy brief developed through the Planetary Health Working Group illustrate how members can help shape our educational activities and advocacy. Reflections on research and mentorship reinforce the value of supporting diverse paths within medicine.

As Chair of the WMA Junior Doctors Network, I believe our role is to connect these experiences with opportunities for meaningful participation and change. Junior doctors must be heard in decisions about their training, working conditions, and patient care. Their commitment must be matched by institutions that provide safe environments, fair opportunities, and support for well-being.

I thank our contributors and the Publications Team for sustaining this exchange. May this edition encourage us to learn across contexts, challenge inequities constructively, and translate shared concerns into action that strengthens both our profession and the care we provide.

Regards,

Dr Pablo Estrella-Porter

Chair - Junior Doctors Network

World Medical Association

FOREWORD BY

SECRETARY



Dear All,

It is both an honour and a pleasure to introduce the 33rd Edition of the World Medical Association Junior Doctors Network Bulletin. This edition brings together the voices of early-career physicians from across the globe, each offering thoughtful and unique perspectives on the ethical, clinical, and systemic challenges that are shaping medicine in our time.

The articles within these pages reflect the remarkable breadth and urgency of issues faced by junior doctors today - from safeguarding health systems against climate disasters and misinformation, to advancing equity in resource-limited settings and ensuring the ethical governance of AI in clinical training and patient care. In this edition, the Junior Doctors generously share their frontline experiences, including a physician's account of Ethiopia's first Marburg virus outbreak, insights into how spiritual beliefs shape healthcare-seeking in the Democratic Republic of Congo, and the realities of supply chain vulnerabilities in the Philippines.

What unites these diverse narratives is a shared commitment to ethical practice, health equity, and the professional duty to speak up safely and effectively for patients and communities. As the WMA JDN continues to amplify junior doctors' voices globally, this bulletin serves not only as a record of challenges but as a call to action: to innovate, to collaborate, and to lead with integrity in an era of rapid change.

I extend my heartfelt appreciation to all authors, the publications team, and the WMA JDN management team for their dedication to fostering international dialogue and empowering the next generation of medical leaders. May this edition inspire reflection, meaningful dialogue, and action among readers worldwide.

Regards,

Dr Shiv Joshi

Secretary - Junior Doctors Network

World Medical Association

FOREWORD BY

PUBLICATIONS

DIRECTOR



Dear Junior Doctors and Esteemed Colleagues Worldwide,

It is a distinct privilege to present the 33rd Edition of the WMA JDN Bulletin - proudly marking our fourth bulletin of this year. Delivering four comprehensive editions in a single year reflects our steadfast commitment to ensuring that the perspectives of early-career physicians remain visible, impactful, and front-and-centre on the global stage.

An achievement of this scale is possible only through collective effort. I extend my sincere gratitude to our WMA JDN Management Team for their leadership, to our tireless Publications Team whose dedication and rigour ensure excellence across every page, and to our brilliant authors who generously share frontline insights from wards and communities across continents. My heartfelt thanks also go to the WMA Secretariat for their continuous guidance and unwavering support.

The remarkable surge in submissions we have witnessed with every successive issue is the clearest proof of your growing trust and readership. It demonstrates that the JDN Bulletin has evolved into a vibrant, peer-driven forum that truly resonates with the priorities of young doctors worldwide.

If you have not yet joined us, I warmly encourage you to become a member of the WMA JDN family and submit your work for upcoming editions. As we look ahead, I remain deeply committed to sustaining this momentum, expanding our collective footprint, and serving our global community with purpose and integrity.

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



Speaking Up Safely: The Ethical Perspective of Whistleblowing in Medicine

Shiv Joshi



Shiv Joshi,
-Secretary, WMA
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Introduction

The act of whistleblowing in medicine, is the ethical practice of exposing unsafe or unlawful practices to help ensure the safety and welfare of patients. Because it is built not on malice, but moral bravery. Speaking out safely is thus an ethical responsibility for junior physicians. It requires healthcare systems to tear down hierarchies and create supportive reporting structures. This obligation is clearly defined in the World Medical Association (WMA) International Code of Ethics (1). The need to report behaviours that challenge ethical principles is emphasised in order to preserve public confidence in the profession (1).

The Ethical Imperative of Whistleblowing in Medicine

All whistleblowing is fundamentally based in virtue ethics. When they sound the alarm, healthcare professionals are fulfilling their professional conscience obligations in good faith. Such responsibilities are well-settled in the existing medical ethics policies of the WMA. Emphasis is placed on the primary loyalty of physicians to patient safety, not to institutional self-protection or personal gain (1). The onus is on physicians to be accountable for their clinical decisions, and they must enforce both among themselves and colleagues the highest standards of professional conduct (1). The medical paradigm has, for long time, been one of so-called "guild mentality," which valued solidarity among professionals and collegial relationships over transparency. However, bringing attention to misconduct or systemic failures is a vital contribution to detecting harm and improving the overall quality of clinical care.

The Junior Doctor's Dilemma

Despite the clear ethical duty to protect patients, junior doctors face major challenges due to rigid power structures in medicine. They often hesitate to voice concerns about senior consultants or systemic issues because of significant power imbalances and fear of retaliation. The case of Dr. Anand Rai from India, who exposed the large Vyapam medical admission scam, highlights this vulnerability. He started his investigations as a junior doctor (2). He faced harsh retaliation, including termination from his hospital role, forced transfers, and ongoing threats to his safety, all for fulfilling his ethical responsibility to uphold the medical profession's integrity (2). Cases like his show that while there is a strong ethical need to report issues, junior doctors often bear the heavy consequences of institutional backlash when they act as whistleblowers, lacking proper protections.

This vulnerability is not confined to healthcare systems in developing countries. In the UK, Dr. Chris Day raised concerns about dangerously low staffing levels in an intensive care unit at night (3). After making his claims, he experienced severe professional repercussions, lost his training number, and saw his career interrupted (3). His legal battle, which stretched for years, revealed a significant flaw that left junior doctors unprotected by whistleblowing laws. This demonstrates the serious risks junior doctors face when advocating for patient safety. As a result, the moral duty to report wrongdoing often clashes with the realities of a junior doctor's early career.

Cultivating a Culture of Safety

Hospitals need to set up transparent, anonymous reporting systems that can bypass traditional professional hierarchies to encourage whistleblowing. The benefits can be significant when healthcare systems support reporting. For example, in a five-month span, a hospital's quality improvement project raised the number of incidents reported by junior doctors from just two per month to 76 (4). This was possible simply by providing training and support. Clinical supervisors should encourage junior doctors in training to report incidents without fear of retaliation. Institutions must also close the feedback loop by sharing the results of investigations with the junior doctors. This shows that their ethical decisions lead to real improvements in patient care.

Advocacy for speaking up safely as a Junior Doctor

Empowering junior doctors to meet their ethical responsibilities requires a major change from a system that silences to one that encourages advocacy for patient safety. Healthcare systems must create environments where bringing up ethical concerns is seen as an important part of the job instead of an act of defiance.

To achieve this cultural transformation, the following framework outlines essential advocacy principles and the necessary actions institutions should take to ensure junior doctors can report misconduct without risking their careers (Table 1).

Table 1: Key Advocacy Principles and Institutional Responsibilities for Safe Reporting

Advocacy point	Why it matters	What institutions should do
Speaking up is a professional responsibility, not disloyalty	The WMA International Code of Medical Ethics states that physicians should report practices or conduct that conflict with ethical principles or endanger patients.	Understand reporting as part of professionalism, patient advocacy, and ethical duty during training and healthcare delivery.
Junior doctors need protection from retaliation	Junior doctors may hesitate to report concerns because of hierarchy, career dependence, and fear of negative consequences.	Guarantee non-retaliation policies. Provide access to independent review pathways, and fair access to legal and professional support.
Safe channels must be clear and accessible	Reporting is more likely when junior doctors trust that the process is confidential and taken seriously.	Create confidential, well-informed reporting routes, including options outside the direct management structure.
Reporting should lead to action and feedback	Junior doctors are more likely to engage when they see that concerns are investigated and that reporting leads to meaningful system improvement.	Close the feedback loop by acknowledging reports. Share outcomes and demonstrate corrective action.
Culture matters as much as policy	Hierarchical cultures can silence junior doctors even when formal reporting systems exist, whereas supportive teams make speaking up more likely.	Train senior consultants/clinicians to invite concerns, respond respectfully, and model openness during routine clinical work.
Speaking up strengthens patient safety	Better reporting helps identify risks earlier and supports safer care.	Treat speaking up as a patient-safety strategy, not merely a compliance exercise.

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Safeguarding Health in the Face of Climate Disasters: Ensuring Service Continuity for All

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**This submission is supported by the WMA JDN Planetary Health Working Group*

During the Fall 2025 Meeting of the JDN-WMA in Porto, Portugal, a working group session of the JDN Planetary Health Working Group culminated into this mini policy brief. The aim of this activity was to challenge participants to draft a mini policy (one-page proposal) using templates as guidance that addressed a climate-health link, analyze it with a framework to identify gaps and impacts, and present core recommendations.

Content/Scope of Problem

When disasters strike, health services often collapse — leaving the most vulnerable populations without care. The most immediate, actionable, and accountable measure to prevent this is to require every health facility to develop, fund, and regularly test Health Service Continuity Plans (HSCPs). These plans are the cornerstone of Climate-Resilient Health Systems, upon which more complex equity and coordination strategies depend. Despite mounting climate threats, most health systems remain unprepared to ensure continuity of care during crises.

Methods

The aim of this activity was to challenge participants to draft a mini policy (one-page proposal) using pre-existing templates (1) as guidance that addressed a climate-health link, analyze it with a framework to identify gaps and impacts, and present core recommendations.

Effects of Ineffective Health Services during Disasters:

- Collapse of Care: Fragile, climate-vulnerable infrastructure leads to service interruptions during floods, storms, or heatwaves.
- Inequitable Access: Vulnerable groups, including low-income communities,

older adults, persons with disabilities, and those in remote areas - face disproportionate barriers when services fail.

- Siloed Response: Limited coordination between health, climate, and disaster management sectors results in chaotic, inefficient emergency responses.
- Unsupported Workforce: Health workers, especially junior doctors, lack disaster training and psychosocial support—facing burnout and unsafe working conditions.

Target audience

National Medical Associations (NMAs) and Governments are in a position to advocate for health systems to have contingency plans in place to ensure continuity of care.

Policy Recommendations

Strengthening climate-resilient health systems requires a shift from reactive crisis management to proactive, coordinated planning across all components of the health sector. The WHO Health Systems Framework (2) provides a structured approach for identifying policy gaps and enhancing institutional preparedness.

Embedding service continuity within each system component—from governance and financing to supply chain management and workforce planning—ensures the sustained delivery of essential health services, the protection and support of frontline personnel, and the promotion of equity during climate-related emergencies.

We have used this framework to put into perspective identified gaps and its impact on service delivery and equity (Table 1).

Table 1: Assessment of Climate Disaster Preparedness Gaps and Equity Impacts Using the WHO Health Systems Framework

Building Block	Identified Gap (Policy vs. Practice)	Impact on Service Delivery & Equity
Service Delivery	No legal requirement for facilities to plan for service continuity during disasters.	Complete service collapse for non-COVID emergencies; structured abandonment of vulnerable populations.
Health Workforce	Staff are expected to be heroes rather than supported with clear plans, surge capacity, and mental health resources.	Frontline burnout; unsafe working conditions; poor retention of crucial staff like junior doctors.
Leadership & Governance	Reactive, ad-hoc coordination replaces pre-defined, accountable emergency protocols at the facility level.	Chaotic response; delayed decision-making; inability to leverage pre-arranged resources.
Health Information Systems	Failure to pre-identify at-risk patients in facility catchment areas for prioritized support.	Inability to proactively protect the most vulnerable during evacuations and service disruptions.
Access to Essential Medicines & Supplies	Lack of stockpiling or pre-negotiated access to essential medicines and supplies during emergencies; Weak local production and over-reliance on disrupted global supply chains; No dynamic inventory tracking system during crises.	Stockouts of critical medications (e.g., insulin, antibiotics, psychotropics) for vulnerable patients; Delays in emergency response due to logistical failures; Disproportionate impact on marginalized or remote populations.
Health Financing	No earmarked funding for facility-level emergency preparedness or continuity planning; Emergency funding mechanisms are slow, bureaucratic, or politically influenced; Lack of financial protection for patients during disasters.	Facilities unable to activate contingency plans due to lack of funds; Increased out-of-pocket costs for patients during crises; Widening of health inequities due to affordability barriers.

A Call to Action

Core Recommendation: To mandate the development, funding, and testing of Health Service Continuity Plans at all health facilities.

Key Mandatory Components: Based on identified gaps and its impact on service delivery & equity, we recommend the following key mandatory components for a health service continuity plan.

- Risk & Vulnerability Mapping: Identify hazards and map at-risk populations in each facility's catchment area (3).
- Essential Services Protocol: Define a minimum level of care for emergencies, maternal health, and chronic diseases (4,5).
- Infrastructure & Supply Chain Assurance: Secure backup power, water, and pre-negotiated supply and transport agreements (6).
- Staff Surge & Support Plan: Clarify roles, ensure backup staffing, and integrate psychosocial support for health workers (7).
- Regular, Mandatory Drills: Test and update plans annually through simulation exercises (8).
- Sustainable Emergency Financing Mechanisms: Allocate dedicated budgets at facility and system levels, ensuring flexible and rapid fund deployment for continuity, supplies, and staffing during crises (3, 9).

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Empowering the Next Generation of Medical Leaders: Insights from the WMA JDN Medical Education Survey to Transform JDN Webinars Together

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The World Medical Association Junior Doctors Network (WMA JDN) has always been committed to the professional growth of its members. Recognizing the critical role of Continuous Medical Education (CME) in the careers of junior doctors, the Medical Education Working Group launched a comprehensive survey to better understand the needs and preferences of its members regarding webinars. The survey, conducted from 2023 to 2024, involved 37 members. The survey participation was voluntary, anonymous, and a significant undertaking led by Dr. Merlinda Shazellenne, the Working Group Chair, and Dr. Hassan Ali, a dynamic Working Group member. The findings are not only a testament to the team's dedication but also a crucial roadmap for the future direction of medical education initiatives.

The survey findings provide a clear and compelling picture of the priorities of junior doctors. When asked about their participation, a significant portion of respondents indicated they occasionally participate in the WMA JDN's webinars, representing 51.4% of respondents. This indicates a strong existing interest that can be further cultivated. Despite the recognized value of webinars, participation remains mixed:

- 51.4% of respondents attend occasionally
- 24.3% attend rarely
- 24.3% have never attended

This suggests a critical opportunity: either webinars are not sufficiently promoted, or current formats and scheduling are not meeting member needs.

An overwhelming majority of junior doctors—64.9%—consider continuous medical

education webinars to be highly important for their professional development. This highlights the necessity of providing high-quality, relevant content to meet this demand. The data also reveals a strong interest in live virtual conferences and symposiums, with 70.3% of respondents expressing interest in participating.

A key focus of the survey was to identify the most sought-after topics for future webinars. The responses showed a clear preference for a mix of clinical skills and broader, systemic knowledge. The highest demand was for Healthcare Management and Leadership, with 70.3% of respondents selecting it. This was followed by Global Health at 62.2%, and Medical Research and Innovation at 56.8%. Other highly-ranked areas include Clinical Skills Enhancement (51.4%) and Mental Health (43.2%).

The survey's open-ended questions provided even greater detail. Within the broad category of Healthcare Management and Leadership, junior doctors are interested in "Developing Ethical and Compassionate Leadership in Healthcare" and gaining insights into the "Health care systems of each country in the world". For Medical Research and Innovation, topics like "Artificial Intelligence in Medical Field" and "Medical Research and Innovations," as well as "Latest Innovative Management That Can Be Provided at the Primary Care Level" were frequently mentioned. Other notable topics requested include Infectious Diseases, with a specific focus on "the latest ones COVID and its late consequences," as well as "Updates regarding regular diseases like diabetes hypertension".

The results clearly signal a desire among junior doctors to develop not just their clinical expertise but also their roles as leaders and innovators within the complex healthcare landscape. Lower-priority areas included LGBTQAI+ medicine, JDN working conditions, and bioethics, which received only one vote each (Table 1).

Table 1: Preferred Thematic Areas for Continuing Medical Education Webinars

Topic	% Interested
Healthcare Management & Leadership	70.30%
Global Health	62.20%
Clinical Skills Enhancement	51.40%
Medical Research & Innovations	56.80%
Public Health Initiatives	51.40%

The survey also explored the preferred format and timing for webinars to maximize engagement. In terms of structure, there was a nearly even split between preferences for Interactive workshops (32.4%), Lecture format with Q&A (29.7%), and Panel discussion with experts (27%). This suggests that a variety of formats should be utilized to cater to different learning styles. Flexibility is key. Depending on the topic, webinars should rotate between interactive, lecture-based, and expert panel formats. Participants also suggested including pre/post readings, projects, and certificates where applicable.

The most convenient time for attending webinars, based on the GMT time zone, was found to be the Evening (5:00 pm - 9:00 pm GMT), which was selected by 48.6% of respondents. The Late evening (after 9:00 pm GMT) was also a popular choice, with 40.5% of responses. These findings are crucial for scheduling future events to ensure maximum attendance across different time zones. Lastly, the

survey found that a majority of participants access webinar content via smartphones (45.9%) or desktop/laptops (43.2%). Satisfaction with the current quality of webinars was generally positive (Table 2).

Table 2: Satisfaction with Current Quality of WMA JDN Webinars

Rating (1 to 5)	% of Respondents
5 – Very Satisfied	18.90%
4 – Satisfied	32.40%
3- Neutral	45.90%
2 - Somewhat Dissatisfied	0.00%
1-Not Satisfied	2.70%

Members also expressed interest in Mentorship opportunities, Hands-on workshops, Medical editing and publishing, and Country-specific healthcare systems. Based on this feedback, JDN can enhance its webinar offerings with the following action points:

1. Expand Focus Areas: Prioritize leadership, mental health, global health, and clinical practice updates.
2. Optimize Scheduling: Host webinars in evening GMT slots to reach more members globally.
3. Diversify Formats: Use a mix of lectures, workshops, and panel discussions.
4. Offer On-Demand Access: Provide recordings, reading materials, and certificates.
5. Enhance Interactivity: Encourage Q&A, case-based learning, and participant engagement.
6. Listen Continuously: Use quarterly feedback to stay aligned with member needs.

This survey, championed by the Medical Education Working Group, has provided invaluable insights. The data clearly shows that junior doctors are eager for training that goes beyond traditional clinical skills to include leadership, management, research, and public health. The findings serve as a direct call to action for the WMA JDN and future leaders of the working group to develop a curriculum that reflects these priorities. By focusing on the topics and formats most desired by junior doctors, the WMA JDN can continue to be a vital

resource, fostering a new generation of medical professionals who are not only skilled clinicians but also compassionate leaders, effective advocates, and visionary innovators.

To further strengthen the impact of future JDN webinars, the Medical Education Working Group may also consider establishing long-term thematic series that build skills progressively over multiple sessions, creating continuity for participants. Partnering with global experts, national medical associations, and academic institutions could enrich content quality and diversify perspectives.

Introducing regional breakout sessions may also help address context-specific challenges faced by junior doctors across different health systems. Finally, implementing a structured mentorship pathway linked to webinar themes could translate learning into practical career development, ensuring that educational activities create sustained and meaningful professional growth for all members.

We thank everyone who took the time to complete the survey. Your input is shaping the future of JDN's educational offerings. Together, we can build a stronger, smarter, and more connected community of healthcare professionals.



Report on Participation in “Youth Voices for Action: Shaping Sexual and Reproductive Health and Rights (SRHR) Priorities”

Shiv Joshi



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Participation Context

I attended the session “Youth Voices for Action: Shaping SRHR Priorities” in my capacity as JDN Alternate on the WHO Youth Council (Figure 1). The session brought together young participants and advocates to reflect on current priorities in sexual and reproductive health and rights, with particular attention to the changing role of digital technologies in health communication and access. The discussion was participatory in nature and combined moderated interaction with active contributions from participants.

Main Discussions

Overall, the session was useful in surfacing contemporary youth perspectives on SRHR and in showing how strongly digital transformation is shaping current conversations. It also reaffirmed the importance of ensuring that youth voices remain central in discussions on health systems, communication strategies, and reproductive justice. Some of the key ideas discussed are mentioned below:

AI Opportunities in Youth SRHR

Artificial intelligence is increasingly influencing how young people seek and receive information on health, including sexual and reproductive health and rights (SRHR); Digital tools like chatbots and health applications provide private, quick, and accessible information, especially for youth hesitant to raise sensitive questions in conventional settings; These platforms present a crucial opportunity to expand access to information and make SRHR communication more youth-friendly.

Risks and Ethical Considerations

Technology must not be treated as a universal or complete solution for health communication; AI introduces serious risks when the information provided is inaccurate, lacks an evidence base, or fails to adapt to specific user needs. Major concerns include the spread of misinformation, misleading content, and the reality that digital access remains unequal across different settings and populations. The potential of AI in SRHR can only be safely realized when embedded in responsible practice, ethical communication, and strong digital literacy.

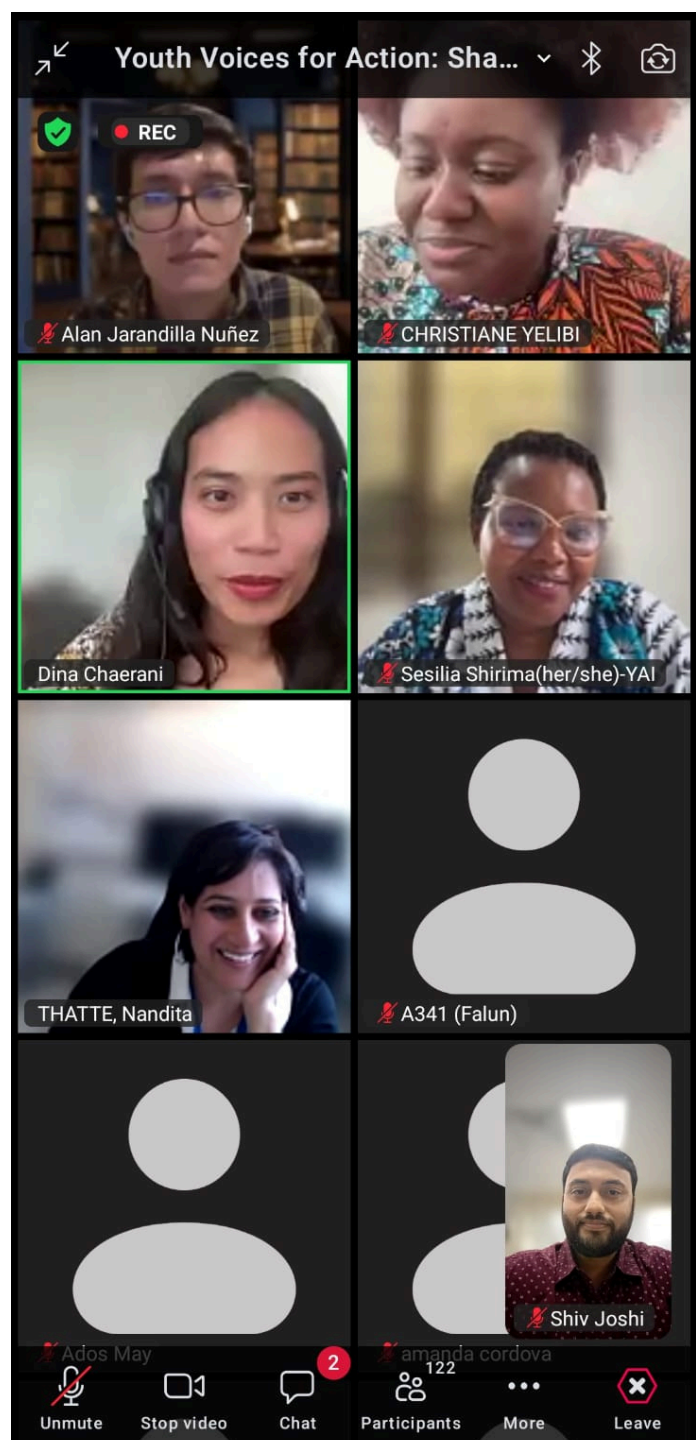
Youth Leadership and Advocacy

Youth leadership and advocacy are central to advancing reproductive justice through a rights-based approach. Youth-led networks are essential for breaking stigma, building solidarity, and shaping the public discourse surrounding sexual and reproductive health. Collective advocacy is vital not only for improving information access but also for driving justice, equity, and ensuring young people actively influence the health agendas that affect their lives.

Reflections

I found the exchange valuable because it linked technological innovation with broader public health and rights-based concerns. Rather than focusing only on the benefits of innovation, the discussion consistently returned to questions of equity, access, accountability, and the quality of information being shared. The discussion

Figure 1: WMA JDN representation at the “Youth Voices for Action: Shaping SRHR Priorities” virtual consultation.



recognized both the promise of digital tools and the need to guard against harm, exclusion, and misinformation.

During the discussion, I contributed my perspective on the role of AI in sexual and reproductive health communication. My comments emphasized that AI use in SRHR holds immense potential to improve access to accurate, data-driven information and personalized care. Yet its true impact depends on maintaining a delicate balance where technological insight strengthens, rather than replaces, the trust, cultural sensitivity, and empathetic human communication that define meaningful conversations about sexuality and health.

In my view, the session contributed meaningfully to ongoing dialogue on how health institutions and youth representatives can engage more effectively with emerging technologies while remaining grounded in rights, evidence, and inclusion.



From Prevention to Preparedness: Why One Health Matters in Pandemic Response

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Introduction

The COVID-19 pandemic demonstrated that infectious diseases are no longer isolated clinical events but global disruptions affecting healthcare systems, economies, education, and social stability. Emerging pathogens continue to pose significant threats due to globalization, environmental degradation, climate change, and increasing interaction between humans and animals. In this context, pandemic preparedness requires a broader and more integrated framework. The One Health policy has emerged as a critical public health strategy for improving preparedness against future pandemics. By recognizing the interconnectedness of human, animal, and environmental health, One Health promotes multisectoral collaboration to prevent, detect, and respond to infectious disease threats. From a public health and epidemiological perspective, One Health is not simply a theoretical concept; it is an operational necessity for reducing pandemic risk (1).

Why One Health Matters in Pandemic Preparedness

Approximately 60% of known infectious diseases and nearly 75% of emerging infectious diseases originate from animals. Diseases such as SARS, avian influenza, Ebola, Nipah virus, and COVID-19 demonstrate the importance of zoonotic transmission pathways (2). Traditional health systems often focus primarily on human disease surveillance. However, pandemics frequently begin long before human cases are detected. Environmental disruption, wildlife trade, intensive livestock farming, and ecosystem imbalance can create conditions for pathogen spillover. One Health addresses these gaps by integrating surveillance across human health, veterinary systems, wildlife monitoring, and environmental assessment.

Pandemic preparedness therefore requires moving beyond hospital-centered response toward upstream prevention (3).

The Role of One Health Policy

Effective One Health policy creates formal mechanisms for coordination among sectors that traditionally function independently (1, 3, 4). Public health agencies, agricultural departments, veterinary authorities, environmental ministries, and research institutions must work together to monitor emerging risks.

A strong One Health policy framework should include:

- Integrated disease surveillance across human and animal populations
- Shared data platforms for early warning systems
- Joint outbreak investigation teams
- Environmental monitoring for ecological risk factors
- Antimicrobial resistance surveillance
- Cross-sector emergency preparedness planning

Countries that invest in coordinated surveillance systems are more likely to identify outbreaks early and reduce transmission. Policy integration also supports evidence-based decision-making. Epidemiological data from animal reservoirs, environmental indicators, and climate trends can strengthen predictive risk assessment.

Epidemiological Surveillance and Early Warning Systems

Pandemic preparedness depends heavily on surveillance. Epidemiologists play a key role in detecting disease patterns, identifying transmission pathways, and assessing population risk. One Health expands surveillance by including non-human data sources.

Examples include:

- Monitoring wildlife mortality to identify zoonotic threats
- Tracking livestock outbreaks to prevent human spillover
- Wastewater surveillance for pathogen detection
- Climate-linked vector surveillance for mosquito-borne diseases

Integrated surveillance systems improve situational awareness and allow earlier intervention. Early warning systems supported by epidemiological intelligence can reduce delays in outbreak recognition.

Challenges in Implementing One Health Policy

Despite global recognition, implementation remains inconsistent. Many countries face fragmented governance structures, limited coordination between sectors, and insufficient funding.

Barriers include:

- Weak interdepartmental collaboration
- Limited workforce capacity in veterinary and environmental health
- Inadequate data-sharing frameworks
- Fragmented surveillance systems
- Lack of One Health training within medical education

In low-resource settings, competing healthcare priorities may reduce investment in preventive systems. However, the cost of inadequate preparedness is far greater than the cost of prevention.

The Role of Junior Doctors and Public Health Professionals

Junior doctors and early-career public health professionals can contribute meaningfully to pandemic preparedness. Their involvement in surveillance, research, outbreak investigation, and community health programs provides valuable frontline insight. Training programs should incorporate One Health principles into medical education. Understanding zoonotic disease ecology, outbreak epidemiology, environmental health, and interdisciplinary collaboration can improve future preparedness. Junior doctors also have an advocacy role. They can support evidence-based policies, promote vaccination programs, strengthen risk communication, and participate in public health leadership.

Conclusion

Pandemics are no longer rare global events but recurring public health realities. Preventing future outbreaks requires a shift from reactive crisis response toward proactive preparedness. One Health policy provides a comprehensive framework for addressing the interconnected drivers of disease emergence. By integrating human, animal, and environmental health systems, countries can improve surveillance, strengthen preparedness, and reduce pandemic risk. From an epidemiological perspective, pandemic preparedness depends not only on healthcare infrastructure but also on cross-sector collaboration and early detection. The future of global health security will rely on policies that recognize health as an interconnected system. One Health is therefore not an optional strategy—it is a necessary foundation for resilient and sustainable pandemic preparedness.

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Walking Toward Death Each Day: A Frontline Physician's Experience During Ethiopia's First Marburg Virus Disease Outbreak

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The first case of Marburg Virus Disease (MVD) in Ethiopia was identified in Jinka, southern Ethiopia, on November 14, 2025. Four days afterward, I was asked by the Federal Ministry of Health (FMoH) to be deployed as a frontline emergency doctor. I agreed without delay. It was a decision that I made alone without informing my family. I didn't let them know of my destination to shield them from worry.

After a brief orientation from FMoH, I travelled to Jinka and went directly to Jinka General Hospital Marburg treatment Center. Marburg virus was new to Ethiopia. There is no prior documented case of MVD in the country. It was a time of uncertainty with limited evidence, and fear was at its peak. Our early priorities were urgent but uncertain. Initiating antiviral therapy for confirmed patients and providing post-exposure prophylaxis for exposed health care workers was the primary task. Every decision felt consequential.

The following day, I entered the treatment unit for the first time. I had experience with full personal protective equipment (PPE) during the COVID-19 pandemic, but this one was different. Each time I zipped the suit, the fear of possible contamination made my heart race. The heat was also overwhelming inside the unit. Sweat was blurring my vision, and dehydration set in quickly. Every movement required deliberate preparation and caution. Removing the PPE safely was even more stressful than wearing it. It demands careful steps to avoid contamination.

I was one of the three emergency physicians leading the clinical response. Our days began before dawn with multidisciplinary briefings and ended late at night with national reports. Decisions frequently had to be made with incomplete data and limited precedent.

When two patients died early in the outbreak, their deaths were devastating and deeply personal. That experience reinforced the lethality of the disease. Yet hope emerged back when our first patient tested negative and recovered. Over the following weeks, a few patients were discharged alive. Each discharge felt almost unreal. We celebrated each discharge like a birthday with cake. It was indeed a rebirth. It was another chance for life. Patients spoke of second chances at life. Their gratitude was humbling. Those small ceremonies were sources of hope and positive energy.

That sense of relief was short-lived. The most difficult moment during my one-month stay occurred when one of our nurses in the treatment unit became infected. She was showing clinical deterioration. It was a brush with death. We were all faced with immense fear. Despite guideline recommendations, we even administered a higher-than-recommended dose of antiviral therapy. It was a decision made with uncertainty. We tried to balance potential harm against a high likelihood of death. That close encounter of the virus with one of our members was a terrifying realization of how narrow the margin had been. This was the lesson. No one was fully immune. No one was fully safe.

At night, sleep was fragmented. Anxiety was common. Intrusive thoughts and vivid dreams followed me. Despite no documented breach in infection-prevention measures, fear compelled me to begin post-exposure prophylaxis. Rational reassurance could not fully quiet the persistent awareness of vulnerability. In the quiet long nights, consistent prayer was my source of strength to face the uncertain days ahead.

When our colleague recovered and was discharged after 15 days of treatment, relief gave way to tears. Her illness was a reminder of our shared vulnerability, while her survival felt like a collective victory.

Throughout my stay, each call from colleagues and mentors was encouraging. Colleagues and senior physicians from the Department of Emergency Medicine at Addis Ababa University reached out with guidance and encouragement, including clinicians with prior experience managing Marburg outbreaks from Rwanda.

This outbreak reshaped my understanding of professional duty. I was able to experience the psychological burden quietly fought by frontline clinicians and the ethical weight of decisions made without clear evidence. The whole experience taught me the power of teamwork, shared purpose, mentorship, and trust. Together, we brought some patients back toward life and lived to tell the story.



When False Information Harms: The Ethical Responsibility of Doctors in the Misinformation Era

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Introduction: Why misinformation is now a clinical ethics issue

Gone are the days when poor medical advice spread slowly; today, it trends. What was once dismissed as background noise in media or everyday conversation has become a direct clinical hazard. Misinformation, digital quackery, “ChatGPT doctors,” sensational headlines, and half-understood health claims now shape how patients interpret symptoms, whether they trust vaccines, complete antibiotic courses, or decide when to seek care. It spreads not only through social media, but through family WhatsApp groups, television debates, community influencers, and waiting-room conversations. The result is a troubling paradox: unprecedented access to information, but not necessarily to reliable information. When falsehoods contribute to preventable harm, the ethical question becomes unavoidable: is a doctor’s silence still neutral, or has it become a form of neglect? In this environment, medical responsibility extends beyond diagnosis and treatment to active clarification, correction, and trustworthy communication.

What counts as misinformation, and why it harms

Not all false or misleading health information is the same. Misinformation refers to false information shared without intent to deceive, while disinformation is deliberately created or spread to mislead. A related problem arises when technically accurate information is presented selectively, without context, or in a distorted way that provokes fear or confusion (1,2). In practice, all three can alter patient beliefs and behaviour. Patients may seek antibiotics for viral infections, delay vaccines because of false claims about infertility, or become unduly fearful after reading rare adverse effects without understanding their actual likelihood (1,3).

The harm, therefore, lies not only in whether information is factually wrong, but in how it influences decisions that lead to delayed care, refusal of treatment, unnecessary anxiety, or loss of trust. These effects often fall hardest on those who are already vulnerable because of low health literacy, marginalization, or poor access to reliable care (4).

Why doctors have special ethical responsibility

Doctors remain among the most trusted sources of health information, and that trust carries ethical weight (4). A brief consultation can influence whether a patient accepts treatment, rejects a rumour, or reconsiders a harmful belief. This gives physicians responsibilities grounded in beneficence and non-maleficence: to act in the patient’s best interests and to reduce avoidable harm through accurate, proportionate, and clear communication (5, 6, 7). Respect for autonomy also depends on this duty. Patients cannot make genuinely informed choices if the information guiding them is false, misleading, or left unchallenged (5, 6).

In this sense, misinformation is not merely a communication problem; it is an ethical problem. The WMA Declaration of Geneva and the International Code of Medical Ethics both reinforce duties to place patient well-being first, respect dignity, and communicate honestly and professionally. In practice, this means doctors should avoid speaking beyond their competence, repeating unverified claims, or overstating uncertain findings. But it also means that simply ignoring misinformation is often inadequate. When false beliefs are pervasive and clinically consequential, silence may allow harm to continue (4, 5).

Core ethical duties in the misinformation era

The first duty is accuracy in one's own professional communication. Doctors must ensure that what they say in consultations, public forums, teaching settings, and digital spaces reflects the best available evidence and is presented with appropriate nuance. The second duty is correction. When misinformation directly affects care, physicians should address it respectfully rather than dismissively, because patients are more likely to reconsider false beliefs when they feel heard rather than humiliated (1, 3, 8).

A third duty is consistency. Conflicting messages from different healthcare professionals can deepen confusion and create space for falsehoods to flourish. Where possible, doctors should align with evidence-based public health messaging and avoid amplifying uncertainty in ways that mislead rather than inform (3, 4). This is especially important during outbreaks, vaccination campaigns, and rapidly evolving clinical situations.

A fourth duty is guidance. Doctors should direct patients toward trustworthy sources and help them distinguish between credible evidence, anecdote, marketing, and fear-based content (2). This aligns with broader WHO concerns around infodemic management and with professional expectations that physicians contribute to public understanding, not merely individual treatment. Finally, doctors have a justice-based duty to recognize that misinformation does not affect all groups equally. Patients with limited digital literacy, low education, language barriers, or restricted access to reliable health services are more easily harmed by deceptive narratives. Clear, culturally sensitive, and accessible communication is therefore not optional; it is part of ethical care (2, 8).

Ethical tensions and practical limits

These duties are real, but they are not limitless. No individual doctor can monitor every rumor, respond to every viral claim, or carry the entire burden of correcting public falsehoods (4). Time spent countering misinformation must also be balanced against direct patient care, especially in already overstretched systems. There is also a delicate ethical balance between correcting false beliefs and respecting the patient's perspective. Communication must be honest without becoming patronizing, and uncertainty must be acknowledged without eroding confidence (5,6).

Public engagement carries risks as well. Doctors who challenge popular falsehoods may face online abuse, institutional pressure, or political criticism (4). Ethical responsibility must therefore remain proportionate to role, experience, and practical capacity. The physician's duty is not to win every public argument, but to uphold professional integrity, protect patients from avoidable harm, and contribute responsibly where their voice has value.

A cross-country lens

Health misinformation is global, but it is shaped by local context. In Italy, the pandemic highlighted how quickly confusion can grow when evolving scientific evidence is communicated inconsistently, showing the need for clinicians to support public understanding without oversimplifying uncertainty. In India, vast digital reach, linguistic diversity, and widespread use of messaging platforms allow both useful advice and dangerous rumors to spread rapidly, particularly around vaccines, antibiotics, and chronic disease treatment. In Pakistan, misinformation has been amplified by variable health literacy, social media use, and reliance on family networks or local informal authorities for health advice. During the COVID-19 pandemic, false claims about vaccine safety and alternative remedies contributed to hesitancy, and similar patterns continue in relation to antibiotics, incomplete treatment courses, and misconceptions about infertility or long-term harm. Misbeliefs surrounding epilepsy, depression, and other stigmatized conditions may also delay appropriate medical care. Across these settings, the lesson is the same: misinformation is not just about false content, but about trust, culture, language, and access to credible health communication.

What should doctors and institutions do?

Reducing harm from health misinformation requires more than individual effort. At the clinical level, doctors should address misconceptions through respectful, clear, evidence-based conversations and guide patients toward trustworthy sources (1,3). At the institutional level, hospitals, professional associations, and public health agencies should ensure that messaging is consistent, timely, and understandable, especially during periods of uncertainty or crisis (3,4). Training in risk communication and misinformation response should become part of medical education and continuing professional development, so doctors can respond effectively even in busy settings (2).

Digital platforms and media engagement also matter. Health institutions should work proactively with media and online channels to counter recurring myths before they cause widespread harm (3,8). This is consistent with WHO's emphasis on timely, transparent, and people-centered communication, and with professional ethical standards that require honesty, responsibility, and protection of patient welfare. Ultimately, the goal is not only to correct false claims, but to preserve trust in the doctor-patient relationship while making reliable health information easier to recognize and use (5,6).

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Health Equity Cannot Wait: Ethical Duties of Junior Doctors in Resource-Limited Care

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Introduction: Why Health Equity Cannot Wait?

In many low-resource settings, junior doctors make frontline decisions amid shortages of staff, medicines, diagnostics, beds, oxygen, blood, transport, and referral options. These constraints are not limited to one type of health system; they appear in overcrowded urban hospitals, remote rural facilities, underfunded public services, and conflict-affected settings, though in different forms and intensity. In urban centers there may be more specialists, better infrastructure, and faster access to investigations, while in rural or fragile settings junior doctors may be the main clinicians available at first contact. This can create the false impression that ethics matter less where options are fewer. In reality, scarcity does not erase ethics; it makes ethical duties more visible, more difficult, and more urgent. The WMA Declaration of Geneva states that the health and well-being of the patient must be the physician's first consideration and that care must respect human dignity and autonomy. Junior doctors therefore need support and protection, but they also carry important responsibilities toward equity in everyday care.

What "health equity" means in clinical practice

In clinical practice, equality and equity are not the same. Equality gives everyone the same thing; equity responds to different needs, barriers, and disadvantages. A simple example makes this clear: giving every patient the same amount of time may look fair, but a patient who is actively bleeding needs more immediate attention than someone with a mild, stable complaint. Bedside inequity appears when treatment is delayed because a patient cannot pay, when language barriers prevent proper assessment, when stigma shapes clinical attitudes, or when socially powerful patients receive faster access than

others. Gender bias can also influence care, including whether privacy, dignity, and patient preferences are taken seriously. Junior doctors often witness these inequities first because they are the first point of sustained contact with patients and families. The WMA International Code of Medical Ethics requires physicians not to allow discriminatory or irrelevant factors to interfere with patient care and affirms duties of respect, fairness, and advocacy for equitable access. Once inequity is seen, it creates an ethical obligation to respond.

Core ethical duties of junior doctors

The first duty is to recognize inequity rather than normalize it. Junior doctors should notice who is waiting longer, who is being asked for informal payments, who cannot navigate the system, who is not being understood, and who is being quietly deprioritized because their suffering is common or socially invisible.

The second duty is fairness in clinical judgment. In a crowded ward or emergency room with limited oxygen, blood, or beds, decisions should be guided by clinical need, urgency, and likely benefit, not by wealth, influence, caste, gender, social standing, or family pressure. This is especially hard when influential relatives, administrators, or senior staff push for exceptions, but fairness is central to ethical care.

The third duty is to preserve dignity in the small moments of care. Taking an extra minute to explain a delay to a patient with low health literacy, ensuring privacy during examination, listening seriously to a stigmatized patient, or making sure a language barrier does not become a diagnostic barrier are not minor gestures; they are ethical acts.

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The fourth duty is honest communication. Patients and families deserve truthful explanations about shortages, delays, risks, and realistic options. Respect for autonomy is not only about formal consent; it also requires understandable information and openness about limits of care.

The fifth duty is advocacy within one's role. Junior doctors may not control staffing or supplies, but they can document repeated problems, seek senior review, escalate unsafe conditions, and resist practices that are clearly unfair. The WMA International Code supports independent professional judgment and advocacy for the patient's best interests.

Ethical tensions and limits

Ethical practice in these settings is never simple. Junior doctors work under hierarchy, long duty hours, fear of blame or punishment, and limited power to change institutional decisions. A doctor may know the right course but still be unable to secure a referral, obtain a bed, waive a payment, or challenge an unsafe instruction without personal risk.

This is where ethical tension lies: between duty to the patient, duty to colleagues, duty to follow rules, and duty to protect one's own well-being. Junior doctors should not be expected to compensate indefinitely for state failure, institutional neglect, poor management, or dangerous staffing gaps. Professional duty is real, but it is not limitless. The Declaration of Geneva also reminds physicians to attend to their own health, well-being, and abilities so they can provide care of the highest standard. Recent disputes involving junior doctors and physicians in South Korea also show that the limits of professional duty and the claims of self-protection can become ethically salient when system conditions are seen as threatening both patient safety and professional integrity, even though such actions remain contested because of their effects on patients.

A cross-country perspective

This challenge is global, even if it appears differently across countries. In India, very high patient volumes, out-of-pocket spending, public-private divides, and social stratifiers such as poverty, caste, gender, and rurality can shape who reaches timely diagnosis and treatment. In Nepal, mountain geography, remoteness, transport barriers, and uneven specialist distribution mean that timely care may depend heavily on where a patient lives rather than what they need. In Tunisia, junior doctors often face ethical dilemmas created by out-of-pocket costs, rural-urban disparities, and

workforce shortages that force rapid prioritization under pressure. In Myanmar, damaged health infrastructure, insecurity, supply instability, and attacks on health systems intensify the moral burden on trainees, who may be pushed into responsibilities beyond their level of training while treating patients who arrive late with advanced disease.

What links these settings is a common moral pattern: the people with the fewest resources often face the greatest barriers to care. That is why health equity should not be treated as a distant policy ideal. It is a bedside issue, a training issue, and a professional ethics issue. Individual conscience matters, but solidarity, supervision, and functioning health systems matter too.

What must change

The answer cannot rest on individual goodwill alone. Medical schools should teach practical ethics for scarcity, triage, discrimination, and structural inequity, including exposure to resource-limited settings rather than only well-equipped teaching hospitals. Hospitals should create safe reporting channels for stock-outs, discriminatory practices, and unsafe care conditions, and they should establish accessible ethics support mechanisms for junior staff facing difficult decisions. Senior clinicians must model fair decision-making and protect junior doctors who raise concerns responsibly. The WMA's core ethical texts support non-discrimination, respect for dignity, independent professional judgment, and advocacy for equitable care. Policymakers, finally, must recognize a simple truth: calling junior doctors "resilient" while denying them staff, supplies, and institutional protection is not leadership. It is exploitation.



How Junior Doctors Network from National Medical Associations Can Ensure Ethical Governance of AI in Clinical Training and Patient Care

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The rise of artificial intelligence (AI) in healthcare promises to revolutionize clinical training and patient care. However, as these technologies gain momentum, ethical governance becomes paramount to ensure that AI enhances rather than compromises medical practice and patient welfare. Junior doctors, through their national medical associations and the World Medical Association Junior Doctors Network (WMA JDN), are uniquely positioned to champion and shape this ethical governance.

The Unique Position of Junior Doctors

Junior doctors occupy a critical nexus between frontline clinical practice, medical education, and healthcare innovation. They engage directly with emerging AI tools in training and clinical environments, offering invaluable insights into the practical benefits and ethical challenges posed by AI. Their experiences provide fresh perspectives on potential biases, data privacy concerns, transparency issues, and patient-centered care implications (1,2).

Building a Networked Approach to Ethical Governance

National medical associations can empower junior doctors to collaboratively contribute to ethical AI governance in several strategic ways:

1. Education and Capacity Building : Junior doctors require structured education to deepen AI literacy—covering both technical understanding and ethical considerations, such as bias mitigation, data security, transparency, and accountability. National bodies should spearhead AI-focused curricula, workshops, and seminars to equip juniors with critical appraisal skills to assess AI applications' safety and fairness. Such initiatives foster responsible AI

integration into clinical decision-making and augment ethical awareness from early career stages (2,3).

2. Establishing Ethical Guidelines and Frameworks: The WMA JDN should specifically incorporate the WMA Statement on Artificial and Augmented Intelligence in Medical Care. This statement explicitly frames AI as a tool to augment, rather than replace, human judgment, empathy, and accountability. It further emphasizes that educational contexts require responsible use with strict human oversight to ensure that AI serves as a support system for learning rather than a substitute for clinical reasoning (7).

3. Fostering Collaboration Between Disciplines: AI governance extends beyond medicine into data science, ethics, law, and policy. Junior doctors should be encouraged to participate in multidisciplinary forums, linking clinical insights to technical and regulatory expertise. National associations can facilitate such collaborations through conferences and working groups, enabling juniors to influence AI design, validation, and implementation policies with ethical rigor grounded in clinical realities (2,4).

4. Advocacy and Policy Engagement: Junior doctors, empowered through their national associations, can play a vital role in policy advocacy. By articulating frontline experiences and ethical concerns related to AI, juniors can influence national health authorities, regulatory bodies, and healthcare institutions to prioritize strong AI governance, transparency mandates, and patient-centred safeguards. Such engagement ensures policies are responsive to both technological evolution and clinical ethics (3,4).



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5. Establishing Feedback Mechanisms and Monitoring: As AI is deployed in clinical environments, junior doctors can create channels to report ethical issues, data breaches, algorithmic disparities, or unintended harms observed in real-time use. National networks can aggregate and analyze these inputs to inform continuous improvement and governance adjustments. Such participatory monitoring is critical to maintaining trust and safeguarding patient welfare (1, 5).

Intangible but Essential: Preserving the ‘Human Touch’

Beyond being custodians of empathy, junior doctors must take a normative role in ensuring that AI supports, rather than displaces, empathic communication, shared decision-making, and accountable physician judgment. This directly aligns with the WMA’s ‘augment, not replace’ framework, ensuring that technological integration does not erode the foundational human connection in medical practice. This ethic must be embedded explicitly in governance frameworks and reinforced through education and mentorship (6).

Conclusion

Junior doctors networking via national medical associations and the WMA JDN are well-positioned to drive ethical AI governance in clinical training and patient care. By fostering education, contributing to ethical frameworks, engaging multidisciplinary expertise, advocating for sound policy, and establishing monitoring systems, they can ensure that AI advances are harnessed responsibly, transparently, and with respect for patient dignity.

Through united action and continuous ethical vigilance, junior doctors will help shape a future where AI serves as a trusted ally—augmenting clinical skills and enhancing care quality—while preserving the core humanity of medicine.

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Confidentiality Beyond the Clinic: Ethical Duties in a Digitized Health System

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Introduction

Confidentiality has long been a cornerstone of medical ethics, rooted in the Hippocratic tradition and embedded in professional codes worldwide. Historically, it referred to the physician's obligation to safeguard patient information disclosed within the clinical encounter. However, the rapid digitalization of healthcare has fundamentally transformed the context in which this duty operates. Electronic health records (EHRs), telemedicine, artificial intelligence (AI), and patient-generated data have extended the boundaries of clinical information far beyond the consultation room. In this evolving landscape, confidentiality can no longer be understood as a static, individual obligation. Instead, it has become a dynamic, system-level ethical responsibility that involves clinicians, healthcare institutions, and technological infrastructures. This shift raises critical questions: who is responsible for protecting patient data, and how should ethical duties adapt to increasingly complex digital ecosystems?

Expansion of Digital Health Ecosystems

Modern healthcare systems are deeply integrated with digital technologies. EHRs enable seamless information sharing across providers, improving continuity of care. Telemedicine platforms expand access, particularly in underserved regions. Wearable devices and mobile health applications generate continuous streams of patient data, often outside traditional clinical oversight. Simultaneously, AI-driven analytics leverage large datasets to enhance diagnostics, predict outcomes, and personalize treatment.

While these innovations offer substantial benefits, they also introduce significant vulnerabilities. Data breaches, unauthorized access, and secondary use of data without explicit patient consent are increasingly

common concerns. Importantly, a distinction must be made between data use for direct care delivery and secondary uses such as research, analytics, public health surveillance, and commercial applications. As highlighted in the WMA Statement on Digital Health, large volumes of digital and mobile health data may be reused beyond their primary clinical purpose, creating risks of misuse and abuse (1). Furthermore, the WMA Declaration of Taipei provides ethical guidance for the governance of health databases and biobanks, particularly in the context of cross-border data flows and secondary data use (2). Health data frequently cross national borders through cloud-based systems, complicating regulatory oversight. In this environment, control over patient information is no longer confined to the physician. Instead, responsibility is distributed across multiple actors, creating a diffusion of accountability that challenges traditional ethical frameworks.

Ethical Tensions in Modern Confidentiality

The digital transformation of healthcare intensifies classical tensions between the four core principles of biomedical ethics: autonomy, beneficence, non-maleficence, and justice.

Respect for autonomy requires that patients understand and consent to how their data are used. Yet, in digital systems, consent processes are often opaque, with patients unaware of how algorithms process or share their information. Beneficence supports the use of large datasets to improve care quality and advance medical knowledge. However, this must be balanced against non-maleficence, as data misuse or breaches can result in psychological harm, discrimination, or loss of trust.

Justice introduces another layer of complexity. Data protection standards vary significantly across regions, leading to inequities in privacy safeguards. Patients in low-resource settings may be more vulnerable to exploitation or inadequate protection, while benefiting less from the advantages of digital innovation. Additionally, the use of health data by third parties, including insurers or employers, raises concerns about fairness and potential discrimination.

These tensions illustrate that confidentiality is no longer a binary concept of disclosure versus non-disclosure. Instead, it exists within a spectrum of ethical trade-offs that require continuous ethical and regulatory evaluation.

The Changing Role of the Physician

In this new paradigm, the physician's role is evolving. Beyond being a custodian of patient information, the clinician must now act as a data steward, digital communicator, and ethical gatekeeper. This expanded role includes not only understanding the risks associated with digital platforms but also advocating for responsible data practices within clinical and institutional settings.

Physicians are increasingly expected to explain the implications of telemedicine, mobile health applications, and AI-based tools. They must also critically evaluate third-party technologies integrated into clinical practice, ensuring that these tools meet ethical and professional standards. Digital literacy is therefore becoming an essential component of medical professionalism.

Importantly, confidentiality now requires proactive engagement. It is no longer sufficient to simply refrain from disclosing information; physicians must actively participate in safeguarding data within complex systems. This shift demands both technical awareness and ethical vigilance.

System-Level Responsibility

Although physicians play a crucial role, they cannot bear the burden of confidentiality alone. The protection of patient data must be understood as a shared responsibility across the healthcare ecosystem. Healthcare institutions must implement robust data governance frameworks, including secure infrastructures and clear protocols for data access and use. Technology companies developing digital health tools must prioritize “privacy by design” and “data protection by default”, ensuring that ethical considerations are embedded from the outset.

Policymakers also have a critical role in establishing regulatory standards that keep pace with technological advancements. International collaboration is particularly important, given the global nature of data flows. Harmonized frameworks can help ensure consistent protection of patient information while enabling responsible innovation.

Without coordinated efforts at the system level, individual ethical commitments will remain insufficient to address the scale and complexity of digital health challenges.

Practical Recommendations

To address these issues, several practical steps can be implemented.

- First, digital ethics should be integrated into medical education and continuing professional development, equipping clinicians with the knowledge required to navigate emerging technologies.
- Second, informed consent processes must be updated to reflect the realities of digital data use, with greater transparency and clarity. In accordance with the WMA Statement on Digital Health, informed consent in digital settings should be specific to the modality used and must include clear explanations of how the system operates, potential privacy risks, possible technological failures, risks of confidentiality breaches, and the potential for secondary use of data. Such consent processes should also account for varying levels of patient digital and health literacy, ensuring comprehension and voluntariness (1).
- Third, interdisciplinary collaboration between healthcare professionals, data scientists, and ethicists is essential to develop balanced solutions.
- Fourth, healthcare systems should prioritize transparency in how patient data are collected, stored, and utilized.
- Finally, empowering patients with greater control over their data—through access, consent management, and the ability to opt out—can strengthen patient trust and support ethically responsible data governance.

Conclusion

Confidentiality in healthcare is undergoing a profound transformation. In the digital age, it is no longer confined to the private interaction between physician and patient but extends across interconnected systems involving multiple stakeholders. While this evolution presents significant ethical challenges, it also offers an opportunity to redefine professional responsibilities in a way that aligns with contemporary realities.

Physicians remain central to this process, not as sole guardians of information, but as ethical anchors within a complex network. Protecting confidentiality today requires more than technological safeguards; it demands a reimagining of medical ethics that embraces accountability, transparency, and collaboration in an increasingly connected world, while ensuring that patient rights and dignity remain at the center of digital transformation.

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Between Faith and Medical Emergency: Impact of Spiritual Beliefs on Healthcare-Seeking Behavior in the Democratic Republic of Congo

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Abstract

This study examines the impact of spiritual beliefs on healthcare-seeking behavior in the Democratic Republic of Congo (DRC). Surveying 70 citizens and 30 physicians, results show that 35.7% prioritize pastoral approval during emergencies, while 64.3% have delayed medical visits for prayer. Among doctors, 76.7% reported clinical aggravation due to religious practices, identifying severe sequelae as a major risk. These findings highlight that religious authority often supersedes clinical urgency. A collaborative model between medical professionals and religious leaders is essential to reduce avoidable mortality and ensure timely care.

Introduction

In many sub-Saharan African countries, and particularly in the Democratic Republic of Congo (DRC), the practice of medicine is deeply intertwined with a complex socio-cultural and religious landscape. For a large part of the population, health is perceived through a holistic prism where the spiritual and the physical are inseparable (1).

While religious faith can be a source of psychological resilience for patients, it often becomes a barrier to timely clinical intervention when spiritual leaders are consulted as a first-line alternative to medical professionals.

The consequences of these "spirituality-first" health-seeking behaviors are often tragic. It is not uncommon for clinicians to receive pediatric patients in a state of terminal coma or advanced status epilepticus after days of "deliverance prayers" aimed at casting out "evil spirits" believed to be the cause of neurological symptoms. These delays in consultation

significantly increase avoidable mortality and morbidity, placing junior doctors in a difficult ethical position: balancing respect for the patient's (or their family's) religious freedom with the duty to provide urgent, evidence-based life-saving care (2,3). This article aims to analyze the prevalence of these behaviors and discuss the ethical challenges they pose for young physicians in the DRC.

Material and Methods

Study Design and Population

A cross-sectional descriptive study was conducted to evaluate the influence of spiritual beliefs on medical consultation delays. The target population consists of two main groups:

1. General Public & Medical Students (n=70): To assess health-seeking intentions and spiritual perceptions of disease.
2. Junior Doctors (n=30): To document clinical observations of religious-related healthcare delays.

Data Collection Tool

Data was collected using a structured electronic questionnaire developed via Google Forms. The link was disseminated through professional medical networks and social media platforms (WhatsApp and facebook) to ensure broad geographical representation within the DRC. The questionnaire includes sections on socio-demographic characteristics, therapeutic preferences in emergencies, and documented experiences of delayed care due to religious or traditional reasons.

Data Analysis

The collected data was exported and analyzed using IBM SPSS Statistics. Descriptive statistics (frequencies, percentages, means, and standard deviations) was used to summarize the findings. Bivariate analysis was performed to identify potential correlations between educational level and the choice of first-line healthcare providers.

Ethical Considerations

The study ensures participants' anonymity and informed consent. Participants were informed that the data collected will be used solely for scientific publication in the WMA JDN Bulletin.

Results

Public Intentions and Beliefs

Out of 70 respondents, 35.7% stated that their first reaction to a sudden medical emergency (e.g., seizure) would be to call a pastor for prayer and wait for their approval before heading to a hospital. Furthermore, 64.3% of participants admitted to having personally delayed a hospital visit to prioritize prayer or traditional treatment. The primary reason for this delay was "Religious conviction/Trust in God first" (41.8%), followed by "Financial constraints" (13.4%)(Figure 1). Regarding disease etiology, majority believed that diseases could be "absolutely" or "sometimes" of purely spiritual origin (Figure 2).

Figure 1: Primary Reason for Delay in Seeking Care (n=67)

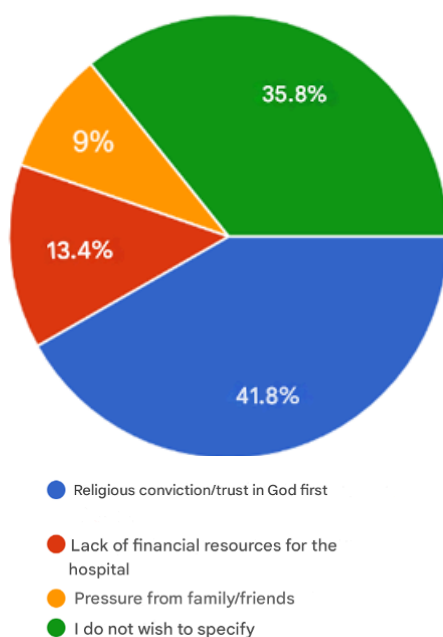
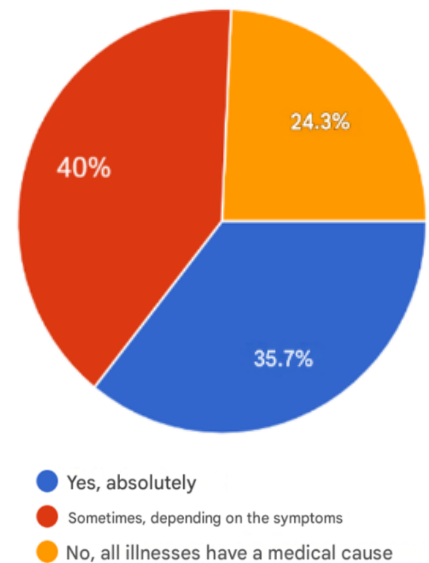


Figure 2: Public Perceptions Regarding the Spiritual Etiology of Illness (n=70)



Clinical Impact

Among the 30 surveyed doctors, 76.7% reported having received patients whose clinical condition had significantly worsened due to delays caused by religious practices (fasting or prolonged prayer) (Figure 3). The major risks identified by practitioners were "Severe complications/sequelae" (80%) and "Increased overall cost of care" (56.7%) (Figure 4). Notably, 86.7% of physicians believe that sensitizing religious leaders to medical emergencies could significantly reduce mortality rates.

Figure 3: Physician-Reported Clinical Deterioration in Patients Due to Religious Practice Delays (n=30)

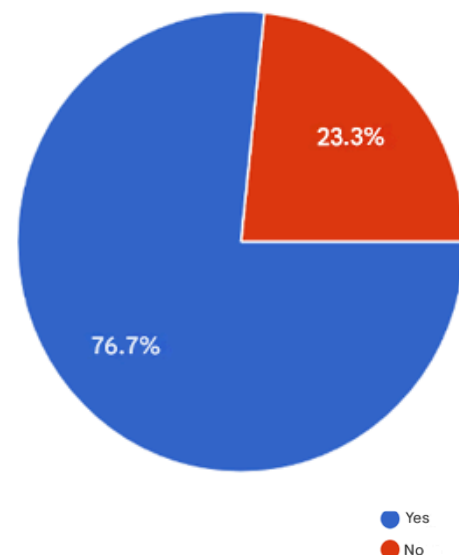
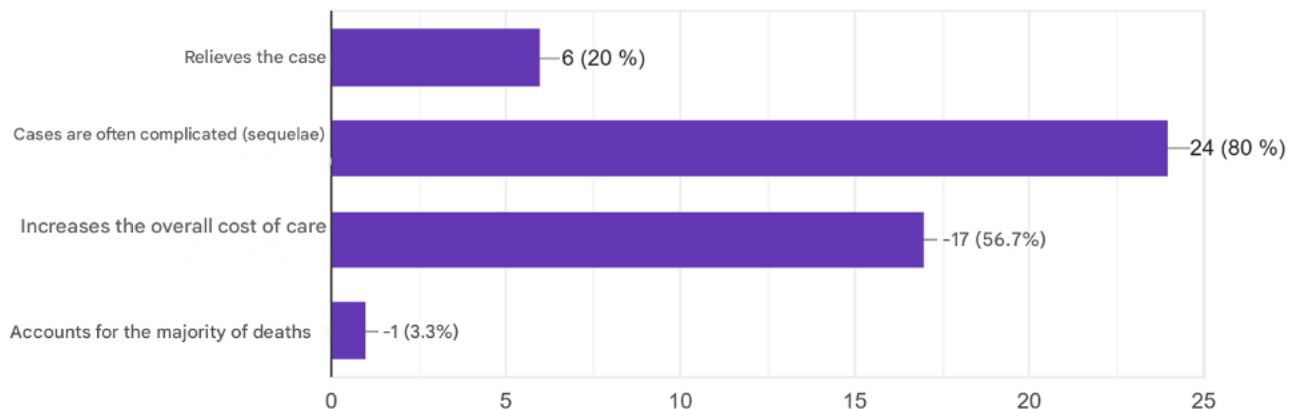


Figure 4: Major Risks and Consequences of Faith-Based Delays in Healthcare Seeking as Reported by DRC Physicians (n=30)



Discussion

The results demonstrate a critical tension between cultural identity and clinical urgency. While 62.9% of the total sample reported they would go directly to the hospital in an emergency, a nuanced analysis reveals a more concerning reality. Since over half of the respondents (51.4%) were medical students or healthcare professionals, a demographic with high medical literacy the 35.7% who prioritize seeking a "pastoral green light" likely represent a much larger majority within the general, non-medical population. This suggests that for a typical citizen without medical training, the default reflex remains spiritual intervention, showing that religious authority often supersedes clinical urgency.

This is poignantly illustrated by a recurring clinical scenario in the DRC: an 8-year-old child presenting with irreversible neurological damage after days of "deliverance prayers" for what was initially a treatable febrile seizure. As junior doctors, we face a profound ethical dilemma: respecting the spiritual autonomy of families while fulfilling our duty to protect the patient's life. The data suggests that education alone is insufficient, as even university-educated respondents showed a high reliance on spiritual intervention.

Conclusion

Spiritual beliefs are a major determinant of healthcare-seeking behavior and mortality in the DRC. To bridge this gap, a collaborative model between the medical community and religious leaders is essential. Integrating spiritual leaders into public health awareness programs could transform them from barriers into allies, ensuring that "faith" and "science" work together to save lives rather than compete in times of emergency.

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Shipping Lanes and Survival: When Supply Chains Become Health Risks in the Philippines

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For many countries, shipping lanes are discussed as matters of trade, fuel, and geopolitics. For lower-middle-income countries such as the Philippines, they should also be discussed as matters of public health. When maritime routes are disrupted, the consequences do not stop at delayed consumer goods or higher freight costs. They reach hospital shelves, rural pharmacies, dialysis centers, vaccination programs, and household budgets. In countries that depend heavily on imported medicines, medical devices, laboratory reagents, and food, a supply-chain shock can quickly become a health shock (1-3).

Recent events have made this connection hard to ignore. Rising tensions and security concerns around the Strait of Hormuz, a critical chokepoint for global oil and trade, have heightened the risk of supply disruptions and driven up shipping insurance premiums and freight costs. These pressures, alongside broader geopolitical instability, continue to ripple across global supply chains, affecting both availability and prices worldwide (1,2,4). These changes may appear distant from everyday life in the Philippines, but their effects travel with every container. If a route lengthens by days or weeks, essential medical products arrive later and at higher cost. If shipping prices rise, importers pass costs along to hospitals, pharmacies, and patients. In a health system where many families already pay a significant share out of pocket, even a modest increase in the price of antibiotics, insulin, or maintenance medicines can mean skipped treatment and preventable complications (1-3).

This risk is sharper in the Philippines because geography magnifies dependence. The country is not only reliant on international shipping; it also relies on domestic inter-island transport to move supplies from ports to provincial hospitals and local clinics. A medicine that reaches

Manila is not yet truly available to the patient in Samar, Basilan, or an upland municipality in Mindanao. Every transfer point adds another chance for delay, spoilage, stock imbalance, or price escalation. For temperature-sensitive products such as vaccines and some biologics, each disruption also threatens product quality, not just availability. In an archipelago, logistics is not a background function. It is part of care delivery (2,3).

Climate change makes this even more dangerous. The Philippines faces repeated typhoons, flooding, and infrastructure damage, all of which can interrupt port operations, road transport, power supply, and cold-chain systems. In practice, this means a global disruption can collide with a local disaster. A delayed shipment of medicines may be manageable under normal conditions, but not when a storm has already cut off roads or damaged storage facilities. Resilience, therefore, cannot be defined only by how many hospital beds or doctors a country has. A health system is also only as resilient as its warehouses, shipping routes, power backups, and transport plans (3,5).

Medicine shortages are not new, and they rarely have a single cause. They often arise from concentrated manufacturing, limited suppliers of active pharmaceutical ingredients, regulatory bottlenecks, sudden demand spikes, and transport failures (6). But shipping disruptions are uniquely dangerous because they affect multiple products at the same time. A single bottleneck can delay antibiotics, surgical gloves, diagnostic cartridges, and infant formula all at once. For poor and geographically isolated communities, the result is not abstract "supply stress." It is a mother who cannot find amoxicillin for her

child, a diabetic patient who stretches insulin beyond safe use, or a public hospital that postpones procedures because a disposable component has not arrived (2,6).

The burden is also unequal. Wealthier hospitals and private chains can sometimes cushion shocks by buying larger inventories, paying higher freight, or sourcing from alternative suppliers. Smaller hospitals, local government units, and independent drugstores often cannot. This creates a two-tier response to the crisis: continuity for those who can pay, scarcity for those who cannot. That pattern contradicts the promise of universal health care. A system cannot claim equitable access if treatment depends on whether a facility has enough purchasing power to outbid others during a logistics emergency (3,5,6).

The Philippines should therefore treat shipping and health security as connected policy domains. First, the government must identify a practical list of essential products whose supply should be protected during crises: common antibiotics, insulin, antihypertensives, dialysis supplies, vaccines, emergency obstetric medicines, diagnostic reagents, and selected consumables. Not every product can be stockpiled, but the most critical ones can be mapped, monitored, and buffered (5,6).

Second, the country needs smarter redundancy rather than unrealistic self-sufficiency. The goal is not to manufacture every medicine locally. That would be costly and inefficient. The better goal is strategic capacity: diversify import sources, maintain emergency buffer stocks, expand regional procurement options, and build domestic manufacturing for a limited set of high-priority products such as basic generics, intravenous fluids, and selected protective equipment. If one supplier or route fails, the system should not fail with it (3,5,6).

Third, supply chains need visibility. Health authorities should know, in near real time, where essential items are, which hospitals are nearing stockout, and which ports or routes are congested. Without this information, response becomes reactive and political rather than preventive and evidence-based. Digital inventory systems, coordinated procurement data, and early-warning dashboards are not luxuries; they are public health tools (6).

Fourth, ports, customs, and transport policy should include explicit health priorities during disruption. Essential medical goods should move through fast lanes, receive predictable clearance, and be backed by

contingency protocols during storms and geopolitical crises. If governments can prioritize fuel or food under emergency conditions, they can also prioritize lifesaving health commodities (2,4-6).

Ultimately, shipping lanes are not separate from survival in countries like the Philippines. They are part of the hidden architecture of health. A delayed container may look like a commercial inconvenience on paper, but at the bedside it can become a missed chemotherapy cycle, an interrupted vaccination schedule, or a stockout in a district hospital. For lower-middle-income countries, supply-chain fragility is no longer only an economic vulnerability. It is a clinical risk, a social equity issue, and a test of whether universal health care can withstand the real world (3,5,6). If policymakers continue to treat logistics as secondary to medicine, they will keep discovering the same lesson too late: when supply chains break, patients pay first.

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Prescribing Intelligence: The Case for AI-Assisted Clinical Decision Support in Antibiotic Stewardship Across Resource-Limited Health Systems

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It is 3 a.m. in a prehospital emergency unit on the outskirts of Algiers. A general practitioner on medical regulation duty fields a call: a febrile child, uncertain diagnosis, a caregiver asking which antibiotic to retrieve from the family medicine cabinet. In the absence of microbiological data, a clinical decision support tool, or a reliable regional antibiogram, the physician decides on the basis of pattern recognition and instinct. This scenario, repeated thousands of times daily across North Africa, the Middle East, South Asia, and sub-Saharan Africa, is not a failure of individual competence — it is a structural failure of health systems to equip frontline clinicians with actionable intelligence at the point of care.

Antimicrobial resistance (AMR) is accelerating at a pace that demands urgent systemic responses. The landmark global burden analysis published in *The Lancet* estimated that bacterial AMR was directly responsible for approximately 1.27 million deaths in 2019, with low- and middle-income countries (LMICs) accounting for the vast majority of this burden (1). Antibiotic self-medication — unsupervised acquisition and use without a prescription — is among the most potent structural drivers of AMR in these settings, with prevalence exceeding 40–78% across LMIC regions (2). The gap between evidence and prescribing practice is not a matter of physician unwillingness — it is a matter of missing infrastructure, missing data, and missing tools.

Artificial intelligence, and specifically AI-assisted clinical decision support systems (AI-CDSS), represent a credible, scalable, and contextually adaptable response to this

gap. This Expert Opinion argues that deploying AI-CDSS for antibiotic prescribing in primary and prehospital care across LMICs is not a futuristic aspiration — it is a policy imperative that the WMA Junior Doctors Network should champion without further delay.

THE STRUCTURAL PROBLEM: WHY FRONTLINE ANTIBIOTIC PRESCRIBING FAILS

Rational antibiotic prescribing requires three concurrent inputs: accurate clinical diagnosis, knowledge of local resistance profiles, and awareness of available agents' pharmacological properties. In primary care and prehospital settings across LMICs, all three are frequently absent. Culture services may require days or be entirely unavailable. Local antibiograms are rarely updated or integrated into clinical workflows. Prescribers — many operating in professional isolation — fall back on empirical patterns that may bear little relationship to current resistance epidemiology (3).

The result is predictable: overuse of broad-spectrum agents, under-treatment of resistant infections, and sustained selection pressure amplifying resistance at population level. Inappropriate antibiotic prescribing in LMIC primary care ranges from 50 to 80% of all prescriptions, attributable not to negligence but to the structural absence of point-of-care decision support(4). Junior doctors — disproportionately staffing first-contact care systems with the highest patient volumes and least institutional support — bear this burden daily.

WHAT AI-CDSS CAN REALISTICALLY OFFER

AI-CDSS for antibiotic prescribing can perform three well-defined, clinically actionable functions directly relevant to LMIC primary care contexts.

First, syndromic pattern recognition: integrating symptoms, vital signs, and epidemiological context, AI models stratify infection likelihood and guide empirical prescribing without culture data. Point-of-care biomarker testing has helped reduce unnecessary antibiotic prescribing for respiratory infections in primary care (5). Second, local resistance integration: AI systems trained on regional antibiogram data provide resistance-adjusted recommendations at the point of care, addressing the critical gap between siloed institutional data and frontline prescribing reality (6). Third, real-time stewardship feedback: AI-CDSS embedded in electronic prescribing platforms can flag redundant or overly broad selections and generate aggregate analytics for quality improvement.

Critically, such systems need not require high-bandwidth connectivity or complex hospital infrastructure. Offline-capable mobile health information systems remain a practical option for settings with limited connectivity, though infrastructure and implementation challenges persist across many low-resource health systems (7). The technological barriers are lower than commonly assumed; the primary barriers are political, regulatory, and financial.

THE POLICY GAP: WHAT IS MISSING AND WHAT JUNIOR DOCTORS SHOULD DEMAND

Despite a maturing evidence base, AI-CDSS for antibiotic stewardship remains absent from most LMIC national health strategies. Regulatory frameworks for AI-based medical devices are nascent or nonexistent across much of North Africa and sub-Saharan Africa, creating legal ambiguity that discourages institutional adoption (8). Health information infrastructure remains fragmented, and funding for digital health AI consistently underperforms — WHO's global strategy notes that LMICs face major resource and infrastructure barriers to adopting digital health technologies, including AI (9).

Junior doctors are uniquely positioned to change this. We are the largest clinical workforce in LMIC primary and prehospital care, experiencing daily the consequences of inadequate decision support. The WMA Junior Doctors Network should advocate for three explicit policy commitments.

First, national antibiogram surveillance as a non-negotiable public health investment. AI-CDSS is only as accurate as its underlying resistance data. Surveillance must expand beyond tertiary hospitals to primary care and prehospital settings — because the resistance profile guiding a rural health center prescription is not that of a national capital university hospital (6).

Second, regulatory fast-tracking for validated, open-source AI-CDSS tools. The expedited model applied to essential medicines for neglected tropical diseases should extend to AI-driven AMR tools — with robust post-deployment outcome surveillance built in. The current regulatory vacuum actively perpetuates the problem it purports to manage.

Third, AI-CDSS literacy integrated into postgraduate medical training. Junior doctors should graduate able not only to use decision support tools, but to critically appraise their outputs and participate in their improvement. The WMA and national medical associations should enshrine this in postgraduate training guidance.

CONCLUSION

Antimicrobial resistance will not be solved by willpower alone. It will be mitigated — durably and at scale — by building systems that make rational prescribing the path of least resistance for every frontline clinician, in every setting, at every hour. The evidence for its feasibility is established, the technology accessible. What remains missing is the political will to deploy it, the regulatory infrastructure to govern it, and the investment to sustain it.

We are not passive observers. We are its most essential advocates — the ones answering the call at 3 a.m., who understand with clarity what the absence of intelligence costs.

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When Training Becomes a Bottleneck: Brain Drain, Induction Inequities, and the Future of Young Doctors in Pakistan

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Across many low- and middle-income countries, the medical workforce paradox is increasingly visible: more doctors are graduating each year, yet fewer are able to access structured postgraduate training. Pakistan is no exception. The introduction of centralized induction pathways such as the Central Induction Program (CIP) has improved transparency in some respects, but it has also exposed deeper structural imbalances between undergraduate expansion and postgraduate capacity (1,2). These gaps are shaping the career trajectories—and migration decisions—of an entire generation of junior doctors.

Pakistan produces approximately 20,000–25,000 medical graduates annually. However, postgraduate training opportunities have not expanded at the same pace (3). As a result, many young doctors experience prolonged periods of uncertainty after house job completion, often working in unpaid or underpaid clinical positions while waiting for formal residency placements. These transitional years are increasingly becoming a defining feature of early medical careers rather than a temporary stage.

One major contributor to this imbalance is the rapid expansion of private-sector undergraduate medical education over the past decade. While this expansion has increased access to MBBS training, it has not been accompanied by proportional growth in accredited postgraduate training slots (1). Private hospitals frequently lack structured residency pathways or offer limited paid training opportunities, forcing graduates to remain in unpaid roles to maintain clinical continuity and competitiveness.

This mismatch creates a secondary consequence: graduates from the private sector increasingly compete for limited public-sector postgraduate seats. In the absence of a nationally uniform scoring

framework that adequately balances institutional variability and training exposure, induction outcomes may reflect structural inequities rather than purely academic merit (2).

The Central Induction Program (CIP) was introduced to streamline residency allocation and improve transparency. While the initiative represents an important step toward standardized selection processes, differences in scoring systems across provinces, variations in house job structures, and unequal access to research opportunities continue to influence candidate ranking outcomes (2).

Regulatory bodies such as the Pakistan Medical and Dental Council (PMDC), provincial universities such as the University of Health Sciences (UHS), and postgraduate training authorities such as the College of Physicians and Surgeons Pakistan (CPSP) each play central roles in shaping this landscape (1,2,4). However, coordination between undergraduate expansion policies and postgraduate workforce planning remains limited.

Importantly, the consequences of this imbalance extend beyond individual careers. Training uncertainty contributes directly to physician migration. For many junior doctors, the decision to pursue licensing examinations abroad is motivated by the predictability and structure of training pathways elsewhere rather than financial incentives alone (8,9).

Recent indicators suggest policymakers are increasingly aware of these structural pressures. Regulatory authorities have placed temporary limits on further expansion of medical colleges due to

concerns about faculty shortages and training capacity constraints (5). However, such steps must be accompanied by expansion of accredited residency positions and protected training posts.

Equally important is the integration of private-sector hospitals into structured postgraduate training systems. Incentivizing accredited training slots within private hospitals—through regulatory recognition, supervision models, and structured collaboration—could help bridge the gap between undergraduate output and postgraduate opportunity (4).

Another priority is the development of transparent and nationally harmonized scoring criteria for residency induction. A unified national framework incorporating academic performance, clinical exposure, research engagement, and service commitment could ensure training allocation reflects both merit and workforce needs.

Ultimately, the challenge facing Pakistan's junior doctors is not a shortage of motivation or competence ,but a shortage of structured opportunity. Addressing this imbalance requires coordinated planning between regulators, universities, training institutions, and healthcare employers. Expanding postgraduate training capacity, strengthening public-private partnerships, and standardizing induction frameworks are essential steps toward retaining skilled physicians within the national health system (8,10).

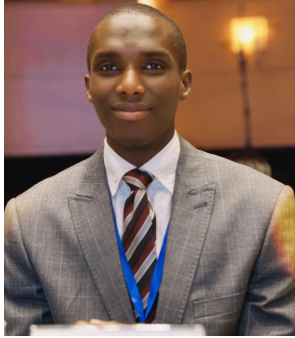
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Is the Juice Worth the Squeeze?

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“Amor fati” or “love of fate” played subtly in the background as I started typing this in my Microsoft Word document, at the Embedded Systems Building along University Road. It is more than a phrase. I first heard this phrase from a Greek colleague during a volunteer event in the midst of the Corona virus disease 2019 (COVID-19) pandemic. “Love of fate” the song by Christen Lien, became a frequent play in the background whenever I am writing. The phrase and the song became a philosophy that has come to define my journey into scientific research.

Like many young physicians, I, graduating from medical school, was full of enthusiasm to meticulously listen to the patient and provide evidence-based care that suits their goal aiming at least to do no harm in the process.

During the COVID-19 pandemic, uncertainty forced many junior doctors away from traditional bedside learning, meaning lots of time to think. At that time, senior clinicians were by the bedside, providing care, triaging, and ensuring COVID-19 cases were detected in a timely and quarantined. In contrast, physician-scientists were by the benchside, racing to answer urgent questions: mortality rates, incidence rates, viral mechanisms, etcetera. Research protocols were accelerated; at the same time, execution of the research was at an unprecedented pace. Data were analyzed swiftly; peer review accelerated for COVID-19-related articles, all with one objective—to save lives. It was during these moment, the divide between clinical practice and research proved to be a mirage.

As you drive through the suburbs of Bamako towards Kati, along Avenue de La Liberte, is a red one-story building on a hill: The Centre for Research and Sickle Cell Control (CRLD). The headquarters is charged with providing specialist care for sickle cell patients in the Republic of Mali. This is where I first had my official research mentorship. An unforgettable experience I still reminisce. In the clinics, I witnessed how collaboration through scientific

research directly influenced care delivery in resource limited setting. Here, scientific research is not abstract, it was immediate and practical. This was the aha moment, that clinicians who chose research are strengthening medicine.

Since the time of the ancient Greek physician, Hippocrates, physicians have been solely comforters and observers of the unwell (1). Sanitation engineers have been the main innovators and advancers of health at that time. As a physician, you are either training with the giants or becoming the giant.

Recent discourse in the medical community including commentaries from some senior physicians was to differentiate research from clinical medicine. The main argument was, some physicians just want to provide care. These ideas have been a major point of discourse since the mid-1900s. However, in 1984 Gordon N. Gill described the role of economic forces, rise of Ph.D driven science leading to the separation of clinical practice and basic research hence, automatically extinguishing the physician-scientist. Accordingly, we witnessed the breakthrough development of the messenger RNA vaccines which was only possible through a strong collaboration between a physician-scientist—Dr. Drew Weissman and a scientist Dr. Katalin Kariko. This vaccine was instrumental during the fight against COVID-19 pandemic (2). Finally, in the quest for having a strong healthcare system, research and clinical practice cannot be mutually exclusive. Research has its peculiar challenges that are not exclusive to funding and uncertainty. But when you have the right mentor and ideas, I believe the juice is still worth the squeeze!

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The West African College of Physicians at 50: Building a Future Young Doctors Still Want to Choose

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Introduction

In 2026, the West African College of Physicians (WACP) marks fifty years since its establishment in 1976 as a regional professional body dedicated to postgraduate medical education and excellence in medical practice across West Africa. Its golden jubilee celebration and Annual General and Scientific Meeting are scheduled for 26–28 October 2026 in Abuja under the theme “WACP at 50: Celebrating a Legacy, Envisioning the Future.” (1)

For many senior physicians, this milestone is rightly a moment of pride. For younger doctors, however, it should also prompt a more practical question: can regional specialist training still offer a future worth choosing?

As a family physician working within the realities of West African health systems, I have seen how postgraduate institutions can either widen young doctors’ horizons or seem too distant from their daily struggles. That is why this anniversary matters not only as a commemoration of institutional history but also as a test of future relevance.

Why this Jubilee Deserves Reflection

The West African College of Physicians has already demonstrated that West Africa can build and sustain an indigenous institution for postgraduate specialist training. Established in 1976, the College now operates across 13 West African countries, bringing together specialists in Community Health, Family Medicine, Internal Medicine, Laboratory Medicine, Paediatrics, and Psychiatry through a faculty and chapter structure that supports training, certification, professional standards, and scientific exchange (1,2).

The College was created not merely to examine doctors, but to promote

professional training, uphold standards of practice and ethics, support research, advise governments and regional bodies, and collaborate with institutions that advance its objectives (1,2). Its current institutional messaging also emphasises training physicians to the highest international standards while remaining rooted in the realities of African healthcare, which is precisely why the institution remains so important to the region (3).

Keeping Specialist Training Attractive in a Competitive World

Legacy alone will not secure the College’s future. The next challenge for the West African College of Physicians is not legitimacy alone, but attraction and retention.

Many junior doctors across West Africa are making career decisions in settings marked by service pressure, variable supervision, financial constraints, and growing awareness of opportunities outside the region (4,5). In that context, regional colleges can no longer assume that talented young doctors will automatically remain within the system. The College must actively persuade future specialists that regional postgraduate training is not only rigorous, but also credible, supportive, modern, and worth committing to. That means the future agenda must become more explicitly trainee-centred and forward-looking.

A pragmatic future agenda for the West African College of Physicians

1. Engage the pipeline earlier

Too many young doctors encounter

postgraduate colleges only when preparing for examinations. By then, the institution may appear distant, procedural, and intimidating rather than aspirational. The West African College of Physicians should engage earlier through structured outreach to medical schools, resident-focused career sessions, and faculty-led mentoring for house officers and medical officers. If the College wants the next generation to choose specialist training within the region, it must be visible long before the examination stage.

2. Make training pathways easier to navigate

Excellence does not require avoidable confusion. Clearer communication around accreditation, examinations, timelines, progression requirements, and faculty expectations would make training more navigable without lowering standards. The College's own 2024–2028 strategic plan already emphasises membership and fellowship support, training, skills and continuing education, and strengthening institutional capacity, which provides a strong policy basis for more trainee-friendly systems (3).

3. Pursue curriculum parity and benchmark against leading global colleges

If the College is to remain attractive to future specialists, it must be seen not only as regionally relevant, but also as globally benchmarked. This does not mean copying external models uncritically. Rather, it means ensuring that curricula, assessment methods, faculty development, and subspecialty pathways are comparable in quality to those of respected postgraduate colleges elsewhere, while still reflecting West African realities.

There is already a basis for this. The College states that it has extensive collaborations with counterpart organisations worldwide, including the Royal Colleges of the United Kingdom and the Colleges of Medicine of South Africa (3). In 2022, for instance, the Faculty of Laboratory Medicine entered a memorandum of understanding with the Royal College of Pathologists that explicitly included curricular development for subspecialty training and opportunities to observe each other's examinations (6).

The next step is to make such benchmarking more systematic across faculties: curriculum review cycles, faculty exchange, external examiner observation, and clearer parity frameworks with peer colleges in the United Kingdom, United States, Australia, South Africa, and other comparable

systems. This would strengthen credibility, reassure trainees, and enhance the portability of competence without undermining regional ownership.

4. Build stronger intra-regional career pathways

The value proposition for staying in West Africa must be more compelling. The College's growing regional scope, including its expansion beyond the original Anglophone base and its more recent movement towards a tri-lingual West African identity with the inclusion of Cabo Verde and Guinea-Bissau, is a major strength (1,3). That breadth should translate into practical opportunities for trainees and young Fellows: cross-country mentorship, faculty development, collaborative research, short exchange placements, and clearer pathways for regional mobility within accredited institutions.

5. Mitigate brain drain deliberately, not rhetorically

If the College is to thrive over the next fifty years, it must address brain drain as a strategic priority rather than an unfortunate background condition. Encouragingly, the College's 2024–2028 strategic plan explicitly includes "Addressing Brain Drain in the West African Sub-Region" and speaks of retaining talented health professionals within the region while attracting members of the diaspora back home (3). That commitment should now be operationalised through concrete measures: stronger professional belonging, better mentorship, opportunities for academic progression, diaspora engagement, faculty recognition, and partnerships that allow global exposure without permanent loss of talent.

Brain drain cannot be solved by sentiment alone. It is mitigated when young specialists believe they can build meaningful, respected, and intellectually rewarding careers within the region.

6. Make mentorship and wellbeing institutional priorities

Every strong postgraduate system depends not only on examinations and curricula, but also on relationships. Young doctors are more likely to remain in demanding training pathways when they feel seen, guided, and supported. Mentorship should therefore become an explicit institutional strategy not an informal bonus. If the West African College of Physicians is experienced only as an examining authority, attachment will weaken; if it is also experienced as a professional home, it will endure.

Conclusion

The West African College of Physicians has every reason to celebrate its first fifty years. It has survived, expanded, and remained central to postgraduate medical education in West Africa. It has built faculties, chapters, scientific platforms, and international partnerships, while continuing to define itself as a College committed to high standards and regional relevance.

But the most important work now lies ahead. The next phase of the College's history will depend on whether it can preserve standards and build a specialist training ecosystem that young doctors still want to join. That means earlier engagement, better training experiences, curriculum parity with global peers, purposeful benchmarking, stronger regional career pathways, and a serious agenda to mitigate brain drain.

That is how the first fifty years of the West African College of Physicians can become the foundation for the next fifty.

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Mental Health Literacy: A Foundation for Global Mental Health Equity

Victoria M. Thomas



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Mental Health Literacy: A Foundation for Global Mental Health Equity

Mental health disorders represent a substantial and growing global health burden, affecting an estimated one in seven people worldwide (1). Despite this prevalence, access to timely and effective care remains profoundly unequal, particularly in low-resource settings where mental health services are limited and stigma remains pervasive (2,3). Of the more than one billion individuals living with mental health conditions globally, approximately two-thirds remain untreated (1,4). Beyond shortages of trained professionals and infrastructure, one often overlooked yet critical barrier is inadequate mental health literacy (5).

The ability to recognise symptoms, understand available treatments, and seek appropriate help is foundational to early intervention and improved outcomes (5). Without strengthening mental health literacy at community and systems levels, efforts to improve global mental health equity will remain incomplete (4).

In many parts of the world, limited mental health literacy contributes significantly to delayed recognition and treatment of mental health conditions (5). Misconceptions surrounding mental illness remain widespread, often fuelled by cultural beliefs, stigma, and misinformation (3).

In many African communities, stigma and misunderstanding around mental health are closely tied to cultural interpretations that attribute mental illness to curses, spiritual attacks, or consequences of wrongdoing. These interpretations, while culturally significant, often arise from limited access to accurate mental health information. At the root of many harmful misconceptions is insufficient mental health literacy, which

prevents individuals and communities from recognizing mental illness as a health condition that can be understood, treated, and managed (5).

Addressing these misconceptions requires intentional investment in culturally sensitive mental health education and awareness initiatives that improve mental health literacy, challenge harmful beliefs, and empower communities with accurate, evidence-based knowledge (3,4).

In the absence of structured education on emotional wellbeing, many adolescents lack the vocabulary and awareness needed to identify distress in themselves or others, making them particularly vulnerable to the consequences of poor mental health literacy (5,6).

Schools, as central environments for learning and development, often lack the resources or trained personnel to provide adequate mental health education, particularly in underserved communities where competing health priorities limit integration into mainstream services (6). Strengthening mental health literacy through schools offers a practical, scalable way to address gaps in care. Integrating age-appropriate education into school curricula can equip students with the knowledge and language to understand emotional wellbeing, recognise distress, and support their peers (5,6).

Experiences from youth engagement and outreach initiatives conducted through the Safeguard Mental Health Initiative in settings such as The Gambia demonstrate how limited awareness often delays recognition of distress, while targeted

education sessions significantly improve understanding and encourage open dialogue around mental health.

Community and youth-led advocacy initiatives are critical for bridging mental health literacy gaps. NGOs and grassroots programmes have shown that culturally sensitive education through workshops, campaigns, and peer engagement can be highly effective (3,4). Youths are especially powerful change agents within their families and communities. By equipping them with accurate knowledge and practical coping strategies, communities can create supportive environments that encourage open conversations about mental health (5).

Digital platforms further present innovative opportunities to expand the reach of mental health literacy programmes, allowing information to reach populations that may otherwise face barriers to in-person services, thereby complementing existing systems and promoting early help-seeking behaviours (4).

Sustainable change will depend on integrating mental health literacy into public health policies, primary healthcare services, and national education systems (4). Governments and policymakers must recognise mental health literacy as a core public health priority and allocate resources toward sustainable education initiatives (3,4). Integrating mental health literacy into national health promotion strategies and school curricula can significantly improve early identification and intervention, ultimately reducing the long-term burden of untreated mental illness (1,2).

Healthcare systems must prioritise training for frontline providers, particularly in primary care, where healthcare workers are often the first point of contact for individuals experiencing psychological distress (2). Equipping them with skills to recognise mental health conditions and provide basic psychoeducation can strengthen referral pathways and improve outcomes (4). Medical educators and training institutions have an equally important role to play. Embedding mental health literacy into undergraduate and postgraduate curricula can empower future healthcare professionals to serve as advocates within their communities (5).

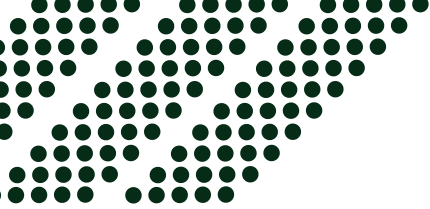
Junior doctors occupy a unique position at the intersection of clinical care and public health, making them valuable contributors to awareness initiatives, community education programmes, and policy advocacy. Even in resource-limited settings,

they can lead mental health literacy efforts by organising school outreach programmes, facilitating community awareness sessions, and advocating for the integration of mental health education into primary healthcare systems (4).

Achieving global mental health equity requires more than increasing the number of mental health professionals or expanding treatment facilities (4). It demands empowering individuals and communities with the knowledge to recognise, understand, and respond to mental health challenges (4,5). In low-resource settings where access to specialised care remains limited, strengthening mental health literacy offers a practical starting point. Prioritising mental health literacy today is essential to building a future where mental health care is not only available, but understood, accepted, and accessible to all (4).

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