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Editorial

It is already a whole year since the world has been talking only about Covid-19, about 6 feet distancing, masks, vaccination, oxygen-breathing, treatment with monoclonal antibodies, cytokine storms and death.

Therefore, this time the Editorial is about the flu – a dangerous infectious disease that now seems to have disappeared, but will certainly come back. Thanks to the flu virus and vaccination against it, in an incredibly short time the world managed to develop a modern vaccine against Covid-19. Let us remember – how difficult it was with flu vaccination and how the WMA called on all doctors' organisations in the world to be more actively involved in it.

Seasonal flu is an acute, highly contagious influenza virus-induced respiratory disease that spreads through aerosols and manifests itself with temperature and various symptoms ranging from mild fatigue to respiratory failure and even death. Influenza is associated with a significant number of working days lost, human suffering and increased mortality.

According to WHO figures, a quarter-million or even half a million people worldwide die of influenza and related complications each year, but at least 5 million people are severely affected. In tropical regions, the flu season lasts throughout the year. In the Northern Hemisphere, the flu season typically starts in autumn, reaching the peak in mid-February, but ending in late spring. The duration of the influenza epidemic and the severity of the disease are determined by the sub-type of the virus involved.

Physicians are usually worried about influenza virus types A and B. Influenza A viruses are able to induce epidemics and pandemics. For type A viruses, the host may be not only humans, but also a variety of animals (pigs, horses, dolphins, whales) and birds (including poultry: chickens, ducks, turkeys, etc.). Type A is very variable. Type B may cause short epidemic with clinically lighter forms. Influenza B is mostly found in humans, but the virus variability is less pronounced.

The influenza virus belongs to compound viruses, but its genome consists of 8 (-) fragments of single-stranded RNA (type A).

Currently there is no flu. Millions of flu tests have been conducted in the world since autumn, but only a half percent is positive. This

winter is and apparently also spring will be the quietest and calmer flu season since we know the flu and monitor it, i.e. since the end of the 19th century.

Fewer flu cases mean fewer deaths, fewer hospital beds occupied, and that is good news for every country and the world in the grip of SARS-CoV-2 virus.

However, the nullity of influenza is a concern for us. Without flu cases, scientists have no relevant data to develop vaccines and forecast the next outbreak.

Flu viruses are not extinct. Influenza viruses are still present in chickens and pigs as well as in wild animals and birds. The largest source of influenza virus for future influenza epidemics and pandemics is birds. And these are not to be wild forest or water birds. Wild birds mostly stay 6 feet apart; very rarely they are indoors (in a bird cage?) together for more than 15 minutes. On the other hand, chickens, turkeys and ducks in poultry farms, confined there by humans, are densely packed in a closed space with relatively poor ventilation. In the largest poultry farms, tens of millions of birds live together and there are virtually unlimited possibilities for the mutation and spread of the influenza virus.

Influenza viruses are hiding from people now, and no one knows when and how they will come out into the open again.

It is interesting that not only influenza viruses have disappeared, but other respiratory viruses keep silent as well – the respiratory syncytial virus, the parainfluenza virus, even other coronaviruses, usually causing fever, coughing and snuffling in autumn and winter. The only virus which thrives, spreads, replicates, creates new mutations is the new coronavirus SARS-CoV-2.

The public area is dominated by the view that radical behavioural changes occurring worldwide due to the Coronavirus pandemic play an important role in reducing the spread of the influenza virus. People wearing masks, committed to distancing and different levels of lockdowns are the factors that have helped to reduce the coronavirus, and possibly reduced the incidences of other respiratory viruses.

But it is not so simple. Last summer (June-August), the zero spread of influenza was surprising, particularly in the Southern Hemisphere, in the countries and cities of South America, Africa and Australia, where there were cases of influenza, but in extremely low numbers.

Man considers himself the summit of creation. Viruses see themselves the same way. There are more viruses on the globe, both by their number, species, weight and the impact they have on the earth's oxygen cycle, climate, soil, plants, animals and humans. The virus is a life's indicator. Wherever there is life, there can be found viruses – they are everywhere in the ocean, sea, soil, plants, animals, bacteria.

Viruses existed on the globe at least 4 billion years before humans appeared, and viruses will also be here after human extinction people may cause themselves with chemicals, weapons and oxygen depletion, making the world uninhabitable for chordata (including mammals, including humans).

It will not be possible for man to eradicate viruses from the world. We are not so sure of the opposite – whether viruses can destroy people. In any case, neither SARS-CoV-2 nor the influenza virus will destroy humanity. But viruses occasionally cause and will cause some kind of pandemic that will thin out the number of people on the globe. Probably, viruses deliberately control the number of population on the planet.

The virus is not the smallest creature on earth. Perhaps viruses see prions as tiny creatures, just as we see viruses. The virus itself lives only in an alien cell as a mandatory parasite, but outside the cell it simply exists.

The virus must be considered as a compulsory parasite: the virus is considered to be a parasite, but the virus treats the human cell as a home, a maternity hospital, a canteen, and possibly a parliament, because the viruses swamp in the cell in hordes. Similarly, people regard the earth as their own home, and very likely the earth sees humans as parasites. Just as man pollutes the planet with all possible chemicals, explodes nuclear bombs or digs gravel pits (damaging the earth's skin), namely, destroys his only planet, his own home, so from time to time the virus destroys its home – the human cell.

Theoretically, the purpose of the virus should not be killing the cell together with the man because there will be no place to live in. But sometimes the virus destroys its home, just as people cut forests depriving themselves of oxygen for breathing in the future.

Viruses treat a man as a home, but they don't seem to perceive it as a hotel or a dorm. To some extent, the dominant virus stimulates the immune system so that the latter becomes more aggressive to other

viruses and prevents them from settling in “one room.” Always in late autumn, with the outbreak of influenza epidemic, infections from other respiratory viruses significantly drop in the list of diseases.

In the long run, however, such a balance of power is not always maintained. Viruses settling into a human can ultimately learn to cooperate with one another, perhaps, become affectionate room-mates and even affecting each other cause simultaneous infection of the individual.

The next outbreak of influenza is inevitable. What is interesting – the assumption that the flu will surge in countries that will better carry out vaccination against Covid-19. If the coronavirus can be contained, other viruses will be able to return to the human airway epithelium, and first of all – the influenza virus.

In each flu season, influenza affects mainly people who have no immunological memory of the influenza virus. People, who have not been sick with influenza for a long time or not at all (e.g. small children,) are hit harder by this influenza virus – they are affected more severely, the virus spreads more fiercely. Seen from this point of view, in one or two years' time until the world has reduced coronavirus with vaccines, there will be a number of people who had influenza long ago and their immunity will have relatively lost its memory – and the flu virus will have the chance to reign.

The next flu is likely to be less familiar with our immune system leading to a more severe clinical passage. The flu of the century that changed every year was more easily predictable thanks to a well-working network of flu surveillance centres around the world. No one can predict exactly when the flu will return.

However, the coronavirus SARS-CoV-2 has provided new opportunities for the fight against influenza, mainly concerning vaccine technologies. mRNA vaccines can be made significantly faster, even within a few weeks. Parts of viruses in such vaccines can easily be replaced. I really believe that mRNA vaccines will be edible or sprayed in the nose already this year.

In a year or two, we will have universal vaccines that do not have to be inoculated every year and for every new influenza virus. We do not think that one flu vaccine will last for a lifetime, but still at least for several years. In any case, four universal influenza vaccines are in Phase 3 trial, and that is at least very promising.

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Israel's Coronavirus Vaccine Program



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Abstract

In December 2020, Israel began vaccinating its population against the coronavirus. Currently, Israel has the highest rate of vaccination in the world, thanks to a number of salient features, primarily related to the size of the country, its governmental structure, and its healthcare system. Along with the increase in the rate of people vaccinated, the health authorities in Israel are conducting studies that have so far indicated the effectiveness of the Pfizer-BioNTech vaccine, the main vaccine used in the country.

The vaccination campaign to combat this disease has rekindled the debate over the imposition of mandatory vaccination against infectious diseases among the general population and especially among medical staffs. The Israeli government is currently pursuing a policy that links the abolition of coronavirus-related restrictions and providing relief to the public with vaccination against the disease. The progress of the vaccination program, therefore, is helping to open up the economy. Immunization is being made a condition for returning to a normal life in order to encourage Israelis who have not yet been vaccinated to do so soon.

Background

The coronavirus pandemic originated with the novel coronavirus (Sars-CoV-19) outbreak in Wuhan city of China in December 2019. From there it spread rapidly around the world, with the first verified case of coronavirus in Israel detected in February 2020 [1]. With the increase in morbidity, and around the time that the World Health Organization declared the coronavirus a global pandemic in March 2020, Israel, like other countries around the world, began to take various measures to prevent the spread of the disease. Restrictions imposed on the public in the fight against the pandemic included: restricting gatherings, reducing public transportation, partially closing the economy and the educational system, and, later, imposing a mandate to wear masks covering the mouth and nose whenever outside the home [2].

Between March and October, 2020, Israel underwent two severe closures, during which restrictions were tightened and it was even forbidden to travel more than a specified distance from one's place of residence. In the summer of 2020, the Israel Ministry of Health announced that morbidity in Israel was among the highest in the world, with dozens of patients dying every day [3].

By the end of 2020, Israel had not been able to control the pandemic to an extent that would allow for the removal of restrictions and a return to normal life while coping with the coronavirus disease. Like other countries, it had to declare a third closure in December. During this period, there was a significant jump in morbidity, from 3,500 verified cases daily at the end of December to over 8,000 verified daily at the beginning of January 2021. The number of hospitalized patients quadrupled, with 20% of them on respirators [4]. Gradual relief began during February 2021, with the launch and execution of the vaccination campaign, which will be described in this article.

The coronavirus pandemic has claimed many lives worldwide, and continues to do so. In addition, there is a growing body of evidence of severe and long-term systemic damage caused by the virus. Moreover, the disease increases the existing burden on healthcare systems, and therefore impairs the quality of service and medical care in general, including for those who are not ill from the coronavirus. While closures and restrictions may reduce the extent of infection, at least in the short term, their consequences can be devastating economically, socially, medically, and psychologically.



Against this background, and under the assumption that eventually and inevitably countries around the world would need to return to and maintain some routine of life in the shadow of the coronavirus, intensive global efforts began in 2020 to find a medical solution that would change the rules of dealing with the coronavirus. The race to develop a vaccine for this disease was the primary manifestation of these efforts, and research institutes and pharmaceutical companies took on this task.

On December 11, 2020, the U.S. Food and Drug Administration (FDA) granted the first emergency permit to Pfizer and its partner BioNTech for a vaccine they had developed against the coronavirus [5]. Shortly afterwards, an emergency permit was also issued for a vaccine developed by the Moderna company [6]. A third emergency permit was issued for a Johnson & Johnson vaccine in February 2021 [7]. Additional vaccines have been developed in Russia and China. About 60 other vaccines are currently in various stages of clinical trials, according to the World Health Organization, including a vaccine being developed by an Israeli company [8].

The Vaccination Program in Israel

Authorization for the Pfizer and Moderna vaccines was a critical milestone in the race to curb the virus. The Israeli government announced in early December that it had entered into agreements with both Pfizer and Moderna to ensure an adequate supply of vaccines for Israeli residents. After the imposition of the third closure, Israel began vaccinating its population, using mainly the Pfizer vaccine (it is not clear to what extent the Moderna vaccine was used, if at all). Currently, Israel ranks first in the world in its vaccination rate, with a rate of 11 vaccine doses per 100 people. Behind Israel are Bahrain, with a rate of 3.5 doses per 100 people, and the United Kingdom, with a rate of 1.4 doses of vaccine per 100 people. All other

countries have vaccinated at a rate of less than one vaccine dose per 100 people [9].

Therefore, Israel's immunization program is considered a model for global success. According to published reports, as of the end of February 2021, Israel had already vaccinated about half of its citizens with the first vaccine dose and about 36% had received two doses of the vaccine. At the same time, it should be noted that there are significant gaps in the immunization rates among various population sectors. Immunization rates among Arab-Israelis and ultra-Orthodox Jews are lower than among the general population. Additionally, the rate of vaccination is lower among younger people as opposed to older ones [10].

The CEO of Pfizer called Israel and its advanced immunization program the "laboratory of the world". This follows an agreement under which Israel provides Pfizer with statistical-medical data on vaccinated people in Israel, in order to extensively assess the effect of the vaccine on various populations. The data are anonymous and without any identifying personal details [11].

Israel has a number of advantages that enabled it to launch its vaccination campaign relatively quickly and efficiently. First, Israel is a small country, both in terms of its geographic size and its population of about 9 million people. Further, Israel is characterized by one central government, which directly controls the entire territory of the country. This is in contrast to decentralized or federation states, which consist of multiple jurisdictions, among which significant differences may exist in various aspects of law, regulation and bureaucracy. Israel's unique features made it an easier starting point for the transport, administration and control of vaccines [12, 13, 14].

In Israel, there are four large health maintenance organizations (HMOs) that all operate under one regulator – the Ministry of Health – to insure all residents of the coun-

try. All the HMOs have organized electronic medical records, which are managed in a way that maintains the privacy and confidentiality of the insured [13]. This offers a huge advantage in terms of obtaining an appointment to be immunized and registering immunization rates, in comparison to countries lacking Israel's type of infrastructure, and with healthcare systems that are distributed among various insurers. During this period of launching and carrying out the vaccination program, supplementary staff had to be added to the infrastructure of the healthcare system in Israel, such as immediately available nurses in all four HMOs in order to provide vaccines to the general public simultaneously and immediately. The effective cooperation of the HMOs with the government authorities, along with the availability of nurses in the community, are other significant parameters in Israel's success [9,12].

One of the most important logistical aspects of the vaccination program is the storage and supply infrastructure of vaccines. This is not an issue that is usually at the heart of public healthcare interests. Israel has a main supply center and an efficient infrastructure, which was able to supply vaccines for the benefit of remote areas and enabled vaccinations to be given simultaneously in numerous areas and to diverse populations. The main supply center in Israel is located near its main airport, and millions of packages can be stored there in a freezer. When storage packets are required to be moved to more remote areas, the vaccines are repackaged into parcels of the appropriate size, depending on the target population and its size [12].

The immunization program began by securing the necessary doses of the vaccine, and continued with the optimal allocation of vaccines to the population. First, the populations in Israel who were most vulnerable to the disease were vaccinated: residents in nursing homes, people aged 60 and over, people at high risk due to medical conditions, and healthcare workers [12]. Subsequently, and in accordance with meeting

targets, the general population was invited to receive the vaccine, in decreasing age cohorts. The responsibility for administering the vaccines to each of these groups was clear and pre-defined, with Israel's four HMOs responsible for administering the vaccine to those aged 60 and over, people at high risk due to background medical conditions, and the general population. Vaccination of the elderly in nursing homes was carried out by Magen David Adom (MDA), and vaccination of healthcare teams was the responsibility of the hospitals [12].

The Israeli vaccination program is structured but flexible. While being orderly and organized according to the degree of risk of the various populations, the authorities in Israel are making an effort to vaccinate everyone as quickly as possible. Thus, although the effort was initially directed at the high-risk members of the public, citizens of other age groups who arrived at vaccination centers with the aim of trying to receive the vaccine as early as possible were admitted and vaccinated without any fines or sanctions. The HMOs allowed all insured people who wished to be vaccinated to arrive at the end of each day to receive any unused vaccine doses, so that no unused vaccine doses had to be discarded. Currently, all the HMOs allow immunization for any insured person aged 16 and over [15].

Yet another significant parameter for the success of the immunization program in Israel can be attributed to the effectiveness of the media campaigns encouraging immunization. These campaigns used a wide range of strategies, such as recruiting influencers, including Israeli Prime Minister Benjamin Netanyahu, who, in front of the cameras, was the first person vaccinated in the country, followed by other senior government officials. Credible messages, tailored to appeal to various segments of the population, including Arabs and the ultra-Orthodox, were delivered by people recruited from the field of health and medicine. The vaccines were already available when these messages

were broadcast to all sectors [12]. Although some of these parameters are not unique to Israel, their simultaneous existence, as part of a national effort during an emergency, combined to bring about the success of the immunization program in Israel.

Concurrently, with advancement in the number of people vaccinated, authorities have begun conducting studies to test vaccine effectiveness. A major study published in February 2021 confirmed the findings of Pfizer's clinical trial regarding the effectiveness of the vaccine. It found that one week after the second dose, the vaccine has an efficacy of 94% in preventing symptoms of the disease, 92% in preventing serious illness from the disease and 92% in preventing infection [16]. Data published by the Israel Ministry of Health reinforced these findings, showing that the effectiveness of the vaccine in preventing symptomatic disease, hospitalization, morbidity and mortality stands at 98%–99%. The vaccine has also been found to be effective in reducing morbidity (95.8%) [17]. Hence, the Israeli test case not only confirms the effectiveness of the vaccine in preventing the development of symptomatic disease, but it also indicates efficacy in reducing infection.

Moreover, the vaccine appears to change the age composition of patients hospitalized with coronavirus. Since the start of the vaccination campaign, there has been a decrease in the proportion of adults aged 60 and over who are hospitalized, as this population group began to be vaccinated first. At the same time, there was an increase in the rate of hospitalization of younger people, who began to be vaccinated at a later stage, and among whom the rate of vaccination is lower [18].

The Question of Mandatory Vaccination against Coronavirus

The coronavirus vaccine program has rekindled a debate that has taken place in recent years in Israel over the imposition of

mandatory immunizations. According to the World Health Organization, in order for a vaccine to be effective and produce herd immunity, 60%–70% of a population must be vaccinated [19]. Thus, the question arises as to whether it is possible to enact a legal obligation for people to be vaccinated and impose sanctions against those who are not vaccinated. Making vaccination mandatory raises a legal difficulty, due to its broad violation of the basic rights of citizens who do not wish to be vaccinated, such as “human dignity and liberty” and “the right to autonomy.”

Currently, in the State of Israel, vaccinations in general, and vaccines against coronavirus in particular, are not legally mandated. However, in cases where there is a risk of a significant epidemic, the Public Health Ordinance of 1940 grants the Ministry of Health the authority to impose mandatory vaccination, including financial fines and even imprisonment for those who refuse [20].

In addition, current legislation does not prohibit employers from imposing restrictions, including unpaid leave and dismissal, on employees who refuse to be vaccinated. Nor is there any legal impediment to prohibiting the entry of an unvaccinated person into any place. For example, for several years, initiatives of private kindergartens to prohibit the entry of unvaccinated children has been operating in some local authorities throughout Israel [21].

Rulings by the Supreme Court of Israel during the coronavirus crisis have recognized the need to disproportionately infringe on individual rights for the protection of public health and the fight against the pandemic. The Supreme Court also ruled, before the outbreak of this pandemic, that the violation of rights that result from refusal to be vaccinated is legal and legitimate [22]. While the legislature has not yet explicitly addressed the special state of affairs that exists today, it is recommended



that it do so in order to establish a clear, definitive arrangement. However, even in the current situation, there is no legislation that explicitly prohibits harm to the employment terms of workers who refuse to be vaccinated. Thus, in the absence of a legal norm that prohibits this – it is permissible. Employers may encourage employees to be vaccinated through various incentives and hold informational talks on the subject. It is, of course, advisable to try and find solutions, such as allowing employees to work via remote technologies, or requiring presentation of an up-to-date negative coronavirus test at the entrance to the workplace.

The situation is even more complex regarding mandatory vaccination for healthcare workers, due to the risk of infection of patients and co-workers. Circulars published by the Ministry of Health stipulate that healthcare workers, who may be infected with pathogens by their patients and who may infect their patients, must be vaccinated against any serious diseases for which there is a safe and effective vaccine, with a special obligation to receive the vaccination against seasonal flu [23,24]. However, the data show that the immunization rate among physicians and nursing staff is quite low (between 36%–45%) [25]. The position of the Israel Medical Association (IMA) is that the public in general, and the medical public, in particular, should be encouraged to be vaccinated against infectious diseases. At the same time, the IMA rejects any attempt to force or coerce physicians to get vaccinated, including discrimination or putting pressure on physicians in the workplace [26].

To date, 10%–15% of the medical staff in the HMOs and about 20% of the staff in hospitals have still not been vaccinated against coronavirus, with some even refusing to do so [27]. In light of these data, the management of Hadassah Medical Center in Jerusalem, one of the largest hospitals in Israel, recently decided that staff members who have not been vaccinated, and who

have not received medical dispensation to decline the vaccine, will not be permitted to treat patients at the hospital [27].

A recent directive issued by the Director General of the Ministry of Health to encourage healthcare workers to be vaccinated against the coronavirus imposes restrictions on the work that can be performed by non-vaccinated staff, and prohibits the admission to medical institutions of new employees who refuse to be vaccinated [28]. This directive demonstrates the tension that exists between individual rights and the public and professional responsibilities that apply to health care workers, and the dilemma that coronavirus vaccines pose to employers, managers, regulators and legislators.

The Green Pass and the Green Passport

The Israeli government is currently pursuing a policy linking the abolition of restrictions to the public and businesses with immunization against the coronavirus. This is being done by issuing an entry permit or “green pass” to buildings and certain venues, granted to those who have been vaccinated or have recovered from the coronavirus. The green pass is valid only within Israel’s borders, in accordance with the policy of the Ministry of Health. Those with a green pass will have access to services defined as “green-pass required.” In order to enter a place designated as green-pass required, the green pass must be presented along with an identity card. As an alternative to the green pass, a vaccination certificate can be presented, which is issued to anyone who has received both doses of the vaccine. People who have recovered from coronavirus may present a recovery certificate. However, the Ministry of Health recommends using the green pass as much as possible [29].

The only entity authorized to issue a green pass is the Ministry of Health (not the HMOs, workplaces, or businesses). Issu-

ance of a green pass is possible via a website or an application dedicated to this purpose. The list of businesses to which entry is conditional on presentation of a green pass will be updated from time to time, in accordance with government decisions. Currently, the list of these businesses includes gyms, swimming pools, theaters, cinemas, cultural halls, sports fields, conferences, event parks, and the like. In addition, the government allows the activities of businesses without the need for a green pass within the framework of the permit known as the “purple pass.” Under certain restrictions, such as maintaining distance between people and setting maximum occupancy in the building, it will be possible to enter places such as street shops, food markets, malls, houses of worship, and more [30].

The Ministry of Health is currently examining the issuance of a “green passport” for those who have received two doses of the vaccine. This is, in essence, an international travel permit, allowing air travel to countries that allow entry for tourists who have received the two vaccine doses [31].

Summary

Israel’s coronavirus vaccination program is currently underway. The rate of vaccination in Israel is the highest in the world today. Israel enjoys a number of significant advantages that enable it to vaccinate its population quickly and efficiently, including its basic national characteristics (size, governmental structure, etc.) and characteristics of its healthcare system. As a result, Israel is considered a global “test case” for assessing the success of the vaccination program, not only in terms of medical aspects, i.e., the vaccine’s safety and effectiveness in the general population, but also in terms of logistical and organizational aspects, such as storage, transportation, distribution of the vaccine and public access to vaccination, via cooperation between all parties in the system, including the government, HMOs,

medical institutions, and caregivers in the public sector.

Equally important, the success of the program depends on the willingness of the public, including the medical community and all medical staff, to get vaccinated. This is dependent, among other things, on raising awareness of the importance of vaccines, conveying messages in a credible and convincing manner, and providing incentives that encourage immunization.

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Socio-Medical Affairs Committee



Nigel Duncan

An extraordinary virtual meeting of the Socio-Medical Affairs Committee was held on January 12 to discuss items left over from October's online Assembly. More than a hundred participants logged into the resumed meeting to be welcomed by Dr. Frank Ulrich Montgomery, Chair of the WMA.

Dr. Osahon Enabulele (Nigeria) took the chair and called the committee to order.

Taiwan

The first item on the agenda was a proposal by the Taiwan Medical Association to revise the WMA Council Resolution on observer status for Taiwan to the World Health Organization.

The Taiwanese delegate submitted the proposal, arguing that the Covid-19 pandemic had highlighted the urgency and importance of inclusiveness and leaving no one behind in the global health network. By continuing to refuse to grant Taiwan observer status to the WHA and full access to its meetings,

mechanisms and activities, the WHO had failed to fulfil the principles of universality and equality established in its constitution, as well as the ethical standards of the organization. Taiwan, located at a key position in the Asia-Pacific region, had long enjoyed close relationship with countries and areas of the region, with more than 20 million regional and international travellers a year.

From 2009 to 2016, Taiwan had been invited to participate in the World Health Assembly (WHA) as an observer, with very limited access to WHO technical briefings, mechanisms and activities. Since 2017, the WHO had not granted observer status to Taiwan. Although Taiwan had been officially included in the implementation framework of the International Health Regulations since 2009, its contact point information was not included on the IHR Portal established by WHO. This had impeded the timely exchange of information and communication to the detriment of Taiwan. As a result, delayed and incomplete medical information could impact adversely on the Taiwanese population, causing a gap in Taiwan's domestic disease control network, with unavoidable implications for global health.

The Taiwan Medical Association argued that allowing the participation of Taiwan in the WMA and fostering its inclusion in all WHO's health programmes and in the International Health Regulations would benefit the people of Taiwan, but also the WHO and its member states.

Its motion urged the WMA and its constituent members to call on the WHO to grant Taiwan observer status to the World Health Assembly and to ensure Taiwan's participation in all its health programmes based on a substantive, timely and professional basis, and to include Taiwan as a full participating

party to the International Health Regulations, allowing its critical contribution to the global health protection network.

But the Chinese Medical Association objected to the motion, and proposed that it be withdrawn. It argued that there was no barrier to Taiwan's inclusion in the WHO's technical activities.

However, when no seconder came forward, the Chinese proposal fell.

The main motion from the Taiwan Medical Association was then agreed by 13 votes to one.

Solar Radiation and Photoprotection

A proposed Statement on Solar Radiation and Photoprotection was submitted by the Romanian College of Physicians.

The committee was told that the Statement had been circulated among constituent members for comment and these comments had been included in a compromised version of the Statement.

The document declared that solar UV radiation was an extremely important, yet neglected causative factor for skin cancers, both melanoma and non-melanoma, for ocular pathologies, such as cataracts and age-related macular degeneration, and harmful effects on the immune system. Recurrent and severe sunburns were a risk factor for non-melanoma skin cancer. The incidence of melanoma and non-melanoma skin cancer was increasing.

Evidence from the WHO indicated that four out of five cases of skin cancer could be prevented and simple preventive measures, such as limiting UV exposure in the mid-day sun, wearing UV protective clothing and hats or using mineral-based sunscreens, were recommended.



The proposed Statement made a number of recommendations for national governments, for national medical associations and for physicians. These included support for skin cancer screening campaigns, improved reporting, better education of the public and the promotion of policies to fight climate change and air pollution.

During the debate that followed, a number of friendly amendments to the Statement were agreed. The Chinese Medical Association proposed a new paragraph stating that broad-spectrum photoprotection should be advocated and the intake of photosensitive foods and drugs should be reduced.

The Spanish Medical Association wanted the Statement to make it clear that the sun, despite its harmful consequences, was also a great source of health benefits. It proposed several amendments relating to the characteristics which sunscreens should meet, the environmental impact of sunscreen and the need for more health education.

The Statement, as amended, was agreed.

Ensuring the Availability, Quality and Safety of Medicines Worldwide.

A proposed Statement on Ensuring the Availability, Quality and Safety of Medicines Worldwide was submitted by the French Medical Association (Conseil National de l'Ordre des Médecins Français).

The CGCOM delegate explained that over the past decade, supply pressures had resulted in shortages of certain medical products, including vaccines. In many situations, these shortages had resulted from the prioritisation of economic goals over public health. Such shortages were detrimental to patient welfare, to the preservation of public health and to the organisation of health systems.

The proposed Statement set out a series of recommendations on the availability of medicines and the continuity of supply of quality medicines while ensuring their safety, with further action proposed on illegal internet sales of drugs.

Several NMAs proposed various amendments to the document. The Chinese Medical Association submitted additional wording for action on falsified and substandard drugs, while the Spanish Medical Association proposed a number of amendments to make it clear that the rational use of drugs required ensuring research, regulation, production, distribution, prescription, financing, dispensing and proper administration of drugs with consistent and rational scientific, professional, economic and social criteria. It also proposed the establishment of a national body charged with gathering and sharing information about demand for and supply of medicines within their jurisdiction, and urged the pharmaceutical industry to guarantee the continuity of the supply of medicines.

Although these changes were accepted by the French as friendly amendments, the debate then shifted direction after the American Medical Association proposed splitting the Statement into two documents. It suggested one document should deal with the availability of drugs and the second should deal with their quality and safety.

After further discussion, the proposal to divide the Statement, as amended, was supported by seven votes to six. The proposed Statement will now be reconsidered and brought back to the committee for further discussion.

Medical Technology

The Israeli Medical Association proposed the setting up of a workgroup on Medical Technology.

The Association argued that technology now played a crucial role in every industry, as well as in people's personal lives. Technological developments in the healthcare arena had helped to save lives, by allowing physicians to better diagnose and treat their patients, and generally improve patient care. Advances in biotechnology, pharmaceuticals, information technology, and the development of medical devices and equipment had all made significant contributions to improving the health of people all around the world. These advances were now helping in the current Covid-19 pandemic.

Medical technology covered a vast range of areas within healthcare, from introducing doctors to new equipment to connecting patients and doctors thousands of miles away through telecommunications. With an ever-increasing number of hospitals and medical practices using medical technology as part of their daily practice and with this field growing at an astounding speed, it was important for the medical profession to be well-informed and it was also essential that this field was monitored and regulated appropriately.

The Israeli proposal was for a workgroup to focus on new technologies, physicians and industry. It could recommend those areas where the WMA could voice its opinion, where the policy should be and decide overall how the WMA should work in the area of medical technology. Big players such as Amazon and Google were now interested in health. The WMA could act as a network facilitator, with the workgroup reviewing medical ethics in this developing technological arena. The WMA could host an educational conference on new medical technologies and innovations and examine areas such as privacy and could reach out to new stakeholders and engage in joint ventures.

Currently the WMA had a number of statements which addressed some of the areas included in the field of medical technology. This number would vastly increase

in the coming years and each of the current statements would need regular updating in order to keep them relevant to the rate of advancements in this field.

The proposal from the Israelis was given a warm reception by members of the committee, many of whom expressed an interest in joining the work group. On one issue, however, there was opposition. The suggestion that the WMA could receive sponsorship from commercial organisations was objected to by the Norwegian Medical Association. The committee agreed to delete this idea from the proposal.

The Israeli proposal, as amended, was agreed by the committee and it will now be for the Chair of Council to decide the membership of the workgroup.

Pandemic Preparedness

The committee received a report on WMA policies on epidemics, pandemics and emergencies.

Members were reminded that as part of the annual policy review process, it was being recommended that there should be a major revision of the Resolutions on Unproven Therapy and the Ebola Virus and on Ebola Viral Disease.

The recommendation put to the committee was to archive both Ebola specific documents and to have a major revision of the

Statement on Medical Ethics in the Event of Disasters and the Declaration on Disaster Preparedness and Medical Response.

The Chinese Medical Association emphasized that the issue of emerging technologies should be considered when revising the Statement on Medical Ethics in the Event of Disasters. This should cover issues such as big data, AI, and contact tracing.

The Spanish Medical Association wanted to see triage, priority criteria for hospitalization and the role of primary care included in the revision.

The recommendation was agreed by the committee, along with the points raised by the Chinese and Spanish Medical Associations.

Plain Packaging of Cigarettes

The committee considered minor revisions to the Resolution on Plain Packaging of Cigarettes. These included a new sentence reaffirming the WMA's Resolution on Implementation of the WHO Framework Convention on Tobacco Control and emphasizing the importance of this global mechanism to protect people from exposure and addiction to tobacco. A further revision suggested by the Danish Medical Association called for national governments to support the introduction of plain packaging to break the brand recognition/smoking cycle and to deplore strategies from the tobacco

industry to oppose the adoption and implementation of such policy.

It was argued that the producers of tobacco products were very creative in their efforts to brand their products. This included adding brand names and logos to the product itself. It was therefore relevant to consider breaking brand recognition in other ways than just through plain packaging. It was also relevant to mention other tobacco products, not just cigarettes.

The committee agreed the revised Resolution.

Classification of Policies

The final item on the agenda related to the classification of those policies that were five years old. Constituent members had been consulted on the issue and had put forward their recommendations.

The Spanish Medical Association argued strongly that the Resolution on Drug Prescription should not be rescinded because of the importance of a medical professional prescribing.

This was agreed by the committee and the recommendations as a whole were accepted.

The meeting was then brought to a close.

Nigel Duncan



WMA Wins Prestigious Award

18th Vienna Congress

A prestigious award honouring physicians around the world for their work in combating Covid-19 was presented to the World Medical Association in Vienna on January 31. At the 18th Vienna Congress 2021, Dr. Otmar Kloiber, Secretary General of the WMA, received in person the Golden Arrow Award, given annually in recognition of the achievements of individuals for their life's work and of institutions for their social relevance. Previous winners include the former Presidents of Israel and South Africa and a number of Nobel Laureates.

The award was the highlight of a two-day conference held in the splendid baroque Haus der Industrie under the patronage of the Federal Chancellor of Austria and the Austrian Medical Chamber. The event, entitled "Back to the Future", was intended to examine the world after the Covid-19 pandemic. The annual Congress brings together decision-makers from around the world to discuss new ideas. This year's event focused on the subject of Covid-19, vaccination and therapies and was attended by a number of Nobel Laureates and physician leaders. National and international experts discussed what could be learned from Covid-19 and how health systems could be made fit for future pandemics. Because of travel restrictions, the Congress took place in a hybrid form, with some speakers attending in person, others online and the speeches and panel discussions being streamed via the internet.

The Golden Arrow Award

Announcing that the winner of this year's Golden Arrow award was the World Medical Association, David Ungar-Klein,

initiator of the Vienna Congress, said that countless doctors had fallen ill or had lost their lives treating patients with Covid-19. Among the first was the Chinese ophthalmologist, who recognised the danger of Covid-19 at an early stage and had warned his medical colleagues about it. He was reprimanded by the Chinese authorities for spreading rumours and later died of the virus aged 33. Mr Ungar-Klein said the medical profession would play the key role in protecting billions of people from the virus.

President Václav Klaus, former President of the Czech Republic, and chair of the Congress award Advisory Board, said the award belonged to all doctors, not just the institution. He said everyone expressed their gratitude to physicians around the world. The past 12 months had been a very special era of human history. Almost no one living now had experienced anything similar. They had all, slightly irresponsibly, assumed that nothing like this could happen. They were wrong. They should have expected this pandemic. The question should have been when it would come, not whether it would come. They were just too self-assured and had not prepared themselves for such a situation. So today they were honouring people who had been saving their lives.

He reminded people that the medical profession and freedom of science, but also freedom of expression, were inextricably linked.

He concluded: 'I would like to thank doctors all over the world for their services and hope that they all will hear about this thank you from the heart of Europe. Congratulations to the World Medical Association, which will receive the Golden Arrow 2021 on behalf of all doctors of the world'.

Professor Dan Shechtman, Nobel Laureate in Chemistry, spoke about the five partners in this pandemic – the decision makers or politicians; the public, who could be obedient, or disobedient, and who suffered; thirdly, the health system and those working in it, the heroes who had worked round the clock for a whole year saving lives and treating the ill; fourthly, the scientific community, who gave the background to the development of future vaccinations and current vaccinations; and finally the vaccine producers, the people who took all the knowledge, put it together and produced amazing vaccines.

He said all these five parties would have to continue to fight the pandemic, because it was not going away. It was going to stay and billions of vaccinations would have to be produced.

He said the global medical profession was not an anonymous mass, they were highly trained specialists who they encountered every day.

'They are part of our life infrastructure. There are there when we need them. And we need them often. The medical profession is at the forefront of the war on the virus. For us, for our health and our freedom.'

Dr. Leonid Eidelman, former President of the World Medical Association and a member of the Congress Advisory Board, said physicians had been ready to deal with the pandemic and had been acting according to the Declaration of Geneva. He said he was honoured and privileged to express his deep gratitude to the organisers of the award.

Dr. Thomas Szekeres, President of the Austrian Medical Association, spoke of the super human achievements of physicians in treating the pandemic. They had often worked with insufficient protection, having to make stressful decisions about continu-

ing or ending therapy and they were still only at the beginning of the way back to normality.

Dr. Otmar Kloiber, Secretary General of the WMA, then formally received the award ([see p. 13](#)).

Dr. David Barbe, President of the WMA, speaking online from the USA ([see p. 14](#)).

Testing, Vaccination and Therapy

The Congress then moved to discuss Testing, Vaccination and Therapy.

Dr. Leonid Eidelman talked about testing in Israel and said they had to learn from countries like Taiwan, New Zealand, South Korea, Australia and Japan. From the beginning, they decided to perform tests and isolate those who were positive. They now had data that performing screening tests of the population, along with quarantine, may be efficient. He spoke about the importance of point of care testing devices for everyone and about the different vaccines being used by various countries. For him, the heroes of 2020 were health care providers, physicians and medical science.

Dr. Kloiber said the pandemic had become one of the challenging factors about what the medical profession and society did. There had been more than 100 million cases of Covid-19 and 26 million active cases. More than two million people had died. But they had learned how to deal with pandemic patients much better than they did to begin with. The success story was approving vaccines in such a short time. But the pandemic had also been a story of missed opportunities. There had been complacency in a large part of the western world. Plans that had been made for a pandemic had proved to be little more than pieces of paper. But some countries in south east Asia were prepared and had done much better. Taiwan,

South Korea, Singapore, and Japan had all had better outcomes. There had been warnings that such a pandemic would happen. The World Health Organisation had for the last 20 years warned that there would be a disease X that would hit the world. The WMA had a number of strategic papers it had produced that warned this would happen. But these did not lead to any meaningful preparation. The pandemic had also been a lost opportunity for solidarity. Yet it could have been a test for international solidarity. Instead, within days, it turned out to be a showcase for the worst examples of nationalism, including the European Union, about which he was very sad.

Dr. Kloiber said people should think about the pandemic like a fire that was spreading. Would anyone sit in their house and say 'these are my buckets of water and my fire extinguisher and you can't have them, because I may need them'. No, they would run out and help to put out the fire with their own water and fire extinguisher. He said there was a global programme to finance vaccination in poor countries. But currently it was the rich countries that were fighting for the first doses of the vaccines, and nobody was thinking of the poorer countries. He said the pandemic started with lies and camouflage and an unwillingness to invest in proper scientific surveillance. There had been a chance to study and measure how the virus spread by testing. But it turned out to be a missed opportunity to find a science based vaccination strategy. Yet they had the data on hand that could be used to determine which strategy would be better to save most lives.

He referred to the early collapsing supply chains for personal protective equipment and said that the global financing systems had not supported the health care systems. Finally, he said they should be spending more effort on developing therapies. This was not the first pandemic and it would not be the last. Other pandemics would not be avoidable, but they should be able to learn

from this pandemic and they should be able to do better next time.

Dr. David Barbe spoke about the large number of doses of vaccines in the pipeline in the world, but said that at the moment they would only cover half of the world's population. Yet the number of Covid cases was increasing, with more and more people at risk. At the moment there was an unequal supply of vaccines, when what was needed was an equitable distribution. But in many countries there were infrastructure issues that could inhibit the acquisition and distribution of vaccines. Turning to the problem of prioritizing vaccinations, he said the easy part was deciding the top priority tiers – the elderly, the obese and those with chronic diseases. However, there were some risk groups that were often overlooked. For instance, there were the communities where the incidence of the disease and death rates were higher. Potentially, the vaccines could be distributed to them. In addition, ethnic minority communities were more likely to experience severe illness or death than Caucasians. Did it not make sense to prioritise these groups?

Dr. Barbe also talked about the issue of what was called vaccine hesitancy. This was a multi factorial problem. There were the pre-existing vaccine hesitancy or anti-vaxxers, who seemed to be on the rise in many countries around the world. There was scepticism and fear of vaccine, most of which was sadly misinformed. That was already there. When you added on top of that the fact that the vaccines for this disease had been developed in an extremely short period of time, there were many questions raised, both about the safety and efficacy of these vaccines. Although they now had experience of multiple tens of millions of doses given worldwide and the severe reactions were extremely low that science did not seem to be persuasive in the current environment. He said there was more scepticism of science now around the world than they had ever seen before. Much of this, particularly in the USA, relat-



ed to the political high-jacking of science. It was not the science behind a decision, it was where the recommendation came from, from which political party. In the worst case, there were the conspiracy theories. This played out in the USA with very low uptakes of vaccination. Among health care workers there was an uptake of only 40-50 per cent, and even among physicians it was barely 70 per cent. That was an extremely sad comment. The solution to this was to continue to promote the science.

During the panel discussion that followed, Dr. Kloiber said he was astonished at the speed with which new vaccines had been developed and tested. However, he remained concerned about the lack of investment going into health care. He said it was better to invest in health care than it was to invest in many companies. Investing in health care was something that paid off.

Three Nobel Laureates

The Congress had opened the health session earlier in the day with speeches and a panel discussion between three Nobel Laureates – Sir Timothy Hunt, Nobel Laureate in Physiology or Medicine, Professor Dan Shechtman, Nobel Laureate in Chemis-

try and Kurt Wüthrich, Nobel Laureate in Chemistry.

Sir Timothy Hunt said it looked as if the Covid-19 vaccines were working. ‘What an amazing triumph of science this is’, he said. But there was still a lot of room to better understand how the virus spread between people. His plea was for there to be more experiments and less propaganda in these matters.

Prof. Shechtman said it was the scientists who were now solving the problem of the pandemic. Science had never been as appreciated as it was now, and rightly so. The development of the vaccines had been done at a very impressive pace with companies producing billions of vaccines in a record time.

He talked about the way in which some countries had done very well in controlling the virus, and they had done it in different ways under different types of government. Wearing masks in the far east was common practice. It meant social responsibility. In the west, people did not behave in the same way. Yet only countries where everybody had social responsibility could survive this pandemic with minimum damage.

He concluded by saying that the pandemic was not going anywhere and would stay with them for years. They would be vaccinated every year like the flu. So, health systems would have to reorganise to provide such vaccinations every year to everybody.

Kurt Wüthrich said he had travelled between several countries as the pandemic first developed and he contrasted what he experienced. In China, people quickly began wearing masks. In other countries, such as Saudi Arabia, nobody was worrying about Covid. In Switzerland he was told that wearing a mask was a health hazard, although the Swiss Government would have liked people to wear masks. He said that really very little was known about the virus, how it was spread by aerosols and lay on surfaces. And yet nobody was looking ahead and talking about the impact of this on the architecture of public buildings and theatres. Because, he warned, the epidemic would flare up again.

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Otmar Kloiber Acceptance Speech

‘I would like to thank the Vienna Congress, the award committee, the organizers, that they have honored the doctors of this world for their efforts in fighting the pandemic.

A difficult year is behind us, and the Covid-19 pandemic still has a tight grip on this world. Many of my colleagues have been tireless in treating Covid-19 patients, and it is them and their colleagues of other health professions and caregivers who deserve the honor of being recognized.

The workload that has been mastered by them has been unbelievable. The tragedies that they had to witness and often endure seemed to be endless and often nerve-racking. Many of them have lost their lives, and many others suffered long-lasting health damage. And yet, we have been learning together; we understood to contain and cope with the disease.

Yes, we are far away from mastering or preventing it, but there is hope, and the new

vaccines are our best chance to see light at the end of the tunnel. There are a few things the pandemic has taught us:

Respect for nature. We are far away from controlling our environment, and we have to humbly accept that nature is ruling us. There is no mercy for our mistakes, neither in the pandemic nor in the climate change.

Our science relies on cooperation. Together we were able to work on strategies to mitigate the pandemic’s consequences and develop therapies and vaccines. Alone, no nation would be able to cope; no scientist would make the break-through, no doctor



Otmar Kloiber

could provide the necessary care. Cooperation, international cooperation is the key. And as we progress together, we have to share together, to leave no one behind, no frail person, no frail state. Now is not the time for egotisms and nationalism.

Stronger health care systems are better than weaker ones. Universal health coverage is even more critical in times of pandemics. High-quality health care accessible for all requires proper investment, meaningful financing, and resilient reserve capacities. Over the past years, we may have made some savings in streamlining the health care systems for what is

called strict cost-efficiency. We have even squeezed some health care systems to the minimum with austerity measures. These have been short-sighted economic strategies, which now led to a deadly payback with so many lives lost and tremendous damage to our economies.

Finally, a word to my fellow citizens: You can help your doctors, nurses, and other caregivers: Reduce contacts, maintain distance, wear masks, follow hygiene rules, and most important: get vaccinated. This is our best and most likely our only chance to get back what is worth calling a “normal life”.

David Barbe Acceptance Speech



David Barbe

On behalf of the WMA and millions of physicians around the world, we are very honored to receive the Golden Arrow Award. It is without precedent that an organization such as the WMA is a recipient of this award rather than an individual – but, perhaps that is fitting as we can certainly agree that we are suffering through a pandemic that is also without precedent in the last 100 years.

This pandemic has impacted all of us very deeply – but also very differently. The risk of contracting COVID-19 has struck fear into the hearts of many around the world. Physicians have been vocal advocates for patients and their colleagues in calling for adequate personal protective equipment, improved access to hospital care, equipment and life-saving treatments, rapid deployment of vaccines, and responsible social policies to reduce the burden of disease, save lives, and bring an end to this devastating pandemic.

However, physicians and other healthcare workers have been in an especially challenging situation. Their very calling and service have exposed them to the risk of COVID in ways that few others have experienced.

Physicians have demonstrated their professionalism by willingly placing themselves in grave personal danger by caring for patients with COVID – often under less-than-ideal conditions. As a result of this, untold tens of thousands have become seriously ill and thousands have died as a direct result of their commitment to their patients and society.

Receiving this award on behalf of the WMA fills me with deep emotion for a reason you may not expect. You will not see this from the outside, but there are many physicians around the world who do not feel appreciated or supported for the risk they have taken or the sacrifices they have made in caring for patients with COVID. Many are demoralized. Many feel their governments, and, in some cases, their hospitals have let them down. Some feel taken for granted or even taken advantage of.

This Golden Arrow award proclaims to the physicians of the world – “You are appreciated. We recognize all you have done and thank you for the sacrifices you have made.” Physicians desperately needed to hear that. It is very gratifying and encouraging! We will make sure they know your appreciation.

My sincere thanks to Professor Leonid Eidelman for nominating the WMA and to Mr. Ungar-Klein, Vaclav Klaus and the entire Advisory Board and jury committee for recognizing the WMA and physicians around the world with this Award. Thank you!

WMA Declaration of Taipei on Ethical Considerations regarding Health Databases and Biobanks (DoT). Possible impact



Jon Snaedal

The Icelandic Saga

In the spring of 1998, the Health Ministry of Iceland introduced a new Bill on the commercial use of health data and planned for a speedy and uneventful process in the parliament. It usually goes unnoticed to the outside world what happens at the Icelandic Parliament but this time something new was emerging that obviously could have impact far outside the country. The Icelandic Medical Association (IcMA) was stunned by the ideas put forward in the Bill and reacted immediately and publicly. The idea, presented in the Bill, was to collect all health data, both prospective and retrospective, from the whole population and from all health institutions. No consent would be sought and on top of that, a private company would have the sole responsibility and rights of the use of data according to a contract but granting Health authorities rights of use. The Bill immediately generated intense public debate among Iceland's scientific and clinical communities, but

was supported by the public at large according to polls. The fierce debate caused a delay in the process but eventually the Bill was passed as Law from Althingi (The Icelandic Parliament) in December 1998 following several amendments such as an introduction of "assumed consent" giving individuals the possibility to actively opt out. In the following year, the Health Department worked on a detailed regulation and subsequently, these were formalized in January 2000 along with a contract with De Code Genetics on their sole responsibility to establish and run the database. During this time and in the following years, discussions took place internationally by articles and debate letters. The leaders of De Code Genetics, Jeffrey R. Gulcher and Kari Stefansson published a debate article in *New England Journal of Medicine* in 2000 [1] in which they highlighted the scientific value of a health database on the population of a whole country. This was followed by a balanced article on the use of health data in the same issue [2] and a number of articles on the use of big health data followed in the coming years [3-8]. Amongst these was a thorough study into the case published by Welcome Trust with the aim to cast a light to the fast developing world of bio-information [9]. The main focus of many of these articles was consent, discussing various models such as the classical "informed consent" as well as "broad consent", "open consent" and "opt out procedures", many of them using the Icelandic database as a deterring example.

The Icelandic database was never materialized as the technical issues surrounding security proved to be very complicated and the cost became an obstacle. The law on the health data had to be revisited 10 years later but in 2018, the law was abolished.

The WMA policy of 2002

In the fall of 1998, the IcMA brought the case to the WMA, which immediately initiated work on a policy within the Standing Committee of Social Medical Affairs (SMAC). A workgroup was established, chaired by Jim Appleyard from BMA and the intention was to develop a policy on the use of health data in general. The matter was debated at the Council meeting in Santiago in Chile in 1999 and the Ministry of Health in Iceland took the unusual step to send two representatives to the meeting to defend the case. The workgroup continued its work with input from National Member Associations (NMA's) but no external discussion took place. Dr. E. Doppelfelt acted as a special adviser to the workgroup and at the General Assembly in Washington DC in 2002, the "WMA Declaration on Ethical Considerations regarding Health Databases" was adopted, now being replaced by the current version with a different naming; "WMA Declaration of Taipei on Ethical Considerations regarding Health Databases and Biobanks" [10]. The main purpose of the new policy was to give guidance to physicians worldwide in how to ethically work with health data and what ethical requirements should be required by those responsible for running health databases. Two ethical principles were introduced in the first paragraphs; privacy and confidentiality, followed by reference to major WMA Declarations. Rigorous rules were given on consent: *Patient's consent is needed if the inclusion of their information in a database involves disclosure to a third party or would permit access by people other than those involved in the patient's care (par 17).* One exception was given to this rule: *"...information may be withheld from a patient if it is*

likely that disclosure cause serious harm to the patient or another person (par 11). However, paragraph 18 gave leeway and proved to be problematic, not least due to its circular argumentation rendering it rather meaningless. The paragraph was added at the last moment and is a good example of the conflict that can exist between ethical principles and law and how *not* to deal with such conflict in an ethical policy:

“Under certain conditions, personal health information may be included on a database without consent, for example where this conforms with applicable national law that conforms to the requirement of this statement or where ethical approval has been given by a specially appointed ethical review committee (Par. 18).”

The standing committee on health at the Icelandic parliament viewed this as a support of WMA to the main principles of the new law on Health databases and that the case of the IcMA had been refuted.

The WMA policy of 2016 (DoT)

Based on the principles of revisiting WMA policies at ten years, it was decided in 2012 to enter a major revision of the 2002 policy. The leaders of WMA regarded this to be a very important matter and therefore it was decided to have a broad process with a bigger workgroup than usually. After the first year of working on the policy, it was decided to enter an open consultation process, which is an exception in the work on WMA policies. Furthermore, it was decided to include ethical considerations regarding Biobanks as well. This increased the work substantially, not least as the interest turned out to be very great and almost 100 comments were received, some extensive. The workgroup had several meetings, both in conjunction with the statutory WMA meetings and in between with invited external experts as well as WMA’s own ethical advisers, prof. Urban Wiesing from the University of Tübingen and Dominique Sprumont from

Neuchatel. Following more than three years of work, the policy was adopted at the 67th General Assembly in Taipei and thus the name of the Declaration.

Ethical principles are at the center of the policy as laid down in 12 out of 24 paragraphs. In par. 9 the main ethical principles are mentioned: *dignity, autonomy, privacy and confidentiality*. Par. 12, is detailed in its requirements for validity of consent by giving ten different items to inform individuals of the database.

The DoT refers directly to the *WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects* (DoH) [11] already in its first paragraph. In paragraph 3, this reference is clarified further:

“In concordance with the Declaration of Helsinki, it provides additional ethical principles for their use in Health Databases and Biobanks”. The WMA has thus divided ethical considerations in research into broadly two categories, research involving humans directly by one policy (DoH) and research involving humans indirectly in another (DoT) but those policies share many fundamental ethical rules such as autonomy, non-maleficence, justice and equality.

The origin of DoT can be traced to this paragraph 32 in DoH that reads:

“For medical research using identifiable human material or data, such as research on material or data contained in biobanks or similar repositories, physicians must seek informed consent for its collection, storage and/or reuse. There may be exceptional situations where consent would be impossible or impracticable to obtain for such research. In such situations the research may be done only after consideration and approval of a research ethics committee.”

The last revision of DoH was adopted in 2013 and thus it includes no reference to DoT as this was adopted 3 years later. This should be kept in mind at the next revision of DoH.

The importance of DoT

Many policies of WMA are seemingly not having much effect after following their adoption. This is not correct. Even though many policies seem to live in silence, they form the basis WMA work; its secretariat and elected officers. In their collaboration with international partners, the policies are referred to and those talking on behalf of WMA base their views on its policies. Only a handful of the policies are having a “life of their own” such as the DoH that is referred to in the work of medical scientists and ethical committees around the world and is occasionally found in national laws and regulations. Other major ethical policies are having effect mainly inside the medical profession such as the Declaration of Geneva that is intended to be the physicians pledge and the International Code of Medical Ethics that has been used as a template for national medical ethical codes or is referred to.

What about DoT?

In the years following the adoption of DoT; it gained some attention with several publications in peer reviewed articles and discussions on home pages [12–18]. Most of the authors discussed the new policy in general terms but others focused on the relevance for legislators [15] and in a paper published in 2019, its authors focused on incidental findings and the importance of how these are handled with reference to DoT [19]. In 2020, a review article on DoT and DoH was published on behalf of Working Group on Ethics of the International Federation of Associations of Pharmaceutical Physicians and Pharmaceutical Medicine [20]. The authors discuss topics that should be better clarified in these two policies, not least to link them more definitely together by referring to each other. The authors point out for example that in DoH, there is no mention of how to deal with incidental findings in research but this has become a real issue in many projects,

not least in genetics. This is only mentioned superficially in DoT.

The authors also mention other areas that should be considered, not least for the next revision of DoH such as data sharing plans [20].

Conclusion

The Declaration of Helsinki (DoH) is a living document, used in everyday life in research with human subjects around the globe but its younger sister policy, Declaration of Taipei (DoT) needs more attention. It was positively received when it was adopted five years ago but there is no guarantee that it will continue to have any impact without some push from its developer, the World Medical Association. The DoH will be revisited in the coming years and when the revision process begins, both of these policies on research on human subjects, their biomaterial and data should be revised taken into consideration ideas for changes that have been presented in recent years.

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Psychosomatic Medicine in China: the Current Development and Role in Future Medicine



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Introduction to Chinese Society of Psychosomatic Medicine

The Chinese Society of Psychosomatic Medicine (CSPM), founded in 1993, has developed rapidly in the past 20 years. Now it is an important active professional association under the Chinese Medical Association (CMA) [1]. The CSPM is mainly composed of provincial, municipal and county branches of psychosomatic medicine, youth committees and party leading groups (see Fig. 1). There are 21 provincial-level administrative regions that have developed psychosomatic medicine. Today, the CSPM has 20 professional committees including specialists from diverse clinical departments [2]. The assessment, diagnosis, intervention, psychotherapy and self-management education based on psychosomatic ideas have a profound influence on clinical medicine in China. Under the guidance of national psychosomatic medicine, various forms of medical, teaching and research activities have been carried out.

At present, the rapid economic and social transformations increasingly have triggered serious individual psychological and behavioral problems, especially during the outbreak of the novel coronavirus pneumonia (COVID-19). Therefore, there is an urgent

need to establish a health service system focusing on psychological care. The CSPM has entered a new critical period to develop a new mission.

Research Progress of Psychosomatic Medicine in China

Important Role of CSPM in COVID-19 epidemic

At the end of 2019, a highly infectious disease – novel coronavirus pneumonia (COVID-19) – was reported in Wuhan, Hubei province, China. At this critical moment, the Chinese government and the whole society tried their best to save the lives of the patients. From the very start, the CSPM worked together with the government to battle against the COVID-19 epidemic. First, the CSPM issued a proposal for preventing and controlling the new coronavirus infection in the whole country on 27 January 2020. The CSPM actively encouraged its committee members and relevant experts to participate in establishing a psychological rescue group, where specialists provided technical advice and carried out emergent psychological crisis interven-

tion and psychological counseling under the coordination of the health administration in the early stage of the COVID-19 epidemic. Second, on 28 January 2020, the CSPM established a psychosomatic intervention program for prevention and control of the novel coronavirus infection which serves as an important basic guidance for psychosocial and psychosomatic work to battle COVID-19. On 30 January 2020, Dr. Wu, President of the CSPM, published the paper titled “Thinking about Psychological Intervention in Epidemic Disaster”, pointing out that psychological intervention should be carried out online based on the specific cases, individuals and different stages in the epidemic development. He also stated that we needed to avoid over-intervention. Third, the CSPM published three E-books with guidelines for physical and mental health education for public through internet-plus technology, mass media, hotline and live broadcast platforms. Fourth, the CSPM has held series of lectures about COVID-19 in live webcasts, given by eleven professors, since 6 February 2020.

The CSPM also conducted psychosomatic symptom surveys via WeChat in the period 3–11 February 2020 for the whole country and found that the prevalence of psychosomatic problems was 21.4% according to the psychosomatic symptom scale (PSSS) [3]. Sleeping difficulty, lack of interest and avoidance were the most frequent symptoms, with prevalence of 10.3%, 6.2% and 5.1%, respectively [4]. We wrote the standard guideline for diagnosis and treatment of psychosomatic disorders related to the novel coronavirus pneumonia [5]. The PSSS was recommended for evaluating the severity of psychosomatic symptoms. Psychotherapy, medications and traditional Chinese medicine can be used for the treatment of psychosomatic disorders caused



by COVID-19. The experience in dealing with this public health emergency, the development and implementation of psychosomatic problem assessment, treatment and services provide crucial information for the efficiency and quality of future crisis intervention by the Chinese Government and authorities around the world.

Establishment and Implementation of Classifications and Diagnostic Criteria of Psychosomatic Disorders

Psychosomatic related disorders refer to somatic organic diseases and are a dysfunction that plays an important role in the pathogenesis and development of psycho-

social factors. In 1982, *psychosomatic disease* ranked as the last type of mental illnesses in the classification of psychosis of the Chinese Medical Association. In 2017, the CSPM proposed a classification of psychosomatic related disorders characteristic of the Chinese, organizing the psychosomatic disorders into five categories, including

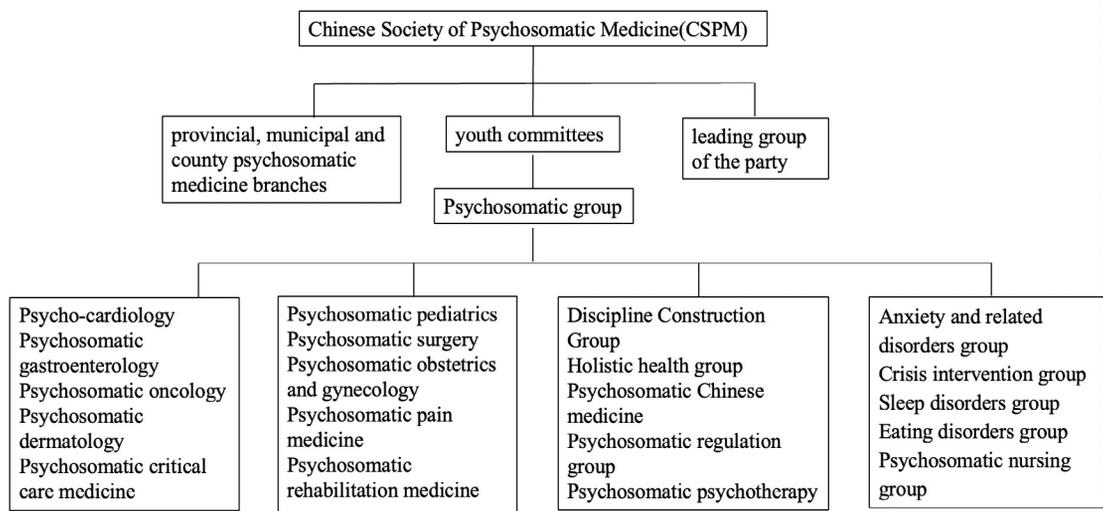


Figure 1. Composition of Chinese Society of Psychosomatic Medicine

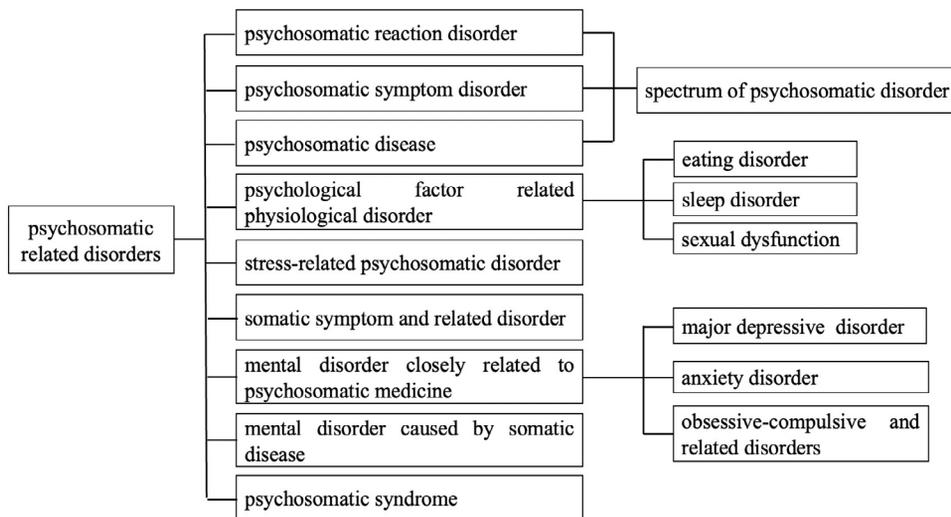


Figure 2. Classification of psychosomatic related disorders

psychosomatic reactions, psychosomatic symptoms, physiological disorders related to psychological factors, psychosomatic diseases, and psychosomatic symptoms associated with physical diseases. In 2019, they were split further into 9 categories, including psychosomatic reaction disorder, psychosomatic symptom disorder, psychosomatic disease, psychological factor related physiological disorder, stress-related psychosomatic disorder, somatic symptom and related disorder, mental disorder closely related to psychosomatic medicine, mental disorder caused by somatic disease, and psychosomatic syndrome [2]. In principle, psychosomatic reaction is referred to a temporary physiological reaction, lasting less than one week. Psychosomatic symptom disorder is a group of syndromes closely related to acute and chronic psychosocial factors. They root in the patients' personality, mainly manifested as one or several symptoms, e.g. anxiety, depression, insomnia, pain, somatization, etc. Psychosomatic disease refers to a kind of psychosomatic disorders with organic damage, which often refers to primary psychosomatic diseases, i.e. physical diseases caused by psychological factors. Primary psychosomatic diseases include 43 diseases in six disciplines. Psychological factors related to physiological disorders refer to the general class of diseases with psychological and social factors as the main predisposing factors, and physiological disorders are the main clinical manifestations. Stress related psychosomatic disorder refers to a group of

psychosomatic disorders caused by a group of psychological, social (environmental) factors or major diseases (including admission to ICU due to major diseases, cancer and uremia). Mental disorders closely related to psychosomatic medicine are a group of mental disorders characterized by depression, anxiety and compulsion. Mental disorders caused by somatic diseases refer to mental disorders caused by various physical diseases, such as somatic infection, visceral diseases, endocrine disorders, nutritional and metabolic diseases which affect brain function. Psychosomatic syndrome includes 18 syndromes referring to stress and personality, illness behavior, emotional performance (see Fig. 2). The classification will help clinicians to standardize the treatment of psychosomatic diseases and improve the level of diagnosis and their treatment. It is possible to realize the standardized diagnosis and treatment of psychosomatic disorders in China.

The CSPM has also developed and introduced psychosomatic scales, such as health anxiety scale [6], Chinese Version of the Metacognitions about Health Anxiety Questionnaire [7], post-stroke depression scale [8], post-traumatic resentment scale and psychosomatic symptom scale [9]. There is also a scale to estimate the severity of psychosomatic symptom disorder (see Table 1). These scales provide important assessment tools for patients with psychosomatic related disorders.

Table 1. Psychosomatic symptom disorder severity rating scale

| Item | Score | | | |
|---------------------------------|--------------------|------------------------------------|--|---------------------------------------|
| | 0 | 1 | 2 | 3 |
| Stress (Reasons) | no | mild | moderate | severe |
| Course of disease (Time) | less than one week | less than one month | less than three months | more than three months |
| Severity (Degrees) | no effect | mild impact on daily life and work | moderate impact on daily life and work | serious impact on daily life and work |
| Symptoms (Numbers) | no symptom | less than three symptoms | less than five symptoms | more than six symptoms |

Investigation of Epidemiology and Disease Burden of Psychosomatic Disorders

It is very important for health administrative departments to formulate relevant prevention and control strategy to clarify the diagnostic criteria of various psychosomatic disorders, followed by further investigation of the epidemiology and disease burden of various psychosomatic related disorders. Previous studies have analyzed the incidence rate and susceptibility factors of some common psychosomatic diseases. The results may provide reliable data for the government when making decisions concerning health policy.

Exploring the Pathogenesis of Psychosomatic Diseases

The CSPM studied common psychosomatic disease and achieved significant results. Yuan et al. [10] found that, compared with a healthy control group, the major depressive disorder (MDD) patients had small volumes of right superior frontal cortex, left central posterior cortex and right middle temporal gyrus. However, patients with RGD had larger left cingulate gyrus volume compared with healthy control subjects. There was a significant negative correlation between left cingulate gyrus volume and Rey Auditory Verbal Learning Test delayed recall raw score in the MDD patients. The genetics study displayed that TalleandC/T genotype of Methylenetetrahydrofolate reductase C677T was significantly different between the case and control groups [11]. Post stroke depression (PSD) is a subtype of depression, which is a frequent complication after stroke. The previous study demonstrated that neuropeptide Y was significantly decreased in PSD patients compared with the control group [12]. Asthma is often accompanied by a variety of mental disorders, such as depression, anxiety and panic. Zhang et al. [13] explored the brain mechanism of depression in asthmatic patients through multimodal functional magnetic resonance technology,



and found abnormal functional connectivity between left ventral anterior insula and left middle temporal gyrus in asthmatic patients with depression. Moreover, compared with the asthmatic patients without depression, the regional cerebral blood flow in the right posterior cerebellar lobe was significantly increased in patients with depression.

Hyperthyroidism is the most common endocrine disease, often accompanied by emotional and cognitive problems. Zhi et al. [14] found that the voxel mirror homotopy connectivity (VMHC) of bilateral medial frontal lobes in patients with hyperthyroidism decreased, the amplitude of low frequency fusion (ALFF) and local consistency of left prefrontal lobe decreased, and ALFF of left posterior cingulate gyrus decreased. VMHC in medial frontal lobe was positively correlated with episodic memory score. ALFF in medial frontal lobe was positively correlated with anxiety scale score, and negatively correlated with processing speed score. Anorexia nervosa (AN) is a typical psychological disorder related to psychological factors. Guo et al. [15] reviewed the changes of white matter in AN patients by magnetic resonance diffusion tensor imaging (DTI), and pointed out that white matter changes were common in AN patients, including corpus callosum, cingulate gyrus, temporal lobe, thalamus, hypothalamus, radiation corona, thalamus radiation and superior longitudinal tract. Professor Zhang focused on the correlation between cortisol level and clinical symptoms of posttraumatic stress disorder (PTSD). It was found that the serum cortisol level of PTSD patients was lower than of healthy people. The serum cortisol level of PTSD patients was related to the total score of Hamilton depression rating scale, which provided biological basis for clinical evaluation of PTSD symptom severity [16]. Panic disorder patients exhibited an enhanced mismatch negativity (MMN) in response to panic-related sounds but a reduced MMN responding to neutral sounds [17]. Furthermore, MMN responses were delayed irrespective of stimulus type in panic disorder

patients compared to healthy controls. The findings of etiology and mechanism of psychosomatic disorders will provide new therapeutic targets for these diseases.

Promoting Green Psychosomatic Therapy to Realize Simultaneous Treatment of Mind and Body

The CSPM is also interested in developing new psychosomatic therapies, especially green psychosomatic therapies, such as physical therapy and psychotherapy. The development of psychosomatic integrated therapy and green psychosomatic medicine is another goal of psychosomatic medicine. Combined with the popularization and promotion of the biopsychosocial medical model, integrated treatment also needs to be considered. Concerning treatment with drugs, there are still some problems, such as inconsistency in research and evaluation tools, inconsistent evaluation methods of efficacy, and more side effects, although the previous studies have proved that existing drugs can significantly improve the treatment of psychosomatic diseases. In the future, there is needed investment in the research and development of new drugs that are safe, effective, economic and tolerable. Physical therapy can noninvasively regulate nerve function and treat brain diseases by precise control of electrical, magnetic, ultrasonic and other physical stimulation output. At present, there is a variety of physical therapy methods, such as electric shock therapy, repetitive transcranial magnetic stimulation, transcranial direct current stimulation, etc. Body therapy, such as dance therapy, singing therapy, and aromatherapy [18], has also been proved to be effective in the treatment of psychosomatic diseases. The various forms of psychotherapy training develop all over the country and the effectiveness has been fully proved in the past clinical practice and scientific research [19]. Balancing psychotherapy (BPT) is a kind of psychological treatment based on the oriental philosophy system, which uses the

relevant theory of balance, centering on the two core contents of “degree” and “relationship” in order to help individuals achieve the state of mind-body balance. The correct use of BPT is conducive to the psychosomatic rehabilitation and the improvement of life quality of patients with psychosomatic diseases [20]. The way of choosing appropriate psychotherapy for specific psychosomatic diseases is worth an in-depth discussion.

Carrying out Psychosomatic Medicine Education and Training

Education in medical colleges and universities should include gradual and systematic study of psychosomatic related courses, mainly the basic courses, professional basic courses and professional courses, strengthening the concept of new medical model and psychosomatic holistic treatment. In residency training, all professional doctors are to carry out the identification of common psychosomatic problems and undergo related training that will be included in the training plan of doctors in various departments.

We should train primary health care workers in psychosomatic medicine. Establishing of multi-disciplinary consultation-liaison system is needed in hospitals. Increasing the interest in psychosomatic medicine and cognitive level of medical staff is very important to promote psychosomatic medicine. The Chinese College of Psychosomatic Medicine (CCPM), Chinese Multidisciplinary Integrated Center of Psychosomatic Medicine (CMDC-PM) and Chinese Psychosomatic Medical Education Alliance Base were established to provide guarantee for the establishment of psychosomatic medicine and acquiring of psychosomatic medicine related professional knowledge and skills. Books like *Chinese Psychosomatic Disorder Diagnosis and Treatment Guide*, *Chinese Psychosomatic Disorder Clinical Diagnosis and Treatment Skills Training Course* [21] and *Clinical Psychosomatic Medicine* can guide clinicians in the recognition,



diagnosis, evaluation and treatment of common psychosomatic problems.

Summary and Prospect

As to the future, the CSPM sees its role in the following four aspects: (1) Promote the overall diagnosis and treatment technology and level of clinicians through continuous education and training; (2) Focus on tackling difficult and complicated diseases by integrating a model of psychosomatic medicine to reduce the distress of these patients; (3) Further improve doctor-patient relationship by training communication skills, since doctor-patient conflict is a prominent problem in the current health service system; (4) Strive to solve the general problem of expensive and burdensome medical treatment so as to make the medical resources reasonable and effective.

In conclusion, psychosomatic health is an essential part of building Healthy China, in which the CSPM plays an important role in achieving this great goal. Based on the current situation, the CSPM will continue to promote psychosomatic medicine in China and establish more contacts and have wide international collaboration. Furthermore, the CSPM will integrate experts from various disciplines and the goal of its members is applying precision medicine. We will go on contributing to the improvement of human health in China and even the world.

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Threats to Professional Autonomy Continue in Turkey



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Dr. Şeyhmus Gökalp, member of the Turkish Medical Association's (TMA) High Disciplinary Board, was detained during a police raid on his home early in the morning of 20 November 2020 and officially arrested on 23 November 2020 in the context of an ongoing investigation. Appeals by Dr. Gökalp's lawyers for a trial without arrest were turned down and, along with the indictment prepared, the date for the first court hearing was announced on 10 February 2021. Beyond being an operation targeting a single person, placing our colleague Dr. Şeyhmus Gökalp under arrest is actually nothing less than an assault against a professional organization, professional values and autonomy assuming its concrete form in the victimization of an elected board member of the TMA, the organization of physicians in Turkey. The examination of the TMA history reveals that it is not the first time when professional autonomy and values have come under threat through oppressive policies pursued in different periods.

Threats to Professional Autonomy and World Medical Association

The medical profession has been in the focus of interest of political power throughout

the history due to the knowledge it accumulated, ethical values that were developed and authority it earned. The dominant production systems, totalitarian regimes, global or regional wars and internal conflicts confront us when professional independence is threatened and professional values erode. In the time when the medical profession and medical practice are placed under the control of power groups, there are innumerable cases where physicians are forced to engage in practices that are in contrast with the nature and ethical values of the profession. In the past century, the crisis of the capitalist system that wreaked havoc throughout the world, the rise of militarism leading to two world wars and totalitarian regimes all provided the ground for the abuse of the profession of medicine. These gloomy experiences brought along the need for international cooperation and organization to protect and defend the professional autonomy and values. Indeed, the establishment of the World Medical Organization (WMA) by 27 national medical organizations, including the Etibba Chamber, in 1947, when the ashes of the Second World War were still warm, was a response to this need and it has its place in history as a strong institution. The organization was created "to ensure the independence of physicians, and to work for the highest possible standards of ethical behaviour and care by physicians, at all times."

In line with this purpose, the WMA has since then provided for physicians guidelines at a universal level with its statements and declarations on issues relating to medical ethics, medical education, professional autonomy, and social medicine.

TMA and Struggle to Defend Professional Values

The TMA is a professional organization of public character established in 1953 on the basis of Article 1, Law No 6023, stating the foundation purpose as "protecting professional deontology and solidarity among physicians, ensuring the development of the profession of medicine to the benefit of the public and individuals, and defending the rights and interests of the members of the profession." It is within the purview of the TMA to lay down ethical norms for medical practice and, in this context, to prepare Disciplinary Regulations and Statutes related to Medical Deontology. As a professional organization, the founding and operational principles as well as the establishing of the executive, disciplinary supervision and general assembly that are prescribed by law are also functional and they conduct self-audits. Indeed, all these organs consist of elected members and operate in ways to safeguard the independence of the profession and autonomy of the organization.

Besides its legal status, the TMA is also an organization known for its decades-long struggle for public health, good medical practices, professional independence, physicians' rights as well as dealing with environmental health problems and possible solutions. The TMA has maintained its uncompromising position concerning the delivery of quality health services that are equal and accessible to all and in line with the ethical principles of the profession.



The organization's approach proceeds from this principled stance that medical practice cannot be abstracted from fundamental human rights including the right to life and the right to health as well as universal professional values enshrined in WMA documents. Accordingly, the same principle required standing against the destructive consequences of neoliberal patriarchal capitalism prevailing in the country with its effects on public health, oppressive regimes, and militarism. It is for this challenging tradition that the TMA has been one of the main targets of political power groups. At all times when the attitude of the professional organization clashed with the opinion of the political power, the policy of oppression and intimidation has been directed against the professional organization that is regarded as the centre of opposition. In this context, it will be sufficient to take a look at the acts of oppression within the last forty years which are also known as "TMA's Trials of Honour."

Following the military coup of 12 September 1980, many trade unions, associations and professional organizations became the target of military oppression while the archive of the TMA in its head office in İstanbul was seized to erase the organizational memory of the organization and the President of its Central Council was arrested. Then Decrees with the force of Law (KHK), issued in 1983, made many changes in TMA Law No 6023, transferring the head office of the organization to Ankara and compulsory membership for physicians working in the public sector was lifted with the intention of weakening the organization. It is after this rearrangement that the majority of physicians are still members of the TMA (total 65%).

The attempts by ruling governments to de-functionalize and undermine the autonomy of the professional organization unfortunately did not remain limited to the periods of military coup. For example, KHK No 663 of 2011 provided for establishing

the Board of Medical Occupations, most of whose members were appointed by the government. The Board was authorized to deal with many issues that used to be the responsibility of the TMA including decisions on and assessment of issues related to curricula in medical education, fields of specialization, professional competence and employment, professional ethics, and expulsion from the profession. Moreover, the phrase "ensuring the practice and improvement of the profession of medicine to the benefit of the public and individuals" in Article 1 of the TMA Law was deleted. This multi-pronged assault on the autonomy of the professional organization triggered the reaction of medical community in the country and in the world and the WMA made a call on national medical associations to denounce the assault and to act in solidarity with the TMA. At the meetings – WMA Comes Together with Doctors for their Independence and Autonomy of their Professional Organization – organized in Ankara and İstanbul on 16-17 April 2012 jointly by the TMA and WMA, the importance of professional independence and autonomy was voiced strongly. The amendment (KHK No 663) made to Article 1 of the Law on TMA was later annulled by the Constitutional Court in 2013.

In the first lawsuit brought against the TMA in 1985, the removal of the Central Council from office was requested on the ground that the association was engaged in an inappropriate activity by asking for the abolishment of capital sentence. Prof. Dr. Nusret Fişek, President of the TMA Central Council, said in his defence statement that "the TMA has the right to state its opinion on the right to life, which is a fundamental human right, and on the problems of the country; we just performed our duty by asking for the abolition of capital punishment", which was in conformity with the WMA resolution stating that it is unethical for physicians to participate in capital punishment. The case ended in acquittal and capital punishment was abolished in 2004.

With a lawsuit brought in 2001, the indictment had the purpose to have the Central Council of TMA removed from office for informing the public about the physicians' attitude in hunger strikes as laid down by the WMA Declaration of Malta and standing against forced feeding under the pressure of the government and "return to life by killing". Dr. Fusan Seek, President of the Central Council, and Council members of the time stated: "The profession of medicine approaches human life beyond all concepts and concerns and builds its system of values by placing the human life and health at the centre of all issues. Anything and any act that harms human life and health contradict the nature of the profession of medicine and the basis of its system of values and therefore are unacceptable." The TMA leaders were acquitted.

In another case opened in 2014, the leaders of the Medical Chambers of Ankara, İstanbul and Hatay were to be removed from office because their members had provided first aid, in line with WMA principles, to people who were injured during civilian protests known as "Gezi." As in other similar cases, this one ended in acquittal, too.

Another example is the court process starting with the detention of Central Council members following the TMA Central Council statement "War is a Public Health Problem" on 24 January 2018. The case opened with the allegation of explicitly inciting people to hatred and enmity, spreading the propaganda of an organization that stands against war and defends peace was defined as "crime"; the Central Council members, including Dr. Şeyhmus Gökçalp, were sentenced to imprisonment for twenty months. This statement by the TMA, however, falls in with the opinion of the WMA, which says, "Physicians should encourage politicians, governments, and others in positions of power to be more aware of the consequences, including the impact on health, of their decisions on the commencement or continuation of armed conflict." Presently,

the Ankara Regional Court of Appeals examines the case. During the court cases in 2014 and 2018, many professional organizations, including the WMA and Standing Committee of European Doctors, sided with the TMA and enjoyed international professional solidarity.

Besides the court cases brought against the TMA and intimidation policies in general, it must be added that there are also frequent threats to and even court cases against clinical independence. In this context, there are colleagues who stood trial for having acted in line with professional ethics, i.e. refusing to submit reports contradicting the realities in detention processes and standing against handcuffed medical examination of persons under the supervision of security forces or refusing to conduct sexual intercourse examination upon the pressure of third parties without the approval of the person concerned.

Preparations for Legislative Intervention in Professional Organizations

Much broader in scope than the oppressive policies mentioned above is another policy the government has on the agenda for the last two years. Besides the TMA, professional organizations of public character, like the Turkish Bar Association and the Union of the Chambers of Architects and Engineers, have also become the targets of the government for standing against policies that have the effect of undermining the right to health, fair trial and environment and defending democracy and professional autonomy. The prevailing authoritarian and oppressive regime is now trying to stultify and control professional organizations opposing its policies through various legislative arrangements. In fact, the government gave effect to an amendment to the Law on Bar Associations making it possible to have more than one bar association in a specific

constituency which was a step to split these associations by changing election methods and the number of delegates. It is known that a similar path is also considered for the TMA and in fact openly stated as accompanied by the discourse "TMA must be banned" by the partner party. Presently, there is a political climate where those opposing the government are readily labelled as "terrorists"; the elected mayors are replaced by trustees; legal system and visual/printed media are both instrumentalized for supporting the ruling government; and where civil society/democratic organizations and opposing voices are silenced without any reasonable justification. The Covid-19 pandemic breaking out and spreading in such an environment laid bare that face of the government, which is far from scientific evidence and transparency, incapable of managing the pandemic and ineffective in protecting people's health. While the TMA as a professional organization is capable of making its unique contribution to the management of the process with its endowment of knowledge and experience, it confronted many obstacles including exclusion from pandemic boards and concealment of relevant information and data. In spite of all these obstacles, the TMA became a focus of interest with its scientific, rational and ethical approach to the issue starting from the early days of the pandemic and gained wide trust with its efforts to inform the public. The political power who sought to discredit and block the TMA on every occasion, of course, is annoyed by this situation.

Who is Dr. Şeyhmus Gökalg?

Born in Nusaybin District of Mardin in 1977, Dr. Şeyhmus Gökalg spent his childhood and adolescence in a region that seemed to be destined to internal conflicts and poverty. Dr. Gökalg graduated from the Faculty of Medicine in Fırat University in 2002 and the same year started participating in the activities of the Diyarbakır Chamber of Medicine where

his fields embraced worker's health and occupational medicine, human rights, health services in emergencies, and press/media relations. He was elected to the Auditing Board of Diyarbakır Chamber of Medicine for the term 2004-2008 and a TMA General Assembly delegate from Diyarbakır in the period 2014-2020. Recognized for his productive work and commitment to the organization, the Medical Chambers of the region nominated Dr. Gökalg and he was elected to the Central Council of the TMA for the term 2014-2018. During his Council membership, Dr. Gökalg made intensive efforts to ensure that TMA policies are translated into life in line with professional ethics. Dr. Gökalg is one of the Central Council members who were detained and then sentenced for the Central Council statement "War is a public health problem" made in January 2018 at the time when war and militarist policies escalated, and internal conflicts were refuelled in the country. His statement during the trial "We cannot just ignore the truth and don't hesitate to express the truth we see" remains fresh in our memory as the key concept in a philosophy of life. Dr. Gökalg was dismissed from public service upon a KHK decree issued during OHAL (State of Emergency) and was elected a High Disciplinary Board member by the 72nd General Assembly meeting of the TMA held in 2020.

What Does the Arrest of TMA High Disciplinary Board Member Dr. Şeyhmus Gökalg Mean?

The TMA High Disciplinary Board, where Dr. Şeyhmus Gökalg serves as a member, occupies a critical place in protecting professional deontology and ethical values. Disciplinary boards of individual chambers of medicine and the High Disciplinary Board are authorized to act in their capacity to launch investigations when examining medical practices with reference to

professional deontology and ethical principles including applications made by other parties, as well as to examine files sent by public agencies that conduct their own administrative investigations. Qualifications required to be elected to the High Disciplinary Board include 15 years of work in the profession and not being penalized for any deed specified in the relevant regulations. The Board is composed of members from the profession who are recognized for their commitment to good medical practices and scientific standards in their respective fields of specialization. Gender, age and geographical representation are other factors considered in nominations. This sensitivity regarding the composition of the Board is also guaranteed by regulations on its working principles and procedures. The High Disciplinary Board fulfils its obligation to protect the prestige of and trust in the profession, rights of patients and physicians, professional deontology and ethical values through meticulously conducted disciplinary investigations with reference to national and universally recognized principles. These principles are laid down by a set of legislative texts and other documents including TMA Law No 6023, the Law on the Practice of Medicine and Other Health Professions, Medical Deontology Statute, Ethical Rules in the Profession of Medicine, TMA Disciplinary Regulations, Biomedicine Convention and WMA and TMA Declarations and Statements as guiding documents. In other words, the domain of the TMA High Disciplinary Board is at the intersection point of professional ethics and health legislation and its working principles are based on legal validity and professional ethics. The TMA High Disciplinary Board is the highest decision-making body to conclude disciplinary investigations within the profession. Challenges against penalties given by individual chamber boards and penalty of expulsion from the profession are directly handled and resolved by the High Disciplinary Board.

The supervision of medical practices by boards of discipline of individual medical chambers and the High Disciplinary Board whose members are elected in democratic ways by physicians and that are independent of all outer influences is vital in ensuring and safeguarding professional autonomy. This principle is also in full conformity with WMA policy documents including the Seoul Declaration on Professional Autonomy and Clinical Independence, Cesky Krumlov Memorandum on Public Functions and Professional Representation by Chambers of Physicians (and Dentists) and Madrid Declaration on Professionally-Led Regulation.

As mentioned above, the TMA High Disciplinary Board member Dr. Şeyhmus Gökalp was detained and arrested under investigation while his statement could have been taken without any such measure. The reason for the arrest is based on the testimony of an anonymous witness who became a confessor in 2016. The interesting point is that while Dr. Gökalp was not mentioned at all in the first testimony of this witness, a new testimony given in 2019 is full of groundless allegations against Dr. Gökalp with whom the witness had never met. Despite resolutions by the Court of Appeals, Constitutional Court and the European Court of Human Rights that statements of this kind by confessors should have no evidential value, the arrest of Dr. Gökalp was based on such statements. Moreover, calls from the country, the WMA and the Standing Committee of European Doctors for the release of Dr. Gökalp were ignored. Above all, it must be stated that Dr. Gökalp's commitment to professional ethical values and human rights has earned him a professional career that cannot be stained by the statements of false witnesses. Given his status as a representative of an institution, Dr. Gökalp's arrest also means an assault to the autonomy of a professional organization.

Conclusion

The arrest of the TMA High Disciplinary Board member Dr. Şeyhmus Gökalp is not a practice that can be grasped by missing the political climate that surrounds the event. We regard this as an act moving beyond human rights, law and justice by targeting a physician committed to the principles and ethics of his profession. It can be said that the prevailing anti-democratic, unjust and unlawful practices in the country are epitomized in the case of Dr. Gökalp, a respected member of one of the most esteemed organs of our organization. The expectation of justice is maimed by acts that target physicians with false statements by confessors, ungrounded accusations, slanders, unproven allegations and unlawful procedures. Especially in the present pandemic environment, these practices are tantamount to a multifaceted violation of human rights including the right to work, right to health, right to a decent life and the right to be free from any stigmatization; it also brings along serious threats to professional autonomy and independence.

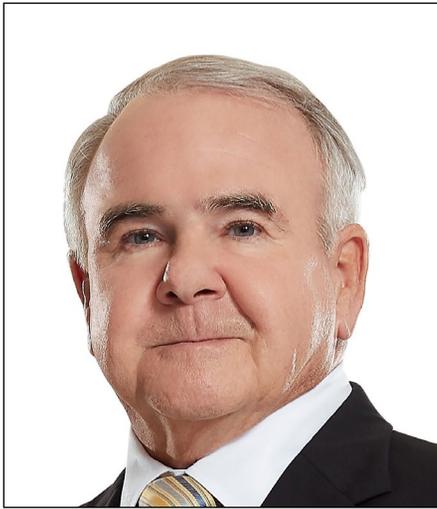
We are aware that the intention is to criminalize Dr. Gökalp, our colleague known for his uncompromising stance in defending the ethics and values of the profession of medicine. However, we are also sure that the truth will finally prevail, his innocence will be proved, and all efforts will be made for his release. We declare once more that we are in solidarity with our colleague and expect the same from our colleagues worldwide.

*Prof. Mustafa Taner Goren,
The Chair of the High Disciplinary Board*

*Assist. prof. Hafize Ozturk Turkmen,
Member of the High Disciplinary Board*

*Dr. Naki Bulut
Member of the High Disciplinary Board*

Physicians and Ethical Issues Related to Covid-19 Vaccines



Gerald E. Harmon

The COVID-19 pandemic has heightened awareness of the public health role of physicians. Falling rates of immunization for childhood illnesses, public scepticism, and emergence of new diseases have served to underscore physicians' responsibilities related to vaccines. These responsibilities include protecting the health of the physician, patients, and the larger community by promoting shared decision-making and counteracting vaccination misinformation. The pandemic has brought the physician's public health role with respect to vaccinations and intertwined ethical considerations to the fore.

Physician Vaccination

In the context of a disaster, such as the COVID-19 pandemic, a physician's ethical obligation is to subordinate their personal interests to those of their patients. The American Medical Association (AMA) *Code of Medical Ethics* states that a physician's first duty in a disaster is to "provide

urgent medical care...even in the face of greater than usual risk to physicians' own safety, health and life."

Since the physician workforce is not an unlimited resource, physicians are also expected to assess the risks of providing care to individual patients against the ability to provide care in the future. The AMA *Code of Medical Ethics* also requires that "physicians protect their own health to ensure that they remain able to provide care."

These two opinions, when considered together, argue strongly for the physician to accept immunizations unless medically contraindicated. This is especially true for diseases like COVID-19 that are easily transmitted and represent a higher medical risk for patients, co-workers and others with whom the physician is in contact. A physician's responsibility is balanced against other factors including the safety and efficacy of available vaccines and the prevalence of the disease the vaccine wards against. Physicians should not be required to accept immunization with a novel agent until and unless there is a scientifically valid body of evidence that supports its safety and efficacy.

Non-medical exemptions for physician vaccination pose ethical concerns. Physicians who decline to be vaccinated for non-medical reasons such as long-held personal beliefs put themselves and others at risk for contracting a vaccine-preventable disease. Non-medical vaccine exemptions should be limited and squarely balanced against other interests.

Physicians who are not or cannot be vaccinated have an obligation to protect patients, fellow health care workers, and the larger community. This includes refraining from direct patient contact when appropriate.

Responsibility to Promote Shared Decision-making

The patient-physician relationship is based on trust, and patients rely on their physician to provide them with accurate information and sound guidance. Physicians play a significant role in influencing patient perspectives about vaccine safety and efficacy and have an obligation to educate patients about the danger of delaying or denying vaccination, while also acknowledging patient concerns in a credible and trustworthy manner.

With regards to COVID-19 vaccinations, patients have the following main concerns.

- **Vaccine Safety:** The speed at which COVID-19 vaccines are being developed and manufactured is unprecedented. This was in part due to steps in the development process being done simultaneously, and that many administrative roadblocks were streamlined or eliminated. Physicians should reassure patients that no shortcuts were taken in the scientific process, including the careful evaluation of the results of clinical trials and receipt of regulatory approvals on an expedited basis. Physicians should also educate patients about the characteristics of mRNA vaccines, including the fact that none of them contain live virus and therefore will not infect vaccine recipients.
- **Vaccine Side-Effects:** Even though available COVID-19 vaccines generally have few and mild side effects, as with any vaccine, more severe effects may occur. Physicians should carefully listen to a patient's concerns and provide reassurance that side effects serious enough to require medical attention are rare and are experienced by only a small fraction of those receiving the vaccine. Providing positive anecdotes about others who have successfully received the same vaccine may be beneficial.
- **Vaccine Efficacy Across Various Patient Cohorts:** In the United States, Hispanics made up 20% of those participating in the Moderna vaccine trial and 13%

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of the Pfizer vaccine trial, while African Americans made up 10% of each trial's participants.

The National Medical Association (NMA) – the largest organization for African American physicians and their patients in the United States – found those percentages to be large enough to have confidence in the overall health outcomes in the clinical trials. The NMA COVID-19 Task Force on Vaccines and Therapeutics met with clinical scientists from Moderna and Pfizer and reviewed clinical outcome data from the U.S. Centres for Disease Control and Prevention and the Food and Drug Administration (FDA) to look for any indications that the African American community might be at higher risk of unfavourable outcomes from the vaccine.

The task force found that efficacy and safety of the vaccine were observed and consistent

across age, gender, race, ethnicity and in the elderly. As a result, the NMA supported the FDA grant of emergency use authorization for both vaccines.

Responsibility to Counteract Misinformation and Vaccine Hesitancy

Misinformation and conspiracy campaigns against vaccination are common and pervasive. Physicians have an obligation to inform themselves of these campaigns and ideally to counteract misinformation, especially on social media. Failure to do so may allow unproven theories to proliferate and overtake scientific truths which in turn will thwart progress in achieving widespread immunity.

Patients who believe vaccination is a personal choice are not likely to be moved by

scientific evidence or statistics. A more effective method for physicians to encourage vaccination amongst those who would otherwise decline a vaccination may be to appeal to the patient's desire to protect family members and others who live or interact with them regularly, using simple language that communicates effectively and makes it easy for patients to apply to their own lives. Physicians can use their established trust-based relationship with their patients to communicate that they themselves have been vaccinated and why they personally believe it is important and safe to vaccinate in general, and for COVID-19 specifically.

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Myanmar Doctors Solidarity against Military Coup d'état

COVID-19 has wreaked havoc on the lives and livelihoods of Myanmar communities, who are dealing with an unprecedented crisis. Myanmar doctors from public and private sectors have collaborating together and sacrificing their lives starting from March 2020 till early February which enable the country to flatten the curve at this time of greatest need. The military junta unlawfully captured all three powers of the state on February 1, 2021, and detained Myanmar President U Win Myint, State Counsellor Daw Aung San Suu Kyi, legitimate government officials, and parliamentarians who were elected routinely, according to democratic rules and the people's free will. On the evening of the coup, assistant surgeons, who are newly graduated doctors who have joined civil hospitals across the country

Myanmar, began discussing the issue and how to save patients from the dictatorship on their social private channels. On February 3, 2021, assistant surgeons and post-graduate doctors from Myanmar's public hospitals, along with other health professionals, launched the Civil Disobedience Movement (CDM), vowing to close public hospitals across the country in defiance of the new military junta that took control of the government and seized civilian leaders in a coup [1]. These doctors made a difficult decision in the best interests of the Myanmar patients' health and well-being in the future. They have seen how the Myanmar military dictatorship has harmed the health and well-being of patients with limited resources in the past. If the doctors allowed a coup to succeed, the patients would be the



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ones who suffered the most. Government hospitals are only accepting emergency cases, and some hospitals are refusing new patients because the majority of their staff is enrolled in the CDM. One week after the coup, specialist assistant surgeons, con-



sultants, and other government employees joined the fight against the coup. No new patients are being accepted at hospitals in Yangon, Mandalay, Patheingyi, Muse, and Sagaing. On February 9, the health and sports ministry, which is illegally controlled by the military junta, issued a letter urging the doctors to return to their civil hospitals [2]. How, however, can doctors provide clinical care and apply their medical knowledge without infringing on human rights and civil liberties under military dictatorship? While participating in the CDM, doctors provide free medical treatment at charity clinics, private clinics, and hospitals with the assistance of well-wishers from within and outside the country [3]. Furthermore, doctors have a strong sense of commitment and care for their patients in the event that they are unable to visit the clinic in person, and they offer teleconsultation via various telecommunication channels to provide management for the diseases [4]. In the latter weeks of February, some CDM doctors fled from their homes to other towns to avoid being abducted by the military regime, but some were apprehended [5]. Doctors providing emergency care and ambulances transporting patients have been targeted and shot by security forces for no apparent reason. In the last week of February, the World Medical Association issued a strongly worded statement urging the immediate release of all health-care workers and ensuring the physical and psychological integrity of those who have been arrested in Myanmar, as well as the cessation of all forms of harassment [6]. On February 28th, more than 200 doctors protesting the military junta were arrested in a single day. The military junta was increasingly targeting doctors who provided emergency medical care, whether they were CDM or not. Armed security occupied West Yangon General Hospital by force on March 7, 2021, and later Yangon General Hospital; North Okkalapa Hospital; South Okkalapa Women and Children's Hospital; East Yangon General Hospital; and Central Women's Hospitals and other hospitals across

the country including Mandalay, Monywa, and Taunggyi [7]. The United Nations Office for the Coordination of Humanitarian Affairs (UN OHCHR) has condemned such activity as completely unacceptable, as hospitals are protected by international humanitarian law. (8) These strong international statements are doing little to alleviate the strain on doctors who provide emergency care in clinics and hospitals. Every day, Myanmar doctors are forced to relocate their clinics after being abused and threatened by security forces attempting to prevent them from treating injured people. Nowadays, many front-line doctors are willing to give up their own lives to save others because they do not want to die with guilt and want to do their best for their country [9]. There have been two doctors killed on the frontlines while providing medical care, and one of them left his handwritten last will and testament before being fatally shot, stating that we must never give up until we achieve democracy [10]. On behalf of doctors in Myanmar, we would like to appeal to National Medical Associations and doctors worldwide for solidarity and understanding during these challenging times in Myanmar.

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Substance Use Disorders and Addiction in Physicians: a Dutch Physician Health Programme



Marlies de Rond

Introduction

Substance use disorders and behavioural addictions are treatable diseases that can happen to anyone, physicians included. These disorders not only affect the health of the individual in question, but in the case of healthcare professionals they can also have a potential impact on their professional image and on patient safety [1]. An American study showed that substance use disorders are more prevalent among physicians than the general population, affecting 1 in 7 physicians (15.3%) compared to 1 in 8 (12.6%) members of the general population [2]. Healthcare professionals are more likely to misuse alcohol and prescription drugs such as sedatives and opiates than the general population [3]. Risk factors for addiction in physicians include high levels of stress and responsibility at work, a disrupted lifestyle due to inconsistent working hours and easy access to prescription drugs [4].

Against this background, the Royal Dutch Medical Association (RDMA) took the



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first steps in 2011 to set up a counseling service for physicians (and those around them) who are affected by substance use disorders and addiction. Alongside this counseling service, the RDMA committed to raising awareness of physicians with substance use disorders and addiction in healthcare since 2019. The Dutch Physician Health Programme (PHP) is called ABS-physicians in the Netherlands. The 'ABS' abbreviation in ABS-physicians stands for abstinence from addictive substances.

The Dutch Physician Health Programme (PHP) currently has two tasks:

1. A counseling service for physicians that provides confidential help, advice, guidance and/or monitoring to physicians who are affected by substance use disorders and addiction and to those around them.
2. Raising awareness within the healthcare sector about substance use disorders and behavioural addiction, which are treatable diseases. Informing and motivating physicians and those in their profes-

sional environment to act upon this, to ensure a healthy and safe working and learning environment, where substance use and addiction can be openly discussed. A special tool kit has been developed to achieve this.

Physician Health Programme: counseling service

The RDMA set up the physicians counseling service in 2011 to help physicians who are affected by substance use disorders or addiction and those around them. The team, consisting of psychiatrists, addiction doctors, psychologists and social workers, is specialised in supporting physicians, who are affected by substance use disorders or addiction.

Help and advice

Known barriers that prevent physicians from seeking help include; embarrassment, wanting to stay in control and concerns about privacy [5]. Some physicians also feel a great deal of responsibility towards their patients or colleagues, which prevents them from seeking help. These factors contribute towards denial, downplaying matters and delaying seeking help, creating an additional risk to the physician's own health, patient safety and quality of care.

The PHP is an accessible service that provides physicians and those around them with (anonymous) help, advice, guidance and/or monitoring. The special phone number is available on working days, between 9 a.m. and 8 p.m. Callers can speak directly to an expert in addiction care. This expert listens without judgement and provides advice. The expert helps to answer

important questions such as ‘Do I have an addiction?’, ‘What steps can I take to address this?’ and ‘Where can I receive appropriate and confidential treatment?’ Physicians calling on their own behalf are always invited to attend a personal consultation, preferably accompanied by someone close to them.

Family, friends, and colleagues can also contact the PHP for advice. For instance, regarding the suspicions or doubts whether an individual is experiencing substance use disorder or addiction. Or how to raise the topic of substance use disorder or addiction to allow it to be discussed, and about potential ways to address the topic with the physicians in question. Finally, physicians’ employers can call the PHP for advice on next steps that can or must be taken to limit risks to patient safety and to help their employee. The PHP therefore acts as a confidential support and counselling service, not a point of contact to report a physician, for those in the environment of the physician in question.

Support towards and during treatment

Physicians often have difficulties in seeking help, and becoming a patient themselves. Obtaining help in the conventional way, for instance by visiting a colleague physician, does not always live up to expectations. Moreover, treating a colleague physician requires special skills on the part of the treating doctor [6]. The PHP refers physicians to practitioners who specialise in addiction medicine and are experienced in treating physicians. As in the US PHPs, the Dutch PHP does not carry out the treatment itself, but rather refer physicians to an appropriate setting [7]. However, the PHP does provide support during the treatment, to accept the role of being a patient and to direct physicians towards monitoring. It is not always necessary for physicians to go on sick leave during treatment.

Monitoring during the return to work

Following successful treatment, the PHP can support physicians in a safe and successful resumption of work by providing a special five-year monitoring programme. During the monitoring programme, participating physicians are supported by individuals in their immediate environment and remain in close contact with their case manager of the PHP. A colleague acts as a workplace buddy, while someone close to them acts as a personal buddy. The occupational physician assesses the physician’s ability to work and the physician contacts his GP or addiction doctor when needed, self-doctoring is not permitted within the programme. Finally, the programme also includes participation in a self-help group.

In addition, the physician will undergo random abstinence testing. This involves the random collection of urine, sputum, or hair samples. The frequency of laboratory testing decreases over the years, but can be scaled up temporarily if needed in the event of a potential or actual relapse. Tests are tailored to the physician’s situation as much as possible to ensure minimum disruption to their professional or personal life without losing the effect of randomisation.

There are two reasons for physicians to take part in the monitoring programme. The first is a greater likelihood of personal recovery with this programme, than with conventional treatment alone. The programme is based on the PHP’s conducted in the US and Canada. These initiatives are effective: 79% of physicians continue to work after following a five-year monitoring programme and still have their substance use under control after this period.

A second reason for taking part is the physicians’ need for support in resumption to work. Physicians who have undergone treatment often find it very difficult to return to their workplace. They need to learn to handle work-related risk factors

differently. Risk factors, such as high levels of stress and responsibility and varying working hours are inherent to the medical profession. It is therefore important to learn how to deal with them differently, in order to minimise the risk of relapse and to obtain rapid and appropriate help if relapse occurs. Moreover, by taking part in the programme physicians demonstrate to themselves, their colleagues and employers that they are doing everything they can, to work safely [9].

Physician Health Programme: raising awareness

The experience gained by the support service since 2011 shows that individuals in a physician’s immediate environment can play a vital role in identifying substance use disorders and addiction, and allowing the topic to be discussed. This has been confirmed by RDMA research, which shows that getting a colleague to open up about substance use is not easy. Almost all physicians (95%) indicated that they would take action upon a substance use presumption in a colleague. Of the 29% who ever had this presumption, 65% took actual action while 35% took no action [10]. To increase the percentage of physicians who actually take action, the RDMA launched an awareness project in 2019 that involved the development of a campaign and a tool kit designed to stimulate and facilitate a dialogue on substance use disorders and addiction with a colleague.

Campaign

The RDMA has developed a special awareness campaign on substance use disorders and addiction, to encourage physicians to engage with and talk about this topic. The campaign is themed around thought-provoking questions and facts, see Box 1. These questions and facts prompt physicians to raise the topic of substance use disorders and addiction with their colleagues or net-

work, and to emphasise the urgent need for these discussions. The questions can also be used during peer support sessions or educa-

tion programmes. Charts, roll-up banners, ads and online banners featuring the questions and facts are available.

Box 1. Questions and facts used in the campaign

| Examples of questions | Examples of facts |
|--|--|
| <p>Would you send a text message saying 'get well soon' to a colleague who has an addiction?</p> <p>Treat addiction as a disease</p> | <p>Out of every ten physicians, seven are in favour of workplace rules on substance use and addiction.</p> <p>Treat addiction as a disease</p> |
| <p>What do you prescribe yourself?</p> <p>There is also an options menu for coping</p> | <p>About 80% of physicians want to learn how to act on a presumption of substance use or addiction in a colleague.</p> |
| <p>Substance use and addiction: do you recognise the signs?</p> <p>Talking about addiction is complex</p> | <p>Talking about addiction must be approached with care</p> |

Box 2. The four pillars of the policy plan

1. Standards and rules. The organisation describes the applicable standards and rules regarding substance use before and during work and regarding addiction. The rules are designed to avoid a reduced level of performance by employees as a result of substance use or addiction.
2. Provision of information, training and education. This section focuses on raising awareness of the risks of substance use disorders and addiction and preventing or reducing these risks.
3. Possibilities of help. This section describes what an organisation can offer in terms of assistance and support to employees affected by substance use disorders and addiction. The basic principle is that addiction is a disease and is treated as such. It is important that employees are aware of this underlying principle and feel able to seek help and treatment where needed.
4. Measures. This section deals with enforcement and the measures that may be taken, for instance if an individual is under the influence at work or drops out of a treatment programme for no reason.

Box 3. Declaration of intent text

- We endeavour to ensure that:
- Substance use disorders and behavioural addiction are a top priority for our organisation and our employees
 - Substance use disorders and behavioural addictions are treated as diseases
 - After receiving treatment, healthcare professionals with substance use disorders or a behavioural addiction can safely return to work through a monitoring programme
 - Policy or a procedure aimed at substance use and addiction is developed and implemented

Tool kit

With the PHP tool kit, RDMA supports healthcare organisations and private practitioners in creating a healthy and safe working and learning environment, where addiction is treated as a disease, and substance use disorders and addiction are open to discussion. The tool kit contains tools and tips for both organisations and individual physicians.

For organisations: developing policy and signing a declaration of intent

Substance use disorders and addiction impact on an individual's performance and health, and do not mix well with work. In the case of healthcare professionals, this can lead not only to sickness and absenteeism, but also risks to patient safety and quality of care. Research shows that 20–25% of accidents at work are alcohol-related [11]. The annual productivity loss due to alcohol use in the Netherlands is an estimated 1.3 billion euros [12].

It is essential for organisations to develop policy to safeguard employees, patient safety and quality of healthcare. Organisations can opt on the harm reduction model or the prevention model. The harm reduction model focuses only on setting standards, rules and measures. The prevention model, which is preferred, is also aimed at preventing substance use disorders and addiction and policy aimed at offering help and support to those affected, as well as during their rehabilitation. Most important is, that the policy is aimed at helping employees affected by substance use disorders and addiction and keeping them in work. See Box 2.

The tool kit provides a policy plan for organisations entitled Working in healthcare: substance use and addiction. This format can be used as guide for formulating and implementing policy or optimising existing policy. In addition, there is an instruction manual and a communication plan. The instruction manual explains how organisations can use the format to develop their

own policy. The communication plan can be used to inform all individuals within the organisation.

The RDMA has also drawn up a declaration of intent. By signing the declaration of intent, organisations declare their commitment to a healthy and safe working and learning environment, where addiction is treated as a disease, and where substance use disorders and addiction can be openly discussed, see Box 3.

For physicians: increasing knowledge, opening up a dialogue and becoming an ambassador

For physicians affected by substance use disorders and addiction it is often not easy to seek help and to become a patient themselves. This is often due to feeling ashamed and the stigma of addiction. Colleagues can take an important role in identifying potential problems at an early stage. The accredited teaching module allows physicians to increase their knowledge of substance use disorders and addiction, see Box 4. Physicians, including those still in training, can also follow the e-learning component of the teaching module separately.

To accompany the teaching module, the PHP has produced an animation and an information card with tips on how to enter the dialogue when presuming substance use in a colleague. Choice of language is very important when raising this topic with a colleague. There is a difference between opening up a dialogue or engaging in conversation, and confronting an individual about their behaviour. Opening up a dialogue and engaging in conversation in an early stage of concern creates an opportunity to express concerns to a colleague in a setting between equals – without judgement – which is vital in the case of a disease such as addiction, see the 10 tips in Box 5. In certain situations a direct confrontation with the behaviour is necessary, it is important to take in account the underlying disease, especially for the help and the measures.

Box 4. *Content of the teaching module*

- 1. E-learning component on 'Addiction in physicians – how to identify substance use disorders and addiction' (aimed at knowledge).** Research carried out by the RDMA shows that physicians struggle to recognise the early signs of substance use disorders and addiction [13]. Physicians also want guidelines on how to open a dialogue with a colleague they are concerned about and what action they can take if patient safety is at risk. To improve physicians' knowledge, the teaching module starts with an e-learning component on recognising substance use disorders and addiction.
- 2. Preparatory homework assignment (aimed at self-insight).** Prior self-reflection is essential if physicians want to discuss substance use disorders and addiction: knowing your own assumptions and ideas on this topic enables you to start a supportive dialogue in a better way when presuming substance use in a colleague. This is why the homework assignment also looks at the coping strategies of physicians themselves. Carrying out the preparatory homework assignment helps physicians to develop greater self-insight.
- 3. Group session (aimed at communication skills).** In order to discuss substance use disorders and addiction, in addition to knowledge and self-insight physicians also need to rehearse the conversation. Physicians receive training in how to talk to patients. If a physician wants to open a dialogue with a colleague, physicians need to use their communication skills in a different way. Research carried out by the RDMA shows that physicians wish training in this area in order to actually engage with a colleague [14].

Box 5. *Summary of the 10 tips for opening a dialogue on substance use and addiction when you are concerned about a colleague*

Preparing the conversation

1. Ensure you prepare properly for the conversation with your colleague.
2. Arrange a quiet location at a quiet time of day with sufficient time at hand.
3. You should be aware of the fact that in many cases a colleague will need multiple signals from his environment or conversations before he recognises that he needs help and/or seeks help.

The conversation

4. Start the conversation by saying that you are concerned about your colleague and/or patient safety.
5. Talk to your colleague about situations and behaviours you have observed, without judgement or subjective input.
6. Give your colleague the opportunity to respond and express their emotions.
7. Remain aware of your own emotions and non-verbal communication.
8. Be prepared for two scenarios: your colleague denies the problem or your colleague acknowledges the problem.

Concluding the conversation

9. Discuss how you are going to record your agreements confidential and provide this to each other.
10. Close the conversation as you started, by saying that you are concerned about your colleague and/or patient safety.

Box 6. Summary of an ambassador's duties

What does an ambassador do?

- You will be working within your organisation and professional or scientific association to promote the discussion of substance use disorders and addiction.
- You will be encouraging and motivating colleagues to be aware of and pay attention to substance use disorders and addiction in healthcare professionals.
- You will be encouraging cooperation at all levels of the organisation on this topic.
- You will function as an expert on this topic within your organisation and professional or scientific association.
- You will inform your colleagues about the PHP (the support service and the tool kit).
- Your name and profession will be listed at www.abs-artsen.nl/toolkit if you agree.

Finally, the PHP has created a network of ambassadors. This network comprises physicians and other healthcare professionals who are committed to ensuring a healthy and safe working and learning environment where addiction is treated as a disease, see Box 6.

Conclusion

The past decade major steps have been taken in making substance use disorders and addiction in physicians in the Netherlands a topic. Although substance use disorders and addiction in physicians formerly was a taboo, the topic is now discussed more openly and receives greater attention in the community of physicians. This article describes how the RDMA has achieved this through their PHP the past decade.

Since the launch of the counselling service in 2011, more than 400 physicians and individuals in their environment have contacted the PHP for confidential help, advice, guidance and/or monitoring. Over the years the number of people contacting the PHP has gradually increased, and the PHP currently receives calls from around 60 individuals every year.

Significant progress has also been made in raising awareness:

- The website of the support service and tool kit is viewed by around 250 visitors every week.

- Over 30 healthcare organisations signed the declaration of intent in 2020, making substance use disorders and addiction part of their agenda.
- Nearly 300 physicians followed the e-learning module in the first six months after release.
- There are 60 ambassadors who actively work for the PHP within their organisation and who use the tool kit for this purpose.
- Four other professional groups (dentists, pharmacists, psychologists and physician assistants) are investigating into how they can set up a programme like the RDMA PHP for their own members.

The success of the Dutch PHP is mainly due to the combination of offering help with the counselling service and investing in raising awareness with the tool kit. Both components are essential and have a mutually reinforcing effect.

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Tackling Regional Epidemics through One Health Social Policy and the UN-2030 Sustainable Development Goals

Problem Statement

Planet Earth has been here for over 4.5 billion years but in just two human generations we have managed to place our only 'home' at great risk. Given existential challenges – climate change, biosphere degradation, zoonotic diseases, while tackling issues of diversity and inclusivity, there is a pressing need to re-orient society towards a sustainable future.

The overarching aim of this One Health multidisciplinary research project is to build regional capacity for valuing and promoting the One Health concept (OH) as the foundation for achieving the UN-2030 SDGs and thereby – creating a “more just, sustainable and peaceful world.”

Project Objectives

Collaborating with regional/global organisations, many of which presently engaged with the international One Health for One Planet Education (1HOPE) initiative, we propose – in association with 1 HOPE education advocacy groups (Annex) – the establishment of regional multi-institutional One Health-SDG social policy research consortia to

1. investigate the root causes (socio-economic, geopolitical, environmental) and impacts of epidemics;
2. explore how OH and the SDG-related curricula across educational systems can become key drivers of transformative social change;
3. formulate specific systemic and social policy recommendations (within and across LMICs) that pursue goals of social equality and responsibility–developing and sharing values and cultures by, as one example, working together on projects with communities, and learning to contribute to positive change in society.

4. address the effects of Covid-19 on realising the target of SDG 5: “Achieve Gender equality and empower all women and girls,” fully recognising that the limited progress which has been made is in danger of reversing and that extensive *efforts* will be urgently required “to redress long-standing inequalities in multiple areas of women’s lives, and build a more just and resilient world.” Regions and countries are therefore tasked with
 - “including women and women’s organizations in COVID-19 response planning and decision-making;
 - “transforming the inequities of unpaid care work into a new, inclusive care economy that works for everyone;
 - “designing socio-economic plans with an intentional focus on the lives and futures of women and girls.”

Rationales

As mentioned previously, our fragile planet is highly vulnerable from human activity that continues to prioritise wealth over sustainable values, division over unity, and generally failing to consider the health and well-being of the planet and the sanctity of all life over vested interests. Many lessons from history have not yet been learned and new lessons may prove equally, if not more, difficult to take on board as we head deeper into the twenty-first century. Two of our greatest social problems are changing the way we relate to the planet and to one another, and confronting how we use technology (dataism) for the benefit of both humankind and the planet.”¹ HOPE reinforces the urgency put forth by the Earth Charter to “embrace a new sense of care and responsibility to the Earth community” with particular emphasis

1 Survival: One Health, One Planet, One Future (including reviews)

Countries

- Africa: Cameroon, Kenya, Rwanda, South Africa
- SE ASIA – Thailand, Malaysia
- Latin America – Chili, Brazil, Peru

Lead Applicant

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Principal Investigator

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Funding Request CAD \$3,000,000

on the “Respect and Care for the Community of Life” and “Ecological Integrity.”²

Lifelong learning is key to our survival and the sustainability of life on earth as we know it.^{3,4}

“Education is not only a human right it enables the realization of other human rights – reducing poverty, boosting job opportunities and fostering economic prosperity”⁵ and is pivotal for achieving gender equality while also ensuring that Youth and Young

2 Earth Charter International

3 Global Population Health and Well-Being in the 21st Century

4 Future Africa-1 HOPE Transdisciplinary Research Webinar Series

Adults “care about the well-being of their friends and families, their communities and the planet.”⁵

“*Social justice* is at the heart of climate justice and that is where we need to start...”

Methodology

Research methods will be informed by the nature of the research problems and the worldview assumptions the consortium researchers bring to the study including both procedures of inquiry (strategies) and methods of data collection, analysis and interpretation. Important considerations will be the impact of Covid-19 on the countries, on-going investigations at country and regional levels, time available, the researchers’ personal experience along with potential audiences of the research project. The research will encompass quantitative, qualitative and mixed method (e.g., ethnography, surveys) . While socio-economic, political, and ecological findings of each country will be treated independently, it will be important to synthesise these findings across the regions to determine common issues and arrive at meaningful solutions. The regions involved have some of the highest proportion of young people and, as UN Secretary-General António Guterres observed several years ago, they need to come “into the conversation, to enable them to express themselves, to listen to them, invest time and resources in them and empower them to realize their goals.” The Secretary-General’s determined advocacy for intergenerational knowledge exchange has become even more compelling given the impact of recent epidemics on education, health, incomes and regional sustainability generally.

It is conceivable that the overall approach to the research will be a combination of postpositive, social constructivist, advocacy/participatory and pragmatic in terms of conclusions and recommendations.

5 Naidoo J., Antoninis M. UNESCO paper (2018) on global education financing

Provisional Lines of Research Inquiry

1. What are the main root *causes* (socio-economic, geopolitical, environmental) of LMIC epidemics (e.g., HINI, MERS-Cov, H7N9, Ebola)?
2. What impacts – socio-economic, political, environmental – have regional epidemics had on LMIC communities? How have these been addressed (e.g., government policy (e.g., poverty reduction, infrastructure developments, veterinary and human public health systems)? What part have preventive measures played in LMICs to ensure regional sustainability? What have been the immediate and longer-term outcomes on the quality of life index (health, education, employment)?
3. How have these epidemics affected progress in terms of meeting UN-2030 SDG targets across LMIC regions?
4. To what extent has Covid-19 raised global awareness about the urgency to address large-scale interconnected problems, such as “environmental degradation, economic and political threats, ideological extremism”^{6,7}?
5. What lessons are being learned from Covid-19 that may be timely and highly relevant for LMIC regions and their future sustainability?
6. The challenges facing our world generally and regions in particular cannot be solved by individual nations or regions alone. What fundamental values and principles – partly derived from the OH concept and the SDGs (e.g., propositions for global sustainability¹) – need to underpin the development of intersectoral Social Policy (especially with regard to green and inclusive recovery, income and jobs, well-being, climate action, resilience)?
7. In terms of progressing understanding and valuing of OH and the SDGs, what fundamental contributions can the

6 Universities in the Early Decades of the Third Millennium: Saving the World from Itself?

7 UN Sustainable Development Goals –Climate Justice

international *One Health for One Planet Education* initiative (*1 HOPE*) make across LMIC regions? How can these assist in operationalizing Social Policy initiatives guided by the integration of transformative education and the building of transdisciplinary research capacity (e.g., *embedding an ecological knowledge framework across higher education curricula*)? 8. (e.g., *UNSA-A Diplomats Leadership Conference – University of Cape Coast* [Ghana-26.06.2020]).

8. How can digital communication systems – within and across regions – be evolved to strengthen networking and collaboration with regard to implementing Social Policy strategies relating to the prevention and mitigation of future epidemics.
9. How can the younger generation play a more pivotal role in social policy development and implementation across LMICs?

Expected Results

The overall aim of the 1 HOPE education initiative (below) is to “Build global capacity for promoting and valuing the One Health (& Well-Being) concept as the foundation for achieving the UN-2030 Sustainable Development Goals. To these ends Development and Advocacy Teams are being established across several regions (2021–2023), as shown below. The findings of the research consortia are vital in order to support the social policy recommendations necessary to underpin the 1 HOPE vision and purpose: “a world where people of all ages in civil society, government/non-government and corporate organisations apply the One Health (and well-being) concept/approach – recognising the interdependencies of humans, animals, plants in a shared environment – thereby collaboratively ensuring the sustainability of the planet and the species.’ A major criterion of success of both 1 HOPE and the epidemic research would be the extent to which regions (e.g., ministries of education, teacher training colleges, schools, colleges/universities and

societies in general will have adopted the 1 HOPE concept and the SDGs in their missions and strategic planning.

AFRICA (Sub-Saharan)

- Primary-Secondary
- Technical-Vocational Education
- Tertiary/Higher – Adult Education
- Civil Society/Govt/Corp – Lifelong Learning
- 1 HOPE Youth & Young Adults

AMERICAS (Canada, US, Latin America)

- Primary-Secondary
- Technical-Vocational Education
- Tertiary/Higher – Adult Education
- Civil Society/Govt/Corp – Lifelong Learning

- 1 HOPE Youth & Young Adults

ASIA (South East & India)

- Primary-Secondary
- Technical-Vocational Education
- Tertiary/Higher – Adult Education
- Civil Society/Govt/Corp – Lifelong Learning
- 1 HOPE Youth & Young Adults

Team Expertise

- Prof Liesel Ebersöhn: Director, Centre for the Study of Resilience Full Professor: Department of Educational Psychology Secretary General: World Education Research Association, University of Pretoria-p/note correct email – liesel.ebersohn@up.ac.za
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- Dr. George Lueddeke, Programme Lead, International One Health for One Planet Education Initiative (1 HOPE), United Kingdom, Research Associate, University of Pretoria, Author, Advisor, Higher, Medical, One Health Education
- Dr. Irene Naigaga, Programme Manager, Africa One Health University Network (AROHUN)
- Dr. Vipat Kuruchittham, Executive Director, South East Asia One Health University Network (SEAOHUN)
- Ms Alicia Jimenez, Program Manager, Earth Charter International

- Dr. Daniele Fuega, Founder, One Health Caribbean and Latin America Network
- Dr. John Amuasi and Dr. Andreas Winkler, Co-Chairs, The Lancet One Health Commission
- Dr. Zeev Noga, Executive Director, World Veterinary Association
- Ezra Yego, Sustainable Development Sustainable Youth Initiative, Deputy Project Lead

Budget and justification (36 months)

CAD\$ 3,000,000

To be determined asap

Supporting documents

To be completed and sent asap

Concept Note

Prepared by George Lueddeke (PhD, MEd, Dipl. AVES [Hon.])
05.04.2021

Short bio

Originally from Canada (northern/southern communities) working in secondary and post-secondary education, I now reside in the UK. Previously with the [Faculty of Medicine](#), University of Southampton, (education&research development, UG/PG quality assurance), one of my current projects is leading the international *One Health for One Planet Education* initiative (1 HOPE) in association with national and global organisations (p/see below). Complementing this role is as research associate with the [Centre for the Study of Resilience](#), Faculty of Education, at the University of Pretoria, South Africa.

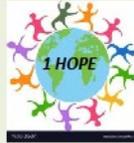
Publishing and presenting widely on education transformation, innovation and leadership (including threads from two prior volumes, *Transforming Medical Education for the 21st Century* and *Global Population Health and Well-Being*), a recent book is entitled [Survival: One Health, One Planet, One Future](#) (2019/2020). Three key themes weave through this publication: (1) that the survival of all species – including *homo sa-*

piens- depends on a healthy planet; (2) that urgent action is needed to tackle existential risks and counter the thinking that perpetuates the ‘folly of a limitless world’; and (3) that the One Health concept and the SDGs are key drivers for enacting transformative change toward global sustainability. Reference to the [IRDC consultations](#) carried out in 2016 and 2017 contributed to the book’s contextualization of global health and social transformation. Underpinned by a pressing concern for the whole Earth, an invited follow-up chapter to *Survival* was [Universities in the Early Decades of the Third Millennium: Saving the World from Itself?](#), which relates to the development of *interconnected ecological knowledge systems* across tertiary/higher education – programs, research and services.

Current priorities involve establishing and coordinating the 1 HOPE initiative across several global regions and supporting student and colleague capacity for engaging in [transdisciplinary research](#) – focusing in particular on climate change, biosphere degradation, zoonotic diseases, alongside issues of inequality, diversity and inclusivity. In addition, I contribute to several publications (e.g., guest editor/author [chapters, articles]) with a recent [commentary](#) on a timely article, ‘More for The World Organisation for Animal Health (OIE).’

Recognising that Africa and the Middle East have the highest proportion of young people on the planet (average age – 24), many would have agreed with UN Secretary-General António Guterres’ observation in 2018 that the time had come to bring young people “into the conversation, to enable them to express themselves, to listen to them, invest time and resources in them and empower them to realize their goals.”¹ His advocacy has gained even more importance in the past few years given today’s climate and ideological challenges and, in particular, the socio-economic impact of Covid-19 on the regions prioritised in this concept note – collectively arguing for a global mindshift toward sustainability – the main rationale for the 1 HOPE initiative.

**International
One Health for One Planet Education
Initiative**



*in association with
regional / global organisations*

SDG #



VISION

A world where people of all ages embrace a *One Health & Well-Being (OHWB)* approach recognising the fundamental interdependencies of humans, animals, plants and their shared environment

AIM

Build regional and global capacity for valuing and promoting the *One Health* concept as the foundation for achieving the *UN-2030 Sustainable Development Goals (SDGs)* and helping to transition toward a new 'normal'

REGIONAL AND GLOBAL APPROACH

Focusing on *Africa, Americas, Asia, Europe, Middle East, Oceania* via multi-disciplinary *1 HOPE ADVOCACY & DEVELOPMENT TEAMS* and *AFFILIATIONS*

OBJECTIVES

Raise public awareness and identify education / research *OH* and *SDG* priorities with stakeholders
Develop pilot project proposals for potential external funding

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Tree of Life

In a void beyond places
and aeons of time,
it flickers with power
of primordial chime.

A single small tree,
a firing strife,
burns unburnt,
rooted in life.

The leaves of its branches
are we.
Be there meaning or not;
it is thee.

When battered by tempests
of decay and delight,
may it not be forgotten;
the oath is to life.

by Rikhard Ihamuotila MD