IFMSA was founded in May 1951 and is run by medical students, for medical students, on a non-profit basis. IFMSA is officially recognised as a non-governmental organisation within the United Nations’ system and has official relations with the World Health Organisation. It is the international forum for medical students, and one of the largest student organisations in the world.

The mission of IFMSA is to offer future physicians a comprehensive introduction to global health issues. Through our programs and opportunities, we develop culturally sensitive students of medicine, intent on influencing the transnational inequalities that shape the health of our planet.
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Cover: What will health look like in the future? Anny Huang, Australia
Editorial

Remember the 1950s? I don’t either, but a quick bit of research shows me that their predictions for what the year 2000 would hold included airports in the centre of cities, and candy made out of sawdust. Dirty plates would never have to be washed - instead, they would dissolve in super-heated water, and replaced by new disposable dissolvable plates. Houses would be able to be thoroughly cleaned simply by turning on a hose - all household items would be waterproof. Hurricanes would be averted by predicting impending storms building over the oceans, and then spreading oil over the waters and setting this on fire.

Some of the medical predictions were equally as far-fetched. For example, our forbears predicted that by the year 2000, cerebral palsy and Parkinson’s Disease would be curable. They also imagined that with time-saving devices, the availability of nurses would be such that the patient would have everything that he or she needs at the push of a button. Signs of ageing, such as wrinkles and leathery skin, would be “signs of neglect” rather than the norm.

However, some of the other prophecies, such as reheatable frozen dinners, were startlingly accurate. In the 1950s, it was predicted accurately that by the year 2000, there would still be no cure for cancer. It was also imagined that by the start of this millennium, electron microscopes would be able to visualise viruses, and synthetic versions of antibiotics would be created, so that we will no longer be harvesting fungi to treat infections.

There were still some other prophecies that have made me realise how far we have come in just the past 50 years, and what we take for granted in the year 2011. For example, people in the 1950s talked about telephones being connected to televisions so that conference calls can be made, and also about there being a faster alternative to telegrams - the facsimile. The fact that I am sitting here and checking my e-mail inbox on my laptop is testament to the fact that in the area of communications, we exceeded the expectations of those who lived before us by far.

In the area of medicine, we have also exceeded expectations. In the 1950s, people spoke of polio becoming similar to influenza - a common occurrence that people could “get over” easily. Little did they know that just a few decades later, polio would be on the verge of elimination from the world.

Now, in the year of the 60th anniversary of IFMSA, it is our turn to imagine what the future will hold. What kind of a world will we live in when we turn 70 or 80? How will we get to that point? Some of our predictions may become true, but some, no doubt, will be wildly inaccurate. We will never be able to take into account those inventions and discoveries, like the internet, that take us by surprise and change the way we live forever. However, for some more realistic and hopeful ideas and aspirations, please continue to read this publication!

Finally, I would like to take this opportunity to thank my Publications Team for all of their hard work this year. Every one of them has contributed to make IFMSA publications entertaining, thought provoking, and of high quality. I would also like to thank my fellow IFMSA Officials for their help, for making this year enjoyable, and for being a constant source of motivation.

Enjoy reading!

Anny Huang
IFMSA Publications Support Division Director 2010-2011

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Right: A 1958 prediction of what hospitals of the future would look like. Containing “weightless operating rooms for heart surgery” and “crystal balls that use concentrated sun rays to cure cancer”, this hospital design was endorsed by the American Rocket Society. Photo courtesy of the Chicago Tribune.
Message from the President

Healthcare is changing at an unprecedented rate and in a multi-pronged manner. Technology has revolutionized diagnostic and therapeutic procedures. Today’s patient differs from those of the past, in their increasing strive for empowerment and involvement in their healthcare. The change in healthcare is already evident and we need every opportunity to have some further insight into what tomorrow’s healthcare may hold. It should therefore not come as a surprise that Health and the Future is our theme for this edition of Medical Students’ International (MSI) and indeed for the coming August Meeting.

Whether we are talking about the year of the patient rising, or about leveraging cross-disciplinary exponentially growing technologies or indeed about purely health-related technological advancements such as virtual autopsies or self-use stethoscopes, it does not take much to see that the future of health and healthcare is bright. However, a major hindrance still exists and is one which the next few lines will focus on.

A major hindrance lies in the anticipated rise in the cost of healthcare associated with integrating the technological advancements available. Research requires financing. Production and supply of newer technologies to healthcare providers also requires financing. The importance of this problem then, is not lost on any, and having identified it, it is our responsibility to find ways to ensure that this hindrance is removed.

One way that we can work on this is by increased promotion and participation in research, ensuring that medical students and doctors strive to become producers, in addition to being consumers of research. More and more research increases the likelihood of identifying key diagnostic and therapeutic elements that will come at affordable prices. We as medical students and future physicians must be the driving force towards discovering and integrating affordable technology into healthcare. This is quite simply because we as medical students understand the need for research, and the need to ensure that research should produce new directions that are affordable.

As medical students, we also have the opportunity to eliminate the obstacle of affordable technology in healthcare by lobbying both governmental agencies and other members of civil society to increase funding support, both for research and for actual delivery of technology to resource poor settings. Advancing technology in healthcare will be of more value, if it is affordable in all settings. The international health community does indeed have the potential to address this issue of affordability and we as medical students have the ability to ensure that our voices are heard.

We are a unique group of medical students, living in an age when the international health community has the knowledge and technology to improve global health and achieve health for all. It is now up to us to embrace and advocate for more integration of the available knowledge and technology into today’s healthcare. It is up to us to demand that these technological advancements of healthcare be integrated in a way that ensures that healthcare remains affordable.

The future of health and healthcare looks bright and we do have an important role to play in ensuring that the necessary advancements are made, while keeping healthcare affordable.

Let us keep working together for a healthier world.

Chijioke Kaduru
President 2010/2011
International Federation of Medical Students’ Associations (IFMSA)

Accra, Ghana.
Adieu, old Standing Committee Logos, Good Morning New Face of the IFMSA!
BY IFMSA STANDING COMMITTEE DIRECTORS

Dear IFMSA Members,

Since a couple of years ago, we have been discussing the process of unifying and standardizing our Standing Committee logos. Finally, after some years, the time to show them off has come. Nothing is better than now because we are also celebrating the 60th anniversary of IFMSA.

As many of you might have already read from our discussions on the standing committee servers, the IFMSA is currently undergoing some changes in its corporate identity. Parts of these changes concern the unification of all standing committee logos.

In the past, the logos of standing committees looked quite different from each other. Many of them did not even have the same format. Additionally, some of our committees did not have a logo they could use widely. In an effort to make the face of the IFMSA more professional, the IFMSA and its members decided to unify the standing committee logos.

Within the past months we have been in contact with designers and our members to work on the new design of our logos. In the end we received several options for each standing committee. Now, IFMSA members all over the world have decided upon our new logos!

We deeply believe that this change is for the better of our Standing Committees and the IFMSA. Not only do we have a strong position between standing committees, but we are also deeply anchored within the corporate identity of the IFMSA now. An additional benefit is that the logo is more easily usable for everyone. In the future it will be easier to incorporate our logo into publications, posters, leaflets, banners, etc.

Finally, we would like to make one more tribute to our old Standing Committee logos. They was AMAZING and served us well for years. They will always be part of our heritage. - May our new logos be even more successful!

Yours,
Ioana Goganau, Joško Miše, Jovana Nedeljkovic, Christopher Pleyer, Beata Syzdul, Pablo Vega Rojas

IFMSA Standing Committee Directors 2010/11

The logos explained:

SCOME: The logo is a medical student with a doctoral cap. The face is replaced by a grid symbolizing the world.

SCOPE: The logo represents a medical student with a suitcase. The suitcase stands for medical equipment and travel. The arrows symbolize exchange.

SCOPH: The logo represents different stages of life. The snake symbolizes health and healthcare, which tries to protect these stages.

SCORA: The logo consists of a heart and a red ribbon.

SCORE: The DNA string in the logo is linked to research, and the arrows stand for exchange.

SCORP: The logo is a combination of the peace sign and two hands.
Health in the Future
BY CINTHIA JAQUELINE BAIA DE SOUZA, BRAZIL

Through the lens of cinema and pages and pages of delightful books, mankind has been playing with what our future would be like. Who has not watched Mad Max? Or The Matrix and Minority Report? And the ones in which topics involving medicine are more evident, for example: Gattaca, symptoms; providing information on what you are going to do based on your genetic profile?

Others have gone further, trying to predict the future; the way society would behave and be, like when we studied Malthusianism ideologies in geography during secondary and high school, or who has Nostradamus and his prophecies. And what about myself, what would I expect from the future, and more specific, how would I picture health in the future?

I just hope.

I hope for a more humanized medicine in the future; that our current mistakes and the past ones will never be forgotten; and that we, as well as the next generation, all learn from it.

During a discussion of a clinical case, my internship teacher said to us: “I expect great things from your generation. Better than the ones from my own, especially at issues beyond medicine we see in the present.”

I expect the same from the ones that are and will be coming after me… Funny, right?

I hope not only technology prevails and develops itself. I hope we too, can develop as humans, as students, as physicians.

It is clear that new situations and problems will be faced in the future. In my country, the elderly people will probably represent a more significant number of the population, and child mortality will become more preventable, since we are already working on its advance.

This is being done through investments on fighting malnutrition due to utilization of a diet with regional components; providing information and education to the families, and secondly instructing them with efficient ways for sustaining themselves; all that as well as an improved socioeconomic state and reduction of total quantity of the miserable population.

Moreover, obesity, hypertension and diabetes have been proving to be a huge challenge to health professionals of the future, as well as psychiatric diseases, abuse of alcohol and external causes such as domestic abuse and homicides. Even facing progresses due to health system decentralization, the results we have obtained during these twenty years are concerning, compared to the Brazil population density (1).

On the other hand, I am not hiding myself behind my hope. This simpleton inside of me keeps on imagining the future as a time when justice can be found, when medicine is for all, when millennium development goals and universal access to medical care truly happen, and we as health professionals take these matters in our hands and fight for them.

I imagine the future as a time when doctors are able to see farthest, not limited by their ophthalmoscopes, and listen with more accuracy, and not limited by their stethoscopes.

I dream of a future when in our medical schools there is an equal emphasis on teaching about dealing with our patients, taking into consideration their beings as a whole, not just as parts. Sadly, this “more humanized medicine and physicians”, that considers the patient as an interaction of the biological, psychological, social, and spiritual areas, has been shouted to the world, but in practice, it sounds nothing more than a whisper. It is not enough right now and will never be in the future. Dignity, rights, singularity, every point is taken into consideration in order for the patient not be treated as a merely carrier of a disease, but seen as a person who has a personal life that is often the catalyst of summation of these physical problems. Often, the mere contact with professionals who are dedicated to helping them charitably, associated with motivating words, reflects on recovery of the patients self-esteem and, consequently, offers a new opportunity for social reintegration.

I hope in the future we will not sit by, watching the wrongs done by our mentors and colleagues, nor get used to them - and what would be even sadder, used to doing these wrongs by ourselves.

I hope we will not forget what we have been doing, preaching and discussing... And on top of that, the future depends on our actions from right now! We need to be humanized. We need to be critics. Above of all, we need to have sensitivity, the feeling and the courage to make a difference. And IFMSA is a remarkable tool to mold the future according to our hopes, hard work and endeavors.

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How medical students can reduce global health inequality by giving poorer patients access to the latest drugs and research

BY TAAVI TILLMANN, UK, NILOFAR KHAN HABIBULLAH, PASCAL GELDSETZER, UK

Abstract
The current paradigm of drug research and intellectual property is a major cause of global health inequality. To overcome this, medical students can raise awareness and campaign on six projects that offer an alternative: Universities Allied for Essential Medicines; Differential Pricing; Government control over the budgets of pharmaceutical companies; the Health Impact Fund; Open-Source Publishing; and the Medicines Patent Pool.

We live in a world of vast health inequalities, where life expectancies between countries can vary up to fifty percent. This is not due to a genetic predisposition to death. This is largely due to a “toxic combination of bad policies, economics and politics that is killing people on a grand scale” (1). The WHO has called for healthcare workers to try to change these policies, and the IFMSA has established a SWG on this issue. We want to inform medical students of the causes of health inequalities and inspire them to take action. This article is one of two, and focuses on drug research, intellectual property and patent policy.

The problem
When pharmaceutical companies take out patents on new drugs, these patents make it illegal for other companies to manufacture the same drug for about 10 years. The original company can then sell its drug at very high prices during these first 10 years. Only after these 10 years have passed can other companies start making the cheaper, generic drugs. On the one hand, this system is good at giving drug companies back the millions they invested in drug trials. This is the step that UAEM changes: it helps students ask its university management to include a special clause in these license agreements that forces the drug company to allow generic versions of the medicine to be sold in poor countries.

This model was demonstrated impressively by students at Yale University in 2001. Yale discovered the antiretroviral drug Stavudine (Ed4T), took out a patent on it, and licensed it to the drug company Bristol-Myers Squibb to conduct clinical trials. Medecines Sans Frontieres (MSF) requested permission to use a generic version of Stavudine in South Africa, which was first refused. However, after massive student campaigning, Yale and Bristol-Myers Squibb changed their mind and gave permission for the generic production of Stavudine in South Africa. Next, competition between different generic drugs lowered the price of Stavudine by 96% throughout Sub-Saharan Africa (5), which has been a critical step in saving the lives of millions of patients with HIV. In a similar way, Berkeley students made a hand-held device for diagnosing Dengue fever, available at a cheaper price in poor countries (6). This shows that patent laws are not only about drugs, but for any kind of medical technology.

Over the past 10 years UAEM has helped create many important documents that try to define these ideas, such as the Philadelphia Consensus Statement, the Global Access Licensing Framework (7), the Equitable Access License (8), and the Statement of Principles and Strategies for the Equitable Dissemination of Medical Technologies (9). These already have the support of many world-leading universities, Nobel Laureates, opinion leaders, as well as thousands of students and academics across

versities Allied for Essential Medicines (UAEM, essentialmedicine.org) wants to make it easier for poor countries to have access to (that means, to be able to afford) the latest drugs and other health-related innovations (4). Universities are well placed to start this change, since as public institutions, they are committed to sharing knowledge and reducing suffering. More importantly, it is the universities and not drug companies who actually discover most of the candidate drugs. Universities, however, cannot afford to conduct large-scale randomized controlled trials. They license (which basically means sell) their drug candidates to a drug company who will conduct these trials. This is the step that UAEM changes: it helps students ask its university management to include a special clause in these license agreements that forces the drug company to allow generic versions of the medicine to be sold in poor countries.

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the globe. However, many universities have still not agreed to these principles, particularly in Europe. You can find out if what students at your university are doing by going to essentialmedicine.org/chapters. If there is no activity at your university, UAEM would be glad to help you start a local chapter (10), and you can email Gloria Taverá (gloria.tavera@gmail.com) for more information.

Another way of getting involved is by joining student organizations that promote the UAEM message. For example, the Non-communicable Diseases Action Network is advocating for access to medicines in their manifesto, as a part of a wider set of policies aimed at reducing non-communicable diseases (11). They will be sending a delegation to a high-level UN meeting on NCDs in New York this September, so look out for their results. If you want to get involved, you can email Nilofer Habibullah (nilo.metairex@gmail.com) or join the mailing list on www.nc-daction.org.

2. Differential pricing

While UAEM improves health inequalities for poor countries, what about countries squeezed by the middle? For example, if all drug companies charge the same price for drugs as Poland and the USA, then the Government of Poland will only be able to afford some of these drugs, while saying no to others that could still save lives. Would it not be better if we made it a little cheaper in Poland (just like how a McDonald’s BigMac is four-times cheaper in poorer countries (12)). We could revise international trade-related intellectual property law, so that the price of drugs is pegged to the wealth of each country. Using GDP-PPP per capita (13), companies would have to sell a drug at $140 in Dubai, $100 in the UK, $50 in Poland, $10 in Thailand $3 in India and $1 in Malawi. Drug companies could always shift their prices up or down, but they must do this evenly in all countries. This idea, known as differential pricing, could bring all the countries of the world to the medicine marketplace, which would not only reduce health inequalities but also amplify competition and innovation. While this idea does have technical challenges, they are relatively easy to overcome (14). The main obstacle is the drug companies, who are afraid that close attention to prices will make it easier for all governments to demand cheaper prices, which will cut their profit margins.

Let’s take a moment to reflect here why it is that Merck should have the right to all this money and power, whilst simultaneously perpetuating grave health inequalities. The taxpayers’ money is channelled into universities, who discover the drugs. These drugs are tested on good-hearted members of the public, often across the globe. Drugs are manufactured by outsourced factories, and doctors carefully select the right drug for each patient. Merck does just three things: firstly, it knows how to recruit thousands of patients very quickly; secondly, it knows how to organize a good study, and finally, it knows how to market the drugs very effectively. These are important functions and we recognize that private sector is well placed for providing these services. However, are these functions more important than the combined roles of the taxpayers, universities, patient volunteers, and the doctors? Personally, I think that drug development should be seen as a public process, funded by public money for public good, and all we are doing is outsourcing three functions to the private sector. From this perspective, the medical community (including medical students) have the right to demand more equitable distribution of drugs in a way that prevents global health inequality, while also allowing innovation to continue. Our Hippocratic Oath dictates that we should do what we can to help the millions of patients who are too powerless to speak. Differential pricing is one such idea, and if you want to work on this issue with me, then send me a quick email (tavai@e4health.org) and let’s see if we can set up an IFMSA SWG on this topic.

3. Controlling pharmaceutical companies’ budgets

Another idea I will quickly mention is tighter control about how a drug company spends its money. Right now, if Merck gets $100 from the taxpayers, $30 will be spent on research, $30 spent on marketing, and $23 left as profits (15). Are we happy with the fact that more taxpayer’s money is spent on marketing and profits, than research? Or instead, can you imagine a future where the governments of the world (collectively, through the World Trading Organization) told the pharmaceutical industry that “for every dollar you take out as profit, you have to reinvest 2 dollars in research” and “you cannot spend more than 20% of your income on marketing.”

Table 1 illustrates the potential benefits this could bring, either 45% extra money for drug development (scenario 1) or a 31% cost reduction in the prices of drugs (blue) that could be passed to middle-income countries like Poland. Governments already regulate industries of public interest, such as banking, to make sure that they serve the wider public interest and not just the wealthiest clients. There are many doctor and student organizations calling for less drug marketing (16), such as PharmAware(UK), PharmFree (USA), PharmaPhacts(Australia), Farmacritics (Spain), Healthy Scepticism and nof-reelunch.org (17). Feel free to contact them, or if you want start a campaign about how governments can regulate the marketing, profit, and
research funders (including Wellcome Trust and NIH) have said that they are happy to give more money to scientists who want to publish in PLoS (23). And if you are a scientist from a poor country, or if you are a student, then you can still publish in PLoS for free. So if you become a famous professor, then we encourage you to submit your articles to PLoS. This way you will personally be reducing health inequalities, one article at a time.

6. The Medicines Patent Pool

Imagine GlaxoSmithKline (GSK) being one man, holding in his hand the patent and drug information about drug1. Now imagine Pfizer as a woman who holds the patent and drug information about drug2. One day, they get an invitation to come and hang out at the pool and bring their drug information with them. At their pool, GSK and Pfizer notice a patient with HIV who is taking out lots of different medicines and having to swallow lots of different pills.

The patient then turns to his friend and complains, “Why can’t they just make one pill for me to take, rather than mess around with four different drugs and four different regimes for taking them?”.

Pfizer feels sad, looks to GSK and asks, “What do you think, GSK, why can’t we just make one pill for them?”

GSK replies, authoritatively: “Well darling, I got my patent for drug1 two years before you did. If we tried to combine both our drugs into one pill, then this creates complicated technical problems to do with patent laws”.

At this point, an old man sitting near them looks at Pfizer and GSK and takes off his sunglasses. “Excuse me, but I couldn’t help overhearing your conversation. I’m a specialist lawyer dealing with multi-drug patent laws, and I may be able to help you…”.

GSK, who had not yet mentioned her background, immediately took off her sunglasses as well. “Alright Gen. Eric. What are you doing here?”

Eric, but my friends have always called me General for some reason.”

“Ok Gen. Eric. What are you doing here?”

“Alright Gen. Eric. Have a seat…” They come up with a plan whereby Gen. Eric will sell drug1-2 to his friends at poor markets for just $10, if Gen. Eric gives them each 10% of the profits.

Later that evening, Pfizer congratulates GSK: “Darling, you are clever, getting money from a market that we had all ignored.”

“I know honey. We have no idea how to make money in those downtown markets – it’s a completely different world out there. But the clever bit is that our Public Relations, marketing and media people are going to love me for this. It makes us look like we care about all these poor people, while Merck is looking like a greedy idiot. Doctors are going to love us, and prescribe even more of all our drugs. Hahahahaha.”

The next morning, Merck is sitting at his office. He picks up the newspaper, reads it for 10 seconds, throws the newspaper violently at the bin, and runs out of his office.

“Hey guys, sorry I’m late” says Merck, as he sheepishly tries to befriend the others at the pool.

This story illustrates how the Medicines Patent Pool is working to improve access to medicines. It is already supported by WHO, MSF, UNITAID, editors of The Lancet (24). Companies like GSK and Pfizer have already joined negotiations, but others like Merck and Johnson & Johnson have said that they are not really interested (25). However, advocacy has made a difference in the past (26), which is why medical students need to push for everyone to join. At the moment of writing this article, an interesting battle research distribution, then send me an email.

4. Health Impact Fund

The main incentive for drug development is the amount of money that the patient has. This means that we spend much more money on research and drug development because neglected tropical diseases. Wouldn’t it be nice, if research and drug development were funded by a principle where the more you can improve Quality-Adjusted Life Years of the world, the more money you get? By getting research to focus on the things that really make people ill, regardless of their income, this would really hit back against health inequalities. Yale University proposed this neat idea and called it the Health Impact Fund (18). After just two years, it already has the support of the OECD (19), Sir Michael Rawlins (NICE), James Orbinski (MSF), and Nobel-laureate Amartya Sen (20). While there is currently no way that medical students can promote this initiative, I ask you to remember this clever idea should you see it in the future.

5. Open-source publishing

We have discussed at length the final stages of producing drugs and diagnostic technology. However, what about the preceding step – all the knowledge published in peer-reviewed articles? Universities in poor countries cannot afford the high price of these journals, leaving its doctors and scientists unaware of the latest advances and creating further health inequalities. While there are currently no medical student projects going on that are trying to change this, there is an important civil society movement we would like to tell you about. An innovative legal concept known as the Creative Commons licence (21) makes intellectual property free to everybody and anybody can try to remix it to create new knowledge. This is the basis of open-source projects like Wikipedia. Some revolutionary publishers have now adopted this to a group of journals called PLoS (22). Anybody from all over the world can read these articles for free. This is all paid by the people who fund the science. So scientists from rich countries will add a publishing fee (about $1000) into their funding applications, and many major re-
is going on between various medical student groups and Johnson & Johnson. One month ago, students went outside the Johnson & Johnson board meeting at Chicago and set up inflatable swimming pools in a stunt to draw attention to the issue. Other students have been posting public comments on the Johnson & Johnson website, and the company has had to fight hard to protect their public image (27). You can keep an eye on the activity by “liking” the facebook.com/MedicinesPatentPool page. If you want to tell other students about it, why not show the 5-minute Youtube video to your class before a lecture (28). You can also email Niilofer Habibullah (USA, nilo.metalex@gmail.com) or Jake Shepherd (UK, Mda08jrs@shef.ac.uk) about getting presentation materials on this topic, or for helping the IFMSA express its support for the Pool.

We hope that we have illustrated to you that there are viable alternatives to the 20th century paradigm of intellectual property. We encourage you to pick one of the six above that most excited you, and do something to support them, today. It doesn’t matter whether you choose to email the co-ordinator, or simply print off an article, or click “Like” on a Facebook page. The most important thing is the psychological flip that takes place when one is no longer content to be a passive observer, but decides to join the ranks of those making a difference.

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Maternal Health: Will we ever see the light at the end of the tunnel?

BY LAURENCE BERNARD, QUÉBEC, CANADA

Laurence Bernard is a global health and reproductive rights advocate. She is currently studying medicine at McGill University, Canada. She is the Vice President for Internal Affairs of IFMSA-Québec.

International Women’s day was only a few days ago, and like every year, a harsh truth came under the spotlight: Maternal Health is not globally improving. The reason? Well, several really. It was, along with Child Health, the main subject of this year’s MonWHO edition. Many topics were discussed, issues raised and solutions proposed. To tackle this important burden of disease in developing areas, the World Health Organization designed Millenium Development Goal 5: “decrease maternal mortality ratio by 75% between 1990 and 2015, and achieve universal access to reproductive health by 2015”.

Considering that the majority of deaths are caused by hemorrhage (35%) and sepsis (15%), and could be easily prevented by the presence of a skilled health worker and administration of oxytocin, antibiotics and immunizations, we find ourselves wondering why this issue is still a major one. But, once we know that in many countries, only 5% of births are attended by a skilled professional, and that the closest health clinic can be found 700 km from the mother’s village usually depleted in basic medical material, health care strengthening seems like the basis of all action. Formation and retention of medical professionals, and improvement of medical and transportation infrastructures: this is what the experts usually agree on in regards to sustainable development. But how can the States finance these investments, especially those who rely on international aid to provide basic services to their populations. Furthermore, these countries are usually rich in natural resources, exploited by international corporations. Should the exploitation model be rethought? Should international aid be better monitored and target sustainable actions to decrease Maternal mortality?

The third leading cause of maternal deaths are unsafe abortions (13%). It is also causing the third of deaths within the 15-19 year-old female population. How can this be prevented, while still being culturally sensitive? Is improving the access to contraception the magical solution? Well, no. It is true many of the countries who experience the most important maternal mortality (640 deaths/100 000 live births) have an incredibly low use of contraception (2-10%), but in others, such as Thailand, contraceptive methods are widely accessible in groceries and shops, contraceptive prevalence rate is 80% and yet, 67% of unplanned pregnancies lead to unsafe abortions. Would a better access to emergency contraception decrease the incidence of unplanned pregnancies? Probably, but the myths surrounding this contraceptive method are very prevalent. Education is usually the key to most problems: safer sexual practices, better knowledge of contraception and family planning. But who will provide this education to rural communities, in a context of scarce health professionals? Education of women is important, yes, but also education for men, who are the political and religious leaders. They were shown as one of the main barriers to access to contraception. In areas where equality between men and women is far from being reached, and where women have little decision power over their reproductive health, empowerment of women through political representation, advocacy and access to basic education, can make the difference.

Maternal Health has many aspects to it; it can be studied under an economical angle, since the costs of maternal mortality to the country, community and family are enormous, a medical angle, and a social angle. But it remains, first and foremost, a human rights matter, the right to life, health, equality and non-discrimination. Respect and protection of women’s rights to information and decision-making in reproductive health, to freedom from gender-based discrimination and violence, and to participation in planning and implementing health policies is critical for making pregnancy and delivery safer for women.

Below: The Save Our Women project team of NiMSA-Nigeria, at a meeting. The details of this project can be found in the Projects Bulletin, Issue 10, August 2011.

References:
Call for a More Peaceful Future for Doctors
Research on Hospital Violence in China
BY ZHIXING LI, IFMSA-CHINA

On June 21, 2009, after 49-year-old patient Yang Junbin died of kidney failure at the No 1 Hospital of Nanping, Fujian province, relatives scuffled with doctors and nurses, leaving seven family members and five hospital staff members injured. (1)

On Jan 31, 2011, 2 days before the Lunar New Year in China, six surgeons in Xinhua Hospital, Shanghai, were stabbed by about 20 relatives of a patient who had undergone aortic valve replacement and died of mediastinitis 47 days after surgery. (2)

There are many tragedies occurring amongst medical workers. If the life of “health providers” is in threat, how can they provide healthcare and save lives in the future? Therefore, IFMSA-China wants to call for a better environment and peaceful future of medical workers. Our slogan is “No hospital violence, better future, and better health!”

Hospital violence among medical workers has been considered an occupational hazard with complex and dangerous conditions against health care staff with negative impacts on their physical and psychological health. (3)

World Health Organization (WHO) gave the definition on health care workplace violence in a news release in 2002 as follows:

“...incidents when staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health.” (4)

In 2010, an article in the Lancet “Chinese Doctors are Under Threat” caught the eyes of IFMSA-China. In this article, the writer described the severe situation of hospital violence due to increasing medical disputes and tension between doctors and patients in recent years. (5) In order to understand the real situation and the sociological reason as well as find out the solutions for the increasing hospital violence in China, a group of members in IFMSA-China surveyed patients and doctors in 10 hospitals in Shanghai, and interviewed some experts on these issues, in a bid to find the reasons for these and find solutions.

1. The current situation of hospital violence in China

According to the statistics by Chinese Medical Doctors Association (CMDA), in 2009, among all the hospitals in mainland China, 73.33% of them encountered hospital violence including stabbing, threatening and destroying medical facilities. (6) Another research showed that in the 350 hospitals in this survey, the average number of times of violence happening in 2007 is 15.31, and the average losses caused by hospital violence in each hospital are 300,000 RMB (about 30,000 euro) (7). According to the Press Office of the Ministry of Health of the People’s Republic of China, the results of the Fourth National Health Service Investigation showed that 66% of health care staff in mainland China has experienced violent attacks in hospital and clinic.

Below: A member of IFMSA-China conducts the survey on a patient

Zhixing Li is a 3rd year medical student of Fudan University in Shanghai, China. He loves travelling, swimming and musicals.
For example, in June 2009 alone, a doctor was stabbed to death in Shandong Province by the son of a patient who had died of liver cancer. Three doctors were severely burned in Shanxi Province when a patient set fire to a hospital office. A pediatrician in Fujian Province was also injured after leaping out a fifth-floor window to escape angry relatives of a newborn who had died under his care.

2. The main cause of increased hospital violence
The causes of increased hospital violence are quite complex. Before our research, we looked into a lot of literature and news items and found that medical complaints and disputes due to malpractice or medical accidents were the major reasons for violent behaviors against health care staff.

For example, over the past year, families of deceased patients have forced doctors to don mourning clothes as a sign of atonement for poor care, and organized protests while bar hospital entrances. Four years ago, 2000 people rioted at a hospital after reports that a 3-year-old was refused treatment because his grandfather could not pay $82 in upfront fees and the child died (9).

Besides that, the imperfection of the medical care system makes treatment for the poor people expensive. The imbalanced distribution of medical resources causes a great burden on the big hospitals in big cities.

The false induction of media is another big cause. Newspaper writers want to attract readers’ attention so that they write tragic, twisted and exaggerated stories, which creates a negative image for doctors in the society.

3. Methods, materials and purposes of our research
After searching for certain literatures and information about the hospital violence in China, we conducted the research from December 2010 to March 2011 in ten hospitals. The hospitals rank from grass-root community hospital, district hospital to top-level hospitals.

The targeted people were divided into three groups, medical workers (doctors & nurses) and patients. We focused on investigating or surveying violent incidents against health care staff by patients and/or relatives and identified the potential cause and solution for violence to health care staff in hospitals. All the questions were multiple choice. 103 doctors and 302 patients participated in this survey.

Our purpose was to find out the level of awareness of hospital violence and physician-patient relationships among doctors, patients and medical students, especially their own opinion on the scale, the causes of hospital violence and their personal experiences. We also interviewed some experts in hospital management and law-making in order to know their opinion in these issues.

4. Results
Here are some of the most valuable outcomes that we got from our survey:

1) Awareness of hospital violence
In this research, 72% of the doctors said the hospitals they worked in encountered medical dispute in a violent way “very often, at least twice a month” and 63% of the doctors described the relationship between doctors and patients as “tense” or “quite tense”. An interesting fact was that, about 90% of them are from top-level hospitals, which means doctors from grass-roots hospital had a more positive vision and less pressure on hospital violence.

Similarly, among the patients, 57% of them agreed that the physician-patient relationship “should be repaired”, “tense” or “quite tense”, while 83.2% of the patients expressed their “strong will” to protect their own rights facing a medical malpractice.

2) Potential causes of hospital violence
In this part, we could see a strong contrast in the patients and doctors’ opinion towards what they regard as the “biggest reason for the tense relationship between doctors and patients”. 67% of the doctors chose “the imperfection of current policies and medical care system” as the biggest one, while 62.7% of the patients owed it to the “less responsibility and low regard for medical ethics”. “Wrong induction of the mass media”, which was the second biggest reason in the view of 52% of the doctors was not chosen by most patients. That contrast shows a big mistrust between doctors and patients.

Another big phenomenon we found during the survey was that 73.7% of the patients hadn’t realized that the “department of medical affairs” was in charge of the medical disputes in the hospital. Patients don’t know where to complain when medical disputes happen so some of them will quarrel or complain directly in the wards or in the lobby of the hospital, which also contributes to the increased hospital violence.

3) Suggested solutions
Many experts gave us a lot of useful information. Ms Wang Hui who worked as a senior procurator in the Shanghai Intermediate People’s Procuratorate gave us her opinion on hospital violence. “Hospital violence is absolutely a crime and will surely be punished. The only problem is how to deal with medical disputes.” She pointed out the problems of current laws on medical accident evaluation, which neglects the informed rights of patients, causing patients’ mistrust of the legal system.

Prof. Shao Xiaoying, who taught medical ethics in Shanghai Medical College of Fudan University talked about the influence of society re-shaping towards medical workers. “China’s society is facing a big change from the 1980s and more doctors have lost their sense of responsibility and started chasing for profits. We should emphasize the importance of medical ethics education. What’s more, the communication skills of the doctors are very important.”

Prof. Xu Hong, who works as the vice president of Children’s Hospital of Fudan University, talked about the issue from the aspect of hospital management. “First it is very important to let every doctor master the standard procedure of medical treatment by training. Any small malpractice would cause severe consequences. Second, doctors and patients have imbalanced information in the process of the medical treatment. As doctors, we should always protect the rights of patients, especially their right to know.”

5. Conclusions and Suggestions
Violence against Chinese medical staff is an escalating problem due to many reasons including imperfection of current policies and laws, less medical ethics of doctors, misleading information of mass media, and the hospital management.

Recently, a piece of news has spread widely in China that in Shenyang Province, the hospital staff in 27 hospitals called for police guards to protect them from patients. They set up a police station inside the hospital. That is definitely not the best solution for hospital violence.

According to the data we found, the prevalence of hospital violence against nurses in Hong Kong was 76% in 2004 and 63% in Australia (10, 11). So hospital violence is still a big problem in many countries. As medical students, what should we do towards this problem?

The first thing we can do is to raise public awareness of the situation. We can go to the communities to inform them about the right way to solve medical disputes. If there is any news about hospital disputes that is made up or wrongly reported, we should at first write articles to correct it and help build a positive image of medical workers. Everyone is a poten-
tial patient, so if everybody has an idea of how to solve disputes peacefully and efficiently, the violence would decrease.

Then many activities could help to ease the relationship between doctors and patients. In May 2011, we started China’s first Teddy Bear Hospital. During the process of the activity, many children had less anxieties towards hospitals, which could also help them “like” the hospital and doctors. If the children spread the feelings to their parents, this may slowly influence the feelings of the society. This is a good “side effect” we found of TBH.

As future doctors, we should also educate our classmates on the importance of communication skills and medical ethics. We can have small group discussions on how to tackle difficult situations in the process of the treatment, or raise debates on some topics of ethics. We should help all the medical students have a responsible and beautiful mind.

The theme of the August Meeting of the IFMSA is “Health and the Future”. Doctors are health providers. But what if the life of the health providers is under threat? I think we must call for a better environment and a more peaceful future for the medical workers. In that way, we could finally have a healthy and better future!

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- Surveying the patients: Sui Yilun, Wang Tian, Tang Xinjun, Lu Xiaoling
- Surveying the doctors: Tang Xinjun, Yuan jia, Liu Hao
- Interviewing: Li Zhixing, Jin Lixia
- (All of them are 3rd-year medical students of IFMSA-China in Shanghai Medical College of Fudan University)

Notes:
10. PRW Kowk YL, KE Li, YC Ng, MH Cheung, VKP Fung, KTK Kwok, JMK Tong, PF Yen,WC Leung. prevalence of workplace violence against nurses in Hong Kong. Hong Kong Med J2006;12.
“We should all be concerned about the future because we will have to spend the rest of our lives there.”

- Charles F. Kettering

Photo Story: Silhouette of the Future
By Adeyemi Oluwaseun John, Nigeria

› The Black Woman…and her Child

“The past can’t see you, but the future is listening.” ~ Destin Figuier

Black is beautiful! The African woman - a symbol of resilience, has been taunted with poverty, wars, natural disaster, and disease. Sadly, these negatives are not leaving humans soon. At least so it seems. The best one can do is hope for the best while policy makers and leaders of the world keep working hard in protecting the health and rights of women and children.

Photo: Adeyemi Oluwaseun John, Nigeria
Technological Gadgets

“I am not afraid of tomorrow, for I have seen yesterday and I love today.” ~ William Allen White

You need not be a doctor to have one. But a cutting-edge doctor needs one. iPads, iPhones, Tablet PCs, and a whole lot of other gadgets would flood our future. The ones with us are stunningly beautiful. The future can only get better with these gadgets making learning easier.

Photo: Adeyemi Oluwaseun John, Nigeria

Robotic surgery

“The future has a way of arriving unannounced.” ~ George Will

Medicine is advancing in giant strides. The field of robotic surgery, in the last twenty years, has continually evolved to its current state. These doctor-robots are not planning on leaving us soon. If anything, they would replicate themselves into all fields of medicine and become an integral part of the medical profession.

Photo: Dr. Adisa AO, Dept of Surgery, Obafemi Awolowo University, Nigeria

Bonding, Friendship, Love

“The bond that links your true family is not one of blood, but of respect and joy in each other’s life.” ~ Richard Bach

What bonds us together is stronger than what separates us. Young people, all over the world, separated across thousands of miles would have stronger ties and relationship, with the divide between the real and virtual blurring into oblivion. Love, not hate, would exist in our future. And that is a choice.

Photo: Anny Huang, Australia
› Medical Education

“Education is the passport to the future, for tomorrow belongs to those who prepare for it today” ~ Malcolm X

The books will not change, I am pretty sure of that. They can only get bulkier with more e-copies. And the stress inherent in the making of a doctor would also not decline. Focus of training and research would only change. The past would require update courses and the future would read the present as history.

Photo: Adeyemi Oluwaseun John

› In Need of Treatment

“When it comes to the future, there are three kinds of people: those who let it happen, those who make it happen, and those who wonder what happened.” ~ John M. Richardson, Jr.

Health inequality within and between countries is an issue all over the world. And somehow, the solutions are staring us in the face. Except drastic actions are taken today, the future would not just be worse but more expensive – health wise.

Photo: Omar Abdel-Mannan
Changing with the World
BY JOHN G. G. BANIN, GHANA

“...health will finally be seen not as a blessing to be wished for, but as a human right to be fought for” – Kofi Annan, former UN Secretary General.

Public attitudes fluctuate regarding the new developments in science and technology. From the discovery of penicillin to the times of smallpox eradication, the public has been full of praise for science and medicine. From the socio-economic rise in the standards of living to the glamour of landing man on the moon, euphoria filled the atmosphere with hope for a prosperous future.

However, as history presents the era of World War II, feelings of scepticism arose in the field of medicine. The observed Nazi Human Experimentation produced moral and ethical reflections, where these physicians were later summoned to trial and the Nuremburg Code of Medical Ethics was established(1).

Going back in history again to the 18th and 19th centuries, Thomas Percival wrote about medical jurisprudence and coined the phrase ‘medical ethics’(2). Since then, many professional bodies have revised these ethical codes to reflect the humanity in the art of medicine.

These described incidences illustrate how medical practice has needed to change to maintain high standards and protocol. In some parts of the world, public scrutiny of the profession has ensured strict adherence to professional codes of ethics and associated protocols. Advancements in the field have also promoted the adoption of ethical codes to incorporate areas such as contraception, abortion and birth, assisted reproduction, genetics and also research and innovative treatment. Coming back home, the African continent has transitioned greatly as more citizens have obtained higher levels of education and are increasingly more aware of their rights as citizens and patients. Ethical issues have generated intense debates in the corners of the governments of several African states, including the debate over legalizing euthanasia in South Africa (3).

“By the time you start practicing, things will be a lot different.” “Maybe we will find a cure by the time you start practicing.” These statements from professors often remind us about the rapid evolution of health and technology in the world, including their utilization in medical practice. First, this change may be visible today as euthanasia, resuscitation and life support, and genetic engineering are common discussions in the field. Coming back home, the African continent has transitioned greatly as more citizens have obtained higher levels of education and are increasingly more aware of their rights as citizens and patients. Ethical issues have generated intense debates in the corners of the governments of several African states, including the debate over legalizing euthanasia in South Africa (3).

The lack of enforcement of patient protection laws in Africa is disturbing. I wish a future for Africa where physicians respect patient rights and dignity, while each national government commits to providing safe healthcare in an equitable manner to the population.

One major concern is that the high prevalence of illiteracy and related ignorance in Africa has established the social image that physicians are demi-gods. Physicians may utilize various diagnostic tests (i.e. CT and MRI scans) for their clinical practice, just as genetic research samples may be analysed in a country rather than being transported to international laboratories. Although they may be satisfied and hopeful in the future of medical care in Africa, physicians may remain overwhelmed with the workload and respective conditions of a developing country and erroneously disregard the dignity of human lives. For this reason, governments are recognizing these scenarios and becoming more sensitive to demonstrations held by physician groups.

John G. G. Banin is a final year medical student at the University Of Ghana Medical School. He served as a national executive of FGMSA between 2009 and 2010 and currently serves on IFMSA’s Publications Team as a text editor. John has special interest in Public Health and believes the solution to Africa’s problems can only be solved by Africans themselves!
A second major concern is that privacy in medical care is considered an illusion, most likely due to patient-related factors and the lack of infrastructural services. The lack of resources, space or staff can complicate the health services provided to the population. Expectant mothers may need to sleep on mattresses in open spaces for clinical examinations and management, whereas two sick children in the emergency room may need to share a cot. These conditions must be seriously addressed by all stakeholders in health as the sanctity of life and human dignity has been denied.

One positive outlook in the development of medical care and services is that the more educated and informed population has learned to be an active patient. Patients are demanding improved quality of health services from their physicians, which serves as a catalyst to change physician behaviours and ethical treatment.

If African governments would commit to establishing more solid public health measures, more work can emphasize preventive medicine. However, technological advancement can be an advantage just as a challenge to our healthcare system. First, according to a study by students of Moi University in Kenya, the utilization of Mobile Health (M-Health) at the regional, community and individual levels may be used to reduce the burden of chronic diseases in Africa. “Mobile” health (m-health) represents the use of mobile technologies, including cellular phones in public health and clinical care.

Second, ethical values regarding patient confidentiality have been challenged with the advent of social networking. Although social communication may serve as a learning platform, it may also serve to share patient information or create discussions on specific patient conditions.

For example, in a study involving sixty percent (78/130) of US medical schools, 60% reported incidents of students posting unprofessional online content. Another 13% reported violations of patient confidentiality. Of 45 schools that reported an incident and responded to the question about disciplinary actions, 30 gave informal warning (67%) and 3 reported student dismissal (7%). Policies that cover student-posted online content were reported by 38% (28/73) of deans.

In conclusion, an ethical healthcare system requires collaborative efforts between the national governments and appropriate practitioner professional conduct. Governments must commit to providing the latest technology and improving the conditions of physicians and other healthcare workers to optimize health for the African population. An understanding of Africa’s basic problems will be paramount to making any future partnerships and also optimal use of World Bank financing or foreign aids. Medical schools need policies and guidelines concerning social media and should organize more training on ethical issues to form the new generation of health professionals, meet the current challenges and prepare for the future.

More ethical issues are bound to proliferate as society becomes more complicated. We may be debating topics, like genetic engineering, euthanasia and life support issues in the near future in African countries. In an era where the patient is informed, we might also expect patients lingering in the corridors of our hospitals and threatening lawsuits.

The practice of the art has always been and will always be influenced by the society and the circumstances that prevail. The next generation of physicians needs adequate training and capacity building to be able to embrace the changes that come with the advancement.

References

Below: Hospital entrance, Lagos, Nigeria. Photo: Anny Huang, Australia
How medical students can treat and prevent poverty

BY TAAVI TILLMANN, UK

Our world is marked by unprecedented and obscene inequalities in health and wealth. Millions of children die from easily preventable disease, as one-sixth of the world does not have access to clean water, education or healthcare. It would cost the world just $40 billion, or 0.05% of global income, to provide everybody with the basic social determinants of health: basic education, basic healthcare, adequate food, clean water and safe sewers. It would be easy for the world to find this money, if there was enough political support for poverty eradication. Medical students and doctors have a key role to play in building up political support for this agenda, by informing themselves and others of the feasibility of poverty eradication. There are currently four projects that directly attempt to address this issue: 1. the Robin Hood Tax, 2. End Tax Haven Secrecy, 3. Global tax on the super-rich, and 4. Economic Governance for Health.

The problem

We live in a world of vast health inequalities, where life expectancy can vary 50% between countries. This is not due to genetic predisposition to death. This is largely due to a “toxic combination of bad policies, economics and politics, that is killing people on a grand scale” (1). Poverty is the single most important root cause of ill health today, whereby one child dies every four seconds as a result of poverty (8 million deaths due to poverty are mediated by 4 main social determinants of health:

1. Clean water and safe sewers - 2 billion people do not have access to safe sewers, and 1 billion people do not have access to clean water (2). As a result, 2 million children die every year due to diarrhoea (3).
2. Access to healthcare - 250 million people do not have access to basic healthcare. As one result, 2 million children die every year because they are not immunized.
3. Insufficient food - this is a significant contributing risk factor to the deaths of 4 million children each year (4).
4. Lack of education - education allows people to understand and practice healthier lifestyles. It also gives them better jobs and salaries with which to purchase healthier lifestyles (5). However, 1 billion people today are illiterate and live in extreme poverty (earning less than $1.25 a day) (6).

It would cost surprisingly little for the world to provide sufficient food, clean water, safe sewers, and access to basic healthcare and education for everybody. Achieving this would cost only $40 billion (7), which is just 0.05% of the total income of everybody in the world today.

This suggests that the main barrier to eradicating poverty is not lack of money, but lack of political will to make this a significant priority, in comparison to all the other things that the world wishes to spend its money on.

The medical profession has for decades provided relief to people in need through organizations like Médecins Sans Frontières and the Red Cross. However, increasing numbers of doctors are saying - what is the point of curing all these people, only to send them back to the miserable conditions that created the illness in the first place? If we are genuinely interested in preventing disease and improving life expectancy, then advocating for more effective poverty relief may be the single most efficient thing that any doctor can do to make the planet healthier. For the first time ever, the WHO has recently begun to rally mass medical support for the political agenda of widespread poverty relief, and provision of the basic social determinants of health (8). Accordingly, the IFMSA has established a SWG on this issue, aiming to inform medical students of ways to take action. This article is one of two, and focuses on the issue of how governments could find the $40 billion necessary to finance these 5 social determinants of health across the world.

1. The Robin Hood Tax could generate $700 billion and make the banks more stable. This tax is technically known as the Financial Transactions Tax, and the Robin Hood Tax Coalition has done well to rename it something which has captured the imagination of the wider public (see robinhoodtax.org/progress). Today, if bank A wants to buy something from bank B (like foreign currency, mortgages or derivatives), then they can do as much trading as they like with no tax. This means that sometimes, lots of bankers can get really excited about one product, such as the foreign currency of Thailand, and raise its value very quickly. Another minute, they can all get nervous and start to reduce its value very quickly. This is called “hot money” which, like financial storms, can destroy a country’s economy (as it did to Thailand in the 1997 East Asian Financial Crisis (9)).

Taxing this hot money would make markets more stable, and also bring much money that could be spent on public services. The Robin Hood Tax campaign’s idea is that 50% should be spent inside each country, 25% be given to fight climate change, and 25% be given for development towards the Millennium Development Goals (MDGs) (10). If implemented in all the countries of the world, this could generate $1.75 billion toward developing the MDGs. This campaign is building more and more momentum, with support from the France (11), Germa-

Taavi was born in Estonia and has spent half his life in the UK. While studying Medicine at Glasgow, Taavi was also able to set up a small translation company in Estonia, so he has a basic grasp of business development. Over the past two years, has devoted himself more to the general cause of alleviating poverty and suffering in developing countries from an economic angle. Most of these energies have centred around the Economic Governance for Health initiative, but this has given him much experience in advocacy and campaigning through partner organizations like Medsin and IFMSA. He is currently on the IFMSA SWG on Health Inequality and Social Determinants of Health.
from my perspective, belongs to the govern-
good people of Dubai enjoy the tax money that, However, on what ethical ground should the (14)).
who seek their help need to “liberalize their and the World Bank have insisted that countries due to two reasons: 1. institutions like the IMF 
and presumably “fair” manner (Figure 1).

tax havens cost the world’s governments $800 bil-
only use some of the excess concentration of
health. Imag-
line this mathematical illustration: there are 225 people in the world, where each person earns an average of $300 million income every year. If we taxed this ultra-rich elite with a sup-
per tax that cut their income in half (so they would only receive $150 million each year and the government would receive the extra $150 million), then this small group of people could single-handedly finance the eradication of pov-
erty, forever. We should review the numbers and make a political decision. We have the
money, we have sufficient democracy, we have the global institutions that can make economic sanctions against “rogue states,” such as Swit-
zerland or Dubai. We can easily make poverty history in our lifetime if we wanted to and be-

ny, the UK and the European Parliament (12),
over time, these institutions
vestorland or Dubai. We can easily make poverty

as diverse as oil in Nigeria, ex-Soviet factories or weapons in Russia, or even clever bankers in the UK or clever IT people in Silicon Valley. Re-
gardless of how one creates, extracts or seizes

2. Tax Havens and Capital Flight cost the world $800 B
I want to tell you a little about the role of tax havens in creating global wealth inequalities. Wealth is generated by harvesting the resour-
ces and assets of the local economy. This may be

3. A global tax on the super-rich could provide healthcare to everybody
however, over time, these institutions

4. Economic Governance for Health – using national democracy to create interna-
tional democracy
I have presented three separate ways that countries can revol

votes, even when most of the money is now coming from poor countries? What is the moral or ethical justification?

There are many civil society groups telling their politicians to increase the transparency, accountability and democracy of the IMF, WB and WTO (bretonwoodsproject.org). Most of their supporters are economists, but more people from other professional backgrounds are starting to realize that these institutions have a major effect on their field. Two years ago, I joined a group of doctors and medical students who were initiating campaigns on the issue that unfair economic governance perpetuates poverty and ill-health (22). This group, called Economic Governance for Health, also raises awareness and campaigns about unhealthy trade policy (e.g. marketing of formula milk, tobacco kills 6 million people annually) through eg4health.org/join-us networking. We already have support from leaders like Sir Michael Marmot (23) and about 400 doctors and medical students. If you want to help by giving presentations, writing articles or letters to politicians, then email myself (taavi@eg4health.org) or our international student coordinator Sharif Ismail (sharif@ eg4health.org).

In conclusion, I hope that this article has managed to inspire you in your efforts to realize the impact that your actions have to help alleviate poverty and push our world away from increasing inequality, toward one of a fairer, healthier future. If you should choose to become more involved, please review the described four issues and select the one that most motivates you. Then, contact the organization and offer your help. From my personal experience, making contact with EG4Health was probably the best thing that I have done in my entire medical school career. Not only have I learned so much in these activities and developed my presentation and writing skills, but also I have transformed as a person. I live and sleep more peacefully, knowing that my ongoing contribution as a global citizen is improving the world.

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Natural Disasters, Crisis Management and Future Preparedness
BY TING-WEI CHANG and HAN-PI CHANG, TAIWAN

In Taiwan, the most prevalent disasters are earthquakes and typhoons. According to the Central Weather Bureau of Taiwan, the island has encountered about twenty earthquakes with a magnitude of five or greater on the Richter scale, and roughly seventy typhoons in the past twenty years. These events are devastating, destroying thousands of homes and causing many casualties. Post-disaster reconstruction then poses a tough task for the government in many aspects, such as to meet the needs of the victims and their families, along with developing a sustainable homeland that would be more disaster-proof in the future. With good knowledge of prevention, it is better to minimize rather than take remedial actions for the devastating effects of these natural calamities. But when a natural disaster really happens, what should we do? More precisely, what should we, as medical students, do to better prepare ourselves in the future?

In preparation for better disaster management in the future, the Federation of Medical Students- Taiwan (FMS-Taiwan) co-organised a “Disaster Medicine Training (DMT) workshop with National Emergency Operational Team from Taiwan on May 15, 2011, involving a total of 83 medical students from all over the nation. Most of them are first and second grade students, and the portion of total is over 60%. The ultimate goal of this program is to equip medical students with basic life-saving skills as well as to sharpen their collaborative and organizational ability in times of emergencies.

Besides providing basic trainings for medical students, a questionnaire designed by EOC (Emergency Operation Center) provided insights into the coverage of Emergency and Disaster Medicine in the current medical curriculum of the nation. According to the results of the survey, medical students demonstrate strong learning motivation in the field of disaster medicine, but with regards to life-saving skills, there is still room for improvement. This is partly due to the structural arrangement of medical curriculum in Taiwan, in which trainings in Disaster Medicine and public health preparedness are completed after graduation.

In Taiwan, awareness of Disaster Medicine began in the 90s. During this period of time, many seminars and organizations concerning the field of Disaster Medicine developed. This dynamic growth in Disaster Medicine has been recognized as an important component of graduate medical education since then, in which future physicians are trained with disaster preparedness from both the medical and public health point. Unfortunately, medical students receive relatively limited exposure to these topics. FMS-Taiwan believes that exposure should start as early as possible in medical education for better crisis management in the future. And this is one of the greatest reasons behind the birth of this DMT workshop.

SCORP of FMS-Taiwan held a workshop of Disaster Medicine training with EOC (Medical Emergency Operation Center). There were about ninety medical students joining. Most of the team of EOC are emergency physicians but are well trained. The curriculum of workshop included introduction of disaster medicine, triage, setup of a medical station, ICS, and emergency treatment. Moreover, there was “tabletop” which can make students practice what they have learned after the curriculum. “Tabletop” is to simulate a disaster situation, and students have to organize a team in a short time and try to solve problems during disaster recovery.

Trainers design lots of different cards to simulate the situations, such as “patient cards”, “medical station cards”, “fuel cards”, “food cards” and so on. They also put message into cards, like “Electricity is suddenly shut down” or “There is someone who donated 1000kg of rice. Any problem which may be faced in reality can be used. Trainers send cards at appropriate time, and see what will the students response. Students are divided into three groups, which are the medical station, the logistic department, and the command center. Every group is in the different class rooms, they can only connect with wireless. In order to review the emergency response, students are required to write each response on the designed form. After the drill, trainers and students make a review of all the problems. Through “Tabletop”, it can test students’ ability of handling numerous patients and the crisis management.

What is the development of disaster medicine in the future? And what can medical students do in public health preparedness? The following are the possible approaches:

The future of Disaster Medicine Training Though the trend of Disaster Medicine learning has begun since the 1990s in America, and it was soon spread all over the world, it’s still an enormous challenge to practice. Due to the differences of focus between regions and general simplification the training becomes irregular. There is currently still a lack of holistic approach to Disaster Medicine Training. Ideally, it should incorporate different fields of studies, including epidemiology, public health, emergency medical treatment, crisis management, and so on. Therefore, creating an education framework that would meet the practical needs of respective health systems becomes an important issue for different countries. The curriculum
Medical students worldwide should offer medical disaster education in a reasonable timeframe, interdisciplinary format, and multi-experiential course, to fulfill the basic education for disaster medicine for medical students. The educational framework should be comprehensive and flexible enough such that it could be built on for progressive and in-depth training for advanced students.

Communication with the government and medical schools
Although disasters have always been a part of world events, recent large-scale natural and man-made disasters have increased the focus on Disaster Medicine.

Therefore, government and medical schools should work together, with medical students playing an active role in determining the direction of their curriculum. Through active discussion, the curriculum designed could better match the learning needs of students.

Concluding statement
In the future, crisis management is an issue as important as disease treatment. As the old saying goes, “An ounce of prevention is worth of a pound of cure”. The more the preparedness, the more health you get. DMT for medical students is a step towards the realization for greater preparedness during disaster times. With natural disasters becoming increasingly frequent, trainings in disaster and emergency medicine should receive greater emphasis in medical education. In its first year, the Disaster Medicine Training workshop has received an enthusiastic response from medical students throughout Taiwan. In the many more years to come, FMS-Taiwan aims to help more medical students to appreciate, explore and discover the field of disaster and emergency medicine.

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I am Seun Adeyemi. I am a Nigerian. And I have hope.

If you are reading this, kindly permit me to share with you my dreams for the future – albeit with a larger emphasis on health. And talking about the future, one unquestionable fact is its dynamicity. So let us put a time frame to it – say twenty years from 2011. In twenty years, I would still be a Manchester United fan but Sir Alex Fergusson might have retired. In twenty years, Nigeria would have enjoyed over thirty years of democracy rule but the political landscape would have changed. In twenty years, I would still be doctor but the health demands of the people around me would have increased.

Three issues I hinge my discourse on: football, Nigeria and choices. Can I start?

Football

Football is one of the greatest tools of unity of mankind. It cuts across countries, race, religion, and gender. It is a game that showcases two things – talent and teamwork. There is hardly anyone who does not love football. Even normally tongue-tied teenagers suddenly become eloquent, confident, and dazzlingly analytical experts when issues of football are thrust on their laps. And the beauty about football is the healthy competition – the struggle to be the best, to score goals.

I wish issues of health would be taken as passionately as football by all and sundry. Imagine a world in which every country struggles to outdo the other in reducing maternal mortality and child deaths, where presidents pride themselves in the health indices of their people as they do with technological advances and wealth, where every man talks openly with great knowledge and expertise about prevention of HIV/AIDS as they do about football. We do not live in that world today but it is possible for us to have such a world.

Attitudes to health vary widely across countries and within countries and until we have the right attitude to the health of our fellow man, good health for the world will remain a mirage. Like football, we are in a game against microorganisms, poverty, ill determinants of health, and a host of others. Talent and team work is important if as a team, humans want to win.

Some countries have great wealth, some have great brains, yet others have population as their strength. We all must come together to make the world a healthy place to live. Wars, natural disasters and famine are not strong
with some degree of myopia, democracy in Nigeria can be said to be twelve years old; eliminating the years prior the military rule. For me, there is no talking of Nigeria without mentioning electrical power. In thirty-two years from today, I have a dream of a Nigeria that will have uninterrupted power supply. And twenty years is a real long time for such to be effected. A lame but veritable statement is: no power, no development. And if in the next twenty years, my dream becomes a stillbirth, your guess is as good as mine – retrogression, in addition to the underdevelopment, would not be an uncommon finding. On the contrary, when there is power, all sectors of the economy will feel the effect – including the health sector.

Accessibility is another key issue when I dream of an ideal healthcare system. In the next twenty years, I hope to live in a country where healthcare is accessible and affordable to all and sundry with proper financing. I honestly pray that the national health insurance scheme would be fully functional for all the people-groups in my country. And this should not be a dream by now. It is a belated gift to Nigerians for the trust reposed in our leaders. In twenty years, the structure should be perfected such that over ninety percent of the Nigerian population would be on the scheme and larger health needs would be taken care of. Questions bordering on integrity and transparency in relation to the health scheme hopefully should have been addressed before my dreams can come true.

In twenty years, I hope the maternal mortality ratio for Nigeria would not just have changed but would be at par with those of the Scandinavian countries. That maternal death would be a rare finding. That hemorrhage, obstructed labour, sepsis, eclampsia and unsafe abortions would be history. That the barriers of access to healthcare would be eliminated and the average Nigerian woman would be knowledgeable enough to make informed choice as regards when to get pregnant, where to deliver and what family planning options to take.

Choices
I am in my final year in medical school. The next two years are somewhat predetermined – internship and national service, after which are myriads of options. As long as I practice medicine, I will do my best to save lives, kill none and live true to my oath as a doctor. The number of years I would practice as a doctor really does not matter. What matters is the health status of people around me. What are the odds against any of my loved ones developing a malignancy – be it breast, prostate, lung or cervical cancer? Is there a chance that my parents would become hypertensive in the next twenty years? What of hepatitis, chronic lung disease, victims of road traffic accident, HIV/AIDS? What of you? The future should not be full of woes. I do not dream of such. That will not be my future.

My health and my future is today’s me. What I do today affects in no small way my future. Yes I pray and I have in faith in God but I will also work actively against all ill determinants of good health. Lifestyle modification would start from now, not then. My choices on marriage, diet, occupation, and many more would be based on informed choices, not on a whim. And it will not stop with me. I will extend the message of healthy living to everyone around me for in their peace, I will have peace.

In Conclusion
The beauty about the future is that the more you look at it, the more you change it. We make our future happen by daily living in our dreams. Every one dreams but not equally. Most people dream in the night, recapitulating events in the dusty recesses of their minds. But those that daydream are few and dangerous because with eyes wide opened, they do all they can to entice their dreams.

Do I have a dream? Yes, but not with my eyes closed. I would not just be a bystander in life awaiting the wind of luck to determine the next course of event in my life. I will actively work out my dreams so that they would be a reality. I might never be the President of my country but my voice would be heard. I might never be a Cleric but I will live a life true to my belief and worthy of emulation. I might never as famous as Mandela or Kofi Annan but I will be the greatest dad to my children, teaching them the value of the family, hard work, integrity and how to protect and uphold the rights of the women and less privileged.

I am Seun Adeyemi. I am a Nigerian and I have a dream of a better Nigeria, a greater Africa and a better world. But not with my eyes closed.
Algeria (Le Souk)  
Argentina (IFMSA-Argentina)  
Armenia (AMSP)  
Australia (AMSA)  
Austria (AMSA)  
Azerbaijan (AzerMDS)  
Bahrain (IFMSA-BH)  
Bangladesh (BMSS)  
Bolivia (IFMSA Bolivia)  
Bosnia and Herzegovina (BoHeMSA)  
Bosnia and Herzegovina - Rep. of Srpska (SaMSIC)  
Brazil (DENEM)  
Brazil (IFMSA Brazil)  
Bulgaria (AMSB)  
Burkina Faso (AEM)  
Burundi (ABEM)  
Canada (CFMS)  
Canada-Quebec (IFMSA-Quebec)  
Catalonia - Spain (AEC)  
Chile (IFMSA-Chile)  
China (IFMSA-China)  
Colombia (ASCEMC)  
Costa Rica (ACEM)  
Croatia (CroMSIC)  
Czech Republic (IFMSA CZ)  
Denmark (IMCC)  
Ecuador (IFMSA-Ecuador)  
Egypt (IFMSA-Egypt)  
El Salvador (IFMSA El Salvador)  
Estonia (EstMSA)  
Ethiopia (EMSA)  
Finland (FiMSIC)  
France (ANEMF)  
Georgia (GYMUC)  
Germany (BVMD)  
Ghana (FGMSA)  
Greece (HelMSIC)  
Grenada (IFMSA-Grenada)  
Hong Kong (AMSAHK)  
Hungary (HuMSIRC)  
Iceland (IMSIC)  
Indonesia (CIMSA-ISMKI)  
Iran (IFMSA-Iran)  
Israel (FIMS)  
Italy (SISM)  
Jamaica (JAMSA)  
Japan (IFMSA-Japan)  
Jordan (IFMSA-Jo)  
Kenya (MSAKE)  
Korea (KMSA)  
Kurdistan - Iraq (IFMSA-Kurdistan/Iraq)  
Kuwait (KuMSA)  
Kyrgyzstan (MSPA Kyrgyzstan)  
Latvia (LaMSA Latvia)  
Lebanon (LeMSIC)  
Libya (LMSA)  
Lithuania (GIMSA)  
Luxembourg (ALEM)  
Malaysia (SMAMMS)  
Malta (MMSA)  
Mexico (IFMSA-Mexico)  
Mongolia (MMLA)  
Montenegro (MoMSIC Montenegro)  
Mozambique (IFMSA-Mozambique)  
Nepal (NMSS)  
New Zealand (NZMSA)  
Nigeria (NMSS)  
Norway (NMSA)  
Oman (SQU-MSG)  
Pakistan (IFMSA-Pakistan)  
Palestine (IFMSA-Palestine)  
Panama (IFMSA-Panama)  
Paraguay (IFMSA-Paraguay)  
Peru (APEMH)  
Peru (IFMSA Peru)  
Philippines (AMSA-Philippines)  
Poland (IFMSA-Poland)  
Portugal (PorMSIC)  
Romania (FASMR)  
Russia Federation (HCCM)  
Rwanda (MEDSAR)  
Saudi Arabia (IFMSA-Saudi Arabia)  
Serbia (IFMSA-Serbia)  
Slovakia (SloMSA)  
Slovenia (SmMSIC)  
South Africa (SAMSA)  
Spain (IFMSA-Spain)  
Sudan (MedSIN-Sudan)  
Sweden (IFMSA-Sweden)  
Switzerland (SwiMSA)  
Taiwan (IFMSA-Taiwan)  
Tatarstan-Russia (TaMSA-Tatarstan)  
Thailand (IFMSA-Thailand)  
The former Yugoslav Republic of Macedonia (MMSA-Macedonia)  
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