

Enhancing International Contributions Centered on WMA Activities and Community Health^{*1}

JMAJ 57(3): 124-134, 2014

JMA Global Health Committee

Introduction

The Japan Medical Association (JMA) launched the Global Health Committee in 2008 to invigorate its domestic activities and to enhance its international influence in the global community. Each committee operates for a term of two years, and the 3rd Global Health Committee carried out its activities in 2012 and 2013.

The 1st JMA Global Health Committee Report summarized the activities and achievements of the JMA's Global Health Committee and was issued in March 2010. In addition, the report detailed the history and significance of the JMA's global health activities and presented examples of activities in recent years. It also indicated that the JMA should strengthen its internal organizational structure to promote global health activities.

For the 2nd term, the JMA President proposed the following theme: "Promoting JMA strategies for future global health and community health." First of all, in response to the recommendations of the 1st report, the Global Health Committee's organizational structure was transformed. It was decided that committee membership would comprise specialists in global health and representatives of prefectural medical associations. In addition, all committee members were made editorial staff of the JMA's international journal, the Japan Medical Association Journal (JMAJ). Moreover, the Great East Japan Earthquake disaster occurred on March 11, 2011, and as the committee identified this disaster as one of the most important issues for the JMA, a report was compiled and it summarized the

domestic and international activities of the JMA centered on the disaster. This report presented four major recommendations: (1) Community health specialists and global health specialists should cooperate and work together to tell the disaster experience to the world, focusing on Japan's characteristic community health activities; similarly, the committee team should communicate the JMA's earthquake support activities to the world as they were characterized by the mobilization of available resources both from the affected areas and other supportive Japanese prefectures; (2) JMA should demonstrate strong leadership in the World Medical Association (WMA), Confederation of Medical Associations in Asia and Oceania (CMAAO), and the Takemi Program in International Health as part of the JMA's global health program; (3) Cooperation should be promoted among several committees within the JMA (coordination between the Global Health Committee and Disaster/Emergency Medical Care Committee, etc.); and (4) The lessons learned from the Great East Japan Earthquake should be put to effective use in the event of future disasters.

For the 3rd term, the JMA President proposed the following theme: "Enhancing international contributions centered on WMA activities and community health." This theme is directly related to the cooperation of Japanese community health and global health specialists as described in the first recommendation above. It is also related to strengthening the JMA leadership in international health programs as described in the second recommendation above, although the JMA has already demonstrated strong leader-

*1 This article is based on the report compiled by the JMA's Global Health Committee in February 2014 (jmaintl@po.med.or.jp).

ship in the WMA, CMAAO, and the Takemi Program as part of committee activities during the committee's 2nd term.

During the committee's 3rd term, WMA undertook the huge task of revising the Declaration of Helsinki, and this was a period in which the JMA's contribution was especially required. As young and upcoming physicians from around the world were beginning to participate in WMA meetings, young Japanese physicians were also expected to join them during this period. Moreover, the 30th anniversary of the Takemi Program took place in 2013, and the Global Health Committee played a key role in organizing it. Lastly, the Great East Japan Earthquake, which had been a key issue since the committee's 2nd term, remained an issue in Japan. As global society had watched the process of recovery in the disaster zone, the Global Health Committee reported the JMA's activities on these throughout the world.

This report first of all describes the JMA's global health activities that are directly connected to the WMA and CMAAO. Second, it describes the activities of the Junior Doctors Network (JDN), which has become active as part of the committee's global health activities. Third, the report provides a summary of events held in Japan to commemorate the 30th anniversary of the Takemi Program. Finally, it describes the JMA's support activities for the Great East Japan Earthquake and other disaster/emergency support activities, and then presents recommendations about how the JMA's future global health activities should be strengthened.

WMA and CMAAO Activities

Of the activities carried out by the Global Health Committee during the 1st and 2nd terms, WMA- and CMAAO-related activities have already been described; however, because they are directly related to the theme proposed by the JMA President for this term, the histories of these organizations are worth mentioning here.

History of the JMA in relation to the WMA and CMAAO

The international activities of the JMA cannot be discussed without mentioning the history of the WMA (established in 1947) and CMAAO (established in 1961).

After WWII, GHQ ordered the JMA to disband, and the new JMA was re-launched postwar as a voluntary membership organization. The new JMA expressed profound regret for the association's undesirable actions during WWII, such as its relationship with the military as a compulsory membership organization. Following procedures stipulated by the international community, alongside the German Medical Association, in 1951 the JMA was allowed to become a member of the WMA as the only organization representing Japanese physicians. Even when simply unrolling and examining this history of how the JMA was re-established in international relations, the relationship between the JMA and the international community should not be overlooked. As the JMA had to resolve huge domestic problems, it tended to be perceived as an organization which focused only on domestic issues, and the significance of its international activities was forgotten. However, when the JMA was re-launched postwar, the *raison d'être* of the association as Japan's representative medical association was undoubtedly established through international activities. We should recall this history from time to time.

In establishing CMAAO, it was the fervent desire of former JMA President Taro Takemi for the JMA to unite the voices of Asian countries and regions. He believed that uniting Asian voices would strengthen the involvement of Asian countries in the WMA. To realize this mission, he worked together with representatives of the relevant national medical associations, eventually launching CMAAO in 1961 as a confederation of national medical associations in the Asia-Oceania region. Formulated over 50 years ago, this broad platform has included Hong Kong and Macao and been centered in Indochina. Now it covers an area reaching from India to Australia and New Zealand, and it of course includes Japan, as well as the Republic of Korea (ROK) and Taiwan. It is useful to look at the characteristics of CMAAO's 18 member national and regional medical associations. It should be noted that there is a variety of different religions (including Buddhism, Hinduism, Islam, and Christianity), languages, cultures, and national situations represented. Despite such differences, CMAAO members have worked together continuously for more than half a century. Unfortunately China—which is a member of the WMA

alongside Taiwan—has not joined CMAAO yet; however, the size of the population included in the CMAAO membership in the Asia-Pacific region is overwhelming other regions.

WMA activities during the 3rd term

During the 3rd term, the Global Health Committee was deeply involved in WMA activities. A major agenda item at the 2013 WMA General Assembly in Fortaleza, Brazil, was the revision of the Declaration of Helsinki (DoH). Its 50th anniversary was celebrated in 2014 and several years have been spent in completing the revision in time for this occasion. As is widely known, the WMA formulated the “Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects” to provide ethical guidelines for physicians. WMA working groups have been continuously carrying out revision work. The revisions adopted at the 2008 WMA General Assembly in Seoul, ROK, were also extensive and also took several years to complete.

However, at the 2013 WMA General Assembly, opinions about the use of placebos differed amongst Latin America, Africa, and other regions of the world. Therefore, the final outcome remains in the balance until the moment when the General Assembly adopts the revisions. For this reason, at the 2013 General Assembly, then-WMA President Dr. J. Edward Hill established a working group to continue discussing the placebo issue. As the deliberations of this working group continued, members also discussed other sections of the DoH. Consequently, the working group was allowed to expand its role to revise the entire DoH document.

Following lively debate within the working group over several years, the structure of the DoH has been changed. For example, subtitles were added and chapters were modified. Furthermore, various elements of the DoH were also revised. These include measures addressing socially vulnerable groups, compensation, big data, advanced medical care, and Ethics Committee functions. The revision process continued, and finally resulted in major amendments.

The Expert Conference on the Revision of the DoH was held in Tokyo from February 28 to March 1, 2013. It provided a precious opportunity for the working group to hear opinions from the Asia region. The JMA also made suggestions about compensation, big data, and Ethics Com-

mittee functions, in particular. The essence of these suggestions was included in the final revision proposal following further discussions by the working group and the expert conference held in Washington D.C. at the end of August 2013. It was then agreed to prepare a separate statement focusing on specific elements—in line with the times, these were information-related themes, including big data, and DoH sections concerning advanced medical care, including gene therapy and iPS cells—while the DoH would provide a general framework.

At the 2013 WMA General Assembly in Fortaleza, a statement regarding individual compensation was removed based on opinions expressed from African countries. In addition, minor amendments were accepted regarding the necessity of not preventing the activities of local researchers. The overall revision proposal was then approved. At the same time, the database working group was strengthened, with the JMA joining this group also.

The General Assembly also adopted other resolutions regarding the conflict between demands for financial reductions and the advancement of medicine; warnings against various forms of governmental intervention in healthcare; and the definition of homosexuality, etc., as normal variants.

CMAAO activities during the 3rd term

The highlight of CMAAO activities during the 3rd term was the 2013 CMAAO General Assembly in New Delhi. The meeting’s main theme was “Stop child abuse.” Improving the well-being of children in the CMAAO region, which is the world’s population center, is very meaningful for discussing the current situations and futures of children. This issue also has a grave impact on our own society as well as the very future of our planet. The General Assembly participants had a common understanding of this idea. It is the role of physicians to realize the importance of the issue of child abuse and to keep a watchful eye on the lives of children in their local communities. The General Assembly also shared this view amongst participants. The meeting adopted a statement titled the “CMAAO Delhi Resolution on Prevention of Child Abuse” as the consensus of the assembly.

Activities of the JDN

JDN

The JDN, which the WMA approved in October 2010, is the first international platform for young physicians. The network provides a forum for these physicians worldwide to share their experiences, ideas, and passion as they play an active role with a common mission from the perspective of global health.

In Japan, the “Junior Doctors and Medical Students Subcommittee” was established under the JMA Global Health Committee in October 2012. Prof. Yasuhide Nakamura (Graduate School of Human Sciences, Osaka University) chairs the subcommittee and is supported by two other members: Dr. Izumi Maruyama (President of the Japan Primary Care Association) and Dr. Naoki Kondo (Graduate School of Medicine, University of Tokyo). They have worked hard to achieve full cooperation for setting up the JDN subcommittee.

JDN members are physicians who are residents undergoing clinical training before specialist training, and many of JDN representatives from various countries attend WMA General Assemblies. For example, 29 junior doctors and medical students from 11 countries attended the WMA Bangkok General Assembly held in October 2012, and their representatives presented a report at the meeting. Unfortunately, however, there were no JDN member attendees at this General Assembly because the JMA had not yet established a JDN at that time.

In response to the recent worldwide trend, the JMA established the JMA Junior Doctors Network (JMA-JDN), mainly to enable young doctors to attend WMA and CMAAO General Assemblies. During the setting-up period of the JMA-JDN, the members of the “Junior Doctors and Medical Students Subcommittee” took leadership, but subsequently JDN members were actively involved in the decision making process for formulating an action plan and structure for the network. Junior doctors and medical students will take a central role in proactively proposing appropriate recommendations to the JMA and WMA as well.

Participation in international meetings

With the support of the JMA, four junior physicians from the JMA-JDN have had the opportu-

nity to participate in international meetings so far. One member of the JMA-JDN attended the WMA Mid-term Council Meeting in Bali in April 2013, one attended the CMAAO General Assembly in New Delhi in September 2013, and two attended the WMA General Assembly in Fortaleza in October 2013. In addition, several JDN members attended both the Expert Conference on the Revision of the Declaration of Helsinki, held in Tokyo in February 2013, and the Harvard School of Public Health Takemi Program 30th Anniversary Symposium, held in Tokyo in November 2013. The JMA-JDN representative at the CMAAO General Assembly in New Delhi learned about the situation regarding child abuse as well as the complicated socio-economic and cultural backgrounds in each country. The General Assembly also provided a once-in-a-lifetime opportunity for the junior doctor to broaden his/her perspective by experiencing the dancing and food culture of India. Participants at the WMA General Assembly in Fortaleza had the opportunity to discuss medical ethics and other health related issues with junior doctors from around the world at the JDN meetings.

Through these experiences, the JMA-JDN representatives gained an understanding of the social backgrounds of many other countries. At the same time, they felt that the meeting provided a valuable forum for junior doctors worldwide to share their ideas and experiences. However, one regret was the lack of interest amongst Japanese junior doctors in global health activities.

The National Medical Associations with Junior-Doctors-Networks have expressed high expectations for the JMA-JDN to continue to contribute to international activities by participating in these kinds of meetings in the future. Also, in the long-term, the JMA-JDN also needs to build up a stronger relationship and cooperation with JDNs in other countries.

Future outlook for the JMA-JDN

The JMA-JDN has a broad potential capacity and resources. Its philosophy is to “serve as a network of junior doctors and aim to improve public health through medical care, medical science, and health services with a broad perspective and high sense of ethics and mission working with the international community.” This philosophy also expresses the desire of the

JMA-JDN for the network to become a new platform for all young Japanese physicians. Previously, groups for young physicians were only seen in medical specialty societies, medical offices at university hospitals, local regions, and NGOs. However, it is now expected that the JMA-JDN will provide a forum that enables a diverse range of young physicians to break away from these various conventional frameworks and facilitates their activity, based on their own fresh and free ideas.

Many young physicians are overwhelmed by their heavy load of daily duties. Their efforts have been focusing on constantly learning and acquiring specialist knowledge and skills. This is a very important period for their careers as medical professionals. In addition to this training, JMA-JDN provides young physicians with new learning opportunities, such as opportunities for discussing medical ethics and other important health issues with colleagues around the world. By this, they can search for solutions to these issues, learning about and gaining an understanding of diverse social and cultural backgrounds in other countries, releasing policy statements which reflect the opinions of young physicians, and studying abroad. These experiences may help them to learn things that they can only do during this period of their lives. Above all, these are precious opportunities for them to meet fellow junior doctors and mentors throughout the world. Thus, junior doctors with a background in JMA-JDN activities may have huge potential to grow and play an active international role in coming decades.

Based on the concept above, the JMA-JDN launched an Annual Survey Project which aims to clarify the current situations of young physicians in Japan. This project surveys the work and life environments, interests and concerns, and requests of young Japanese physicians. Based on the results of the survey, it may be necessary to develop policy statements which reflect the collective opinion of junior doctors. These kinds of efforts, which seem to have been lacking in the past activities, are some of the best ways to convey their opinions to the world community. The JMA-JDN is also planning to investigate the possibility of creating a support program similar to the Takemi Program at Harvard for young doctors to study abroad.

The JMA-JDN will focus its future activities

on the following three points: consolidating the organizational structure of the network, increasing the visibility of the network, and conducting annual surveys of young physicians. This fundamental platform will enable young physicians in Japan to demonstrate their abilities to the maximum. The JMA-JDN has already hosted a JDN meeting in Tokyo following the WMA Council Meeting held in Tokyo in April 2014. The JMA-JDN will continue to contribute to the activities of the JDN worldwide by participating in international meetings such as the CMAAO and WMA General Assemblies.

Harvard School of Public Health Takemi Program 30th Anniversary

To celebrate the landmark 30th anniversary of the Harvard School of Public Health Takemi Program, commemorative events comprising alumni reunions and lectures were held in Boston and Tokyo during 2013.

For the Boston event, Takemi Program graduates (Takemi Fellows) gathered from around the world. Leaving an especially deep impression was the words of praise for the Takemi Program expressed by Fellows—high appreciation for the luxury provided by the program of being able to study for one or two years with virtually no research restrictions together with multinational research fellows. This experience does not immediately influence career formation; however, it was clear that the program has undoubtedly influenced Fellows in their long career histories. Takemi Program Professor Dr. Michael Reich spoke about the principles of “mutual respect” and “individual freedom” after which he described the role of the Takemi Program as follows: “One premise of the Takemi Program is that, ultimately, it is individuals who create the relationship between the local and the global. The growth of each and every person in the Takemi Program, when they go back to their organization, makes the organization better, and when the organization becomes better, the community becomes better, and when the community becomes better, the country becomes better, and when the country becomes better, the world becomes better. This all starts with each and every individual. One year of studying on the Takemi Program is a luxury. For one year in your life, you have the freedom to study whatever you

want to. How will you grow? That is a very rare year in a person's life. This will make the world a better place.”

What awed me about the Takemi Program is this: There was a health economist from South Korea on the program at the same time as me. He was not a physician. People who do economics come into medical schools to do public health and discuss medical economics there. I learned that such people are here and there. I feel that Japanese physicians have fallen into the habit of interacting only with other physicians. But on the program, it was not like that; there were people with all kinds of backgrounds. There were sociologists and journalists, and they would go and talk about health. I learned that to improve health, medical care gets better by having these kinds of discussions not just among healthcare professionals but also with people in various fields. In that respect, I thought that the people from so-called developing countries were ahead of us.

(Prof. Yasuhide Nakamura)

I went to Harvard University twice, and what struck me was that many different kinds of values are respected equally. For example, there was a researcher who, even though he didn't have a doctorate or even a master's degree, loved research and had written more papers than Japanese professors. He was extremely satisfied with his position. There was also a person who was living a happy life, satisfied with his position, engaging enthusiastically in fieldwork as a lecturer; he didn't need to become a Harvard professor to feel happy. In Japanese universities, on the other hand, one gets the impression that becoming a professor is the only goal. However, I felt that having the depth of character to not be like that would be wonderful. On a personal note, a professor previously in my department told me that he wanted me to fulfill a role of connecting the medical front and the university. People on the frontlines of medical and health activities do not write papers, while researchers in universities who write papers do not know the realities of working in the field. He told me that people who have both skills will be needed in Japan from here on. I am grateful to the Takemi Program for allowing me to strengthen myself for that kind of work.

(Prof. Masamine Jimba)

The requirements of Takemi Fellows are that they participate in seminars once a week and write one high-quality paper during their time in the program. It is entirely up to the individual whether they conduct research at the library or enjoy the intellectual environments provided by Harvard University and related graduate schools (government, education, etc.).

The program for the 30th anniversary commemorative symposium held in Tokyo comprised a keynote speech by Dr. Michael Reich and presentations by five past Takemi Fellows. All members of the Global Health Committee participated in the event in roles such as commentator or chairperson for each of the lectures, which ranged in content from Japan's universal health insurance system, which is world-class; to earthquake/tsunami disasters; maternal and child health; key risk factors for health; and obesity.

The 1980s—when the Takemi Program was established—was a period during which healthcare in Japan achieved certain standards.

Under the concept that the JMA should strengthen ties with the international community, especially developing countries, rather than simply taking pride in Japan's healthcare achievements, the JMA President at that time—Dr. Taro Takemi—took the initiative in seeking a forum in which Japan and other countries could mutually cooperate.

That is to say, perhaps the times have finally caught up with Dr. Taro Takemi's idea today, some 30 years later. Undoubtedly this concept was shared from the beginning by Dr. Michael Reich, who has supported the program throughout its 30-year history.

It is most appropriate and natural that the program is named for Dr. Taro Takemi, an outstanding physician as well as a scientist.

New Developments in Disaster and Emergency Activities

Great East Japan Earthquake

The 2nd report focused on the Great East Japan Earthquake in 2011. Subsequently, the JMAJ—the role of which is to disseminate information about JMA activities to the world—published 14 English articles related to the disaster, and the Disaster Medicine and Public Health Preparedness journal published one earthquake-related English article written chiefly by a JMA officer.

At the above-mentioned Takemi Program 30th Anniversary Symposium held in Tokyo, a presentation was made by Dr. Takashi Nagata, who was actively involved in disaster response efforts beginning immediately after the earthquake occurred. His presentation clarified the flow of JMA activities immediately following the disaster. Below is an excerpt from Dr. Nagata's presentation.

The Great East Japan Earthquake, which struck Japan at 14:46 on March 11, 2011 and affected mainly three prefectures in the Tohoku region—Iwate, Miyagi, and Fukushima—wrought immense damage on local communities. Added to the devastation caused by the earthquake and tsunami, the radiation damage caused by the accident at the Fukushima No.1 Nuclear Power Station, operated by Tokyo Electric Power Co., Inc., resulted in a serious situation. Because virtually no victims sustained the severe traumatic injuries that had been projected for such an earthquake disaster, the national government-designated leaders in disaster medical care, Japan Disaster Medical Assistance Teams (DMATs), were unable to fulfill their role sufficiently before their period of activity ended.

Meanwhile, in response to the many problems immediately after the disaster—400,000 victims living in evacuation centers, postmortem examinations, harmful rumors triggered by radiation damage—the JMA instigated new activities on March 15, 2011 in the form of Japan Medical Association Teams (JMATs), comprising physicians from prefectural medical associations throughout Japan. In the four months up until July 15, approximately 1,400 JMATs comprising approximately 9,000 medical professionals were engaged in relief activities and were able to contribute to the disaster response in disaster-stricken communities.

After July 15, the JMA also continued to cooperate with prefectural medical associations in promoting preparedness for responding to disaster scenarios anticipated for an earthquake occurring directly beneath the Tokyo metropolitan area, which the Japanese Government predicts will cause tremendous damage, or a massive Tokai, Tonankai, or Nankai earthquake. JMATs are central to these response efforts.

There tends to be a misconception that JMATs suddenly surfaced in response to the Great East

Japan Earthquake. However, the JMAT concept itself was proposed in the 2009 JMA Emergency and Disaster Medicine Management Committee Report. Established in 2009, the JMA Disaster Management Subcommittee gradually hammered out the JMAT concept while carrying out discussions with Japanese experts on disaster medicine regarding the disaster medicine it would be possible for the JMA and prefectural medical associations to perform.

The springboard for the JMAT concept was the United States' natural disaster response measures. In 2005, the United States was devastated by Hurricane Katrina. In New Orleans, which Hurricane Katrina tore through, residents who had been too late in evacuating took refuge in appalling evacuation facilities and elderly people were transported to other areas by air force planes.

At that time, disaster medicine in the United States focused on terrorism countermeasures, especially bio-terrorism countermeasures, due to the terrorist attacks on the World Trade Center and the anthrax incident. In contrast, preparedness for responding to a humanitarian disaster that leaves huge numbers of victims and generates public health problems was insufficient. Conventional disaster medicine was premised on there being a large number of injured or sick victims (situations such as car accidents in which a large number of people are injured), and triage, trauma care, and transportation were emphasized. Conversely, humanitarian crises such as evacuation center problems were not emphasized in developed countries. A huge paradigm shift in disaster medicine was required.

In considering the form that JMATs should take, something else that was used as a reference was the efforts of regional medical associations in Japan when disasters have occurred domestically in the past. Requests have been made to prefectural medical associations and surveys conducted of their disaster response reports. Of these, the detailed report of activities conducted in the wake of the Great Hanshin-Awaji Earthquake of 1995 that was compiled by the Hyogo Prefectural Medical Association and the Kobe Medical Association became the archetype for JMAT activities. In the Hanshin-Awaji earthquake disaster, the focus was on trauma patients and crush syndrome. However, there were also huge problems with evacuation centers and postmortem

examinations, and the activities of local medical associations drew attention. Furthermore, the surveys enabled us to know about the important role that local medical associations played in disaster response. When a Japan Airlines B-747 crashed on Mt. Osutaka in 1985, the Gunma Medical Association took the central role in performing postmortem examinations. When the Unzen Volcano (Mt. Fugen) in Nagasaki Prefecture erupted in 1991, local medical associations took the central role in treating people who were injured. In this way, it became clear that there is a close relationship between community health and disaster medicine. Based on these experiences, JMATs dispatched to disaster zones make sure that they carry out their activities under the direction of the local medical association, which takes the lead in community health and acts as the final medical stronghold. This has consequently enabled the implementation of JMAT activities in disaster zones to go smoothly.

Economic losses caused by climate change and disasters are increasing year by year. In future, disaster medicine needs to be positioned as a central field of healthcare. In doing so, disaster medicine will need to be based on public health, global health, and community health.

Collaboration with the Japan Self-Defense Forces in the Philippines' Disaster Zone

Super Typhoon Haiyan struck the Philippines on November 9, 2013, causing immense damage. From November 12, three days after the typhoon, the Association of Medical Doctors of Asia (AMDA) began dispatching coordinators and nurses to the disaster zone to provide emergency medical services for the victims. This was the first time a medical team had been sent from Japan to this area. The disaster zone covered the "Typhoon Road" islands: Leyte, Samar, Cebu, and Negros. There were three important issues to be resolved in order for the AMDA teams to be able to carry out rescue activities: medical licenses, safety, and transportation. The Philippine Government does not allow physicians with overseas medical licenses to practice medicine in the Philippines. On the swift decision of JMA President Dr. Yoshitake Yokokura and Executive Board Member Dr. Masami Ishii, JMA sent relief funds to ADMA on behalf of the JMA, while the activities of the Philippine Medical

Association and Japan's Self Defense Forces were coordinated. The Philippine Medical Association helped AMDA to resolve the medical license problem. Joint relief activities were carried out by medical teams from various member organizations of the Asia Sogo-Fujo Network for Emergency Relief (Secretariat: AMDA), which was launched on April 15, 2013; medical teams from various national branches of AMDA; and navy-related medical teams working together with local medical associations of the Philippines Medical Association. These activities were the largest-scale collaborative efforts by multinational medical teams since the rescue activities in the wake of the 2004 Sumatra Earthquake and Tsunami. Furthermore, the International Conference on Yolanda/Haiyan Reconstruction was held in Manila on March 8, 2014.

Disaster medicine and emergency medicine are decisively different. Emergency medicine is aimed at a small number of patients and can be provided in a normal and stable healthcare environment. In contrast, in disaster medicine, a small number of medical staff must treat an overwhelmingly large number of casualties in unpredictable and diverse environments. The role played by medical staff in affected areas comprises 20% of disaster medicine; the roles played by others comprise 80%. For emergency medicine, this ratio is reversed. The most important issue is to ensure the safety of aid stations for relief activities, followed by the transportation of patients to aid stations, and communications among those involved in rescue activities. Only after these three requirements are met and appropriate human and other resources have been secured can medical services begin. The disaster zone in this case comprised several islands. Safety and transportation were secured with the assistance of the Philippine Navy; communications were supported by mobile telephones; medical supplies and living support goods were procured in Manila; aid stations were set up in health centers in local villages; health committee volunteers brought patients to the aid stations; and home visits were carried out. The Philippine Navy acted as bodyguards to protect the rescue teams amidst deteriorated public security. The Japan Self-Defense Forces, which withdrew at the end of the year, demonstrated their important role in crisis management, as the following case example shows.

This is a case example of activities from 1994, when the JMA coordinated with the Japan Self-Defense Forces, which had dispatched relief teams for the first time to the city of Goma in Zaire as part of Rwandan refugee relief activities. A large number of militiamen with weapons were mixed in amongst the refugees. Polluted water from Lake Kivu, which was used for drinking and cooking, was a main cause of problems, with more than 100 people dying from Cholera each day. The “Goma bathtub” provided by the Japan Self-Defense Forces was very popular for washing away the stench of death. The AMDA medical teams dispatched translators not only to the refugee camp but also to the Goma Civic Hospital for surgical operations performed by Japan Self-Defense Forces medical teams. As part of crisis management measures, AMDA and Japan Self-Defense Forces personnel synchronized their wireless frequencies. However, one day members of the AMDA medical team were attacked by refugees in the refugee camp. A small yet heavily-armed company of Defense Forces personnel immediately rushed to rescue them and the AMDA team members were saved. It was later revealed that the reason for the attack was that the car the AMDA medical team had borrowed had been stolen, and the original owner (a refugee) had been trying to retrieve his stolen vehicle. Even after this incident, medical activities continued with the close cooperation of the Japan Self-Defense Forces. At the time of the incident, a member of the Japanese opposition party questioned Japan’s dispatch of Self-Defense Forces overseas, saying, “Rescue is not part of the duties of Self-Defense Forces stationed overseas.” The government’s response was, “They transport victims, not rescue them.” Awareness about the presence and roles of the Japan Self-Defense Forces at that time seems somehow behind the times.

In the aftermath of the Great East Japan Earthquake, the Self-Defense Forces, JMA, and Japanese Red Cross Society also worked hard as the “Big Three” of disaster medicine in Japan. The next step is overseas disaster medical support, the basic concept of which is to carry out the mission of “open and mutual assistance.” Many years ago, the CMAAO health network was proposed by former JMA President Dr. Taro Takemi. It is a comprehensive concept and still holds tremendous potential for ensuring both

the safety of activity sites and transportation as well as medical licenses and medical staff in this region with the support of military forces in various countries. The JMA, which incorporated Dr. Takemi’s philosophy of “Professional Freedom and Noblesse Oblige” into its principles, has made much of this philosophy in regard to disaster medicine activities a reality. What action, then, should the JMA take in order to “help and save lives; never forsake a patient” with regard to people in the Asian-Pacific region? The relief activities carried out in the Philippines in the wake of Super Typhoon Haiyan provide a good opportunity to demonstrate this spirit. Furthermore, based on the sister-city relationship between Tacloban on the typhoon-devastated island of Leyte and Fukuyama City in Hiroshima Prefecture, the Fukuyama Medical Association dispatched a medical team to the disaster affected areas in collaboration with AMDA. The Mayor of Tacloban and the Tacloban Medical Association extremely appreciated this action. When you encounter a fateful difficulty, who will come to help you? Who are your true friends? Disaster medicine is also diplomacy of the heart. These relief efforts were an epoch-making first step in local government medical diplomacy. Expectations are growing for the JMA to take the initiative in formulating a model for the disaster medicine required by Japan, other Asian countries/regions, and the entire world in the 21st century.

Conclusion

The theme proposed by the JMA President for the 3rd term was “International contributions centered on WMA activities and community health.” During this period, the JMA made great contributions globally as part of its WMA activities through the revision of the DoH. In addition, the JMA participated actively in discussions at the CMAAO General Assembly on the theme of child abuse. Moreover, the JMA-JDN was also launched, and junior doctors were able to attend both WMA and CMAAO meetings, providing good opportunities for them to gain invaluable experiences. The Global Health Committee published some 14 articles in the JMAJ, proactively transmitting information to the world. International contributions centered on AMDA activities cannot be overlooked either,

and we hope that these activities will continue in the future.

What, then, is the contribution of the international activities mentioned above to community health in Japan, a question proposed by the JMA President? Further discussion on this question may be necessary. For example, how is the DoH related to improvements in community health? To what extent are discussions on big health data and advanced medicine at international conferences relevant to community health? What kind of influence does the “CMAAO Delhi Resolution on Prevention of Child Abuse” have on future community health? In summary, how best to incorporate themes discussed at international meeting into community health activities is an important issue that requires addressing in the future.

The issue of the maldistribution of physicians in different regions was brought up for discussion in committee meetings several times. The issue of medical interpreters for foreigners was also raised. What hints can global health provide for such important issues faced in community health, and what solutions can it bring about? Another step towards future efforts may be

required.

Finally, based on the discussion above, we would like to propose the following recommendations.

1. Contributing to community health through global health

Several specific examples were given with regard to the Great East Japan Earthquake. Global health contributions should be pursued for community health even in times of peace.

2. International contributions of the JMA and JMA-JDN in WMA and CMAAO

Following earnest discussions about the DoH, the WMA and CMAAO are continuing to discuss global health issues. In future, expectations will further increase regarding the international contributions of the JMA, including the JMA-JDN.

3. Enhancement of information transmission capacity

Using not only the current publications (JMAJ and domestic journals), but also other media, the JMA should enhance its capacity to transmit information regarding successful cases of community health and the contributions of global health to community health.

Members of the JMA Global Health Committee (2012-2014)

Chair

Masamine JIMBA Department of Community and Global Health,
Graduate School of Medicine, The University of Tokyo

Vice-Chair

Keiji TAKEMURA Vice-President of the Nara Medical Association

Members

Akira AKAGAMI Auditor, Tokyo Medical Association (from July 23, 2013)
Shigehito ISHIGURO Executive Board Member, Kochi Medical Association
Tutomu KIKUCHI Board Member, Ishikawa Medical Association
Yoshihiko KUBOTA Board Member, Yamanashi Medical Association
Hideaki KURAMASU Board Member, Hokkaido Medical Association
Naoki KONDO Associate Professor, Department of Health and Social Behavior,
School of Public Health, The University of Tokyo
Mitsuko SHIMIZU Past Auditor, Tokyo Medical Association (up to July 22, 2013)
Shigeru SUGANAMI President, Association of Medical Doctors of Asia (AMDA)
Yasuhide NAKAMURA Professor, Graduate School of Human Sciences, Osaka University
Takashi NAGATA Assistant Professor, Department of Advanced Medical Initiatives,
Faculty of Medical Sciences, Kyushu University (from April 23, 2013)
Sho HASHIMOTO Executive Board Member, Miyagi Medical Association
Masayuki HATAE Board Member, Kagoshima Medical Association
Taro YAMAMOTO Professor, Department of International Health,
Institute of Tropical Medicine, Nagasaki University

Sub-committee for Junior Doctors and Medical Students

Izumi MARUYAMA President, The Japan Primary Care Association

Observers

Kazushi YAMAUCHI Director, Office of International Cooperation,
Ministry of Health, Labour and Welfare
Shiro KONUMA Director, Global Health Policy Division, International Cooperation Bureau,
Ministry of Foreign Affairs (up to February 23, 2014)
Hiroyuki YAMAYA Director, Global Health Policy Division, International Cooperation Bureau,
Ministry of Foreign Affairs (from February 24, 2014)