physicians than there are protecting medical staff. Chinese doctors face excessive legal constraints and have little legal protection. This situation is particularly prominent after the COVID-19 pandemic, with the deterioration of the doctor–patient relationship peaking after the pandemic.[5]

Some medical students who are still studying have expressed serious concerns about the current health-care environment, and some have even entertained the idea of dropping out of medical school.[6] These concerns might further exacerbate the shortage of doctors in the context of China's ageing population, potentially leading to future social unrest.

There is growing evidence that we need stronger means to change this situation, such as increasing police presence in hospitals, accelerating public awareness, and improving legislation. However, the most crucial change should not be superficial, but should go deeper into the mechanisms of doctor–patient conflicts and establish effective channels of communication between doctors and patients. The Chinese Government and health-care organisations should be held accountable for bringing about this change.

We declare no competing interests.

*Rui Zhao, Zhe-an Shen, Yingze Hou
zhaorui@muc.edu.cn

School of Journalism and Communication, Minzu University of China, Beijing 100081, China (RZ); School of Medicine, Zhejiang University, Hangzhou, China (ZS); Sanquan Medical College, Xinxiang Medical University, Xinxiang, China (YH)

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Cuban doctors cannot be the definitive solution for Italy

We read with interest the Correspondence by Francesco Pata and colleagues about Calabria's partnership with Cuban doctors.[1] We agree that their presence could prevent service disruptions and have positive effects on local communities. However, we are strongly convinced that attraction of doctors from low-income countries to high-income countries cannot be the definitive measure to improve health systems. In particular, we want to highlight two aspects.

The first is related to concerns raised by the Human Rights Foundation about the human trafficking possibilities running through a decades-long programme of international medical missions from Cuba.[2] The second aspect is related to health-care management perspectives. Calabria's solution suggests purely commercial activities looking for unquestionable low-cost labour, rather than the valorisation of human resources.

In this era with an inevitably ageing global population and increasing costs of diagnostic and therapeutic advances, a constant lowering of health expenditure—as observed in Italy (in 2023, 12·4% of Government expenditure was for health care *vs* an average of 15·5% from the Organisation for Economic Co-operation and Development[3])—is not sustainable. Even more so, it is unacceptable that this decrease greatly involves and affects health professionals. If Italy improved the working conditions of physicians and nurses with particular focus on medical litigation risks and training, it would not have vocational or migration-related crises of staff. Henceforth, partnerships with doctors from low-income countries should not be considered as valuable low-cost solutions for severe shortcomings in health systems, but as futureless expedients.

We declare no competing interests.

*Stefano Rausei, Andrea Giuseppe Bertolini
stefano.rausei@asst-settelaghi.it

General Surgery Division (SR) and Internal Medicine Division (AGB), Department of Surgery, Cittiglio-Angera Hospital, ASST Sette Laghi, Varese 21033, Italy

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Cuban doctors in Calabria and the Italian health system crisis

We have read with interest the Correspondence by Francesco Pata and colleagues[1] regarding the contribution of Cuban doctors in addressing the crisis of the Calabrian health-care system. We concur with the authors that this mirrors a more general crisis of the Italian health-care system, which has been undermined by policies of defunding and regionalisation, weakening its foundations established in 1978. However, additional elements should be considered: each year,

approximately 1000 Italian doctors emigrated abroad,[2] showing the Italian health-care system's low attractiveness. The high number of legal complaints against doctors increases defensive medicine strategies, which increase the number of inappropriate examinations and costs up to 10% of the national health fund.[3] These factors have led to a reduction in the efficiency of the health-care system that was ranked the second-best in the world just 20 years ago.[4]

Since 2018, the so-called Calabria decree—a law valid at the national level—has allowed for the permanent employment of final-year medical residents in public hospitals.[5] This policy drives residents towards more prestigious hospitals, further diminishing the workforce in peripheral hospitals, where staff numbers are increasingly reduced and often ageing. Furthermore, the rules in place at the time of writing this allow equivalences and affinities among various medical specialties, allowing a doctor trained in one specialty to be employed in an equivalent or affinity specialty; for instance, a doctor specialised in emergency medicine can apply for a cardiologist or pneumologist position.[6] This policy enables medical specialists to practise outside their specialty, undermining efforts towards strategic long-term planning. A short-term scenario of uncertainty is therefore outlined, leaving aside aspects of high specialisation and appropriate training.

We declare no competing interests.

*Mirko Barone,
Giuseppe Massimiliano De Luca,
Felice Mucilli, Mario Testini
mirko.barone@unich.it

Department of General and Thoracic Surgery, SS Annunziata University Hospital, Chieti 66100, Italy (MB, FM); G d'Annunzio University, School of Medicine, Chieti, Italy (MB, FM); Department of Precision and Regenerative Medicine and Jonica Area Academic Department of General Surgery, V Bonomo, University of Bari A Moro, Bari, Italy (GMDL, MT)

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Considerations for the CHH–*Lancet* Commission on Health, Conflict, and Forced Displacement

We read with interest the Comment announcing The CHH–*Lancet* Commission on Health, Conflict, and Forced Displacement: reimagining the humanitarian system.[1] It is a seminal work offering the foundation of evidence-based interventions amidst humanitarian disasters. However, we feel that some key points were missing.

The first is community engagement. The effects of community-based so-called social prescribing on health and wellbeing are widely established.[2] A holistic approach should consider the unique and non-medical needs of patients—such as older patients and those with cancer and chronic conditions—during a crisis to deliver people-centric outcomes. The involvement of communities and patient advocacy groups in identifying barriers to treatment accessibility is essential. Community participation and involvement is crucial to provide assistance and guidance to relevant stakeholders in preparing action plans and to facilitate resource mobilisation and appropriate delivery, including donations and food, during emergencies. Advocacy actions are also vital for establishing communication networks to disseminate information to reach everyone. Lessons learned from the Morocco earthquake, during which there was substantial involvement of non-governmental organisations, showed how relief operations can greatly support front-line government efforts.[3] Community engagement is also crucial to enable acceptable service delivery by addressing social and cultural beliefs. The collective voices of patients through advocates can substantially influence governmental authorities' decisions and policy developments.[4] Community-devoted planning cannot disregard community participation in the preparedness for and response to health crises, as enhanced diversity strengthens the sense of collective responsibility, representation, and resilience.

The second is workforce planning. We believe that in conditions of sudden change, efficiency-oriented solutions must be offered to face increased health-care demands. For example, role delegation and task-shifting are potential solutions to high demand.[5] Innovative educational interventions in teaching oncology to general practitioners and undergraduates during their training could prepare skilled clinicians to support the oncology workforce during times of disaster amid acute shortages. Examples have been reported from Rwanda in revising existing oncology workforce developments.[6] Fostering workforce initiatives through adequate distance-based supervision and mentorship are crucial to ensure that health-care workers doing tasks traditionally handled by specialists maintain the required high standards of care. Adapting practice guidelines of international cancer societies might therefore need to be adjusted to accommodate task-shifting, while