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- Declaration of Helsinki

# World Medical Association Officers, Chairpersons and Officials



# Official Journal of the World Medical Association

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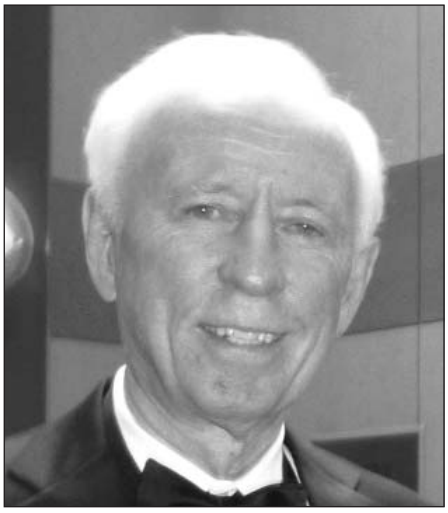
# Address of Past President of WMA Cecil B Wilson, October, 18th 2013



*Cecil B. Wilson*

Members of the World Medical General Assembly, colleagues, guests and our hosts the Brazilian Medical Association:
Since my inauguration last year in Bangkok, it has been my privilege to represent the World Medical Association (WMA) around the world.
I've traveled to at a total of five continents, twelve countries and attended twenty-nine meetings and conferences.
I've also reported on my travels and the varied and important activities of this organization on the WMA website through the President's Blog.

The message I have carried may be summed up as follows:

1. The moral imperative of ethics in medicine.
2. The challenge of noncommunicable disease and the social determinants of health.
3. The threat of climate change.

**First, the moral imperative of ethics in medicine**
As you all are aware, the WMA has been very involved in the process of bringing the Declaration of Helsinki (DOH) up to date in anticipation of its fiftieth anniversary in 2014.
The Expert Conferences convened in Cape Town, South Africa, Tokyo, Japan and Washington, DC, brought together experts in ethics, members of the medical profession, educators and governmental officials to provide input.
The conferences are part of the multi-year effort by the World Medical Association to examine the DOH to determine if changes are needed.
In examining the DOH for potential changes the WMA has focused on transparency and on obtaining a diversity of opinions from experts around the world.
At this meeting, we see the culmination of many hours' work by the workgroup, and especially the facilitating group, who had the unenviable task of taking mountains of comments and distilling them into a new more understandable document.
In addition, the transparency of the process that encouraged involvement by experts in the field and the public is an affirmation that the end product will preserve the DOH as the gold standard for ethical principles in research involving human subjects.

**Second, the challenge of noncommunicable disease and the social determinants of health**
The social determinants of health are the conditions in which people are born, grow, live, work and age; and the societal influences on these conditions.
They are major influences on both quality of life, including good health, and length of disability-free life expectancy.
The primary responsibility for addressing the social determinants of health is that of government and society.
In March I attended the Institute of Health Equity (IHE) which makes recommendations for actions and provides analysis in core areas of work for physicians:

1. Workforce education and training as well as individuals and communities.
2. Government organizations and working in partnership and as advocates.
3. Challenges and opportunities in the health system.

The WMA believes in the importance of health care system strengthening, universal access and emphasizing social determinants of health as the right approach in fighting NCDS.
At all WHO events on this topic, the WMA will advocate for a holistic approach that puts social determinants of health at the forefront of thinking about health care.

**Third, the threat of climate change**
Climate change due to global warming is reality of life on our planet today.
It has health effects that are significant and already being felt.
For example extreme heat events are more frequent, of longer duration and more severe, causing increased deaths in the tens of thousands yearly.
Early research suggests that mitigation of the effects of climate change may have a link with prevention and might have significant health benefits for both individuals and populations.
In climate change vernacular, mitigation and adaption are the buzzwords.
The WMA is committed to being involved in the mitigation of climate change – that is attempting to slow or reverse climate change by decreasing greenhouse gas production through implementation of green policies.
Including for example extremes of weather such as heat events and torrential downpours and flooding;
Changes in insect disease vector populations, and adverse effects on food sources brought on by droughts.
As another part of ongoing efforts to support responses to climate change, the

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WMA established an environmental caucus which meets regularly in conjunction with WMA meetings.
Last fall the caucus surveyed WMA members to assess implementation of WMA's green policies within its membership.
The goal was to evaluate medical associations' involvement in those areas and get useful guidance for potential additional activities.

Based on the results of the environmental caucus survey, WMA members report they are engaged in dealing with climate change and have a variety of suggestions about how further progress can be accomplished.
In conclusion, as I stated in my inaugural address,
I still believe that in spite of the constancy of change and the unexpected events of our lives,

We as physicians can open new doors, share new insights, find new cures, prevent disease We can help our patients the world over to live healthier, happier, longer more productive lives.
I thank you for the great honor of contributing to these ideals as WMA President over the past year, and I look forward to more opportunities to create a brighter future of medicine.

# Inaugural Address of Dr. Margaret Mungherera, President of the WMA, October, 18th 2013

*Margaret Mungherera*

The Health Secretary of the State of Ceara, Mr. Secretary Ciro Ferreira Gomes, the Hon. Minister of Health, Uganda, Dr. Ruhakana Rugunda, the outgoing President of the World Medical Association Dr. Cecil Wilson, the Chair of WMA Council, Dr. Mukesh Haikerwal, the WMA Secretary General, Dr. Otmer Kloiber, the President of the Brazilian Medical Association, Dr. Florentino Cardoso, members of the WMA, ladies and gentlemen.

It is my honour and privilege to express my sincere appreciation to the President of the Brazilian Medical Association, Dr. Florentino Cardoso and his team for hosting the WMA meeting and their warm hospitality and for the choice for such an auspicious venue for the meeting. Please join me in acknowledging the hard work put in by the Secretariat (Sunny, Lamine, Anna and others) ably led by the WMA Secretary General, Dr. Otmar Kloiber in organizing the meeting.

In a special way, I would like to thank Dr. Cecil Wilson for having graciously mentored me a lot over the last 12 months about what it means to be passionate and dedicated to getting things done and he has indeed achieved things done. Thank you, Cecil and I wish you all the best.

Some of you might be asking yourselves but who I am and where I come from.

I come from Uganda, a small country in the eastern part of Africa named which Sir Winston Churchill in 1903 described as the "the pearl of Africa" The weather, the climate, the evergreen scenery, the source of the River Nile and the world's largest population of mountain gorillas make Uganda an exquisitely beautiful country and you are all invited to visit it.

This country which at one time had the best medical school in Eastern, Central and Southern Africa is just beginning to recover from more than 25 years of state inspired violence and civil conflict. It is now heartening to note that it is making progress and we are on the right track.

I have lived in that country all my life not because I had no choice but because I made a conscious decision to stay and make my own contribution to making things right especially in the medical profession.

When I qualified from the medical school, I continued to witness the deterioration in health services. I had spent the whole of my third and fourth years in abject fear for my life and that of my family and friends. For 2 whole years, reading at night was difficult because that was when the gun shots and bombing was worst. Getting to the teaching hospital in the mornings for lectures to find that yet another doctor had been killed on his way from the hospital became the order of the day. I still remember the helplessness I felt as I saw many of my lecturers flee the country and into exile.

The question on our minds as students was, would we be able to complete medical school. By the time, our final year ended, Idi Amin, the former president, had fled the country but leaving

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the country in disarray. Internship was even worse. The scarcity of resources was gross. I spent the whole of my internship putting up IV lines without gloves and draining abcesses of fully conscious patients without a local anaesthetic. And this is when I promised myself that I would do everything I could to be part of the change and I am glad to say that I have been part of it and continue to be. As we completed our internship in 1983, out of a class of almost 100, more than 60 of my classmates left the country in search of greener pastures. But despite pleas from parents, I chose to stay.

This resolve and determination enabled me to be one of the founder members of the Association of Uganda Women Medical Doctors who embarked on speaking out on the need for rural women to be able to access reproductive health services. It is this resolve and determination that led me accept to stand for the post of President of the Uganda Medical Association and become the first woman to hold that position since its formation in 1964. I would like to thank Richard, my husband, for being there for me all the time.

In a country of 36 million people, I am one of 5000 medical doctors, one of the 36 psychiatrists and one of the only 2 forensic psychiatrists the country has. But things are slowly getting better – One of the highlights of my time as President of Uganda Medical Association was when I reluctantly took up that position again in 2010 to fight for better pay for doctors and finally convinced Government to accept our proposal to increase the pay of doctors working in rural areas by 300 percent. It showed me that the decision I made 30 years ago to stay in Uganda was indeed a good decision.

It has been a long journey but it has been worth it. I have tried to take the knowledge and skills I acquired during my training as a doctor and psychiatrist beyond the hospitals and use it to reduce the suffering of poor communities, I have sat in a grass thatched hut with mud and wattle walls with no lunch for days running mental health clinics for Sudanese refugees and internally displaced persons in Northern Uganda, in the scorching heat with bombing and sporadic gun shots as the background music.

I have demonstrated on the streets for psychosocial support for survivors of gender based violence and I have had heated arguments with the tobacco industry on national radios. I am a human rights advocate and a women's rights advocate. It is this passion and determination to fight for social justice for all that I bring to the leadership of the WMA.

It gives me great pride to note that despite the differing environments and circumstances of its members, the WMA remains committed to providing guidance to national medical association as regards promoting their professional freedom, high medical ethical standards and professional conduct, and advocacy for access to quality health care for all.

During my term as President of the World Medical Association, I will advocate for the health of the poor and vulnerable communities. Almost half of the world lives on less than a dollar a day. Therefore we, the Physicians of the world, through our national medical associations have a duty to advocate on behalf of the poor among us – because as the famous adage goes "If you miss the poor, you've missed the point". And there is no part of the globe that does not have poor people who for one reason or another cannot enjoy their basic human rights- the people who cannot access health care, mentally ill people who are discriminated against, and survivors of torture and other forms of violence. As physicians, we have been given the privilege to do something about it. We can do much as individual physicians, but we can have wider and more sustainable impact within our NMAs, under the umbrella of the World Medical Association.

NMAs can ensure poor people have access to health care by ensuring that health systems in their countries are functional. Universal health care or the Millennium Development Goals cannot be achieved where there is for example a gross shortage of health workers or a lack of essential medicines. What the various stakeholders in the Health Sector need is effective leadership and guidance and who better suited than NMAs to provide this leadership? However, NMAs must ensure they have the necessary capacity to be effective and this is where the WMA comes in.

I salute you all, who strive, sometimes risking your lives to minimize the suffering of your communities, working in the aftermath of natural and man-made disasters, in places where the health facilities are less than adequate. Your dedication to maintain the highest standards in the practice of human medicine has helped save and transform the quality of life of individuals and whole communities around the world.

As I conclude I would like to thank my Minister of Health, Hon. Dr. Ruhakana Rugunda for travelling all the way to witness my installation as president.

Through him I would like to express my gratitude and that of Uganda Medical Association to the President of Uganda for his support and interest in the health profession and the health sector.

Once again I would like to thank all of you for having entrusted me with the responsibility of heading this august body for the next 12 months.

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# WMA President – Elect Dr. Xavier DEAU

*Xavier Deau*

Human rights, patients' rights, professional independence, informed consent: the fundamental principles of medical ethics are universal and know no boundaries.

In 1947, doctors from 27 countries united to set up the World Medical Association. Their aim was to serve mankind by establishing the highest standards of ethics in teaching, medical treatment and prevention for all peoples. They did not speak the same language, nor share the same culture but they all had the same ideal, the same commitment to their patients, regardless of their religion, their social standing or their political opinions.

The WMA has shown these past sixty years that our will to defend the independence of National Medical Associations and the independence of each doctor requires nowadays political advocacy at all levels, both national and international.

I wish to strongly collaborate with you all during the next three years with a view to further cooperation in the longer term.

It is an ethical principle that unites us: bringing together physicians in the interests of patients.

*Dr. Xavier Deau*

## Current positions

- President of the European and International Delegation of the French Medical Council since June 2013.
- President of the Departmental Council of Medical Order of Vosges since 1993.
- General Secretary of the European Council of Medical Orders (CEOM) since 2011.
- General Secretary of the Conference of Medical Councils from French-speaking countries (CFOM) since 2011.

## Former positions

- Council Member of the WMA since 2012.
- Vice-president of the French Medical Council in charge of international relations from 2011 to 2013.
- Vice-president of the French Medical Council in charge of relations with University from 2009 to 2013.
- President of the Medical Training and Qualifications Department of the French Medical Council from 2005 to 2009.
- Vice-president of the Professional Practice Department of the French Medical Council from 2003 to 2005.

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# 64rd WMA General Assembly and 195th/196th Council Sessions

*Nigel Duncan*

The General Assembly meeting in Fortaleza, Brazil will be remembered for many things. But chief among them will be that it was the meeting where the revised Declaration of Helsinki was adopted after a process lasting two years. But it was also the Assembly where Dr. Margaret Mungherera was installed as the first African woman to become WMA President.

The meeting, held at Villa Galé Cumbuco, Fortaleza, Brazil, held from October 16th to 20th, was attended by more than 250 delegates and observers from more than 45 national medical associations (NMAs) and other organisations. As usual the proceedings opened on the first day with a meeting of the Council.

## Council

Dr. Mukesh Haikerwal, Chair of the WMA, reported briefly on the activities of the WMA in helping doctors around the world who get into difficulties. The latest example was the case of a Canadian doctor, arrested and imprisoned in Egypt during the recent riots, who had just been released with the help of the WMA and others. He also referred to the multiple global meetings that were held around the world, such as the G8 and the G21. What he found very concerning was that often the place of health care and health was missing. 'Our role and that of the WMA and its members is to bring to people's notice that it is very important to have good clinical care, to have good healthy subjects to make sure the agenda for economic development is actually achieved', he said.

The Secretary General, Dr. Otmar Kloiber, added to an extensive written report on activities during the year, by highlighting the European Union directive on clinical trials, which related to the Declaration of Helsinki. This was now being converted into a regulation and it would have a direct effect as a law on all European countries. He said the WMA was disappointed that in the new regulations there was no longer a requirement to have the approval of ethics committees before a clinical trial could start. The requirement to have ethics committees involved had now been put back into the proposal as the WMA had requested, but not in a way it would like to have seen. However he was hopeful that there would be further changes so that any proposal for a trial would have to be positively considered by an ethics committee.

A second issue in the regulation, which was of global importance, related to the dual use of samples and data in clinical studies. He said the WMA was convinced that for all the research carried out the informed consent of participants was needed. However a problem might occur when there was a second use for the samples from the study and patients might not be able to be reached for a second informed consent. If that was not possible, the Declaration of Helsinki now said that an ethics committee had to give permission to use that data. But major research groups had been lobbying the European Parliament to come to a different conclusion, by saying that there should be a broad consent for the secondary use of samples or data in bio banks or from research projects. The WMA believed that would undermine informed consent completely because it would not allow for the subjects in a study to exercise their self-determination correctly. He said the WMA would like to see a solution closer to that suggested in the Declaration of Helsinki. Discussions were continuing and the WMA would continue to monitor the situation.

*Emergency Motions*

Notice was given to the Council of three emergency motions – on the Prohibition of Chemical Weapons, Chemical Riot Control Agents and Health Care in Syria. It was agreed that all three should be considered as a matter of urgency.

## Finance and Planning Committee

The committee met under the Chairmanship of Dr. Leonid Eidelman (Israel Medical Association).

*Financial Reports*

The Treasurer, Dr. Frank-Ulrich Montgomery, introduced the audited financial statement for 2012, and the Budget for 2014.

Mr Adolf Hällmayr, the Financial Advisor, highlighted some of the main points of the expenditure and income figures for 2012 and went through the Budget for 2014. He said that due to the on-going negative effects of inflation on the expenses an adequate increase in income would be necessary to obtain balanced results and to guarantee financial stability. To this end discussions had already started. It was agreed that the reports be forwarded to Council and then

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to the Assembly for adoption. Mr Hällmayr also reported on the situation on membership dues and categories. A brief debate followed on a proposed new dues structure. It was agreed to recommend that the Council should establish a workgroup to review the proposal for new structure of membership dues and report back

*Strategic Plan*

Dr. Kloiber mentioned the current difficulty with raising sponsorship money, although there were still sponsored projects running. In the areas of ethics and advocacy, the WMA, in collaboration with the World Health Professions Alliance, would be hosting the World Health Professions Regulation Conference in May 2014. There was a global trend for regulation to be taken over by governments and this was a critical issue that required the WMA's attention. He also recognized that the Junior Doctors Network had become very active in the WMA and this was a benefit in terms of new ideas as well as increasing the visibility of the Association.

*Business Development Group*

Professor Vivienne Nathanson (British Medical Association) reported on the first meeting of the business development round table recently held in London. Six of the 12 organisations that had agreed to join the group had attended and it was agreed to meet again. A paper was being prepared about other ideas for producing non dues revenue. The Group was planning its next round table in Tokyo in conjunction with the Council session.

*Future WMA Meetings*

An oral report was given about the Council meeting due to be held in Tokyo from April 8–12. It also agreed that at the next General Assembly in Durban, South Africa in October 2014 the theme of the scientific session would be 'Universal Access to Health Care after MDGs'. The committee agreed that the invitation from the Norwegian Medical Association to host the 200th Council Session in 2015 in Oslo be accepted. It was also agreed that the Council recommend to the Assembly that the theme of scientific session for General Assembly in Moscow 2015 be medical education.

*Declaration of Helsinki – 50th Anniversary*

Dr. Eidelman gave an oral report about plans for an event in Helsinki to celebrate the 50th anniversary of the Declaration of Helsinki in May or June 2014. Dr. Heikke Pälve (Finish Medical Association) explained that the event would begin with a scientific session in the morning followed by a celebration attended by the President of Finland. He said that suitable dates and venues were still being considered

*New Members*

The Committee considered applications for membership from the Medical Chamber of Montenegro, the Ordre National des Médecins du Cameroun, the Sudanese Medical Association and the Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri, Italy. It was agreed that these be forwarded to Council for adoption by the Assembly. Dr. Kloiber reported that the Association of Hungarian Medical Societies (MOTESZ) had agreed to be replaced by the Hungarian Medical Chamber in WMA membership and this matter would be considered by Council.

## Socio-Medical Affairs Committee

The committee met under the Chairmanship of Sir Michael Marmot (British Medical Association).

*Health Care in Danger*

Prof. Nathanson, Chair of the workgroup on Health Care in Danger, reported on the activities of the group. She said the British Medical Association had agreed to work with the International Committee of the Red Cross on a toolkit looking at the ethical dilemmas faced by doctors in situations of armed conflicts and other situations of violence. She also reported on the workgroup's decision to work on the subject of psychiatry and quality of care, and in particular issues related to whether some psychiatric treatment without the consent of the individual amounted to torture or ill treatment.

*Violence Against Women and Girls*

The Chair of the Committee put forward proposals for implementing the proposed resolution on violence against women and girls. He suggested exploring opportunities to collaborate with global organisations working in this area, such as the Global Foundation to End Domestic Violence, initiated by Baroness Scotland. The American Medical Association referred to the US organisation, Futures without Violence, and said they would make contact with them. It was also suggested that the WMA might organise a side-event on this issue at the World Health Assembly 2014, possibly in cooperation with the International Federation of Medical Students Association and the International Federation of Gynaecology and Obstetrics. A third idea was to invite national medical association members to report to the secretariat on their initiatives in relation to violence against women in order to acquire an overview of their involvement in this area. The Indian and Australian Medical Associations also reported on their activities on this issue.

*Right to Reparation of Victims of Torture*

The Committee considered a proposed Statement on the Right to Reparation of Victims of Torture proposed by the Danish Medical Association. The statement urged national medical associations to work with other organisations to ensure the reparation of victims of torture in view of concern at the

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continued use of torture in many countries throughout the world. It was proposed and agreed that the title of the Statement should be amended to use the word 'rehabilitation' rather than 'reparation' and it was agreed that the document should be forwarded to Council for adoption by the Assembly.

*Human Papillomavirus Vaccination*

The Committee considered a proposed Statement on Human Papillomavirus Vaccination. Dr. Ardis Hoven (American Medical Association) said the Statement had been circulated for comments and these had been taken into account. The safety, efficacy and value of a vaccine were well known. Each nation would have its own health priorities and the unique opportunity to prevent HPV associated cancers merited consideration. A brief debate followed, when it was argued that the WMA should be very cautious about getting involved in specific medical issues. However Dr. Hoven replied that a stand-alone Statement was needed because there was little common knowledge, even among physicians, about what this vaccine could do and what it could prevent. A motion to defer the document was defeated and it was agreed that the Statement be approved by the Council with the recommendation that it be forwarded to the General Assembly for adoption.

*Fungal Disease Diagnosis and Management*

Dr. José Luiz Gomes do Amaral (Brazil Medical Association) proposed a Statement on Fungal Disease and Management. He said its purpose was to raise the attention of national medical associations to the problem of fungal disease, which was often considered not as important as tuberculosis, malaria or AIDs. But from the data the global burden of fungal disease compared to these other diseases. In a brief debate, it was decided to remove the statistics from the document because they would quickly go out of date and undermine the fundamental message of the Statement. It was agreed that the proposed Statement be revised and be submitted to the Council for consideration.

*Ethical Guidelines for Recruitment of Physicians*

The Committee considered a proposed revision to the WMA statement on the Ethical Guidelines for Recruitment of Physicians. Prof. Nathanson said none of the principles had been changed but it had merely been updated. It was agreed that the document be circulated to NMAs for comments.

*Non-Commercialization of Human Reproductive Material*

A proposed revision of the WMA Resolution on the Non-Commercialization of Human Reproductive Material was put forward by Dr. Eidelman. In view of the fact that the revisions introduced substantial changes, it was agreed that the document should be circulated to NMAs for comment.

*Ethical Implications of Reality TV for Physicians*

A proposed Statement on the Ethical Implications of Reality TV for Physicians was presented by the Israel Medical Association. It argued that these programmes were a form of experimentation on human beings, putting enormous pressure on participants in the drive to win audiences. Such shows were now popular around the world, and the WMA should have some ethical policy for physicians involved in these programmes. This led to a lengthy debate in which a number of speakers argued that this was not an appropriate subject for the WMA to consider. On a vote it was decided that the document should be circulated to NMAs for comment.

*The Role of Physicians in Preventing the Trafficking with Minors and Illegal Adoptions*

The Committee considered a proposed Statement on the Role of Physicians in Preventing the Trafficking with Minors and Illegal Adoptions. Introducing the document, Dr. Fernando Rivas Navarro (Spanish Medical Association) said the problem of children trafficking and illegal adoptions was an overwhelming one. It was estimated by the United Nations Office for Drugs and Crime that an average of 1.2 million children were trafficked every year. A good number of them would need genetic identification to find out who they are and where their families were, or even which were their countries of origin. In 2006 a pilot program, DNA-Prokids, was started in Guatemala, and extended to Mexico. In 2009 the University of North Texas Health Sciences Center joined with the University of Granada to launch the program in as many countries as possible, basically Latin America and Asia. Since the program started a total of 9330 samples had been analyzed. Among these, 697 positive associations had been made and most of these children had been returned to their families or were in the legal process of doing so. In addition 221 illegal adoptions had been detected and avoided. The intention of the proposed document was to establish a professional observatory within the WMA and, led by the Organización Médica Colegial de España, to learn in detail about the role of physicians in the medical attention of unidentified children and adoption. Such a move would also help to find out how physicians could play a preventive role by warning adopting families and by collaborating with their own national authorities.

*Aesthetic Procedures*

Two papers were received by the committee, the first a proposed Statement on Aesthetic Procedures for Minors presented by the Israel Medical Association and a second, a proposed Statement on Aesthetic Treatment in general proposed by the Swedish Medical Association. Proposing the general paper, Tomas Hedmark (Swedish Medical Association) said that aesthetic treatments had become more common in recent years and were performed by practitioners with widely different backgrounds. Some were

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physicians, but many were not. In Sweden the view seemed to be that aesthetic treatments without medical indication should not be considered as health care. He believed that the WMA should develop policy applying to all practitioners, physicians and others, who performed these treatments. One reason for this was that the negative effects of aesthetic treatments would end up in regular health care where they would be handled by physicians. The committee agreed that the Israel and Swedish Medical Associations should get together to consider if the two documents could be combined and then circulated for comment to NMAs.

*Statement on Variations of Human Sexuality*

A proposed Statement on Normal Variations of Human Sexuality was proposed jointly by the German Medical Association, the Conseil National de l'Ordre des Médecins, and the British Medical Association. After the paper had been proposed by Dr. Xavier Deau there was a lengthy and passionate debate about a proposal to delete the word 'normal' from the document and substitute it with the word 'natural'. Some speakers questioned whether the subject of the Statement was an urgent matter and said that in several countries being homosexual was illegal. But supporters of the Statement argued that widespread concern had been expressed by professional medical societies about the use of conversion procedures, as well as the fact that in many regions being homosexual was still a reason for torture, jail or execution. It was eventually decided that the proposed Statement be amended as proposed and sent to the Council with the recommendation that it be forwarded to the General Assembly for adoption.

*The Role of Physicians and NMAs, Social Determinants of Health and Health Equity*

The Committee considered a proposal from the Canadian Medical Association to organise a symposium of interested constituent members in to develop plans to address the social determinants of health and health equity. NMAs were invited to provide their views on the proposal to the Canadian Medical Association or to WMA secretariat in the coming weeks and a more detailed proposal would be brought to the Council at its next session in Tokyo, April 2014.

*Brazilian Medical Association*

The Committee considered a proposed Resolution in Support of the Brazilian Medical Association introduced by Dr. Miguel Jorge. He explained that the Brazilian Government had introduced a programme, "Mais Médicos", to give recognition to Brazilian citizens who had studied in Cuban medical schools. They received diplomas that were not valid even in Cuba. The programme was created by the Government in order to recognise those diplomas and put these people to work in remote areas of the country. There were some places where no physicians were working because of a lack of health infrastructure. In response to the reaction of the Brazilian Medical Association, the Government had changed the main purpose of the programme and abandoned the idea of using its programme to give validity to these Brazilian physicians who gained their diplomas outside Brazil and changed the focus to import physicians. It was expected that there would be around 12,000 Cuban physicians working in Brazil. From these 12,000 physicians some hundreds had arrived and were starting to work. The problem was that these physicians and others covered by the programme were not being employed by the Government respecting the labour laws. They would just receive pocket money and some support to work in the cities. Those from Cuba would not receive the same amount of money as others. Their payments would be sent from the Brazilian Government to the Cuban Government. These physicians were not allowed to bring their families to Brazil. Most of the physicians that had been imported were not working in remote areas but had gone to work in the big cities and there was some concern about their prescribing competence. The committee approved the Resolution and agreed to send it to Council with the recommendation that it be forwarded to the General Assembly for adoption.

*Advocacy*

Dr. Jeff Blackmer (Canadian Medical Association) reported on the activities of the Advocacy Committee, which had met the day before and discussed two main items.

The first related to a media event to be scheduled in conjunction with the celebration of the 50th anniversary of the Declaration of Helsinki in 2014. The second referred to plans for an advocacy training session during the scientific session to be held in Durban, South Africa in October 2014. It was agreed that the Committee would provide its support to the South African Medical Association with a view to including an advocacy component in the session.

## Emergency Resolutions

*Prohibition of Chemical Weapons*

A proposed Resolution on the Prohibition of Chemical Weapons was introduced by the Turkish Medical Association. After a brief debate it was decided that the Resolution be revised, in particular by removing the references to countries in the text. The British Medical Association volunteered to lead the revision and submit the result to the Council for consideration. It was agreed that a workgroup be set up with a mandate to develop a comprehensive policy on chemical weapons and riot control agents, as referred to in the second emergency resolution.

*Chemical Riot Control Agents*

The second emergency Resolution calling for the Prohibition of Chemical Riot Control Agents was also introduced by the

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Turkish Medical Association with reference to the recent disturbances in Turkey. However, the Resolution failed to gain support. Instead it was agreed that it would be considered by the workgroup.

*Health Care in Syria*

The Committee considered the proposed Emergency Resolution on the Healthcare Situation in Syria. Prof. Nathanson said that attacks on civilians and on hospitals, clinics and those attempting to provide care seemed to be getting worse every day. This was now a crisis situation. Not only were huge numbers of the Syrian population fleeing the country, but those remaining and who were ill were not getting access to healthcare and doctors and others looking after them were at serious risk. The committee agreed that the proposed Resolution be approved by the Council with the recommendation that it be forwarded to the General Assembly for adoption.

## Medical Ethics Committee

The committee met under the Chairmanship of Dr. Heikke Pälve (Finland Medical Association).

*Declaration of Helsinki*

The first of several lengthy debates then took place about revisions to the Declaration of Helsinki. Dr. Parsa-Parsi (German Medical Association), Chair of the workgroup, thanked the members of the working group, including ethics advisors, for their hard work toward the shared goal of revising the document to promote the highest standards in medical ethics. The revised document represented input from many expert stakeholders and organizations throughout the international community, provided over a two year period, in an open and collaborative process. All comments and suggestions had been carefully and systematically considered by the workgroup in the drafting process. Prof. Urban Wiesing, ethics adviser to the workgroup, gave an overview of the changes being proposed. He reported on the revision process and the 150 comments received. It had been the most intensive public debate on the revision of the Declaration that had ever taken place. The workgroup had decided at the outset that the character of the Declaration should remain, that its length should stay about the same and that it should remain distinct from other guidelines. He said the main changes were to introduce more precise wording, a more readable structure, revised paragraphs on vulnerable groups, post study arrangements and research ethics committees and for the first time to mention the issue of compensation. The workgroup had decided to give the Declaration a new structure with a new order and some merging of paragraphs. He explained why the revisions contained no list of specific vulnerable groups. Referring to changes to the post study arrangements, he said that in the 2008 version of the Declaration the wording was vague. The workgroup was now proposing more precise wording and in particular to state clearly the responsible institutions – sponsors, researchers and host country governments. For the first time norms had been set out for members of research ethics committees, that they should be duly qualified. The introduction of compensation was a big step in the history of the Declaration. Until now compensation had not been mentioned for people who were harmed during clinical trials. Now compensation and treatment for subjects who were harmed was being demanded and this improved the protection of participants, in particular in poor countries. He explained the reference for the first time to biobanks. The general principles of informed consent complied for the collection, storage and reuse of samples. Turning to the issue of placebos, he said there had been no ethical change compared to the 2008 Declaration. But a more systematic approach had been proposed. Now a proposal that any control less than the best proven intervention was addressed. He accepted that the issue of placebos was controversial. Another big step was the proposal for every research study to be registered, not only clinical studies.

Dr. Jeff Blackmer, the WMA's ethics adviser, explained in more detail the proposed changes, going through the document paragraph by paragraph. The Chair then opened the meeting to invite discussion and proposed amendments. The Royal Dutch Medical Association asked for clarification about why participants in medical research were 'encouraged' in parts of the Declaration and not imposed. Dr. Blackmer explained that the WMA could not impose things on others involved in research. Dr. Kloiber added that the WMA should refrain from making rules for other groups. Concern about the issue of compensation and the possibility of abuse was raised by the Ugandan Medical Association. Professor Weising explained the scope and intent of the paragraph and further clarification was provided from two members of the workgroup.

The main discussion took place on paragraph 20 concerning medical research with a vulnerable group and the issue of benefits. The South African Medical Association expressed concern about the subject of 'additional benefits' in the paragraph, especially with respect to developing countries, and the possibility of coercion and undue inducement. The Indian Medical Association supported this concern. Prof. Wiesing explained the rational of the workgroup in including this language. Dr. Blackmer also described the advantages and disadvantages of this language. Medical research with a vulnerable group was only justified if the research was responsive to the health needs or priorities of this group and the research could not be carried out in a non-vulnerable group. In addition, this group should stand to benefit from the knowledge, practices or interventions that resulted from the research. A proposal was made to delete the final two sentences in paragraph 20 relating to a group receiving a fair level of additional benefits if certain conditions were met and

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on a vote it was agreed that the two sentences should be deleted.

On paragraph 25, relating to informed consent, the French and Uruguay Medical Associations expressed concern about how this paragraph might relate to the use of placebo. Prof. Wiesing reviewed the history of debate on informed consent over the past two revision processes and the reasons behind the way the current text was written. A motion to amend paragraph 25 by addition was not accepted.

Further debates took place about the requirement to obtain informed consent for the reuse of human material or data and on the issue of use of placebos, but without any further amendments being agreed. At the end of the debate, the proposed revised Declaration, as amended by the committee, was approved for forwarding to Council and the General Assembly with the recommendation that it be adopted.

*Health Databases*

The Committee received the oral report of the workgroup on Health Databases from Dr. Jon Snaedel (Iceland Medical Association). He noted that there were several options for defining the scope of the WMA work in this area. The committee recommended that the workgroup be instructed to continue its work on the broad concept of health databases.

## Associate Members

*Junior Doctors Network*

Dr. Thorsten Hornung, immediate past Chair of the Network, gave an oral report on behalf of the Junior Doctors Network, reporting on its activities during the past year. A new team of officers had been elected at the Network's meeting on Tuesday. In particular he spoke about the JDN's work on a policy paper about physician well-being. He talked about junior doctors having to live in places with no running water and being on call all the time and not going home for 30 days in a row. He said there was much stress among physicians and yet they were a group who should practice what they preached. He said support structures were needed. Dr. Daniel Johnson, past President of the WMA, referred to the system in most US states where impaired physicians – physicians with alcohol or drug problems – were helped to return to practice. The intent was not to keep these physicians from being able to practice, but to correct the impairment and restore them to practice. There was a shortage of physicians and this was the best approach, both from the physicians' point of view and the patients. He suggested that the JDN consider introducing such a suggestion into their paper.

*Chair*

Dr. Guy Dumont, Chair of the Associate Members since 1993, said he would be retiring as a physician next year and would be stepping down as Chair of the Associate Members. He was thanked for his work and received a standing ovation.

## Scientific Session

The theme of the session was 'Life styles and non communicable chronic diseases'.

Opening the session, Dr. Margaret Mungherera, President elect of the WMA, said that the adoption of abnormal lifestyles among populations had had immeasurable adverse impact on the health and survival of peoples of the world, much greater than that created by the epidemics of communicable diseases such as the plague of the middle ages, tuberculosis and syphilis.

'The insidious onset of NCDs is elusive', she said. 'They spread silently through the populations and they kill or maim quick when they emerge. The behavioural contributory factors are known and include inadequate physical activity, cigarette smoking, unhealthy eating habits and excessive alcohol ingestion'.

She said that NCDs were cheaper and easier to prevent and that was where most of the focus and therefore the resources should go. And the targets should include children.

'Rather than focus on a few NCDs, the approach needs to be holistic and therefore strengthening health systems, universal health care and addressing social determinants is where the emphasis should be placed. For instance, effective preventive and health promotion programmes require adequate numbers of motivated and skilled health workers'.

Speakers during the day talked about diet, physical activity, tobacco and alcohol. The opening presentation on the social determinants of health was given by Sir Michael Marmot (British Medical Association), who spoke about health data around the world compared to social gradients. He talked about data from Brazil about cardiovascular disease showing that the more deprived the district the higher the mortality. He referred to data on diabetes based on social gradients and talked about the data on obese children in England and its relationship to the social determinants of health. The challenge was to deal with the social determinants of the risk factors involved. He looked at how Brazil had tackled social inequality and found that they had made progress. And he posed the question about what doctors could do about these problems. Among the areas where they could get involved were education and training, working with individuals in communities, the health service as an employer, working in partnership with others, and working with the health system.

Dr. Howard Bauchner, editor in chief of the Journal of the American Medical Association, spoke about controversies over diet and health in the United States and

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the worldwide epidemic of obesity. He said there had been a seismic shift from organic to processed food. But he said there were very few clinical trials that could help them understand what their public health recommendation should be. Tremendous strides had been made in the US on cardiovascular disease. But as people have lived longer Alzheimer's Disease and cancer had become more important. He spoke of the progress made in dealing with HIV Aids, but said that chronic renal disease had skyrocketed, as had drug abuse. He talked about the controversy over salt and the amount of salt that anyone should consume. And he said that the only common factor that made a diet successful was adherence. On the politics of public health, he said that every country struggled with how much they should dictate to its citizens about lifestyle.

Dr. Luiz Claudio Castro (Brazilian Medical Association), a professor of paediatrics, spoke about childhood obesity. He said that they had to promote health and well-being at childhood in order to assure quality of life in future stages. Obesity disrupted three instances of well-being, physical, mental and social. It had to be managed as a disease and not just a situation. Yet with childhood obesity they had lots of questions but still few answers. There were some certainties – that childhood obesity had reached epidemic levels. But they had to believe that this could be reversed.

Dr. Jeremy Lazarus (American Medical Association) spoke about physicians as role models for physical activity. He said physical activity was both enjoyable and rewarding. He spoke about competing in marathons and said he had completed 13 of them. He and his wife rode a tandem and this was good for relieving stress. He said it was important for physicians to act as role models not only for their patients, but also for their families and their communities. He enjoyed the challenge of pushing himself and said it was important that physicians thought about their own physical and mental health.

Dr. Carlos Serrano Jr. (Brazilian Medical Association), a cardiologist, spoke about cardiovascular risk reduction as a result of physical activity and health promotion. The concept of taking exercise for heath was centuries old. He said physicians should recommend their patients to take exercise. But to educate their patients about health and well-being and for physicians to convince their patients about the benefits of well-being it was important for physicians themselves to exercise.

The session on Tobacco and Public Health opened with Dr. Heikki Pälve (Finish Medical Association) talking about the Finish Tobacco Policy. He stressed the need for co-operation to achieve any results. Finland's battle against tobacco began in the 1960s when the medical association put forward proposals. But it had to persist before its policies began to take effect with legislation introduced in the 1970s. But it was rather the intense discussion leading up to the legislation which caused many people to quit smoking rather than the legislation itself. He said there must be no compromises with the tobacco industry. The aim now was a tobacco-free Finland by 2040. Was this possible, he asked. After their experiences of already achieving things people did not think were possible, he thought the answer was a definite yes. This was followed by Alberto Araujo (Brazilian Medical Association) talking about The Role of Health Professionals on Tobacco Control Policies.

The final session on alcohol began with Dr. Mervi Kattelus (Finish Medical Association) talking about European Union Policies Against Alcohol Related Harm and the session concluded with Dr. Sérgio de Paula Ramos (Brazilian Medical Association) talking about Alcohol Abuse by Adolescents. Dr. Ramos said that there were 2.5 million deaths a year as a result of alcohol. For young people it was the number one risk factor. He talked about the advertising of alcohol in Brazil and said that the alcohol industry was not concerned with ethics or public health.

## Council

Council reconvened on the third day of the meeting to consider reports from the committees held on the first day.

### Medical Ethics Committee

*Declaration of Helsinki*

The Council considered the revised Declaration of Helsinki as amended by the Medical Ethics Committee. This led to a further brief debate on the document, but no further amendments were made and the Council approved the revised Declaration for sending to the Assembly for adoption.

*Health Databases*

The Council agreed that the membership and mandate of the workgroup on health databases be extended to include the issue of biobanks.

*Person Centred Medicine*

It was agreed to recommend to the Assembly that a proposed Statement on Person Centred Medicine be circulated to NMAs for consideration. The paper, from the Iceland Medical Association, calls for a shift in the focus of health care from the providers and healthcare system to the individual.

*Women's Rights to Healthcare and How that Relates to Mother and Child HIV Infection*

The Council agreed that a proposed Resolution submitted by the South African Medical Association should be sent to the Assembly for adoption.

*Forensic Investigations of The Missing*

The Council agreed that a revised Statement on Forensic Investigations of The Missing be sent to the Assembly for adoption.

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## Finance and Planning Committee

*Membership*

Dr. Kloiber said that since 1988 the Association of Hungarian Medical Societies (MOTESZ) had been a member of the WMA. However the Association had experienced problems in maintaining membership and the WMA had now received a request from the Hungarian Chamber, open to all physicians in Hungary, to become the WMA member. The Council recommended to the Assembly that the Hungarian Medical Chamber should be accepted as a member of the WMA.

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Dr. Peteris Apinis, the editor of the Journal, said next year would be the 60th anniversary of the Journal. He talked about the possibility of changing the journal to an electronic journal and indicated that it was time for a younger person to take over as editor.

*Past Presidents and Chairs Network*

Dr. Kloiber reported on the newly-set up Network of Past Presidents and Chairs. It had met for the first time the previous day when terms and reference were discussed on the basis of the network acting as a sounding board for the Council. In an election Dr. Dana Hanson (Canada) was elected Chair, Dr. Kgosi Letlape (South Africa) Vice Chair and Dr. Jon Snaedal (Iceland) Secretary.

## Socio-Medical Affairs Committee

*Human Papillomavirus Vaccination*

Dr. Heikke Pälve referred to the document's recommendation that there should be 'HPV vaccination for all children starting at age 11 or 12, for all females age 13 through 26, for all males age 13 through 21 (any male may be vaccinated through age 26), for all immunocompromised patients who are age 22 through 26, and for men who have sex with men who are age 22 through 26'. He suggested that this was far too detailed and should be deleted from the paper. The Council agreed to delete the sentence and substitute it with the sentence 'Recommend HPV vaccination for all appropriate populations' and to forward the Statement to the Assembly for adoption.

*Fungal Disease Diagnosis and Management*

The Council agreed that the proposed Statement should be forwarded to the Assembly for adoption.

*Brazilian Medical Association*

The proposed Resolution in Support of the Brazilian Medical Association was agreed and it was recommended that it be forwarded to the Assembly for adoption.

*Prohibition of Chemical Weapons*

Prof. Nathanson said that the two papers on the Prohibition of Chemical Weapons and the Prohibition of Chemical Riot Control Agents had now been combined into one document. Reference to specific countries had been deleted and a final recommendation had been added, urging urges states using chemical agents in riot control situations to carefully consider and minimise the risks and to, wherever possible, refrain from such use. The Council approved the Resolution and it was agreed to forward it to the Assembly for adoption.

*Health Care in Syria*

The Council approved the Resolution and agreed to forward it to the Assembly for adoption.

*Variations of Human Sexuality*

A further debate took place on the proposed Statement after Dr. Leonid Mikhaylov (Russian Medical Society) proposed that the word 'natural' be deleted from the document. However several speakers supported keeping the word 'natural'. Prof. Nathanson said it was completely unacceptable to argue that in most of the world this was a question for debate as a scientific issue. It would be unacceptable for the WMA to have a document on homosexuality that did not make it quite clear that this is a natural variation of sexuality. After the proposal to delete the word' natural' failed to find a seconder, the Council agreed the Statement and recommended that it should be forwarded to the Assembly for adoption.

*Presidency*

Dr.Haikerwal, Chair of Council, reported that a letter had been received from the Indian Medical Association requesting that the 2010 suspension imposed on Dr. Ketan Desai's inauguration as President should be lifted. He said the Indian Medical Association had submitted a motion calling for a date to be set for Dr. Desai's Presidency. He explained to Council the background to the case, arising from Dr. Desai's arrest and imprisonment in 2010 which prevented him from attending the Vancouver Assembly. Dr. Haikerwal said that the charges against Dr. Desai had since been withdrawn and he was asking Council to recommend to the Assembly that the suspended inauguration be lifted and to recommend a date when Dr. Desai should take up his Presidency. Dr. Ajay Kumar (Indian Medical Association) said that Dr. Desai's arrest was a result of him becoming too powerful a medical leader for the Indian Government. After a further debate, the Council decided to recommend to the Assembly that the suspension of Dr. Desai's inauguration should be lifted and that the question of when this should take place should be considered at the Council meeting in Tokyo in April 2014 to be confirmed at the next Assembly meeting in Durban in October 2014.

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## General Assembly Ceremonial Session

The Assembly was called to order by the Chair, Dr. Mukesh Haikerwal and a roll call and introduction of delegates and observers was carried out by the Secretary General, Dr. Kloiber.

Welcome addresses were given by Secretary Ciro Ferreira Gomes, Health Secretary of the State of Ceará, and Dr. Florentino de Araújo Cardoso Filho, President of the Brazilian Medical Association, before Dr. Haikerwal paid a tribute to the outgoing WMA President, Dr. Cecil Wilson as a thoughtful, honourable and diligent man. Dr. Wilson then delivered his valedictory address. (p. 161)

Dr. Margaret Mungherera, President of the Uganda Medical Association, was then installed as the 64th President of the WMA, and gave her inaugural address. (p. 162)

## General Assembly Plenary Session

*Election of President for 2014/15*

Dr. Xavier Deau, President of the European and International Delegation of the French Medical Council, was elected unopposed as President of the WMA for 2014/15. Thanking the meeting for his election, Dr. Deau said that for several decades the French Council had built up close links with its European international counterparts. Nowadays this international commitment was more important than ever. National and global health were becoming more and more political issues and the French Council wanted the WMA to be the leader in anticipating the changes in medical practice while preserving the quality of doctors and access to health care.

*Use of the Death Penalty*

The proposed Statement on support for the United Nations Resolution for a Moratorium on the Use of the Death Penalty was put forward for adoption. Dr. Jeremy Lazarus (American Medical Association) said the AMA delegates would be voting against this Statement. Although they respected the views of all their colleagues, the AMA did not take a position for or against the death penalty or on the issue of a moratorium. They believed these were issues for the individual moral decision of physicians, and physicians in the US were deeply divided on this matter. The Chair explained that the Statement would require 93 votes, a three-quarters majority, for adoption. On a vote, the Statement was carried by 94 votes to 25 with four abstentions. (p. 179)

*Declaration of Helsinki*

The revised Declaration of Helsinki was then introduced and Dr. Parsa-Parsi, Chair of the workgroup, Professor Wiesing and Dr. Blackmer explained to the Assembly the revision process that had been undertaken for the past two years and the detailed changes that were being proposed. Prof. Wiesing explained the details of the new compensation proposals included in the Declaration and the revised paragraph on the use of placebos, which he said would always be controversial. Dr. Blackmer talked about the issue of research on vulnerable groups. The only discussion that followed concerned paragraph 33 on the use of placebos. Several delegates spoke against the paragraph and said they could not accept the revised wording. But on a vote the paragraph was approved by 110 votes to 10. On a further vote, the revised Declaration of Helsinki was adopted with a strong three-quarters majority as required. (p. 199) Members of the workgroup were applauded for their work.

*Women's Rights to Healthcare and How that Relates to Mother and Child HIV Infection*

The Resolution on Women's Rights to Healthcare and How that Relates to Mother and Child HIV Infection was adopted with one small amendment to add the word 'unwanted' to the following recommendation for campaigns to 'eradicate myths, stigma and stereotypes that might degrade or dehumanise women. This must include campaigns against genital mutilation and forced adolescent marriages and unwanted pregnancies.' (p. 183)

*Forensic Investigations of The Missing*

The revised Statement on Forensic Investigations of The Missing was adopted as WMA policy. (p. 180)

*Standardisation in Medical Practice and Patient Safety*

The Resolution on Standardisation in Medical Practice and Patient Safety was adopted. (p. 181)

*Criminalisation of Medical Practice*

The Resolution on Criminalisation of Medical Practice was adopted. (p. 178)

*Right to Rehabilitation of Victims of Torture*

The Statement on the Right to Rehabilitation of Victims of Torture was adopted. (p. 182)

*Variations of Human Sexuality*

The Statement on Variations of Human Sexuality was introduced and it was proposed that the word 'natural' should be included in the title to be consistent with the rest of the document. Several speakers opposed this suggestion, but the proposal was accepted for the document to be called 'Natural Variations of Human Sexuality'. It was then proposed by the Russian Medical Association that the document should be sent back for further discussion and comment. This led to a passionate debate with speakers on both sides. The Russian proposal received support from the Ugan-

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da delegation. But Prof. Nathanson argued that this was an emergency. In at least 50 countries people were being criminalised, discriminated against and in some places imprisoned, and threatened with execution because they had a natural normal variation of human sexuality. She added: 'It is completely unacceptable because this is being legitimised by bad medicine and what we are trying to condemn here is bad medicine, medicine which is trying to force a change on people when they are in fact entirely expressing a natural or normal variation of human sexuality.' Dr. Lazarus (American Medical Association) said it was important that the WMA voted on this issue today because they were dealing with an opportunity for homosexuals to live a decent life. He was supported by delegates from Canada and South Africa. Dr. Torunn Janbu (Norway) said the WMA should have adopted such a Statement years ago. The motion to refer the Statement back to NMAs for further consideration was defeated. It was then proposed that the word 'normal' should be put back into the document, but on a vote this was defeated. The Statement, as retitled 'Natural Variations of Human Sexuality', was adopted as WMA policy. (p. 177)

*Human Papillomavirus Vaccination*

The proposed Statement on Human Papillomavirus Vaccination was adopted. (p. 183)

*Brazilian Medical Association*

The Resolution in Support of the Brazilian Medical Association was adopted. (p. 177)

*Health Care in Syria*

The emergency Resolution on the Healthcare Situation in Syria was adopted. (p. 181)

*Prohibition of Chemical Weapons*

The Resolution on the Prohibition of Chemical Weapons was adopted. (p. 178)

*Fungal Disease and Management*

The Statement on Fungal Disease and Management was adopted. (p. 179)

*Financial Statement and Budget*

The Treasurer, Dr. Frank-Ulrich Montgomery, introduced the audited financial statement for 2012, and explained the details to the Assembly. He thanked the Secretary General for exercising very efficient cost control, a risk-free investment policy and a thrifty use of the budget. The financial statement was adopted. He then talked about the budget plans for 2014 which were approved.

*Durban Assembly 2014*

The Assembly agreed that at the next General Assembly in Durban, South Africa the theme of the scientific session would be 'Universal Access to Health Care after Millennium Development Goals'.

*Future Meetings*

It was agreed that the venue for the 2016 General Assembly be Taipei, Taiwan.

*Membership*

Applications for membership from the Medical Chamber of Montenegro, the Ordre National des Médecins du Cameroun, the Sudanese Medical Association and the Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri, Italy were agreed. It was also agreed that the Hungarian Medical Chamber be accepted as a member, replacing the Association of Hungarian Medical Societies.

*Presidency*

Dr. Haikerwal updated the Assembly on the situation relating to Dr. Ketan Desai, whose inauguration as President was suspended in 2010 when he was unable to attend the Assembly in Vancouver following his arrest and imprisonment. The charges against him had now been withdrawn and the Indian Medical Association had requested that Dr. Desai be inaugurated as President. Dr. Haikerwal said Dr. Desai had been badly maligned by the Indian court system. The Council of the WMA were recommending that the suspension be lifted and that further consideration be given to the timing of Dr. Desai's Presidency at the Council meeting in Tokyo in April 2014 to be approved by the Assembly in Durban in October 2014. The Assembly agreed to lift the suspension on Dr. Desai's inauguration. A debate then took place on when a decision should be taken about the timing of Dr. Desai's inauguration. Dr. Ajay Kumar (Indian Medical Association) explained the background to Dr. Desai's imprisonment and said it was up to the Assembly to decide when his inauguration should take place. Dr. Mzukisi Grootboom (South Africa Medical Association) said that a decision about when Dr. Desai should take up the Presidency should be decided straight away to send a strong message to the Indian Government. He proposed that there be no election for President held at the 2014 Assembly for the 2015 term and that Dr. Desai be inaugurated as President in 2015. But Dr. Lazarus said that this was a complicated matter and should be discussed at the meeting in Tokyo in April. A motion to discuss the matter immediately was defeated and the Assembly agreed to defer the matter for further consideration until the Council meeting in Tokyo in 2014.

*Report of Associate Members Meeting*

Dr. Thorsten Hornung, Past Chair of the Junior Doctors Network, introduced the JDN's policy paper on Physicians Wellbeing. He said JDN members from all over the world had shared their experiences and the data was shocking. He gave two examples – there were at least 40 per cent more suicides among physicians com-

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pared to the general population and one in eight physicians had admitted relying on alcohol or drugs for stress relief. He said the medical profession needed to practice what it preached. In many places physicians experienced extreme working hours in excess of 100 hours per week, often with a lack of support structures, bullying and harassment. 'Many times we are taught to deny our own needs and weaknesses, sadly illustrated by physicians having late stage psychiatric disease when finally seeking help', he said. The JDN presented this paper hoping to collaborate with NMAs worldwide to make this an important piece in the WMA's mission of endeavouring to achieve the highest international standards in healthcare for all people in the world. The Assembly decided to refer the paper to the Council for consideration.

*Health Care in Danger*

Dr. Bruce Eshaya-Chauvin, medical adviser on the Health Care in Danger project of the International Committee of the Red Cross, gave a presentation following the recent Memorandum of Understanding between the WMA and the ICRC. He said that medical ethics would constitute a major area of co-operation between the two organisations. The Health Care in Danger project encouraged initiatives with NMAs. He said that violence against patients and health care workers was one of the most crucial yet overlooked humanitarian issues today. He presented data about the numbers of health care providers and facilities affected by violent incidents and updated the Assembly on the progress of the Health Care in Danger project. The ICRC alone would not be able to solve the problem. It would require global co-operation.

*Plain Packaging*

Dr. Andrew Pesce (Australian Medical Association) updated the meeting about the legal situation relating to the plain cigarette packaging legislation in his country. The tobacco industry had challenged the legislation but the courts had found in the Government's favour. This should encourage politicians not to be too intimidated by threats of legal action. Complaints had also been made to the World Trade Organisation. He also reported on the roll out phase of introducing the new plain packs. Research had shown there was a measurable lowering of the appeal of smoking and an increase in the urgency among smokers to give up smoking. He said that all NMAs should increase their efforts to introduce plain packaging.

*Turkey*

Prof. Dr. Gülriz Erisgen, Vice President of the Turkish Medical Association, spoke about threats to the medical profession in Turkey. These followed the peaceful demonstrations in Turkey earlier in the year when extreme violence was used by the police against legitimate demonstrators. During this period the Turkish Medical Association had regularly collected information from physicians about the numbers of wounded and fatalities. They had also surveyed injuries caused by the police use of chemical agents, tear gas, rubber bullets and water cannons. The Ministry of Health had now started an investigation into the Medical Association and the Chamber of Medicine, asking for the names of volunteer physicians during the demonstrations and the names of the injured demonstrators. She said it was impossible to give such information. She thanked the WMA for its support during this difficult period.

*Open Session*

During the 'open session', held to give delegates an opportunity to present to the Assembly any profession-specific problem, policy or project that they believed the WMA should know about or help address, delegates from America, Romania, Bahrain and Nigeria spoke about activities in their countries. Dr. Ardis Hoven (American Medical Association) said her Association had recently undertaken a project to identify the factors that influenced physicians' professional satisfaction. This was of increasing importance as health reforms were changing the practice of medicine. Early research results suggested that the factors contributing to physicians' dissatisfaction could serve as an early warning to deeper quality problems developing in the healthcare system. A common theme was physicians describing stress when they saw barriers preventing them from providing quality care. Solving these problems would be good for both patients and physicians. Specific concerns that had been identified were how electronic record technology interfered with face to face discussions with patients, spending too much time on clerical work, excessive productivity quotas and limitation on the time spent with patients. This was especially true of primary care physicians. Researchers reported that physicians reported being more satisfied when their practice gave them more autonomy, with the ability to employ more staff members to take care of clerical work. By identifying factors that positively influenced physicians' satisfaction, the AMA was committed to supporting physicians and also improving patient satisfaction as well.

## Council

A final meeting of the Council was held to discuss business arising from the Assembly.

It was agreed that the paper from the Junior Doctors Network on physicians' well-being should be circulated to NMAs before being considered by the Socio-Medical Affairs Committee.

It was also agreed that the Executive Committee should consider whether a policy paper should be developed on weapons of mass destruction, as suggested by a delegate from the Bahrain Medical Society.

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# WMA General Assembly Fortaleza, Brazil, October 2013







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# WMA Statement on Natural Variations of Human Sexuality

*Adopted by the 64th General Assembly, Fortaleza, Brazil, October 2013*

## Preamble

Healthcare professionals encounter many aspects of human diversity when providing care, including different variations of human sexuality.

A large body of scientific research indicates that homosexuality is a natural variation of human sexuality without any intrinsically harmful health effects.

As a consequence homosexuality was removed from the American Psychiatric Association's official diagnostic manual in 1973. The World Health Organisation (WHO) removed it from the ICD in 1990 following a similar process of scientific review. The Pan American Health Organization (WHO) states: *"In none of its individual manifestations does homosexuality constitute a disorder or an illness, and therefore it requires no cure."*

Direct and indirect discrimination, stigmatisation, peer rejection, and bullying continue to have a serious impact upon the psychological and physical health of people with a homosexual or bisexual orientation. These negative experiences lead to higher prevalence rates of depression, anxiety disorders, substance misuse, and suicidal ideations and attempts. The suicide rate among adolescents and young adults with a homosexual or bisexual orientation is, consequently, three times higher than that of their peers.

This can be exacerbated by so-called "conversion" or "reparative" procedures, which claim to be able to convert homosexuality into asexual or heterosexual behaviour and give the impression that homosexuality is a disease. These methods have been rejected by many professional organisations due to a lack of evidence of their effectiveness. They have no medical indication and represent a serious threat to the health and human rights of those so treated.

## Recommendations

The WMA strongly asserts that homosexuality does not represent a disease, but rather a natural variation within the range of human sexuality.

The WMA condemns all forms of stigmatisation, criminalisation and discrimination of people based on their sexual orientation.

The WMA calls upon all physicians to classify physical and psychological diseases on the basis of clinically relevant symptoms according to ICD-10 criteria regardless of sexual orientation, and to provide therapy in accordance with internationally recognised treatments and protocols.

The WMA asserts that psychiatric or psychotherapeutic approaches to treatment must not focus upon homosexuality itself, but rather upon conflicts, which arise between homosexuality, and religious, social and internalised norms and prejudices.

The WMA condemns so-called "conversion" or "reparative" methods. These constitute violations of human rights and are unjustifiable practices that should be denounced and subject to sanctions and penalties. It is unethical for physicians to participate during any step of such procedures.

# WMA Resolution in Support of the Brazilian Medical Association

*Adopted by the 64th General Assembly, Fortaleza, Brazil, October 2013*

There are credible reports that the Brazilian Government program "Mais Médicos" to create more medical schools, extend the duration of the medical course, compulsorily place last years medical students to work in public services and attract foreign physicians to work in remote areas of the country and in the poorest outskirts of big cities, was proposed without the appropriate consultation to the medical community and medical schools, and departs from a wrong diagnosis about the causes of the insufficient health care provided to the Brazilian population. The program as proposed bypass systems established to verify physicians' credentials, medical competence and language skills in order to protect patients.

The World Medical Association is concerned that patients are put at risk by unregulated medical license, inadequate medical competence and potential misunderstanding of patient communication and of drugs and medical supplies labels.

Therefore, the WMA:
- Condemns any policy and practice that disrupt the accepted standards of medical credentialing and medical care;
- Calls upon the Brazilian government to work with the medical community and medical schools on all matters related to medical

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education, physician certification and the practice of medicine, and to respect the role of the Brazilian Medical Association on behalf of the Brazilian physicians and population;
- Urges, as a matter of utmost concern, that the Brazilian government respect the WMA International Code of Medical Ethics that guides the medical practice of physicians all over the world.

# WMA Resolution on the Prohibition of Chemical Weapons

*Adopted by the 64th General Assembly, Fortaleza, Brazil, October 2013*

## Preamble

It has been recognised for centuries that certain chemical agents can affect consciousness, or other factors influencing the ability of an individual to take part in fighting, predominantly during warfare. More recently some agents have been used to temporarily disable participants in civil unrest, protests or riots. In warfare such agents have, historically, had a significant morbidity and mortality and included nerve gases and related agents.

Despite widespread condemnation such weapons were extensively used in the early 20th century. A global movement to outlaw the use of such weapons led to the development of the Chemical Weapons Convention (CWC), which entered into force in 1997 having been opened to signature in 1993. Currently only six countries have not ratified or acceded to the CWC.

The production, stockpiling and use of CW is prohibited. Despite this, such weapons have been used by state forces and by non-state actors in a number of countries. By their nature such weapons are indiscriminate. This use has led to deaths, injuries and human suffering in those countries.

Chemical agents used in policing actions, including by the military acting in a policing role, are allowed under the CWC. There is a significant international dialogue underway on the definition of such agents and the situations in which they can be used. It should be noted that the CWC appears to assume such agents will not be lethal, but the use of any agent might have fatal consequences. Those using them, or authorising their use, must seek to ensure that they are not used in a manner which risks death or serious injury to targeted persons.

## Recommendations

The WMA notes that the development, production, stockpiling and use of Chemical Weapons is banned under the CWC, and that use of such weapons is regarded by some to be a crime against humanity, regardless of whether the target populations are civilian or military.

The WMA urges all relevant parties to make active efforts to abide by the CWC ban on the development, production, stockpiling and use of Chemical Weapons.

The WMA urges support from all states party to the CWC for the safe destruction of all stockpiles of Chemical weapons.

The WMA supports UN initiatives to identify anyone who is responsible for the use of Chemical Weapons and to bring them to justice.

The WMA urges states using chemical agents in riot control and related situations to carefully consider and minimise the risks and to, wherever possible, refrain from such use. Any use must follow the establishment of the necessary procedures to reduce the risk of death or serious injury. They should not be used in a manner, which deliberately increases the risk of injury, harm or death to their targets.

# WMA Resolution on Criminalisation of Medical Practice

*Adopted as a Council Reolution by the 194th WMA Council Session, Bali, April 2013 and adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013*

## Preamble

Doctors who commit criminal acts which are not part of patient care must remain as liable to sanctions as all other members of society. Serious abuses of medical practice must be subject to sanctions, usually through professional regulatory processes.

Numerous attempts are made by governments to control physicians' practice of medicine at local, regional and national levels worldwide. Physicians have seen attempts to:
- Prevent medically indicated procedures;
- Mandate medical procedures that are not indicated; and
- Mandate certain drug prescribing practices.

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Criminal penalties have been imposed on physicians for various aspects of medical practice, including medical errors, despite the availability of adequate non-criminal redress. Criminalizing medical decision making is a disservice to patients.

In times of war and civil strife, there have also been attempts to criminalize compassionate medical care to those injured as a result of these conflicts.

### Recommendations

Therefore, the WMA recommends that its members:
1. Oppose government intrusions into the practice of medicine and in healthcare decision making, including the government's ability to define appropriate medical practice through imposition of criminal penalties.
2. Oppose criminalizing medical judgment.
3. Oppose criminalizing healthcare decisions, including physician variance from guidelines and standards.
4. Oppose criminalizing medical care provided to patients injured in civil conflicts.
5. Implement action plans to alert opinion leaders, elected officials and the media about the detrimental effects on healthcare that result from criminalizing healthcare decision making.
6. Support the principles set forth in the WMA's Declaration of Madrid on Professional Autonomy and Self-Regulation.
7. Support the guidance set forth in the WMA's Regulations in Times of Armed Conflict and Other Situations of Violence.

# WMA Statement on the United Nations Resolution for a Moratorium on the Use of the Death Penalty

*Adopted by the 64th General Assembly, Fortaleza, Brazil, October 2013*

### Preamble

The WMA Resolution on Physician Participation in Capital Punishment states that it is unethical for physicians to take part in capital punishment, and the WMA Declaration of Geneva obliges physicians to maintain the utmost respect for human life.

The WMA acknowledges that the views prevalent in the countries of some of its members prevent all members unconditionally opposing the death penalty.

The WMA therefore supports the suspension of the use of the death penalty through a global moratorium.

The WMA has long recognized that it cannot hold its national medical association members responsible for the actions and policies of their respective governments.

### Recommandations

The World Medical Association supports United Nations General Assembly Resolution 65/206 calling for a moratorium on the use of the death penalty.

# WMA Statement on Fungal Disease Diagnosis and Management

*Adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013*

Annual WHO Global Burden of Disease estimates recognize that fungal diseases account for a significant proportion of health problems worldwide. These include cutaneous fungal infections which affect up to a billion persons and vulvovaginal candidiasis which affects tens of millions of women, often multiple times annually.

Even more serious are invasive and chronic fungal diseases that lead to estimated annual morbidity rates that are similar to those caused by commonly recognized global health concerns such as malaria and tuberculosis. In addition to death, these fungal diseases commonly lead to chronic ill health, including blindness with keratitis, respiratory distress *with* ***allergic bronchopulmonary aspergillosis (ABPA)***, severe asthma with fungal sensitisation (SAFS) and chronic pulmunary aspergillosis (CPA), weight loss and nutritional deficiency with oesophageal candidiasis and CPA, and inability to engage in healthy sexual activity with vulvovaginal candidiasis.

Serious fungal diseases are often opportunistic, occurring as a consequence of other conditions that suppress the immune system, such as asthma, AIDS, cancer, post-transplant immunosuppressive drugs and corticosteroid therapies. Some occur in critically ill patients.

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Despite the fact that many fungal diseases can be treated relatively simply, in many cases, these diseases go untreated. Fungal infections alone are often not distinctive enough to allow a clinical diagnosis, and as cultures are frequently falsely negative, missed diagnosis is common. In addition, a relatively narrow diagnostic window to cure the patient is frequently missed, resulting in prolonged expensive hospital stays, often with a fatal outcome. Despite the existence of effective medicine to treat fungal infections, these are often not available when and where they are needed.

### Statement

The WMA stresses the need to support the diagnosis and management of fungal diseases and urges national governments to ensure that both diagnostic tests and antifungal therapies are available for their populations. Depending on the prevalence of fungal diseases and their underlying conditions, specific antigen testing or microscopy and culture are essential. These tests, and personnel trained to administer and interpret the tests, should be available in all countries where systemic fungal infections occur. This will likely include developing at least one diagnostic centre of excellence with a sufficient staff of trained diagnostic personnel. Monitoring for antifungal toxicities should be available.

Physicians will be the first point of contact for most patients with a fungal infection and should be sufficiently educated about the topic in order to ensure an effective diagnostic approach.

The WMA encourages its members to undertake and support epidemiologic studies on the burden of fungal disease in their country and to inform the national government of the results.

# WMA Statement on Forensic Investigations of the Missing

*Adopted by the 54th WMA General Assembly, Helsinki, Finland, September 2003 and amended by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013*

### Preamble

Over the last three decades, forensic investigations into the whereabouts and fate of people killed and missing as a result of armed conflict, other situations of violence and catastrophes, have made an important contribution to humanitarian action on behalf of victims, including [the deceased and] bereaved families. Forensic investigations have also helped in achieving justice and reparations for victims.

In 2003 the International Conference on The Missing and their Families, organized by the International Committee of the Red Cross (ICRC), adopted a set of recommendations to help prevent people going missing, and resolve the cases of those already missing, as a result of armed conflicts and other situations of violence. The recommendations include ethical, scientific and legal principles that must apply to forensic investigations in the search, recovery, management and identification of human remains. These principles have since been further developed by the ICRC›s forensic services and they provide a framework for humanitarian forensic action in situations of armed conflicts, other situations of violence and catastrophes[1]. The principles also ensure the proper and dignified management and identification of the dead, and help provide answers to the bereaved.

National Medical Associations have a role in promoting these principles and encouraging compliance with them, and for ensuring the highest possible ethical, scientific and legal standards in forensic investigations aimed at addressing the humanitarian consequences of armed conflicts, other situations of violence and catastrophes.

In many countries NMAs will not have a role in certifying the qualifications and experience of forensic medical practitioners. NMAs should draw the attention of practitioners to the best practice guidelines produced by the ICRC, the United Nations and Interpol, and recommend or, where possible, require compliance with those standards.

### Recommendations

The WMA calls upon all NMAs to help ensure that, when its members take part in forensic investigations for humanitarian and human rights purposes, such investigations are established with a clear mandate based upon the highest ethical, scientific and legal standards, and conform with the principles and practice of humanitarian forensic action developed by the ICRC.

The WMA calls upon NMAs to develop expertise in the principles collated by the different authorities on forensic investigations for

1 The ICRC defines catastrophes as disasters beyond expectations. See: M. Tidball-Binz, Managing the dead in catastrophes: guiding principles and practical recommendations for first responders. International review of the Red Cross, Vol 89 Number 866 June 2007 p.p. 421-442

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humanitarian and human rights purposes, including those developed by the ICRC to prevent new cases and resolve those of existing missing persons, and to assist their members in applying these principles to forensic investigations worldwide.

The WMA calls upon NMAs to disseminate the principles that should apply to such investigations, including those developed by the ICRC, and to attempt to ensure that physicians refuse to take part in investigations that are ethically or otherwise unacceptable.

The WMA calls upon NMAs to help ensure compliance by forensic medical practitioners with the principles enshrined in international humanitarian law for the dignified and proper management, documentation and identification of the dead, and, where possible, providing answers to the bereaved.

The WMA invites NMAs to be mindful of academic qualifications and ethical understanding, ensuring that forensic doctors practice with competence and independence.

# WMA Council Resolution on Standardisation in Medical Practice and Patient Safety

*Adopted as a Council Resolution by the 194th WMA Council Session, Bali, Indonesia, April 2013 and acopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013*

Ensuring patient safety and quality of care is at the core of medical practice. For patients, a high level of performance can be a matter of life or death. Therefore, guidance and standardisation in healthcare must be based on solid medical evidence and has to take ethical considerations into account.

Currently, trends in the European Union can be observed to introduce standards in clinical, medical care developed by non-medical standardisation bodies, which neither have the necessary professional ethical and technical competencies nor a public mandate.

The WMA has major concerns about such tendencies which are likely to reduce the quality of care offered, and calls upon governments and other institutions not to leave standardisation of medical care up to non-medical self selected bodies.

# WMA Resolution on the Healthcare Situation in Syria

*Adopted by the 64th General Assembly, Fortaleza, Brazil, October 2013*

## Preamble

During wars and armed conflicts, hospitals and other medical facilities have often been attacked and misused and patients and medical personnel have been killed or wounded. Such attacks are a violation of the Geneva Conventions (1949), Additional Protocols to the Geneva Conventions (1977) and WMA policies, in particular, the WMA Statement on the Protection and Integrity of Medical Personnel in Armed Conflicts and Other Situations of Violence (Montevideo 2011) as well as WMA Regulations in Times of Armed Conflicts and Other Situations of Violence (Bangkok 2012).

The World Medical Association (WMA) has been active in condemning documented attacks on medical personnel and facilities in armed conflicts, including civil wars.

The Geneva Conventions and their Additional Protocols are designed to protect medical personnel, medical facilities and their patients in international and non-international armed conflicts.

The parties on both sides of the conflict have legal and moral duties not to interfere with medical care for wounded or sick combatants and civilians, and to not attack, threaten or impede medical functions. Physicians and other health care personnel must act as and be considered neutral and must not be prevented from fulfilling their duties.

## Recommendations

- The WMA calls upon all parties in the Syrian conflict to ensure the safety of healthcare personnel and their patients, as well as medical facilities and medical transport.
- The WMA calls upon its members to approach local governments in order to facilitate international cooperation in the United Nations, the European Union or other international body with the aim of ensuring the safe provision of health care to the Syrian people.

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# WMA Statement on the Right of Rehabilitation of Victims of Torture

*Adopted by the 64th General Assembly, Fortaleza, Brazil, October 2013*

## Preamble

The World Medical Association notes with grave concern the continued use of torture in many countries throughout the world.

The WMA reaffirms its total condemnation of all form of torture, and other cruel, inhuman or degrading treatment or punishment, as defined by the UN Convention Against Torture (CAT, 1984).

Torture is one of the gravest violations of international human rights law and has devastating consequences for victims, their families and society as a whole.

Torture causes severe physical and mental injuries and is a crime absolutely prohibited under international law.

The WMA reaffirms its policies adopted previously, namely:
- The Declaration of Tokyo laying down Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (1975)
- The Declaration of Hamburg concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment (1997)
- The Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment (2003).

The medical evaluation is an essential factor in pursuing the documentation of torture and the reparation of victims of torture. Physicians have a critical role to play in gathering information about torture, documenting evidence of torture for legal purposes, as well as supporting and rehabilitating victims.

The WMA recognizes the adoption, in December 2012, by the UN Committee Against Torture of the General Comment on the Implementation of article 14 of Convention against Torture relating to the right to reparation of victims of torture.

The General Comment outlines the right of rehabilitation as an obligation on States and specifies the scope of these services. The WMA welcomes in particular:
- The obligation of State parties to adopt a "long-term and integrated approach and ensure that specialized services for the victim of torture or ill treatment are available, appropriate and promptly accessible" (paragraph 13), without making access to these services dependent on the victim pursuing judicial remedies.
- The recognition of the right of victims to choose a rehabilitation service provider, be it a State institution, or a non-State service provider, which is funded by the State.
- The recognition that State parties should provide torture victims with access to rehabilitation programs as soon as possible following an assessment by qualified independent healthcare professionals.
- The references in paragraph 18 to measures aimed at protecting health and legal professionals who assist torture victims, developing specific training on the Istanbul Protocol for health professionals, and promoting the observance of international standards and codes of conduct by public servants, including medical, psychological and social service personnel.

## Recommendations

The WMA emphasizes the vital function of reparation for victims of torture and their families in rebuilding their lives and achieve redress and the important role of physicians in rehabilitation.

The WMA encourages its member associations to work with relevant agencies – governmental and non-governmental - acting for the reparation of victims of torture, in particular in the areas of documentation and rehabilitation, as well as prevention.

The WMA encourages its members to support agencies that are under threat of - or subjected to - reprisals from state parties due to their involvement in the documentation of torture, rehabilitation and reparation of torture victims.

The WMA calls on its members to use their medical experience to support torture victims in accordance with article 14 of the UN Convention against Torture.

The WMA calls on its member associations to support and facilitate data collection at the national level in order to monitor the implementation of the State's obligation to provide rehabilitation services.

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# WMA Statement on Human Papillomavirus Vaccination

*Adopted by the 64th General Assembly, Fortaleza, Brazil, October 2013*

## Preamble

Human papillomavirus (HPV) vaccination presents a unique and valuable opportunity for physicians to substantially prevent morbidity and mortality from certain cancers in all populations, and to improve maternal health. The HPV vaccine therefore merits consideration by the World Medical Association (WMA) separately from other vaccines.

HPV is a sexually transmitted virus and is so common that most sexually active adults become infected at some point in their lives. Most infections are asymptomatic and resolve without medical intervention. However, some of the 40 types of HPV can cause cervical cancer. HPV is the cause of nearly 100% of cervical cancer cases and may also cause cancer of the vagina, vulva, anus, penis and the head and neck. Cervical cancer accounts for more than 10% of all female cancers, and the majority of cervical cancer deaths are in developing countries.

Vaccines can protect against infection by the most common HPV types and afford protection against cancer. The U.S. Advisory Committee on Immunization Practices recommends HPV vaccination for both females and males starting at age 11 years up to age 26 years. Benefits of vaccinating young men include protection against genital warts and cancer in addition to preventing transmission of HPV to sexual partners. The additional protection afforded by the quadrivalent vaccine against genital warts as well as cervical and other cancers should be taken into consideration when developing HPV vaccination programmes. The HPV vaccines are effective; post-marketing studies have shown decreases in HPV prevalence and HPV related disorders such as genital warts and abnormal cervical cytology. Studies concerning the safety of HPV vaccines have been reassuring.

These vaccines should be made widely available and should be promoted by physicians as a matter of individual patient wellbeing and public health.

## Recommendations

The WMA urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination and routine cervical cancer screening; and encourages the development and funding of programs to make HPV vaccine available and to provide cervical cancer screening in countries without organized cervical cancer screening programs.

National medical associations (NMAs) are encouraged to carry out intensive education of and advocacy efforts toward their members to:

- Improve awareness and understanding of HPV and associated diseases;
- Understand the availability and efficacy of HPV vaccines;
- Understand the desirability of including HPV vaccines in national immunization programs;
- Understand the need for routine cervical cancer screening; and
- Integrate HPV cancer prevention methods, early detection and screening, diagnosis, treatment and palliative care into existing continuing professional development programs and pre-service training. Such training will leverage existing support for HPV programs and help in capacity building and quality assurance efforts.

NMAs are also encouraged to:

- Integrate HPV vaccination for all adolescents and routine cervical cancer screening for young women into all appropriate health care settings and visits;
- Support the availability of the HPV vaccine and routine cervical cancer screening for appropriate populations that benefit most from preventive measures, including but not limited to at-risk patients such as low-income, disadvantaged and populations that are not yet sexually active;
- Recommend HPV vaccination for all appropriate populations;
- Promote member advocacy for HPV prevention, care and treatment; and
- Create a network of physicians and practitioners who are willing and able to mentor and support one another and establish linkages to existing HPV vaccine and cancer prevention networks.

# WMA Resolution on Women's Rights to Health Care and How That Relates to the Prevention of Mother-to-Child HIV Infection

*Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002 and amended by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013*

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## Preamble

In many parts of the world the prevalence of HIV infection continues to increase. One of the Millennium Development Goals (MDG 6), specifically targets combating HIV/AIDS, malaria and other diseases, with 2015 being its target year to halt HIV/AIDS infection and to begin reversing the spread of HIV/AIDS. In addition, it was hoped that by 2010 universal access to treatment for HIV/AIDS for all those requiring it would be achieved. A December 2012 UN resolution declared that countries must develop programmes for Universal Health Access after 2015 when the MDGs end.

HIV/AIDS is a disease that disproportionately affects people in their reproductive years although today, due to better management of the condition, there are also many older people who are infected. In addition, many who were infected as infants are now reaching reproductive maturity.

In developed countries men who have sex with men and injection drug users constitute significant risk groups for contracting HIV.

In many developing countries, women are at risk due to heterosexual contact with HIV infected partners. In 2011 approximately 58 percent of people living with HIV in sub-Saharan Africa were women, equating to about 13.6 million women living with HIV and AIDS, compared to about 9.9 million men(UNAIDS 'Global Fact Sheet 2012: World AIDS Day 2012).

In the absence of HIV, maternal mortality worldwide would be significantly (20% ) lower (Murray et al. Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5).

HIV infection increases the risk of invasive cervical cancer 2 to 22 fold. Some evidence exists that the use of antiretroviral therapy may decrease this risk. Hence, the appropriate management of patients infected with HIV may have a long-term impact on other aspects of women's health.

The WMA believes that access to healthcare, including both therapeutic and preventative strategies, is a fundamental human right. This imposes an obligation on government to ensure that these human rights are fully respected and protected. Gender inequalities must be addressed and eradicated. This should impact every aspect of healthcare.

The promotion and protection of the reproductive rights of women are critical to the ultimate success of confronting and resolving the HIV/AIDS pandemic.

Many of the MDGs address empowering women and promoting their role in society and specifically in healthcare. MDG 5B, in particular, promotes universal access to reproductive health including contraceptive access, reduction in adolescent birth rate, antenatal care coverage and addressing unmet needs for family planning. In addition, MDG 3 which promotes gender equality and empowers women, and MDGs 1 and 2 will influence women's status in society and therefore their access to healthcare and health promotion.

## Recommendations

The WMA requests all national member associations to encourage their governments to undertake and promote the following actions:

- Develop empowerment programs for women of all ages to ensure that women are free from discrimination and enjoy universal and free access to reproductive health education and life skills training. It is recommended that campaigns be initiated and activated in the media, including social media and popular programmes on radio and television in order to eradicate myths, stigma and stereotypes that might degrade or dehumanise women. This must include campaigns against genital mutilation and forced adolescent marriages and unwanted pregnancies. In addition, promoting the availability and choice of contraception for women, without necessarily having to get input from their partners, and promoting the availability of HIV testing and treatment are essential for reproductive health. It is also important to provide for the economic means for the infected populations in terms of prevention, treatment and medical follow-up.
- Women must have the same access as men, without discrimination to education, employment, economic independence, information about healthcare and health services.
- Laws, policies and practices that facilitate the full recognition and respect of human rights and the fundamental freedom of women should be initiated or reviewed and revised where appropriate. It is essential that women are empowered to make decisions regarding their children, their financial status and their future.
- All governments should develop programmes to provide prophylactic treatment in the form of antiretrovirals to women who have been raped or sexually assaulted. Universal and free access to antiretroviral therapy must also be provided to all HIV infected women.
- HIV infected women who are pregnant should receive counselling and access to anti-retroviral prophylaxis or treatment in order to prevent mother to child transmission of HIV.

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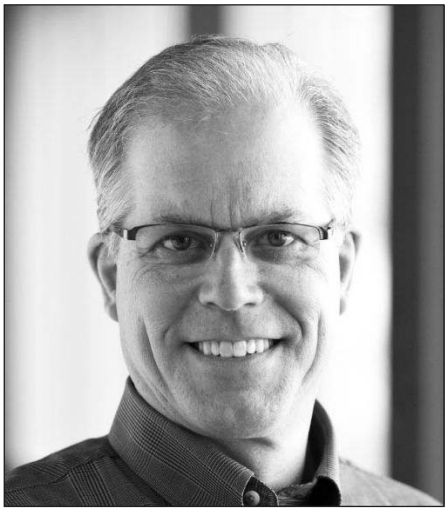
# If Perfect Isn't Possible, Is The Good "Good Enough?"

# Placebos, Post-Trial Provisions and the Politics of Helsinki



*Eric M. Meslin*

## Introduction

*"Le mieux est l'ennemi du bien." (The perfect is the enemy of the good.)"*

The *Philosophical Dictionary* attributes this familiar quote to the French philosopher Voltaire, and more specifically to his poem *La Bequeule* which begins: "*Dans ses écrits, un sage Italien, it que le mieux est l-ennemi du bien*" (which translates as: 'In his writings, a wise Italian says that the best is the enemy of the good'). The translation of "mieux" as 'best' or 'perfect' is a matter of minor translational dispute, but this has become a common aphorism, so common in fact that inserting "the perfect is the enemy of the good" into the Google search engine returns 71,800,000 results (in 0.34 seconds). Like all pieces of good advice, the point being made is clear: sometimes it is preferable to make things better rather than striving for perfection. Presumably the thinking is partly pragmatic: to achieve perfection may take more time or resources than are available and hence the pragmatic solution of achieving *something* (rather than nothing) is considered a wise strategy. It is also likely that advice about pursuing perfection is an epistemic asymptote in that one can constantly try to seek perfection and can move closer, but the effort will ultimately fail given that an accepted definition and understanding of the perfect is either beyond our knowledge or at least beyond political consensus. Achieving perfection is hard. The *Oxford English Dictionary* defines it as: 'In a state of complete excellence; free from any imperfection or defect of quality; that cannot be improved upon; flawless, faultless". This is why debates persist in Olympic scoring, physical attributes, the cut of a diamond, or in a written document.

No one is (or should be) arguing that the Declaration of Helsinki is a perfect document. But after five decades, six revisions and two Notes of Clarification it is an appropriate occasion to look backwards at the evolution of some of its more controversial sections and ponder how much further it still needs to go to get closer to a document worthy of its status as one of the most authoritative statements on ethical standards for human research in the world [1].

## Among the Most Controversial Principles: Placebos and Provision of Care

*Placebos and Standard of Care.* Few topics have occupied the attention of regulators, governments, sponsors, or academic commentators as much as the Declaration's efforts to provide principled advice on the justification for using placebos in biomedical research. I recall vividly the debates over this topic in the late 1990s when the US National Bioethics Advisory Commission was undertaking work on a report on the ethics of international clinical trials [2,3]. It was during the course these deliberations, and subsequent discussions by other groups such as the Nuffield Council for Bioethics [4] that sides were taken on the ethical acceptability of placebos. Stimulated in part by the published responses to the ACTG-076 maternal-fetal HIV transmission trials [5-7], the WMA weighed in on this topic in the 2000 revision and then in a clarifying note in 2002 which, arguably, did little to settle the issues. Indeed, one commentator has referred to the placebo principle (then Principle 29) in a prior version of the Declaration as one of the two "most controversial elements of the whole Declaration" (the other being principle 30 relating to post study obligations [8].

At stake was whether the ethical and scientific justification for including a placebo would meet an agreed standard of care, which itself has been the subject of ongoing deliberation [9]. The choice of whether a new intervention could be tested against a placebo (or no treatment) only when no *established effective,* no *proven*, no *current proven*, no *best available* treatment existed preoccupied much of the debate over the past decade. Wording changes in Principle 33 such as where "methods" replaces "treatments", provide some conceptual clarification, but any gains in clarity may still be lost when considering that the Declaration is translated into the three official languages of the WMA, presenting certain interpretation problems [10].

This has had the effect of creating a policy 'valley of death', which has been described as an environment in which policy advice

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(including guidelines) may actually impede scientific progress if not presented in an implementable way [11]. Little progress was made to traverse what has become a policy valley of death on this issue; that is the 2013 draft revision maintains the *status quo* with only minor grammatical changes for terminological consistency, such as replacing "treatment" with "intervention" and deleting "current" as a qualifier for "proven". This may be as good as it gets so long as the Helsinki reflects the considered judgment of the WMA members on the ethics of placebo controls a position that has not changed in almost 15 years.

Language notwithstanding, this principle has been, and one suspects will continue to be controversial as it relates to the question on when is it acceptable to design a study with a placebo (or no treatment). Regrettably, the debate has been mired in a set of epistemic problems including whether the standard of care is determined locally or globally. Such issues are further influenced by the economics of drug development and pricing. Arguably, one of the objections to the ACTG-076 trials, namely that it would be unethical to test a drug regimen that would be too expensive for implementation in Low and Middle Income Countries [6], would carry less weight if the price of medicines can be reduced in those countries. Given the tremendous progress that has been made to lower drug prices by many organizations, as well as innovative approaches for negotiating price [12], the way should be cleared somewhat for continued discussion about the scientific and ethical merit of using placebos.

*Provision of care at the End of a Study.* Slightly less controversial than the placebo principle is the laudable effort in the Declaration to provide guidance in Principle 34 on the issue of what, if anything, is owed at the end of a study, to whom, and on whose shoulders any obligation may rest. Like the placebo principle, the history of this provision can be traced back to the debate at the end of the last century to recognize and try to encourage implementation of a moral intuition about the ethical obligation to provide some type of care or treatment to those who participate in studies and would benefit from continued access to a beneficial treatment [3]. Unlike the placebo principle, the controversy about which is focused on whether one can set firm conditions on when it should be used *at all*, the post-trial provision principle is controversial because it does *not* set firm limits on the scope of the ethical expectations created. Accepting for the moment that the provision is unique in that (even if not explicitly stated) it is on research undertaken in LMICs since no such provision is found in national guidelines for economically developed countries, it is still a provision that is challenging to implement consistently. Consider the difficulty in identifying those who still need an intervention identified as beneficial, given factors such as symptom improvement, safety monitoring, or other requirements for ongoing care. These and other concerns were partly responsible for the need to produce a further Note of Clarification in 2004 at the Tokyo meeting of the WMA reaffirming the need "during the planning process to identify post trial access by study participants to prophylactic, diagnostic and therapeutic procedures identified as beneficial in the study or access to other appropriate care" [13]. This provision may be as good as Helsinki can get so long as the WMA, like many other organizations, continues to support the idea that among the best ways to respect the best interests of patients involved in studies is by encouraging protocols to include provisions for ongoing care, to empower ethics committees to review these aspects of protocols, and for prospective research participants to be made aware of such provisions during the consent process. However, it is also likely that as more collaborative research occurs involving participants from many different countries – some of whom will not have domestic provisions in their own governance documents that accept this provision in Helsinki – there will be conflicts about the best way to satisfy this provision.

## The Politics and Ethics of the Declaration as a Policy Instrument

One of the great strengths of the Declaration is the impact that its widespread use has on the policy positions of countries throughout the world. Many countries who have not developed their own national ethics guidelines have adopted Helsinki as their national standard. It is, therefore, first and foremost, a governance document intended to guide the conduct of domestic research in a global environment. In this way it is different from the hundreds of domestic guidelines each of which were written to provide substantive direction for the conduct of research in those countries [14]. In becoming a global document, inevitably it also has become a political document, which should come as no surprise as it is reflects the consensus view of the world's medical associations. As such, there is no denying that among the challenges that this increasingly popular document faces is the "politicization" of its content [8]. Five and half years ago, the Declaration found itself the object of a political dispute when the U.S. Food and Drug Administration (FDA) announced that it would be substituting its historic reliance on the Declaration as the standard for judging the ethical acceptability of international clinical trials with those standards adopted by the International Conference on Harmonization's (ICH) Guideline for Good Clinical Practice [15]. Some of us speculated about the possible reasons that the FDA under then U.S. President George W. Bush used to justify this policy maneuver [1]. Just as the plural of anecdote is not data, neither is it appropriate to elevate speculation about political motives to the level of confirmed intention. Still one does not have to be a conspiracy theorist to appreciate the mutual benefits

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of adopting a standard that enjoys consensus among those parties whose interactions require a common standard or benchmark. In the case of licensing and marketing new medicines, there is a decided advantage for the pharmaceutical industry in the U.S., Europe and Japan to abide by the ICH standard – having developed it jointly – as contrasted with adopting the Helsinki standard which was developed by the WMA.

These maneuverings should not, however, diminish the confidence that the public might be expected to have in the integrity of research undertaken in compliance with Helsinki. The WMA should be congratulated for its efforts to democratize the revision process by taking many steps to convene working groups and expert panels in different countries over many months, and to solicit public comments on the revision online. The final draft received fewer than 130 comments from around the world but while this seems an unusually small number for a document of such importance, the explanation may be found in the lessons from other efforts to engage the public in policy making [16–17]. most notably that public commentary is a labor intensive and sometimes technology dependent activity.

## Conclusion

The Declaration of Helsinki is not a perfect document and perhaps it can never be. It has enjoyed a unique status that has improved over time, as each subsequent revision has attempted to be responsive to new developments in science and deeper ethical and policy reflections. No sooner will the current revision be finalized and disseminated then the process will start again as one would expect of a living document in research ethics.

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## References


1. Kimmelman J, Weijer C, Meslin EM, The Helsinki Discords: FDA, Ethics, and International Drug Trials, *The Lancet* 373(9657): 13-14, January 2009 doi:10.1016/S0140-6736(08)61936-4
2. National Bioethics Advisory Commission. Ethical and Policy Issues in International Research: Clinical Trials in Developing Countries (2001). NBAC. Rockville, MD, http://bioethics.georgetown.edu/nbac/clinical/Vol1.pdf
3. Shapiro HT and Meslin, EM. Ethical Issues in the Design and Conduct of Clinical Trials in Developing Countries. *New England Journal of Medicine* 2001;345:139-141
4. Nuffield Council on Bioethics. The ethics of research related to healthcare in developing countries. Nuffield Council (2002). www.nuffieldbioethics.org/research-developing-countries
5. Varmus H, Satcher D, Ethical complexities of conducting research in developing countries. N Eng J Med 1997;337: 1003-1005
6. Lurie P, Wolf SM. Unethical trials of intervention to reduce perinatal transmission of the human immunodeficiency virus. N Eng J Med, 1997;337; 853-855
7. Angell, M. The ethics of clinical research in the third world. N Eng J Med. 1997; 337: 847-9
8. Ashcroft, RE. The Declaration of Helsinki. In Emanuel EJ, Grady C, Crouch RA, Lie RK, Miller FG, Wendler D. eds. *The Oxford Textbook of Clinical Research Ethics.* Oxford University Press (2008): 146.
9. Macklin, R. Double Standards in Medical Research in Developing Countries. Cambridge University Press, 2004.
10. Carlson RV, van Ginneken NH, Pettigrew LM, Boyd KM, Webb DJ, The three official language versions of the Declaration of Helsinki: what's lost in translation? J Med Ethics. 2007 September; 33(9): 545–548. doi: 10.1136/jme.2006.018168
11. Meslin EM, Blasimme A, Cambon-Thomsen A, Mapping the Science Policy 'Valley of Death' *Clinical and Translational Medicine.* 2013, 2:14. DOI: 10.1186/10.1186/2001-1326-2-14
12. Lucchini S, Cisse B, Duran S, de Cenival M, Comiti C, Gaudry M , Moatti JP Decrease in Prices of Antiretroviral Drugs for Developing Countries: from Political "Philanthropy" to Regulated Markets? http://apps.who.int/medicinedocs/documents/s18253en/s18253en.pdf
13. World Medical Association. Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. Tokyo, Japan. WMA: October 2004 [Online]. http://www.wma.net/en/40news/20archives/2004/2004_24/ (Accessed October 16, 2013)
14. Office of Human Research Protections. 2013 Edition of the International Compilation of Human Research Standards. http://www.hhs.gov/ohrp/international/index.html (Accessed October 16, 2013)
15. Department of Health and Human Services, Food and Drug Administration. Human subject protection; foreign clinical studies not conducted under an investigational new drug application. Fed Reg April 28, 2008. 22800-16. http://www.fda.gov/cber/rules/forclinstud.pdf (accessed Nov 9, 2008).
16. Meslin EM. When Policy Analysis is Carried Out in Public: Some Lessons for Bioethics from NBAC's Experience. In: James Humber and Robert Almeder, eds. *The Nature and Prospect of Bioethics: Interdisciplinary Perspectives*. Humana Press: Totowa, NJ. 2003: pp. 87-111.
17. Singer PA, Taylor AD, Daar AS, Upshur REG, Singh JA, et al. (2007) Grand Challenges in Global Health: The Ethical, Social and Cultural Program. PLoS Med 4(9): e265. doi:10.1371/journal.pmed.0040265


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# Justification, Coherence and Consistency of Provisions in the Revised Declaration of Helsinki

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Since the first version of the Declaration of Helsinki (DoH) was adopted in 1964, it has been revised nine times and numerous other bodies have promulgated ethics guidance documents. During this same period, scientific research with human subjects has dramatically increased in size, scope, and importance. If the DoH is to continue to play a significant role in regulating the research enterprise, it must convincingly convey a coherent, if highly general, view of the research enterprise and the basic normative requirements necessary to preserve its integrity and protect the rights and welfare of participants. In what follows, I argue that the emphasis in the DoH on detailed prescriptive requirements untethered from general justificatory grounds means that it is particularly dependent on readers to supply underlying normative justifications. Without these normative grounds, its provisions might appear inconsistent, unfounded, or arbitrary.

To make this argument, I provide a reading of several revised passages in the 2013 DoH. This reading draws on a normative framework that emphasizes a particular view of the proper division of labor between research and medical and public health systems and the threat that biased or poor quality research poses to those systems. It also treats various provisions of the DoH as helping to provide a public assurance to stakeholders that the research enterprise functions as a system of mutually beneficial social cooperation in which all parties are respected as free and equal contributors [1]. Although these commitments are not expressed within the DoH itself, this reading illustrates strengths and weakness of the new document and highlights areas for improvement.

## Integrity of Scientific Information

The 2013 version of the DoH contains several changes that significantly expand the scope of requirements relating to the registration of research and the disclosure of findings. For example, the requirement for trial registration has been expanded from "every clinical trial" in the 2008 version to "every research study involving human subjects" (par. 35). With this expanded scope, this requirement now covers a wider range of research activities. For example, the 2008 wording would not cover sub-studies carried out within larger trials, such as biomarker studies, because these are not separate clinical trials. Such sub-studies are covered under the new language because they are research studies involving human subjects.

This expanded requirement also highlights a tension with the DoH. On the one hand, it claims to explicitly address only physicians. But to the extent that its requirements apply to every study involving human subjects, they would apply to research covered by non-physicians as well. Limiting the scope of the provisions to only research with human subjects that is conducted by physicians seems arbitrary, at best. Moreover, the requirement that research results be published has been expanded to include "publication and dissemination" and this obligation is now ascribed to sponsors as well as researchers, authors and editors (par. 36). The language of this paragraph has also been strengthened from "should" to "must" in several places, including the obligation to publish negative and inconclusive findings and to report conflicts of interest.

These concrete prescriptions assign potentially costly duties to a range of stakeholders and their requirements are not limited by disciplinary orientation or by the degree of risk posed to study participants. It is somewhat surprising, therefore, that the DoH does not contain an explicit statement of their normative grounding or justification. In particular, there have been a number of proposals recently to titrate the level of research oversight to risk as a way of reigning in what is criticized as costly regulatory overreach [2, 3]. The only explicit discussion of the "importance" of a "research objective" in the DoH is to state that it must outweigh the risks and burdens imposed on participants (par. 16, 2013). If a study poses little to no risk to participants, there is no independent ground stated in the DoH to justify requiring uniformly high oversight for it and risker or more burdensome studies.

The DoH would benefit, therefore, from an explicit statement that these requirements are justified because registration of studies and comprehensive reporting of all study data, including negative and inconclusive results, are necessary to ensure the

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reliability, relevance, and validity of scientific information. As the DoH states, the primary purpose of research involving human subjects is "to understand the causes, development and effects of diseases and improve preventive, diagnostic and therapeutic interventions (methods, procedures and treatments)" (par. 6). Reliable, relevant, and valid data are essential to the ability of the research enterprise to fulfill this purpose.

In modern health systems and health policy, many forms of research with human subjects contribute data on which clinicians, patients, researchers, institutions, policy makers, and others rely in making decisions that affect the health and welfare of individuals and groups and the allocation of scarce resources [4]. Because research data are the bedrock of evidence-based health systems and social policy, the quality and reliability of that information affects the health, welfare, and rights of the individuals who rely on those health systems to address their health needs. Even research that imposes little or no risk to study participants can generate data that is biased or of poor quality. Concerns about the quality of low risk studies have surfaced frequently in the context of postmarketing research, where decreased oversight removes incentives and safeguards against using biased evidence to advance marketing objectives, sometimes at the expense of patient health [5,6]. Similar concerns have emerged recently in biomarker studies as well [7,8].

Strengthening registration, publication and reporting requirements is justified by their contribution to ensuring the quality and reliability of research data. Ascribing obligations for registration, reporting, and dissemination of study findings to a broad range of stakeholders is also warranted because responsibility for ensuring the integrity of the research enterprise must be shared by all of the parities that assert some control over critical aspects of that process. The WMA may be uncomfortable stating moral requirements for stakeholders beyond physicians, but omitting the obligations of others would either cripple the document's ability to provide comprehensive ethical guidance across the lifecycle of research or it would lead to unfairly attributing to physicians responsibilities that vest in and must be discharged by other parties.

## Responsiveness and Benefits

In several places, the 2008 DoH states that populations in which research is carried out should stand to benefit from the results of research. Paragraph 17 of the 2008 version reads, "Medical research involving a disadvantaged or vulnerable population or community is only justified if the research is responsive to the health needs and priorities of this population or community and if there is a reasonable likelihood that this population or community stands to benefit from the results of the research." Paragraph 33 of the 2008 version uses even broader language, "At the conclusion of the study, patients entered into the study are entitled to be informed about the outcome of the study and to share any benefits that result from it, for example, access to interventions identified as beneficial in the study or to other appropriate care or benefits."

Although the most direct result of research is new information and knowledge, research can also produce new interventions, improved infrastructure, and potentially lucrative financial rewards. If the core requirement for research in disadvantaged populations is that those populations benefit from participation, and if there are myriad benefits that can flow from research, then critics might wonder why research should be required to meet the responsiveness requirement at all [9].

The current revision of the DoH retains responsiveness as a requirement and eliminates this ambiguity:

*Medical research with a vulnerable group is only justified if the research is responsive to the health needs or priorities of this group and the research cannot be carried out in a non-vulnerable group. In addition, this group should stand to benefit from the knowledge, practices or interventions that result from the research (par 20).*

Although the responsiveness requirement will undoubtedly be subject to further criticism for vagueness, this language makes it clear that the primary consideration in evaluating research in vulnerable groups should be the relationship of the questions being investigated, and the knowledge that is expected to be generated, to the health needs or health priorities of that group.

The current version of the DoH does not contain a justification for this requirement, and some changes to the text obscure one potential justificatory ground. That is, in the 2008 version, the statement "Medical progress is based on research that ultimately must include studies involving human subjects" is followed immediately by the claim that "Populations that are underrepresented in medical research should be provided appropriate access to participation in research," (par 5, 2008). Although both claims are retained in the 2013 revision, the second now appears as an independent statement (par. 13), eight paragraphs after the former claim (par. 5). Separating these claims severs the natural justificatory link that was at least implied in the previous version.

The link that is more clearly implied in the 2008 version is that inclusion in research is necessary for vulnerable groups to share in medical progress. Excluding vulnerable groups from research stifles what is, if not the only, then the most efficient, avenue through which their distinctive health needs can be understood and addressed. If the fundamental purpose of research with human subjects is to produce the evidence necessary to improve standards of care and

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prevention, then exclusion from research creates or perpetuates evidence gaps. This means that health systems have fewer effective interventions for the distinctive health needs of excluded groups and that patients from these groups are exposed to elevated risk when they access those health systems [10].

Although the DoH is not explicit about the relationship between the requirements that have been discussed so far, there is a reading on which they can be seen as playing a crucial role in the social justification of research. On this view, the purpose of research is to produce a unique social good, namely, the information necessary to enable health systems to better understand and address the health needs of the people they serve [1, 4, 6]. This good is unique, because unlike other benefits that stakeholders seek from research participation, it often cannot be produced in any other way. Promoting access to research among underrepresented groups is thus necessary to promote equity in the capacity of health systems to meet the needs of the diverse communities that they serve. The responsiveness requirement, and the requirements relating to registration and publication are necessary to ensure that when individuals and groups participate in research, they have public assurance that they are helping to generate information that is likely to strengthen and improve the health systems on which they depend.

This kind of social justification is important because it legitimates social and individual support for the research enterprise as a collaborative undertaking [1]. In particular, medical and public health research require the support of diverse stakeholders, from researchers and institutions of scientific advancement, to public and private sponsors, participants, policy makers, and the community in whose name research is often conducted and whose interests it is supposed to advance. Many of these parties may contribute to the research endeavor for a variety of reasons. Some may seek profit, career advancement, access to medical care, prestige, or some mixture of these and other motives. These parochial motives alone cannot justify social support for the research enterprise, since not all parties seek the same parochial goals, there are often other means of advancing these ends, and because pursuit of these goals can sometimes come at the expense of other parties.

In contrast, research is often the only way to produce the evidence base necessary for health systems to effectively and efficiently meet the diverse health needs of the individuals that they serve. Because community members must rely on medical and public health services to address their basic health needs, ensuring equity in their capacity to fulfill this mission can be seen as a legitimate focus for social support and the use of social resources. When there is credible public assurance that the research system is designed to advance this goal, all of the necessary stakeholders can participate with the warranted belief that even if they each contribute in order to pursue some parochial interest, the system will not be coopted so as to siphon social support and social resources simply to advance the parochial interests of some at the expense of the others.

I am suggesting that it is useful to view the provisions discussed so far as helping to provide a public assurance to stakeholders that the research enterprise functions as a system of mutually beneficial social cooperation in which all parties are respected as free and equal contributors [1]. Because study participants are the most at risk of having their status as free and equal persons compromised in research participation, they require special assurance that their rights and welfare will be respected. Ethical principles that are traditionally viewed as forming the moral core of research ethics (such as informed consent, the minimization and justification of risk, and protections for confidentiality) can then be seen as special requirements necessary to ensure proper respect for study participants as free and equal.

The 2013 DoH contains a new provision that can be read as trying to ensure that participant interests are not compromised through research participation. It holds that, "Appropriate compensation and treatment for subjects who are harmed as a result of participating in research must be ensured" (par. 15). If the legitimate social purpose of research is to generate a public good – the evidence base for effective and equitable health systems – then compensation for study-induced harms can be grounded in reciprocity. The DoH does not specify who bears this obligation and it would seem unreasonable to saddle researchers alone with it since other stakeholders who contribute to and benefit from the enterprise are better situated to effectuate it.

Similarly, the new paragraph 34 holds that, "In advance of a clinical trial, sponsors, researchers and host country governments should make provisions for post-trial access for all participants who still need an intervention identified as beneficial in the trial. This information must also be disclosed to participants during the informed consent process." This duty is ascribed to multiple stakeholders and the more general language of benefit sharing from the 2008 version has been replaced with specific emphasis on participants who need access to study interventions.

On the reading I have been proposing, this provision fits into a larger view of the proper division of labor between research and medical and public health systems. The social function of research is to generate the evidence necessary to improve the standard of care and prevention and it falls to medical and public health systems to provide access to this improved care on a large-scale basis. When research is contemplated in places where this division of labor may not

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take place, requiring strong assurance that research is relevant to health needs or priorities of the less-advantaged increases the likelihood that information and interventions will later be integrated into the health systems that serve those populations. However, the time horizon for the process of integrating new findings or interventions into health systems can be protracted. The requirement in paragraph 34 ensures that there is some meaningful continuity in the care that is provided to participants whose health depends on access to study interventions until the responsibility for providing access to an improved standard of care can be effectively discharged within the regular health system.

Critics may counter that even if these conditions are met, there is no guarantee that host communities will receive a fair level of benefit from hosting research. After all, most studies do not vindicate successful interventions. Three brief points about this objection are worth considering. First, it is not at all clear what a fair level of benefit is for hosting a research study and the most prominent accounts of this matter are underdeveloped, at best, and internally inconsistent at worst [11]. Second, rigorously designed and well-executed trials that produce negative findings do contribute to the evidence base necessary to improve the standard of care – if they are published. Granted, this is not an immediate benefit to communities. But compliance with the requirements discussed above increases the prospect that host communities will have access to the long-term benefits that come from increased understanding and the eventual development of interventions that can bridge health gaps.

Third, there is a genuine concern that studies might be carried out in ways that divert local resources from other health priorities, consume scarce resources, or otherwise burden members of communities that already suffer from problems rooted in poverty and deprivation. These are legitimate concerns and it would strengthen the DoH if it contained a statement to the effect that research conducted in resource scarce environments must mitigate the prospect of these deleterious effects and should make positive contributions to strengthen the capacity of local health systems.

## Reasonable Risk

In the previous section I suggested that standard research ethics requirements regarding informed consent and the reasonableness of risk can be seen as helping to provide public assurance to potential participants that their moral status and their interests will be respected in the course of research participation. The 2013 revision of the DoH includes a new provision in paragraph 17 that adds to this assurance, namely, that "Measures to minimise the risks must be implemented. The risks must be continuously monitored, assessed and documented by the researcher." However, other revisions are somewhat puzzling.

The 2013 DoH retains language from the 2008 version to the effect that physicians must not be involved in research unless they are confident that the risks have been "adequately assessed and can be properly managed." The 2008 version then states that, "Physicians must immediately stop a study when the risks are found to outweigh the potential benefits or when there is conclusive proof of positive and beneficial results" (par. 20, 2008). The claim that studies must be stopped when findings of benefit or lack thereof are conclusive seems to follow directly from the scientific purpose of research and from concern for the welfare of study participants. Once there is conclusive proof that risks of an intervention outweigh its benefits, or its beneficial effects have been confirmed, the study question has been answered and there is no longer a social purpose that justifies exposing participants to study-related risks.

The language form the 2008 version may strike readers as too simplistic since, for example, it may be difficult in practice to know when the results of a single study represent "conclusive proof." The new version retains this language, however, and reads, "When the risks are found to outweigh the potential benefits or when there is conclusive proof of definitive outcomes, physicians must assess whether to continue, modify or immediately stop the study" (par. 18, 2013). If the risks of participation are found to outweigh potential benefits or there is conclusive proof of definitive outcomes, on what basis would a trial be continued? Where the 2008 version states a condition for stopping studies based on confirmation of risks and benefits, the proposed revision opens the possibility that studies could continue after these issues have been conclusively established without providing substantive guidance about how clinicians should make such decisions. Moreover, continuing a study once "risks are fond to outweigh the potential benefits" seems to undermine any public assurance to participants that their interests will not be knowingly compromised through study participation.

To avoid inconsistency, either the old language should have been retained or the new language should have been be clarified. For example, it might be revised to say that as evidence mounts to indicate that potential benefits do not outweigh risks or that confirms beneficial results, physicians must assess whether to continue, modify or immediately stop the study.

## Conclusion

I have tried to provide a reading of the 2013 DoH that integrates some of its key provisions within a coherent, general view of the research enterprise and the central ethical challenges that it has to address. Although this analysis draws heavily on normative foundations not explicitly stated

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in the DoH, it is clear that those concerns are not alien to the document. This analysis highlights ways in which many proposed changes increase the coherence and comprehensives of the document while indicating particular areas where difficulties and inconsistencies remain. Because the DoH is not explicit about these foundational issues, however, it is vulnerable to appearing inconsistent, unfounded, or arbitrary to readers who approach it with different interpretive starting points.

## References


1. London AJ. 2012. A Non-Paternalistic Model of Research Ethics and Oversight: Assessing the Benefits of Prospective Review. Journal of Law, Medicine, and Ethics 40(4):930-944.
2. U.S. Department of Health and Human Services, *Fed. Regist.* 76, 44512 (2011).
3. Federman DD, Hanna KE, Rodriguez LL, eds, *Responsible Research: A Systems Approach to Protecting Research Participants*. (National Academics Press, Washington, DC, 2002).
4. A. J. London, J. Kimmelman, M. E. Emborg, Research ethics. Beyond access vs. protection in trials of innovative therapies. *Science* **328**, 829 (May 14, 2010).
5. J. Hasford, T. Lamprecht, . Company observational post-marketing studies: drug risk assessment and drug research in special populations--a study-based analysis. Eur J Clin Pharmacol 53, 369 (Jan, 1998).
6. London AJ, Kimmelman J, Carlisle B. 2012. Rethinking Research Ethics: The Case of Post-marketing Trials. Science 336 (May 4):544-545.
7. Tzoulaki I, Siontis KC, Evangelou E, Ioannidis JA. Bias in Associations of Emerging Biomarkers With Cardiovascular Disease. JAMA Intern Med. 2013;173(8):664-671. doi:10.1001/jamainternmed.2013.3018.
8. Nissen SE. Biomarkers in Cardiovascular Medicine: The Shame of Publication Bias Comment on "Bias in Associations of Emerging Biomarkers With Cardiovascular Disease". JAMA Intern Med. 2013;173(8):671-672. doi:10.1001/jamainternmed.2013.4074.
9. Rebecca Wolitz, Ezekiel Emanuel, Seema Shah. 2009. Rethinking the responsiveness requirement for international research. Lancet 374: 847–49
10. Jeffrey P. Kahn, Anna C. Mastroianni, and Jeremy Sugarman eds. Beyond Consent: Seeking Justice in Research New York: Oxford University Press, 1998.
11. London AJ, Zollman KJS. 2010. Research at the Auction Block: Some Problems for the Fair Benefits Approach to International Research. The Hastings Center Report 40(4):34-45.


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# From Justifying Inclusion to Justifying Exclusion of Study Populations: Strengths and Limitations


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*Since the 2000s, international ethical guidelines for human subjects research increasingly emphasize that exclusion from research participation must be justified. Despite increased use of inclusive selection requirements for the choice of study populations, it has so far not been evaluated what the moral strength of these requirements is and who should ensure that study populations are inclusively selected.*

## Methods

We analysed inclusive selection requirements or statements on justifying the exclusion of study populations in ethical guidelines on human subjects research.

## Results

We found that most ethical guidelines focus on inclusive selection requirements

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for reasons of justice, in particular corrective justice for underrepresented groups in research. A few guidelines mention scientific reasons. We found that scientific reasons may outweigh the concern for justice as fair inclusion in some cases. In order to yield generalizable health knowledge it may sometimes be necessary to set up different trials, or to deliberately exclude subgroups. Moreover, if it is unknown whether intervention effects differ between subgroups, the inclusion of these subgroups should be substantial and proportional. We also found that most guidelines leave out who should be responsible.

## Conclusions

Some ethical guidelines seem to have gone from the one extreme into the other: from justifying inclusion to justifying exclusion. However, a sole focus on corrective justice does not necessarily render the choice of study populations more ethically acceptable. Furthermore, guidelines should consider whose responsibility it is and determine reasonable actions for those responsible to ensure inclusive selection.

Since the 2000s, international ethical guidelines for human subjects research increasingly emphasize that exclusion from research participation must be justified. For instance, the International Guidelines for Biomedical Research Involving Human Subjects of the Council for International Organizations for Medical Sciences (CIOMS) state that "the exclusion of groups or communities that might benefit from study participation must be justified" [1]. Likewise, the Canadian *Tri Council Policy Statement* (*TCPS*) states that "researchers should be inclusive in selecting participants" and have a duty "not to exclude individuals or groups from participation for reasons that are unrelated to the research" [2]. The World Medical Association (WMA) has a similar paragraph in its *Declaration of Helsinki*. Although the WMA has never strongly required of researchers to justify exclusion of populations that might benefit, nor to be inclusive in their selection of study populations, it has acknowledged that "populations that are underrepresented in research should be provided appropriate access to participation in research" in the 2008 version of the *Declaration* [3].

Incorporation of requirements on inclusive selection of study participants in ethical guidance documents may be explained from an altered way of thinking about fair inclusion of research participants during the 80s and 90s. Until then, ethical guidelines on human subjects research focused on justifying the use and inclusion of human beings solely for research purposes. For instance the *Belmont Report* emphasizes that populations cannot be chosen for study purposes only because they are readily available [4]. But in the past three decades research participation became to be considered as a good that is not only burdensome but also potentially beneficial and hence should be distributed equally [5]. Therefore, current thinking on fair inclusion not only implies that inclusion of study populations has to be justified but also their exclusion.

Although there may be an historical explanation for incorporation of the idea of inclusive selection in ethical guidelines, several issues are unclear. First, what is the moral strength of this requirement and what are its limitations? Second, who is responsible for fulfilling this requirement? These questions will be studied in this paper. Therefore, we will analyze paragraphs on inclusive selection in main international ethical guidelines on human subjects research and study the rationales that underlie the inclusive selection claims. Accordingly, we will evaluate these rationales. We will also study which actors are mentioned in the guidelines. Furthermore, we will provide recommendations for future use of inclusive selection requirements in international requirements.

## Justice

In the last decades, main ethical guidance documents have grounded the idea of justification of exclusion of subgroups in both formal and material notions of justice (see table).

According to formal justice, people are in principle to be regarded as equal and hence have to be treated equally. For instance, the Canadian *TCPS* claims that "researchers shall not exclude individuals from the opportunity to participate in research on the basis of attributes such as culture, language, religion, race, disability, sexual orientation, ethnicity, linguistic proficiency, gender or age" [2].

Inclusive selection requirements in ethical guidance documents are also incorporated in guidance documents on of corrective justice. In the introduction we mentioned that the WMA emphasizes appropriate access for underrepresented groups [3]. Likewise, the CIOMS guidelines set out that: "as a consequence of exclusions [in the past], information about diagnosis, prevention and treatment of diseases in [these] groups of persons is limited. This has resulted in a serious class injustice" [1]. Thus, in these paragraphs justifying exclusion is a means to restore differences between trial populations.

## Scientific reasons

Scientific reasons for selective inclusion or exclusion follow from the need, or lack thereof, to study effect modification by population characteristics of the benefits or risks of interventions [6]. For instance, the NIH guideline on *The Inclusion of Women and Minorities as Subjects in Clinical Research* is a proponent of inclusive selection of women and minorities for certain types of studies to be able to perform valid analyses [7]. This rationale for inclusive selection is unique and not present in the other guidelines. Furthermore, few guidelines that present more

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**Table.** *Ethical guidance documents on inclusive selection of study populations*

| Content | Rationale: Justice |
|---|---|
| **CIOMS International Ethical Guidelines for Biomedical Research Involving Human Subjects (2002), guideline 12** | |
| "Groups or communities to be invited to be subjects of research should be selected in such a way that the burdens and benefits of the research will be equitably distributed. The **exclusion** of groups or communities that might benefit from study participation **must be justified**." | "**Equity** requires that no group or class of persons should bear more than its fair share of the burdens of participation in research. Similarly, no group should be deprived of its fair share of the benefits of research, short-term or long-term."<br>"Subjects should be drawn from the qualifying population in the general geographic area of the trial **without regard to race, ethnicity, economic status or gender** unless there is sound scientific reason to do otherwise."<br>"In the past, groups of persons were excluded form participation in research for what were then considered good reasons. As a consequence of such exclusions, information about the diagnosis, prevention and treatment of diseases in such groups is limited. This has resulted in a **serious class injustice**." |
| **WMA, Declaration of Helsinki (2008), paragraph 5** | |
| "Populations that are underrepresented in medical research should be provided **appropriate access** to participation in research." | **"Appropriate access"** |
| **Canadian Tri-Council Policy Statement 2: Ethical Conduct for Research Involving Humans (2010), chapter 4** | |
| "Taking into account the scope and objectives of their research, researchers should be **inclusive in selecting** participants. Researchers **shall not exclude individuals** from the opportunity to participate in research on the basis of attributes such as culture, language, religion, race, disability, sexual orientation, ethnicity, linguistic proficiency, gender or age, unless there is a valid reason for the exclusion." | "Appropriate inclusion" is "based on the principle of **justice**", meaning that "researchers shall not exclude individuals from the opportunity to participate in research on the basis of attributes such as culture, language, religion, race, disability, sexual orientation, ethnicity, linguistic proficiency, gender or age, unless there is a valid reason for exclusion".<br><br>"Not to exclude individuals or groups from participation for reasons that are unrelated to the research" (..) "**is explicitly stated because groups have been inappropriately excluded** from participation in research on the basis of attributes such as gender, race, ethnicity, age and disability".<br><br>"[Inappropriate] exclusion of women [in the past], where unwarranted, has **delayed the advancement of knowledge, denied potential benefits to women, and exposed women to harm** when research findings from male-only research projects were generalized inappropriately to women".<br><br>"As is the case with women, the inclusion of children in research advances commitment to **justice** in research by improving our knowledge of, and ability to respond to, the unique needs of children throughout their development." |
| **UNAIDS Ethical Considerations in Biomedical HIV Prevention Trials (2007), guidance point 7, 9 and 10** | |
| "Individuals should not be excluded from the opportunity to participate without a good **scientific reason** or a susceptibility to risk that **justifies their exclusion**." | "In order to conduct biomedical HIV prevention trials in an ethically acceptable manner, (…) the selection of participating communities and individuals must be **fair** and **justified in terms of the scientific goals** of the research. "<br><br>"Women, including pregnant women, potentially pregnant women and breast-feeding women, should be eligible for enrolment in HIV preventive vaccine trials, both as a matter of **equity** and because in many communities throughout the world women **are at high risk of HIV prevention**."<br><br>"Children, including infants and adolescents, should be eligible for enrolment in HIV preventive vaccine trials, both as a matter of **equity** and because in many communities throughout the world children **are at high risk of HIV** infection." |

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| Content | Rationale: Justice |
|---|---|
| **NIH Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research (2001)** | |
| "It is the policy of NIH that women and members of minority groups and their subpopulations **must be included** in all NIH-funded clinical research, unless a clear and compelling rationale and justification establishes (…) that inclusion is inappropriate with respect to the health of the subjects or the purpose of the research." | "Since a primary aim of research is to provide **scientific evidence** leading to a change in health policy or standard of care, it is imperative to determine whether the intervention or therapy being studied affects women or men or members of minority groups and their subpopulations differently." |

justice-oriented reasons for having to justify exclusion of study populations acknowledge scientific limitations for excluding certain populations. The UNAIDS/WHO guideline on *Ethical Considerations in Biomedical HIV Prevention Trials* emphasizes that inclusion of study populations must not only be fair but also "justified in terms of the scientific goals of the research" [8]. The NIH guideline also point at scientific limitations of inclusive selection.

It distinguishes three situations in the selection of study populations: 1) prior studies support the existence of significant differences in intervention effect between groups of subjects; 2) prior studies support no significant differences in intervention effect; and 3) prior studies neither support nor negate significant differences in intervention effect. Regarding the first situation the guideline states that "… if men and women are thought to respond differently to an intervention, then the Phase III clinical trial must be designed to answer two separate primary questions, one for men and the other for women… ". The opposite situation (situation 2) occurs when there is no evidence for a differential intervention effect: "If the data from prior studies strongly support no significant differences in intervention effect based on sex, then gender will not be required as subject selection criteria. However, the inclusion and analysis of gender subgroups is still strongly encouraged." The third situation is most common in practice. "If the data from prior studies neither strongly support nor strongly negate the existence of significant differences in intervention effect based on gender subpopulation comparisons, then the NIH-defined Phase III clinical trial will be required to include sufficient and appropriate entry of gender participants, so that valid analysis of the intervention effects can be performed" [7].

## Actors

Most guidelines are silent on the responsible person for inclusive selection. The Canadian *TCPS* [2] bestows researchers with this obligation, and the NIH has determined that its Director shall ensure inclusive selection [7].

### Discussion

In this paper we studied two issues: 1. the moral strength of the inclusive selection requirement and 2. who should be responsible for inclusive selection. As regards the first issue, we have seen that inclusive selection requirements have their basis in principles of justice which determine the moral strength of these claims. Justice as equity and as corrective justice is put forward with regard to the selection of study populations. The function of equity is to assure that people are not excluded for arbitrary reasons when they meet the inclusion criteria. Corrective justice has a different function. It assures that groups that have been underrepresented in research are not systematically excluded as a class.

Increased attention for inclusion of underrepresented groups is to a certain extent essential since it may render interventions for these groups more evidence-based. For instance, pharmacokinetics and pharmacodynamics of drugs during pregnancy have been poorly studied, which may adversely impact the health of both pregnant women and their fetuses [9].

However, fair inclusion of underrepresented study groups should not be considered as being as inclusive as possible, as some guidelines seem to suggest. There are scientific limitations to justice-based reasons for justifying exclusion. We have seen that the NIH does not always promote the inclusion of women and minorities and sets out that from a scientific perspective three situations should be distinguished.

In the following, we will discuss these three situations indicated by the NIH guideline. We focus on inclusion and exclusion of men and women, though these gender groups could be substituted for other subgroups (*mutatis mutandis*).

*Situation 1*

From a scientific perspective, the NIH guideline seems obvious. The overall observed intervention effect in a population of

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men and women is a (weighted) average of the effect among men and the effect among women. If the intervention effect differs between men and women, the overall effect neither applies to men, nor to women; it will only apply to a population with a similar distribution of men and women as in the trial. Randomized trials are typically designed to provide evidence on the overall effectiveness of treatment in the trial population. To identify differential intervention effects requires much more study participants.[10] Hence, in case of strong prior evidence of a differential intervention effect conducting a trial in a population that is a mixture of subgroups is unreasonable, because it provides an estimate of the intervention effect that is little informative and the study is probably too small to demonstrate differential intervention effects. From an ethical perspective, it is essential that guidelines that focus primarily on justification of exclusion for reasons of justice acknowledge that in case of differential intervention effects, it is scientifically preferable to set up different trials instead of being as inclusive as possible in a single trial. The value of knowledge generated from a study with a heterogeneous study population may then be limited compared to multiple studies each conducted in homogenous populations.

*Situation 2*

Also when strong prior evidence against differential intervention effects, the NIH guideline seems rational. In such situations, a trial can be conducted in either men only, women only, or any combination of the two groups. Actually, results from trials in which not a single woman was included can still be generalized to women as long as the assumption of no differential intervention effects holds. For example, even if trials on the effect of antibiotics in children with acute otitis media are conducted in boys only, one will probably assume antibiotics are equally effective in girls, because the mechanism through which the intervention acts is the same for boys and girls [11]. Thus, in the absence of differential intervention effects, the exclusion of any such subgroup will not affect generalizability.

From both a scientific and ethical perspective, it may even be sensible to deliberately exclude particular subgroups. For example, in a trial on the prevention of cardiovascular disease the exclusion of women will likely decrease sample size requirements or duration of the trial, since women have a lower risk of cardiovascular morbidity than men. Hence, in case of equal intervention effects among men and women, including only men in a trial would require less study participants compared to a trial including both men and women and thus reduce the burden for study participants, without hampering generalizability of results. Therefore, the disclaimer in the NIH guideline in situation 2 (i.e., to include gender subgroups even if prior studies have shown no difference between these subgroups) is remarkable. The ethical value of this disclaimer is questionable since it may increase the required sample size, as indicated above, and hence may extra burden participants as a group. Therefore, the rationale for this disclaimer needs to be explained.

*Situation 3*

If it is unknown whether the intervention effect differs between men and women, as will often be the case, the NIH guideline indicates that both men and women should be included. However the phrase "sufficient and appropriate" inclusion of participants from both genders in the guideline is unclear. If it turns out that the intervention effect differs between men and women, the observed effect is a (weighted) average of the effect among men and the effect among women. In that case, it could be invalid to generalize findings from a study in which say only three out of a thousand study participants were women to a population of whom 40% are women. Hence, if the possibility of a differential intervention effect by gender cannot be excluded, the proportion of women enrolled in a trial should be similar to the proportion of women among typical users. If a random subset of those typical users (e.g., subjects with hypertension, who constitute the typical antihypertensive drug users) is included in a trial, inclusion is proportional and results will generalize to populations with a similar proportion of women. However, physician treat individuals rather than groups and they may thus require more evidence regarding specific subgroups. For example, if 1% of the typical users is female, one may nevertheless require e.g. 10% inclusion of women in a trial in order to generalize results from that trial to an individual female patient. In other words, fair inclusion means that in those cases where it is unknown whether the intervention effect differs between men and women, researchers should clarify whether participation of subgroups is either proportional or substantial.

We note that a trial on the efficacy of an intervention is typically designed to detect an overall intervention effect and will not provide evidence of the presence (or absence) of differential effects [10]. This is acknowledged in the NIH guideline, which states that "the trial will not be required to provide high statistical power for these comparisons". The analysis to assess whether the intervention effect differs between subgroups seems to be (only) secondary and often impossible.

If the question is not what the overall intervention effect is, but whether the intervention effect differs between men and women, one would typically design a study in which the ratio between men and women is not proportional to that ratio among future users. In fact, a design with equal numbers of men and women may be more efficient to detect a differential intervention effect. We note that such a trial is designed to answer a different research question (namely that of differences in the intervention effect between men and women) than the trial that

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is aimed to show an overall intervention effect, on which the NIH guideline focuses.

In summary, although the NIH guideline on women and minorities demonstrates that scientific considerations are essential for fair inclusion, the guideline should be further sharpened. If there are no differential intervention effects it remains unclear why the guideline suggests inclusion of both gender groups. Furthermore, when it is unknown whether the intervention effect differs between men and women the inclusion should either be proportional or substantial.

The second question was who should be responsible for inclusive selection. Most guidelines are very brief at this point. The Canadian *TCPS* sets out that the obligation falls on the shoulders of the researcher. It is however questionable whether the researcher should be solely responsible now we have seen that corrective justices underlies inclusive selection claims. Although the researcher is directly involved in the inclusion process, there should also be an authority or (inter)national organization which is in the position to ensure that a given study population has appropriate access to participation. In theory, there will also be a moment that inclusive selection requirements for reasons of corrective justice are no longer needed. If researchers are imposed with this obligation, they should have access to information on fair inclusion of study populations on a global level. Currently, empirical data on equitable distribution of burdens and benefits among trial populations is lacking.

## Conclusions and recommendations

Many ethical guidelines on human subjects research emphasize inclusive selection of study populations in order to prevent arbitrary exclusion or to prioritize groups that have been underrepresented in research. However, in order to yield generalizable knowledge it may sometimes be necessary to set up different trials, or to deliberately exclude subgroups. Moreover, if it is unknown whether intervention effects differ between subgroups, the inclusion of these subgroups should be either proportional or substantial. We caution that a sole focus on justice as equity and corrective justice does not necessarily render the choice of study populations more ethically acceptable.

Furthermore, we emphasize that guidelines should clarify who is responsible for inclusive selection and what actions are required of this person or organization. The *Declaration of Helsinki* and the *CIOMS guidelines* are unclear at this point. In the (next) revision process the guideline makers may want to consider whether and how the actors of this obligation may be able to fulfil the idea that exclusion of study populations must be justified.

## References


1. Council for International Organizations of Medical Sciences. *International Ethical Guidelines for Biomedical* Research Involving Human Subjects. Geneva, Switzerland: CIOMS; 2002.
2. Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council Canada. *Tri-Council Policy Statement. Ethical conduct for research involving humans*, December 2010.
3. World Medical Association. *Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects*. Seoul: 2008.
4. Office of the Secretary. Ethical Principles and Guidelines for the Protection of Human Subjects of Research. The National Commission for the Protection of Human Subject of Biomedical and Behavioral Research. The Belmont Report. April 18, 1979
5. Emanuel E, Grady C. Four paradigms of clinical research and research oversight. *Camb Q Healthc Ethic* 2006;16:82-96.
6. Grobbee DE, Hoes AW. *Clinical epidemiology*. Boston: Jones and Bartlett 2009, pp 38.
7. National Institutes of Health, *NIH Policy and Guidelines on The Inclusion of Women and Minorities as Subjects in Clinical Research* – Amended, October, 2001.
8. UNAIDS/WHO. Ethical considerations in biomedical HIV prevention trials. Geneva, 2007/2012.
9. Haas DM, Gallauresi B, Shields K, Zeitlin D, Clark SM, Hebert MF, et al. Pharmacotherapy and Pregnancy: Highlights from the Third International Conference for Individualized Pharmacotherapy in Pregnancy. *Clin Transl Sci* 2011;4:204-9.
10. Brookes ST, Whitely E, Egger M, Smith GD, Mulheran PA, Peters TH. Subgroup analyses in randomized trials: risks of subgroup-specific analyses; power and sample size for the interaction test. *J Clin Epidemiol* 2004;57:229-236.
11. Rovers MM, Glasziou P, Appelman CL, Burke P, McCormick DP, Damoiseaux RA, Gaboury I, Little P, Hoes AW, Antibiotics for acute otitis media: a meta-analysis with individual patient data. *Lancet* 2006;368:1429-1435.



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# WMA Publishes its Revised Declaration of Helsinki

Increased protection for people taking part in medical research has been proposed by the World Medical Association in changes to its Declaration of Helsinki.

After a revision process lasting two years, the WMA today adopted and published a revised version of the Declaration on medical research, which next year celebrates its 50th anniversary.

Delegates at the WMA's annual Assembly in Fortaleza, Brazil, voted overwhelmingly to support changes to the Declaration, which not only provide for increased protection for vulnerable groups involved in research, but also include a new provision for compensating people harmed as a result of participating in research. In addition there are expanded requirements for post-study arrangements to ensure that participants involved in research are informed of the results and have access to any beneficial treatments that emerge.

Dr. Margaret Mungherera, President of the WMA, said: 'The changes agreed today are all about providing a greater degree of protection for those involved in research. We have spent two years consulting our national medical association members, outside experts and the public and we are satisfied that today we have a Declaration that requires greater transparency about medical research, greater accountability and increased patient safety.

'The changes also place more obligations on the sponsors of research, on the researchers themselves and on host governments to protect research subjects.'

This is the seventh time the Declaration of Helsinki has been revised since its inception, with notes of clarification being added in 2002 and 2004. It is one of the most important international ethical regulations in biomedical research and is a core document of the WMA. It was adopted by the 18th General Assembly of the WMA in Helsinki, Finland in 1964 and consists of a collection of ethical principles which set out clear and easily readable guidelines for medical research involving human subjects.

***Themes and Soundbites***

**Facts**

- Next year (2014) is the 50th anniversary of the Declaration
- The Declaration has been revised six times with two notes of clarification
- Previous revisions in 1975, 1983, 1989, 1996, 2000 and 2008
- Sixth version was adopted in Edinburgh in 2000. The process lasted three years
- In 2002 there was a note of clarification
- The original version was adopted in 1964 after a 12-year debate
- Originally the Declaration comprised 11 articles and 713 words
- The most recent revision was completed in 2008
- It was the first significant effort of the medical community to regulate research itself, and forms the basis of most subsequent documents
- The Declaration is incorporated into many laws and regulations

**Phrases**

- WMA came into being because of the lack of research ethics
- Declaration grew out of the horrific research during WWII carried out by physicians
- Prominent status
- Unique standing of Declaration
- One of the most important international ethical documents
- It is the cornerstone of contemporary research ethics
- Public trust
- Doctors acting in patients' best interests
- The duty of physicians to safeguard the health of patients
- Recognised internationally as the standard guidance on medical research ethics
- Medical progress is dependent on research on human subjects
- Advances in medicines used today to save lives and relieve suffering would not be possible without research involving human subjects
- Millions of people have benefited from research carried out under DoH guidelines
- The Declaration must be responsive to the fast changing world of medicine
- Declaration lays out the roadmap for trust and ethics
- Medical research is about understanding the causes, development and effects of diseases and improving preventive, diagnostic and therapeutic interventions
- One of the principles of the DoH is that medical research involving the vulnerable or disadvantaged population can only be justified if the research is responsive to the health needs and priorities of this community and if there is a reasonable likelihood that this population or community stands to benefit from the results of the research

**Revision Process**

- Latest workgroup was formed in 2011
- Four expert conferences have been held
- The core principles remain unchanged
- Increased protection for vulnerable groups
- More protection for participants
- DOH requires that research only be conducted if the importance of the objective outweighs the inherent risks and burdens to the research subjects
- New provision for compensation
- Expanded requirements for post study arrangements
- A more systematic approach to use of placebos
- Improved readability
- Clarification of the role of research ethics committees
- The April-June public consultation resulted in 129 submissions

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# WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects

*Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964 and amended by the: 29th WMA General Assembly, Tokyo, Japan, October 1975 35th WMA General Assembly, Venice, Italy, October 1983 41st WMA General Assembly, Hong Kong, September 1989 48th WMA General Assembly, Somerset West, Republic of South Africa, October 1996 52nd WMA General Assembly, Edinburgh, Scotland, October 2000 53rd WMA General Assembly, Washington DC, USA, October 2002 (Note of Clarification added) 55th WMA General Assembly, Tokyo, Japan, October 2004 (Note of Clarification added) 59th WMA General Assembly, Seoul, Republic of Korea, October 2008 64th WMA General Assembly, Fortaleza, Brazil, October 2013*

## Preamble

**1.** The World Medical Association (WMA) has developed the Declaration of Helsinki as a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data.
The Declaration is intended to be read as a whole and each of its constituent paragraphs should be applied with consideration of all other relevant paragraphs.

**2.** Consistent with the mandate of the WMA, the Declaration is addressed primarily to physicians. The WMA encourages others who are involved in medical research involving human subjects to adopt these principles.

## General Principles

**3.** The Declaration of Geneva of the WMA binds the physician with the words, "The health of my patient will be my first consideration," and the International Code of Medical Ethics declares that, "A physician shall act in the patient's best interest when providing medical care."

**4.** It is the duty of the physician to promote and safeguard the health, well-being and rights of patients, including those who are involved in medical research. The physician's knowledge and conscience are dedicated to the fulfilment of this duty.

**5.** Medical progress is based on research that ultimately must include studies involving human subjects.

**6.** The primary purpose of medical research involving human subjects is to understand the causes, development and effects of diseases and improve preventive, diagnostic and therapeutic interventions (methods, procedures and treatments). Even the best proven interventions must be evaluated continually through research for their safety, effectiveness, efficiency, accessibility and quality.

**7.** Medical research is subject to ethical standards that promote and ensure respect for all human subjects and protect their health and rights.

**8.** While the primary purpose of medical research is to generate new knowledge, this goal can never take precedence over the rights and interests of individual research subjects.

**9.** It is the duty of physicians who are involved in medical research to protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subjects. The responsibility for the protection of research subjects must always rest with the physician or other health care professionals and never with the research subjects, even though they have given consent.

**10.** Physicians must consider the ethical, legal and regulatory norms and standards for research involving human subjects in their own countries as well as applicable international norms and standards. No national or international ethical, legal or regulatory requirement should reduce or eliminate any of the protections for research subjects set forth in this Declaration.

**11.** Medical research should be conducted in a manner that minimises possible harm to the environment.

**12.** Medical research involving human subjects must be conducted only by individuals with the appropriate ethics and scientific education, training and qualifications. Research on patients or healthy volunteers requires the supervision of a competent and appropriately qualified physician or other health care professional.

**13.** Groups that are underrepresented in medical research should be provided appropriate access to participation in research.

**14.** Physicians who combine medical research with medical care should involve their patients in research only to the extent that this is justified by its potential preventive, diagnostic or therapeutic value and if the physician has good reason to believe that participation in the research study will not adversely affect the health of the patients who serve as research subjects.

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**15.** Appropriate compensation and treatment for subjects who are harmed as a result of participating in research must be ensured.

## Risks, Burdens and Benefits

**16.** In medical practice and in medical research, most interventions involve risks and burdens.
Medical research involving human subjects may only be conducted if the importance of the objective outweighs the risks and burdens to the research subjects.

**17.** All medical research involving human subjects must be preceded by careful assessment of predictable risks and burdens to the individuals and groups involved in the research in comparison with foreseeable benefits to them and to other individuals or groups affected by the condition under investigation.
Measures to minimise the risks must be implemented. The risks must be continuously monitored, assessed and documented by the researcher.

**18.** Physicians may not be involved in a research study involving human subjects unless they are confident that the risks have been adequately assessed and can be satisfactorily managed.
When the risks are found to outweigh the potential benefits or when there is conclusive proof of definitive outcomes, physicians must assess whether to continue, modify or immediately stop the study.

## Vulnerable Groups and Individuals

**19.** Some groups and individuals are particularly vulnerable and may have an increased likelihood of being wronged or of incurring additional harm.
All vulnerable groups and individuals should receive specifically considered protection.

**20.** Medical research with a vulnerable group is only justified if the research is responsive to the health needs or priorities of this group and the research cannot be carried out in a non-vulnerable group. In addition, this group should stand to benefit from the knowledge, practices or interventions that result from the research.

## Scientific Requirements and Research Protocols

**21.** Medical research involving human subjects must conform to generally accepted scientific principles, be based on a thorough knowledge of the scientific literature, other relevant sources of information, and adequate laboratory and, as appropriate, animal experimentation. The welfare of animals used for research must be respected.

**22.** The design and performance of each research study involving human subjects must be clearly described and justified in a research protocol.
The protocol should contain a statement of the ethical considerations involved and should indicate how the principles in this Declaration have been addressed. The protocol should include information regarding funding, sponsors, institutional affiliations, potential conflicts of interest, incentives for subjects and information regarding provisions for treating and/or compensating subjects who are harmed as a consequence of participation in the research study.
In clinical trials, the protocol must also describe appropriate arrangements for post-trial provisions.

## Research Ethics Committees

**23.** The research protocol must be submitted for consideration, comment, guidance and approval to the concerned research ethics committee before the study begins. This committee must be transparent in its functioning, must be independent of the researcher, the sponsor and any other undue influence and must be duly qualified. It must take into consideration the laws and regulations of the country or countries in which the research is to be performed as well as applicable international norms and standards but these must not be allowed to reduce or eliminate any of the protections for research subjects set forth in this Declaration.
The committee must have the right to monitor ongoing studies. The researcher must provide monitoring information to the committee, especially information about any serious adverse events. No amendment to the protocol may be made without consideration and approval by the committee. After the end of the study, the researchers must submit a final report to the committee containing a summary of the study's findings and conclusions.

## Privacy and Confidentiality

**24.** Every precaution must be taken to protect the privacy of research subjects and the confidentiality of their personal information.

## Informed Consent

**25.** Participation by individuals capable of giving informed consent as subjects in medical research must be voluntary. Although it may be appropriate to consult family members or community leaders, no

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individual capable of giving informed consent may be enrolled in a research study unless he or she freely agrees.

**26.** In medical research involving human subjects capable of giving informed consent, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail, post-study provisions and any other relevant aspects of the study. The potential subject must be informed of the right to refuse to participate in the study or to withdraw consent to participate at any time without reprisal. Special attention should be given to the specific information needs of individual potential subjects as well as to the methods used to deliver the information.
After ensuring that the potential subject has understood the information, the physician or another appropriately qualified individual must then seek the potential subject's freely-given informed consent, preferably in writing. If the consent cannot be expressed in writing, the non-written consent must be formally documented and witnessed.
All medical research subjects should be given the option of being informed about the general outcome and results of the study.

**27.** When seeking informed consent for participation in a research study the physician must be particularly cautious if the potential subject is in a dependent relationship with the physician or may consent under duress. In such situations the informed consent must be sought by an appropriately qualified individual who is completely independent of this relationship.

**28.** For a potential research subject who is incapable of giving informed consent, the physician must seek informed consent from the legally authorised representative. These individuals must not be included in a research study that has no likelihood of benefit for them unless it is intended to promote the health of the group represented by the potential subject, the research cannot instead be performed with persons capable of providing informed consent, and the research entails only minimal risk and minimal burden.

**29.** When a potential research subject who is deemed incapable of giving informed consent is able to give assent to decisions about participation in research, the physician must seek that assent in addition to the consent of the legally authorised representative. The potential subject's dissent should be respected.

**30.** Research involving subjects who are physically or mentally incapable of giving consent, for example, unconscious patients, may be done only if the physical or mental condition that prevents giving informed consent is a necessary characteristic of the research group. In such circumstances the physician must seek informed consent from the legally authorised representative. If no such representative is available and if the research cannot be delayed, the study may proceed without informed consent provided that the specific reasons for involving subjects with a condition that renders them unable to give informed consent have been stated in the research protocol and the study has been approved by a research ethics committee. Consent to remain in the research must be obtained as soon as possible from the subject or a legally authorised representative.

**31.** The physician must fully inform the patient which aspects of their care are related to the research. The refusal of a patient to participate in a study or the patient's decision to withdraw from the study must never adversely affect the patient-physician relationship.

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

## Use of Placebo

**33.** The benefits, risks, burdens and effectiveness of a new intervention must be tested against those of the best proven intervention(s), except in the following circumstances:
Where no proven intervention exists, the use of placebo, or no intervention, is acceptable; or
Where for compelling and scientifically sound methodological reasons the use of any intervention less effective than the best proven one, the use of placebo, or no intervention is necessary to determine the efficacy or safety of an intervention and the patients who receive any intervention less effective than the best proven one, placebo, or no intervention will not be subject to additional risks of serious or irreversible harm as a result of not receiving the best proven intervention.
Extreme care must be taken to avoid abuse of this option.

## Post-Trial Provisions

**34.** In advance of a clinical trial, sponsors, researchers and host country governments should make provisions for post-trial access for all participants who still need an intervention identified as beneficial in the trial. This information must also be disclosed to participants during the informed consent process.

## Research Registration and Publication and Dissemination of Results

**35.** Every research study involving human subjects must be registered in a publicly accessible database before recruitment of the first subject.

**36.** Researchers, authors, sponsors, editors and publishers all have ethical obligations with regard to the publication and dissemination of the results of research. Researchers have a duty to make publicly available the results of their research on human subjects and are accountable for the completeness and accuracy of their reports. All parties should adhere to accepted guidelines for ethical reporting. Negative and inconclusive as well as positive results must be published or otherwise made publicly available. Sources of funding, institutional affiliations and conflicts of interest must be declared in the publication. Reports of research not in accordance with the principles of this Declaration should not be accepted for publication.

## Unproven Interventions in Clinical Practice

**37.** In the treatment of an individual patient, where proven interventions do not exist or other known interventions have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorised representative, may use an unproven intervention if in the physician's judgement it offers hope of saving life, re-establishing health or alleviating suffering. This intervention should subsequently be made the object of research, designed to evaluate its safety and efficacy. In all cases, new information must be recorded and, where appropriate, made publicly available.




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