WMA 209TH COUNCIL SESSION, RIGA 2018

AGENDA

Tuesday, April 24, 2018

9:00 AM - 6:00 PM	**Potential workgroup meetings**	

Wednesday, April 25, 2018

9:00 AM - 6:00 PM	**Potential workgroup meetings**	
11:30 AM - 12:30 PM	**Finance Group**	
12:30 PM - 2:30 PM	**Executive Committee**	
7:00 PM - 10:00 PM	**Meet the Associate Members of the World Medical Association** Informal Dinner sponsored by the Latvian Medical Association	

Thursday, April 26, 2018

7:30 AM - 4:00 PM	**Registration - Radisson Blu Latvija Conference & SPA Hotel**	
9:00 AM - 10:30 AM	**Opening Plenary Session of the Council**	
10:30 AM - 10:45 AM	**Coffee Break**	
10:45 AM - 12:30 PM	**Finance and Planning Committee**	
12:30 PM - 2:00 PM	**Lunch break**	
2:00 PM - 3:30 PM	**Finance and Planning Committee (continuation)**	
3:30 PM - 3:45 PM	**Coffee Break**	
3:45 PM - 5:00 PM	**Finance and Planning Committee (if needed) / Socio-Medical Affairs Committee**	
6:30 PM - 7:30 PM	**Welcome Reception** • Offered by the Latvian Medical Association	

Friday, April 27, 2018

9:00 AM - 10:30 AM	**Socio-Medical Affairs Committee (continuation)**	
10:30 AM - 10:50 AM	**Coffee Break**	
10:45 AM - 12:30 PM	**Socio-Medical Committee (continuation)**	
12:30 PM - 2:00 PM	**Lunch break**	
2:00 PM - 3:30 PM	**Medical Ethics Committee**	
3:30 PM - 3:45 PM	**Coffee Break**	
3:45 PM - 5:00 PM	**Medical Ethics Committee (continuation)**	
7:00 PM - 9:30 PM	**Council Gala Dinner** • Offered by the World Medical Association	

Saturday, April 28, 2018

8:00 AM - 9:30 AM	**Council Plenary Session**	
9:30 AM - 9:45 AM	**Coffee Break**	
9:45 AM - 12:30 PM	**Council Plenary Session (continuation)**	
12:30 PM - 2:00 PM	**Lunch break**	

2:00 PM - 2:30 PM	**Conclusion of Council Session**
3:00 PM - 9:00 PM	**Sightseeing tour and informal dinner** • Offered by the Latvian Medical Association

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**Council 209/Agenda/Apr2018** **Agenda of the 209th Council Session**	Original: English
Destination:	209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note:	The Council will convene on Thursday, 26 April 2018, before the meetings of the Standing Committees. It will then re-convene on Saturday, 28 April 2018, to consider the reports of the Standing Committees.	

Thursday, 26 April 2018, 9:00 am – 10:30 am
Saturday, 28 April 2018, 8:00 am – 2:30 pm

Membership of the Council

Dr David O. Barbe
Dr MooJin Choo
Dr Andrew Dearden (Treasurer)
Dr Louis Francescutti
Dr Michael B. Gannon
Dr Mzukisi Grootboom
Dr Andrew W. Gurman
Dr René Héman
Dr Ardis Dee Hoven (Chair)
Dr Miguel Roberto Jorge
Dr Toru Kakuta
Dr Ajay Kumar
Dr Kenji Matsubara
Dr Mari Michinaga
Dr Frank-Ulrich Montgomery (Vice Chair)
Dr Ramin Parsa-Parsi
Dr Mark Porter
Dr Serafín Romero
Dr Andreas Rudkoebing
Dr Heidi Stensmyren
Dr Thomas Szekeres
Dr Julio Trostchansky
Dr Walter Vorhauer
Dr Shuyang Zhang

Ex-officio (without voting rights)

Dr Yoshitake Yokokura, *President*
Dr Leonid Eidelman, *President-Elect*
Dr Ketan Desai, *Immediate Past President*
Dr Otmar Kloiber, *Secretary General*
Ms Marie Collegrave-Juge, *Legal Advisor*
Mr Adolf Hällmayr, *Financial Advisor*
Ms Joelle Balfe, *Facilitator*

* All statutory meetings of the WMA will be recorded for preparing minutes and reports.

1. GENERAL BUSINESS

1.1 Call to order by the Chair of Council

1.2 Receive apologies for absence

1.3 Welcome new Council Member(s)

1.4 Chair's opening remarks

1.5 Secretary General's announcements

2. MINUTES OF THE PREVIOUS MEETINGS

Approve: Summary Minutes of the 207th and 208th Council Sessions held in Chicago, United States, 10-14 October 2017 (Council 207/Minutes/Oct2017 and Council 208/Minutes/Oct2017)

3. INTERIM REPORT OF THE PRESIDENT

Receive: Report by the WMA President on presidential activities from October 2017 to March 2018 (Council 209/President Report/Apr2018)

4. REPORT OF THE SECRETARY GENERAL

Receive: Report of the Secretary General to the Council (Council 209/SecGen Report/Apr2018)

5. REPORT OF THE CHAIR OF COUNCIL

Receive: Report by the WMA Chair of Council (Council 209/Chair of Council Report/Apr2018)

6. CONSIDERATION OF ITEMS TO BE CONSIDERED AS A MATTER OF URGENCY BY THIS COUNCIL

7. COMMITTEE REPORTS

7.1 Medical Ethics Committee

Consider: Report of the Medical Ethics Committee (*MEC 209/Report/Apr2018)

7.2 Finance and Planning Committee

Consider: Report of the Finance and Planning Committee (*FPL 209/Report/Apr2018)

7.3 Socio-Medical Affairs Committee

Consider: Report of the Socio-Medical Affairs Committee (*SMAC 209/Report/Apr2018)

8. ADVOCACY

Consider: Oral Report of WMA Advocacy and Communications Advisory Panel

9. WORK OF THE WORLD HEALTH ORGANIZATION (WHO)

9.1 71st World Health Assembly

Receive: Oral Report on the Agenda of the upcoming 71st WHA
Receive: Oral Report of WMA Activities at the WHO 71st WHA

10. ANY OTHER BUSINESS

11. ANNUAL CEO REVIEW SESSION (CLOSED SESSION FOR COUNCIL MEMBERS ONLY)

12. ADJOURNMENT

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* Indicates document to be distributed in Riga.

12.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**Council 207/Minutes/Oct2017**	Original: English
Title:	**Minutes of the 207th Council Session**	
Destination:	209th Council Session Radisson Blu Hotel Latvija Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**

Wednesday, 11 October 2017, 8:00 am – 8:15 am
Friday, 13 October 2017, 8:00 am – 10:30 am

Membership of the Council

Dr David O. Barbe
Dr MooJin Choo
Dr Andrew Dearden (Treasurer)
Dr Leonid Eidelman
Dr Louis Francescutti
Dr Michael B. Gannon
Dr Mzukisi Grootboom
Dr Andrew W. Gurman
Dr René Héman
Dr Ardis Dee Hoven (Chair)
Dr Miguel Roberto Jorge
Dr Toru Kakuta
Dr Ajay Kumar
Dr Kenji Matsubara
Dr Mari Michinaga
Prof. Dr med. Frank-Ulrich Montgomery (Vice Chair)
Dr Ramin Parsa-Parsi
Dr Mark Porter
Dr Serafín Romero
Dr Andreas Rudkoebing
Dr Heidi Stensmyren
Dr Thomas Szekeres
Dr Julio Trostchansky
Dr Walter Vorhauer
Dr Shuyang Zhang

Ex-officio (without voting rights)

Dr Ketan Desai, *President*
Sir Michael Marmot, *Immediate Past President*
Dr Yoshitake Yokokura, *President-Elect*
Dr Otmar Kloiber, *Secretary General*
Ms Marie Colegrave-Juge, *Legal Advisor*
Mr Adolf Hällmayr, *Financial Advisor*
Prof. Vivienne Nathanson, *Facilitator*

1. GENERAL BUSINESS

1.1 The meeting was called to order by the Chair of Council at 8:10 am on October 11, 2017.

1.2 The Secretary General welcomed new members, from Dr David O. Barbe (United States), Dr MooJin Choo (Korea), and Dr Serafín Romero (Spain). Apologies for absence were received from Dr Thomas Szekeres (Austria; replaced by Dr Herwig Lindner), Dr Julio Trostchansky (Uruguay; replaced by Dr Alarico Rodriguez), and former WMA Presidents; Sir Michael Marmot, Dr Yank Coble, Dr Dana Hanson and Dr Wonchat Subhachaturas.

1.3 Chair's opening remarks. The Chair reminded participants that live tweeting (Twitter) during the meeting regarding WMA finances, draft policies, and internal matters was not allowed. Debates on policies that had not been adopted by the General Assembly should be kept confidential. She also explained that participants who are not Council members are welcome to participate in the meeting.

2. MINUTES OF THE PREVIOUS MEETINGS

The Council **approved** the Summary Minutes of the 206th Council Sessions held in Livingstone, Zambia, 20-22 April 2016 (Council 206/Minutes/Apr2017).

3. APPOINTMENT OF A CREDENTIALS COMMITTEE

The Council accepted the recommendation from the Secretary General that the Credentials Committee be composed of one delegate each from the following NMAs: Kenya, Belgium, Panama.

4. INTERIM REPORT OF THE PRESIDENT

The Council **received** the report of WMA President, Dr Ketan Desai, on presidential activities from May to September 2017. Dr Desai delivered his report as written in document Council 207/Presidential Report/Oct2017.

5. REPORT OF THE SECRETARY GENERAL

The Council **received** the oral Report of the Secretary General to the Council which complements the Council Report (GA 2017-Council Report-Oct2017). Dr Kloiber explained the structure of the Report of the Council to the General Assembly. He thanked all members who participated in the work of the WMA between meetings, noting in particular the One Health Conference attended by more than 600 and hosted by the Japan Medical Association and meetings on End of Life issues, held in Latin America, hosted by the Brazilian Medical Association and also in Japan, hosted by the Japan Medical Association in collaboration with the Confederation of Medical Associations of Asia and Oceania (CMAAO). The Secretary General stressed that this type of cooperation and support for the regional work of NMAs is essential.

Dr Kloiber reminded the Council that he had reported to last Council session the automatic termination of membership of Russian Medical Society (RMS) for non-payment of Dues. He informed the Council that the RMS had sent a letter challenging that decision and threatening to litigate if WMA accepted another constituent member from Russia. The WMA was not responding to the letter sent from the RMS.

6. REPORT OF THE CHAIR OF COUNCIL

The Council received the Report by the WMA Chair of Council from May to September 2017 (Council 207/Chair of Council Report/Oct2017). Dr Hoven stressed the importance of everyone participating and feeling welcome and able to provide their viewpoints on the issues discussed by the Council. She encouraged participants to ask for clarifications if they had questions about the process. She reiterated that everyone's participation was valued and desired.

The Council Adjourned at 8:45 for the meetings of the Standing Committees.
The Council reconvened to consider the reports of the Standing Committees at 8:06 on Friday 13 October 2017.

7. NEW ITEM TO BE CONSIDERED AS A MATTER OF URGENCY

The Chair informed the Council of a new proposed WMA Resolution submitted after the Council had adjourned for the Standing Committee meetings and that the Council would have to decide whether to accept it as a matter of urgency. The proposal was entitled "Council Resolution on Poland (Council 207/Poland/Oct2017). She read the text of the proposed resolution aloud to enable interpretation in French, Spanish and Japanese.

Dr Kloiber informed the Council that representatives from the Polish Chamber of Physicians and Dentists had asked the WMA for help on this matter and Dr Kloiber proposed that this help consists of the proposed Resolution as well as an immediate press release. He reviewed the issues covered by the Resolution. Dr Mazur, representative of the Chamber, stated that there was not enough public expenditure for health—not enough for patients and not enough for adequate salaries of physicians, especially young physicians. Following ten days of hunger strikes by some junior doctors, the Chamber had declared a Day of Solidarity with the protesters and hoped that the WMA would show its support by approving the resolution. The addition of an explicit statement of solidarity was accepted as a friendly amendment to the Resolution.

The Council **accepted** the Resolution of Poland (Council 207/Poland REV/Oct2017), as amended, as matter of urgency and **approved** it.

8. COMMITTEE REPORTS

The Council used a consent calendar to consider the Committee reports.

8.1 Medical Ethics Committee

The Council considered the report of the Medical Ethics Committee (MEC 207/Report/Oct2017). No extractions were requested and the Council **approved** the report.

8.2 Finance and Planning Committee

The Council considered the Report of the Finance and Planning Committee (FPL 207/Report/Oct2017). No extractions were requested and the Council **approved** the report.

8.3 Socio-Medical Affairs Committee

The Council considered the Report of the Socio-Medical Affairs Committee SMAC 206/Report/Apr2017). No extractions were requested and the Council **approved** the report.

9. REPORT OF THE ENVIRONMENTAL CAUCUS

Dr Vivienne Nathanson reported that the Caucus had met the previous evening and discussed the next phase of the climate negotiations (COP23) to take place in Bonn, Germany. The WMA delegation to the conference had discussed their inputs to the meeting, including the expected revised Declaration of Delhi on Health and Climate Change, which would be voted on by the General Assembly at its plenary session. The Caucus had discussed efforts by NMAs in areas related to climate change and the possibility of bringing all WMA policies related to the environment together into a single document in the future. Dr Nathanson noted that she had finished her term as Chair of this caucus.

10. OUTREACH

The Chair informed the Council that the following reports had been referred to the Council by the Finance and Planning Committee, which had not had time to receive them.

10.1 Report of the Chair of Associate Members

The Chair of Associate Members, Dr Joseph Heyman, referred to the written report (FPL 207/Chair of AM Report/Oct2017). He reminded Council members that after their terms had ended they could stay involved with WMA as associate members.

10.2 Report of the Past Presidents and Chairs of Council Network (PPCN)

Dr Jón Snædal referred to the written report, noting that the activities of this group had been increasing.

10.3 Report of the Junior Doctors Network (JDN)

Dr Caline Mattar, Chair of the Junior Doctors Network presented the report (FPL 207/JDN Report/Oct2017). She noted in particular that the JDN had recently decided to tackle the topics of working conditions and mental health of junior doctors. She thanked the AMA for hosting the two-day meeting of the JDN prior to the General Assembly.

10.4 Report from the World Medical Journal

Dr Peteris Apinis reported that the WMJ continues to publish after 65 years. He thanked Dr Elmar Dopplefeld, assistants Maira Sudraba and Velta Poz, and WMA Public Relations Advisor, Mr Nigel Duncan, for their support.

10.5 Public Relations Report

WMA Public Relations Advisor, Mr Nigel Duncan, explained that it was his job to assess what WMA matters would be of interest to the profession and to the public to generate publicity for the WMA. At this meeting, he anticipated that the revised WMA

Declaration of Geneva would be likely to generate the most publicity and he intended to issue a press release immediately upon its adoption by the General Assembly. All NMAs would receive the press release and should adapt it by including a welcome of the policy by the NMA President or Chair, which would increase its interest to the national press in each country. NMAs have a role to play in increasing the profile of the WMA. He offered his assistance to any NMA that wanted help drafting press releases.

11. ANY OTHER BUSINESS

There were no other items of business for the Council.

12. ADJOURNMENT

The meeting was adjourned at 8:53 am.

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27.11.2017

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**Council 208/Minutes/Oct2017**	Original: English
Title:	**Minutes of the 208th Council Session**	
Destination:	209th Council Session Radisson Blu Hotel Latvija Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**

Saturday, 14 October 2017, 4:40 pm – 4:45 pm

Membership of the Council

Dr David O. Barbe
Dr MooJin Choo
Dr Andrew Dearden (Treasurer)
Dr Leonid Eidelman
Dr Louis Francescutti
Dr Michael B. Gannon
Dr Mzukisi Grootboom
Dr Andrew W. Gurman
Dr René Héman
Dr Ardis Dee Hoven (Chair)
Dr Miguel Roberto Jorge
Dr Toru Kakuta
Dr Ajay Kumar
Dr Kenji Matsubara
Dr Mari Michinaga
Prof. Dr med. Frank-Ulrich Montgomery (Vice Chair)
Dr Ramin Parsa-Parsi
Dr Mark Porter
Dr Serafín Romero
Dr Andreas Rudkoebing
Dr Heidi Stensmyren
Dr Thomas Szekeres
Dr Julio Trostchansky
Dr Walter Vorhauer
Dr Shuyang Zhang

Ex-officio (without voting rights)

Dr Yoshitake Yokokura , *President*
Dr Ketan Desai*, Immediate Past President*
Dr Leonid Eidelman, *President-Elect*
Dr Otmar Kloiber, *Secretary General*
Ms Marie Colegrave-Juge, *Legal Advisor*
Mr Adolf Hällmayr, *Financial Advisor*
Prof. Vivienne Nathanson, *Facilitator*

1. GENERAL BUSINESS

1.1 The meeting was called to order by the Chair of Council at 4:40 pm on 14 October 2017.

1.2 Apologies for absence: Dr Thomas Szekeres (Austria; replaced by Dr Herwig Lindner), Dr Julio Trostchansky (Uruguay; replaced by Dr Alarico Rodriguez)

2. BUSINESS ARISING FROM THE GENERAL ASSEMBLY

2.1 Reproductive Technologies

The Council **received** the proposed revision of the WMA Statement on Reproductive Technologies (MEC 206/Reproductive Technologies REV2/Apr2017; Final annex ítem 2.4) which was sent back to Council.

The document is to be read again by the MEC.

3. ANY OTHER BUSINESS

There were no other items of business for the Council

4. ADJOURNMENT

The meeting was adjourned at 4:45 pm.

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27.11.2017

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**Council 209/President Report/Apr2018** **Report of the Chair of Council (October 2017 – April 2018)**	Original: English
Destination:	209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **To be received**

My major mission as WMA President is, as I stated in my inaugural speech in Chicago in October 2017, to make all-out effort to advance the initiative and assist the past related activities to realize the Universal Health Coverage (UHC) as well as strengthening of the health system of each countries of the world. As the UHC is a very important concept to bring health to all the people in the world, I will continue activities focusing on the developing of this concept.

In the past half-year activities as WMA President, I have worked concentrating my efforts on this important theme in various meetings inside and outside of Japan as mentioned below.

1. The meetings and other events related to promotion of the UHC.

The 2017 Global Health Forum in November 2017:
I was invited by the Taiwan authority to the 2017 Global Health Forum hosted by the Taiwan Health Ministry and Foreign Affairs. It was attended by 35 countries with 1000 people. The discussion was mainly focused on SDGs and I told the forum about the importance of attaining the UHC and strengthening of the health system.

The UHC Forum 2017 in December 2017:
The UHC Forum 2017 was held in Tokyo last December organized by the Japanese government, World Bank, UNICEF, UHC2030 and JICA. I was invited to the forum and joined the high level opening session. It was attended by some global leadership such as Prime Minster Shinzo Abe, UN Secretary General Mr. António Guterres, Chair of World Bank Mr. Jim Yong Kim, and WHO Director General Dr. Tedros Adhanom. I told the meeting that a unity of the cross-over physicians is increasingly needed for infectious diseases and disaster preparedness in progressing borderlessness with globalization. In this forum, one of the highlights is that the WMA and WHO agreed to make an official MOU on collaboration for establishing the UHC on global level and strengthening disaster preparedness. As you know, I and Dr. Tedros signed the MOU on April 5 in Geneva.

JMA Harvard Taro Takemi Memorial International Symposium in February 2018:
The JMA held at its headquarters in Tokyo "JMA Harvard Taro Takemi Memorial International Symposium" The subtheme is "Community Health Systems and Innovations: Building the Foundation for Universal Health Coverage". The symposium was attended by about 350 people with a lecture by Sir Michael Marmot from the WMA. The JMA has an

international health program at the Harvard School of Public Health in Boston working for many years to nurture the middle-career researchers from the world. This symposium was set up to celebrate its 35th anniversary.

Signature of the MOU with the WHO in April 2018:
On April 5, as I mentioned above, I attended the signature ceremony to sign the MOU on UHC and disaster preparedness between the WMA and WHO in Geneva. I believe that this signature of the MOU will surely contribute to further enhance the presence of the WMA in the global community. After the signature, I had a meeting with the leaders of some major international organizations such as The Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI The Vaccine Alliance, International Committee of the Red Cross, Medicins Sans Frontieres and UN Office for Disaster Risk Reduction.

Global Ministerial Summit on Patient Safety in April 2018:
In this month as well, the Global Ministerial Summit on Patient Safety was held in Tokyo attended by 46 countries. I joined the summit as WMA President and chaired the key-note speech by Dr. Günther Jonitz, President of the Berlin Medical Association. I also delivered a short comment on the activities of the WMA about patient safety during the round table session as well as the UHC which may be closely linked to patient safety activities.

2. Other major activities

United Nations Office for Disaster Risk Reduction
In November 2017, I attended the WMA European Regional Meeting on End-of-Life Questions in Vatican. The regional meeting in the Asian and Oceanian region was already finished in Tokyo in September of 2017 and I reported the results of the meeting. I felt some differences in ideas between the European, Asian and Oceanian regions. I hope that we will have a deep discussion about this theme in Riga.

Also in December 2017, I was invited by the Medical Association of Thailand and Tammathat University to attend the **One Health International Conference 2017 Scientific Program** attended by about 400 people. The conference aimed to contribute to the improvement of humans, animals and global health through discussion of specialists for further collaboration between medicine and veterinary medicine.

2018 CMA Annual Scientific Meeting & The 2nd Pak-China Medical Congress & Belt and Road Forum of Medical Associations was held in Beijing, China. The conference I attended was entitled "Lifestyle diseases: Current situation and countermeasures in Japan and China". I emphasized that this theme is one of the extremely serious problems confronted by countries around the world. I also told that all the physicians of the world must make continuing efforts to address this problem.

In February of this year, I was appointed a member of the WHO Civil Society Working Group on the Third High Level Meeting of the UN General Assembly on NCDs.

In the same month, the JMA accepted the specialist group of the Taiwan Medical Association to investigate the present status of the long-term care insurance system in Japan. The JMA helped the group to visit some of the related institutions under the long-term care for the elderly.

In early this month, the JMA invited Professor Ronit Katz, member and former Chair AMA Governing Council to the CBRNE conference focusing the preparedness for the Tokyo Olympic Paralympic Games in 2020. It was an active discussion about terrorism disaster countermeasures by specialists.

Respectfully submitted by Yoshitake Yokokura, MD, President of the WMA

17.04.18

THE WORLD MEDICAL ASSOCIATION, INC.

Document: **Title:**	**Council 209/SecGen Report/Apr2018** **Secretary General's Report to the 209th WMA Council Session (October 2017 – March 2018)**	Original: English
Destination:	209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **To be received**

Chapter I Ethics, Advocacy & Representations

1. Ethics

1.1 Declaration of Taipei
1.2 Declaration of Geneva
1.3 Regional discussions on End-of-Life issues

2. Human Rights

2.1 Right to health
2.2 Protecting patients and doctors
2.3 Prevention of torture and ill-treatment
2.4 Pain treatment
2.5 Health through peace

3. Public Health

3.1 Non-communicable diseases
3.2 Communicable diseases
3.3 Health and populations exposed to discrimination
3.4 Social determinants of health
3.5 Counterfeit medical products
3.6 Food security and nutrition
3.7 Health and the environment

4. Health Systems

4.1 Comparing healthcare systems using PROMS & PREMS
4.2 Patient safety
4.3 One Health
4.4 Antimicrobial resistance
4.5 Health workforce

CHAPTER I ETHICS, ADVOCACY & REPRESENTATIONS

1. Ethics

1.1 Declaration of Taipei

The Declaration of Taipei on Ethical Considerations Regarding Health Databases and Biobanks provides guidance for the protection of persons who allow their health data and/or specimens to be used for future research or other uses. In some aspects, this is a logical continuation of the safeguards provided by the Declaration of Helsinki; extending them into virtual environments and scenarios such as administrative or commercial uses.

An important focus of the Declaration of Taipei is maintaining the protection provided by informed consent. Since information about potential future uses of data or specimens is naturally incomplete, the Declaration offers a multi-step mechanism to replace part of informed consent. This is achieved through a predetermined governance structure and an assessment by an ethics committee.

As regulations on health and medical databases are currently under discussion, the dissemination of the Declaration is being actively pursued with urgency. We are grateful to our members and partner organisations which already use the Declaration or advocate for it.

1.2 Declaration of Geneva

Both before and since its adoption at the General Assembly in Chicago, the Declaration of Geneva has encountered a remarkable and overwhelmingly positive reception. The WMA will use upcoming ethics conferences and other events to promote this revised physicians' pledge. We offer to explain the revision process and provide an in depth analysis of the wording that has been used. Again, we are grateful to the early adopters of the Declaration of Geneva and thank our members and partners for using and disseminating it.

1.3 Regional Discussions on End of Life issues

At the 200th Council Session in Oslo in April 2015 the WMA policies on physician-assisted suicide (PAS) and euthanasia were reaffirmed. However, a controversial discussion about the wording and effect of the current policies led to the submission of a policy document by the Royal Dutch and the Canadian medical associations to the 201st Council Session in Moscow in October 2015. The authors of the document ultimately requested its withdrawal at the 203rd Council Session in Buenos Aires in April 2016. Instead, the Council mandated the Executive Committee to come back with a plan for discussing end-of-life issues, including palliative care, living wills, physician-assisted suicide (PAS) and euthanasia. At the 204th Council Session in Taipei in October the Executive Committee invited its members, especially those from Latin America, Africa and Asia to hold regional meetings to discuss these issues. This took into account the observation that the previous discussion was dominated mainly by voices from Europe and North America.

Since then four regional discussions have been held in Latin America, (Rio de Janeiro, March 2017 in cooperation with CONFEMEL), Asia and the Pacific (Tokyo, September 2017, in cooperation with CMAAO), Europe (Vatican City, November 2017 in cooperation with the Pontifical Academy for Life) and in Africa (Abuja, January-February 2018).

Reports from those meetings are attached to this document. The discussions will be continued on the global level at the joint WMA-Iceland Medical Association Ethics Conference in Reykjavik next October.

2. Human Rights

2.1 Right to health

The WMA Secretariat follows the activities of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dr Dainius Puras, as well as health related matters addressed by the UN Human Rights Council. Further to a meeting between Dr Puras, Dr O. Kloiber and C. Delorme in September 2017 (see item 2.3.3), it was agreed to maintain contact with a regular exchange of views on current topics of mutual interest.

2.2 Protecting patients and doctors

2.2.1 Actions of support

Country	Case
TURKEY January- February 2017 Sources: TMA, Human Rights Foundation of Turkey, Amnesty International	Following a public statement by the Turkish Medical Association (TMA) in mid-January stressing that war is a public health problem and calling for peace its leaders have been confronted with a campaign of intimidation and threats. The Turkish Ministry of Internal Affairs filed a criminal complaint against the TMA and the Ankara head prosecutor opened an investigation. In addition, the Minister of Health filed another lawsuit demanding all TMA's Central Council members to be dismissed from their position on the grounds that they are acting beyond the scope of the mission of the TMA. The 11 members of the Central Council of TMA were arrested and the TMA office was searched. The WMA issued an immediate press release and a joint letter with other health and human rights organisations (PHR, CPME, IRCT, EFMA) was sent to the Turkish authorities (Link to the letter: https://www.wma.net/wp-content/uploads/2018/01/Joint-letter-of-support-TMA-January-2018-final.pdf). A second press release was issued (https://www.wma.net/news-post/global-medical-bodies-in-joint-call-to-president-erdogan/). The UN Special Rapporteur on the Right to Health was alerted. The Secretariat sent a call for support to all WMA members and partners. Many national medical associations reacted immediately with letters, tweets and other social media support. The TMA Council members were finally released on the 2nd and the rest on 5th February, but an official investigation is continuing on the basis of the charges of "Making propaganda in favour of a terrorist organization" and "Provoking people to be rancorous and hostile".

	In the latest developments, the Turkish authorities have announced their intention to amend legislation pertaining to professional organisations (including the TMA, and organisations of lawyers, architects, etc.), which used to enjoy relative autonomy from government. The amendments envisaged include scrapping compulsory membership; making it possible to have more than one organisation representing a specific profession, flexible and changed election procedures. This amounts to abolishing these organisations' authority and function to supervise compliance with professional ethics and makes these organisations weaker. In addition, Prof. Onur Hamzaoglu - an internationally renowned researcher and practitioner, recently re-elected to the Executive Board of the International Association of Health Policy in Europe at its 18th International Conference held at the end of September 2017 – was arrested on 9th February by the Turkish police. Prof. Hamzaoglu is also the editor of Society and Physicians journal, a scientific journal on health policies published by the TMA. He is being prosecuted for complicity in terrorism. The WMA Secretariat remains mobilized and ready to take further action.
ETHIOPIA September 2017 - February 2018 Source: Swedish Medical Association Amnesty International	The Secretariat received a call to sign a petition in support of the Ethiopian-born Swedish cardiologist, Dr Fikru Maru, who has been in detention for 4 years in Ethiopia. In May 2017, he was cleared of all prior charges, but instead of releasing him, new charges were brought against him and 37 other prisoners for being involved in a prison fire and revolt (Dr Fikru was in hospital with a life-threatening condition when the fire occurred). The Secretariat contacted the Swedish Medical Association, which confirmed the case and was positive about the WMA taking action. Dr Ketan Desai signed the petition on behalf of the WMA. The information was shared on Facebook and Twitter. The situation having not changed since the Summer, the Secretariat discussed taking further actions with the Swedish Medical Association (SwMA) and Amnesty's Ethiopian desk officer. The WMA wrote to the Ethiopian Prime minister and President (with copies and an accompanying letter sent to the new Ethiopian WHO Director General Dr Tedros Adhanom Ghebreyesus). On its part, the SwMA wrote to the Swedish embassy in Ethiopia.
IRAN February 2018 Source: Amnesty International Physicians for Human Rights	Dr Ahmadreza Djalali, an Iranian-born Swedish resident and academic, has been sentenced to death for "corruption on earth" after a grossly unfair trial. His conviction was based on torture-tainted "confessions" that he was forced to make while in solitary confinement without access to his lawyer or family. Amnesty International and Physicians for Human Rights consider him a prisoner of conscience. The Secretariat wrote an initial letter last November and issued a press release (https://www.wma.net/news-post/wma-urges-immediate-release-of-jailed-physician/). Dr Djalali's last appeal was rejected by the Supreme Court in February. A second press release was issued on 13th February calling for his immediate release (https://www.wma.net/news-post/wma-appeals-for-immediate-release-of-jailed-physician/).

2.2.2 Protection of health professionals in areas of armed conflict and other situations of violence

ICRC "Health Care in Danger" (HCiD) initiative

The WMA Secretariat has a close working relationship with the International Committee of the Red Cross (ICRC) headquarters within the context of the HCiD initiative, which has been prolonged by the ICRC for a second phase.
In early November 2016, a **Memorandum of Understanding** (MoU) between the WMA and the ICRC was formally signed by Yves Daccord, Director-General of the ICRC, and Dr Otmar Kloiber, WMA Secretary General. This MoU develops and consolidates the long-standing cooperation between the WMA and the ICRC and fosters understanding on topics of common interest, including on the protection of health professionals and patients in situations of violence, on the role of physicians in addressing sexual violence, as well as torture and ill-treatment in detention, and more generally in addressing Social Determinants of Health in the context of insecurity.
On 22 November 2017, the ICRC and the University of Geneva organised an event on the **MOOC (massive Open Online Courses) on Violence Against Health Care** (https://www.coursera.org/learn/violence-against-healthcare) to discuss the best ways to promote and disseminate this tool within our networks. M. Mihaila and C. Delorme from the WMA Secretariat attended the meeting.

The ICRC and the WMA are again planning a side-event during this year's **World Health Assembly** in May, possibly with the Permanent Missions of Switzerland, Canada and Nigeria, the World Health Organization (WHO), Médecins Sans Frontières (MSF) and other partners such as the International Committee of Military Medicine (ICMM) and the International Hospital Federation (IHF). The event will focus on Health Care in Danger best practices with a vareity of country examples.

During the reporting period, C. Delorme established contact with the Disaster Risk Management Focal Point at WHO to discuss ways to promote and support the role of the health workforce in reducing risks to health from emergencies, strengthening emergency preparedness and building the resilience of communities.

During the 142nd WHO Executive Board meeting, the WMA presented a public statement (https://www.wma.net/wp-content/uploads/2017/05/3.3-Public-health-preparedness-and-response-WHPA.pdf) on behalf of the World Health Professions Alliance (WHPA) on WHO's work in Health Emergencies.

2.3 Prevention of torture and ill-treatment

The WMA Secretariat follows relevant international activities in this area, in particular those of the Human Rights Council.

2.3.1 Cooperation with the International Rehabilitation Council for Torture Victims (IRCT)

The Secretariat exchanged information on a regular basis with the IRCT during the reporting period, in particular regarding the recently adopted WMA proposed Statement on forced anal examinations to substantiate same-sex sexual activity and on the role of physicians in preventing torture

2.3.2 Role of physicians in preventing torture and ill-treatment
Last May, the WMA Secretariat was contacted by the Health Care in Detention Unit of the International Committee of the Red Cross (ICRC) to discuss an opportunity to update the **online course for physicians working in prisons**. Discussions are ongoing, including with the Norwegian Medical Association, which played a key role in developing and hosting the original courses.

In February, the WMA was invited to participate in a one-year project on the development of a supplement to the **Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**, commonly called the Istanbul Protocol (IP). The initiative is headed jointly by Physicians for Human Rights (PHR), the IRCT, the Human Rights Foundation of Turkey, REDRESS, the UN Committee against Torture, the UN Subcommittee for the Prevention of Torture, the UN Special Rapporteur on Torture and the UN Voluntary Fund for Victims of Torture. The purpose of the Project is to strengthen the IP with updates and clarifications based on practical experience from users. C: Delorme participate in the working group on ethical codes as one of the drafters.

2.3.3 Psychiatric treatment – Mental Health

Last June, the WMA Secretariat prepared written comments on the recent report on mental health by the United Nations Special Rapporteur on Health, Dr Dainius Purras (Report A/HRC/35/21). These comments were prepared with a key contribution by Dr Miguel Jorge (Brazilian Medical Association), psychiatrist and Chair of the WMA Socio-Medical Affairs Committee, with the aim of providing the physicians' perspective in the global discussion on the challenges and opportunities related to the promotion of mental health as a global priority and a fundamental human right. The written comments were then shared with the World Psychiatric Association. Dr Puras replied by welcoming our report and a meeting took place in September to discuss the matter further. The WMA Secretariat was represented at this meeting by Dr O. Kloiber and C. Delorme.

2.4 Pain treatment

The WMA continues to be active in the field of palliative care in cooperation with the WHO and civil society organisations working in this area. Within the context of the current global discussion and the Special Session of the UN General Assembly on the world drug problem, the WMA made a public statement at the session of the WHO Executive Board (January 2017) on the public health dimension of the issue, underlining the need for a committed public health approach encompassing the availability and access to medicines for effective treatment and related healthcare services.

On 1st March, the advisory group on palliative care of the Pontifical Academy for Life issued a White Paper on Global Palliative Care Advocacy including a set of “Selected recommendations” calling on various stakeholders in the health care sector to step up

advocacy for health. As a representative of professional associations, they called upon the WMA to especially foster the human rights aspect of access to palliative care.

2.5 Health through peace

On 7July 2017, country representatives meeting at a United Nations conference in New York adopted the Treaty on the Prohibition of Nuclear Weapons, the first multilateral legally-binding instrument for nuclear disarmament to have been negotiated in 20 years.

In September, the WMA Secretariat met with a representative of the International Physicians for the Prevention of Nuclear War (IPPN) to explore possible ways of collaboration on the global health imperative to eliminate nuclear weapons in line with the WMA Statement on Nuclear Weapons by using the momentum of the Treaty adoption. The WMA and IPPN are exchanging views on a regular basis within this framework. IPPN offered its assistance on the revision of WMA Statement on Nuclear Weapons in order to include reference to the recently adopted Treaty.

On the occasion of the opening for signature of the Treaty on the Prohibition of Nuclear Weapons in New York on 20th September, the IPPN together with the WMA, the International Council of Nurses and the World Federation of Public Health Associations, adopted a joint Statement urging Member States to sign the Treaty and to ratify it as soon as possible thereafter so that it can enter into force.

3. Public Health

3.1 Non-communicable diseases (NCDs)

3.1.1 General

Member States and the WHO have made progress in fulfilling their commitments according to the 2011 **UN Political Declaration on Prevention and Control of NCDs** and adopted a Global Monitoring Framework with a set of global NCD targets, a Global NCD Action Plan 2013-2020, and a formalized UN Interagency Task Force on NCDs, which will coordinate a UN system-wide response to NCDs.

In response to the first **UN Political Declaration on Prevention and Control of Non-communicable Diseases** from 2011, the WHO also established the **Global Monitoring Framework as a Global Coordination Mechanism (GCM)** on the Prevention and Control of Non-communicable Diseases. The scope and purpose of the coordination mechanism is to facilitate and enhance the coordination of activities, multi-stakeholder engagement and action across sectors at the local, national, regional and global levels. The WMA is an official member of this coordination mechanism, which was launched in March 2015, and has attended several WHO GCM/NCD meetings. Dr Bente Mikkelsen, head of the GCM secretariat, is planning to present their work and achievements at the WMA General Assembly in Reykjavík. The purpose of this presentation is also to discuss possible cooperation with the WMA and how physicians can support activities against NCDs.

During the WHO Executive Board meeting the WMA made an intervention for the preparation of the next high-level meeting on NCDs during the 2018 UN General Assembly in New York and empgasised the strong commitment of the WMA in the fight against NCDs. Following the long engagement of WMA with the WHO GCM secretariat, WHO appointed Dr Yokokura, WMA president, to be a member of the **WHO Civil Society Workgroup** to advise the Director General on the planning and advocacy of the high level meeting on NCDs and on the mobilization of civil society.

Dr Julia Tainijoki was invited by WHO to present WMA's perspective and experience on health literature and education at the third meeting of the **WHO GCM/NCD Working Group on Health Education and Health Literacy for NCDs** in February in Geneva. The Working Group was established to recommend ways and means of encouraging Member States and non-State actors to promote health education and health literacy for NCDs, with a particular focus on populations with low health awareness and/or literacy.

At the same time, the WMA supported the launch of the publication of a new **speaking book for children with cancer**. Previously, and together with other partners, the WMA has supported the publication of speaking books on high blood pressure, tobacco use cessation, kids in hospital and clinical trials.

On the occasion of the 20th European Health Forum in Gastein, Austria in October 2017 WHO invited WMA to speak at the **WHO workshop "investing in healthy cities: "insuring" prevention"**. The workshop focused on investing in healthy cities as a means to improve population health and well-being.

At the **Global Dialogue on Partnerships for Sustainable Financing of NCD Prevention and Control** in Copenhagen Denmark from 9-11 April 2018 the WMA organised a session on 'A vital investment: Scaling up health workforce for NCDs'. The aim of this session was to highlight the importance of the health workforce in the fight against NCDs and the investment needs and roles of various stakeholders in strengthening countries' capacities to develop HRH policies and plans in line with national health strategies to achieve UHC and SDG3.4.

3.1.2 Tobacco

The WMA is involved in the implementation process of the **WHO Framework Convention on Tobacco Control (FCTC)**. The FCTC is an international treaty that condemns tobacco as an addictive substance, imposes bans on advertising and promotion of tobacco, and reaffirms the right of all people to the highest standard of health. The WMA attends every Conference of the Parties meeting. The next Conference of the Parties to the FCTC meeting will take place from 1-6 October 2018 in Geneva.

3.1.3 Alcohol

The Secretariat maintains regular contact with the WHO staff in charge of this topic, as well as with the Global Alcohol Policy Alliance (GAPA). During the 70th session of the World Health Assembly last May, the WMA took part in a Civil

Society consultation meeting organised by GAPA and the NCD Alliance in order to discuss strategies to put alcohol back on the agenda of the WHO governing bodies. The WMA was also invited by GAPA to an informal meeting on the same topic with interested Member States.

In June, Clarisse Delorme represented the WMA at the WHO Forum on Alcohol, Drugs and Addictive Behaviours, which took place at WHO headquarters in Geneva. A statement was made recommending the development of all-inclusive policies addressing the root causes of alcohol patterns as well as strengthening health systems to improve countries' capacity to develop policy and lead actions that target alcohol problems.

Last February, the Secretariat received a request from IOGT International and GAPA to support a joint letter sent on 1st February to the Global Fund denouncing their partnership with Heineken and emphasizing the dangers inherent in collaborating with the producers and marketers of hazardous products such as alcohol. (http://iogt.org/open-letters/joint-open-letter-concern-regarding-global-fund-partnering-heineken/). The letter was endorsed by a number of regional and national organisations and networks. The WMA joined the mobilisation and decided to support the initiative as well. The news was shared on Twitter and Facebook.

3.1.4 Physical Activity

The WHO is in the process of developing a draft global action plan to promote physical activity. The WMA was invited to be member of the strategic advisory network to support and guide the WHO Secretariat in the development of this Global Action Plan on Physical Activity, and attended the first technical advisory meeting in June 2017. Recognising the importance of physical activity to wellbeing and the attainment of the sustainable development goals, the action plan offers the global community a unique opportunity to elevate the profile and set a new ambitious agenda for united action in creating physical activity opportunities for all. The WHO Secretariat hosted an open web-based consultation on a first draft of the report from August to mid-September.

3.2 **Communicable diseases**

3.2.1 Multidrug-Resistant Tuberculosis Project

The WMA participated in the development of the WHO guidance document entitled ‘Guidance on Ethics of Tuberculosis Prevention, Care and Control’ in 2010. Building on this document, the WHO is now in the processes of revising the existing document with the aim of speaking more directly to the challenges faced by healthcare workers (HCW) and decision-makers across the globe in helping fulfil the third principle of the End TB Strategy, namely the protection of human rights, ethics and equity. A first workgroup meeting has taken place with the WMA delivering a presentation on health workers’ rights and obligations.

3.2.2 Influenza

The WMA was invited by Ms Françoise Grossetête, Member of the European

Parliament, and Prof. Thomas Szucs to be a members of the steering group to develop an EU Manifesto on Influenza Vaccination, which aims to help shift the agenda at European and national level in support of influenza vaccination. The Manifesto confirms the need for stronger policy-driven actions to reduce the burden of influenza and emphasises the importance of the health workforce in this topic. The digital launch was on 6th March 2018 with the physical launch planned for 24th March 2018.

3.3 Health and populations exposed to discrimination

3.3.1 Women and health

The WMA continues to follow global activities on women and health and aims to monitor the implementation phase of the "Global plan of action on strengthening the role of the health system in addressing interpersonal violence, in particular against women and girls, and against children", which was adopted by the World Health Assembly in May 2016.

Last August, in conformity with WMA's related policy, the WMA Executive Committee decided to support the United to End FGM knowledge platform. This Platform is a new, free, online training tool to train professionals dealing with those affected by female genital mutilation. It is currently available in nine European languages, with two modules specifically for health professionals. The Secretariat shared this information through social media.

3.3.2 Ageing

The WMA participated in the WHO consultation on the Global Strategy and Action Plan on Ageing and Health, which was adopted by Members States at the last World Health Assembly in May 2016, and is monitoring the implementation phase of the Global Strategy.

For more activities in the area of ageing, please see Chapter III, section 4.

3.3.3 Zero HIV-related stigma & discrimination in health care settings

In March 2017, the Secretariat shared with WMA members the UNAIDS reference document on eliminating discrimination in health care. This report aims to serve as a reference for policy-makers and other key stakeholders engaged in shaping policies and programmes to regulate healthcare and eliminate discrimination and other structural barriers to achieving healthy lives for all. The WMA has been involved in this initiative since it started in November 2015.

3.3.4 Refugees, migrants & access to health

In response to the WHO initiative on migrants' health, the WMA made a public statement on behalf of the World Health Professions Alliance (WHPA) at the 70th World Health Assembly (May 2017) welcoming WHO's efforts in promoting migrant health and highlighting that late or denied treatment is discriminatory and contravenes a fundamental human right.

Clarisse Delorme was invited to present the WMA's views on migrants' health at the Youth Pre-World Health Assembly Workshop organised by the International Federation of Medical Students Association (IFMSA) on 19 May in Geneva.
In July, the WMA Secretariat, represented by Dr O. Kloiber, C. Delorme and M. Mihaila, met with representatives of the Migration Health Division of the International Organisation for Migration (IOM) to explore potential cooperation and exchange information.

Further to this meeting, the WMA has been invited to join a working group led by the IOM and WHO to ensure that the health needs of refugees and migrants are adequately addressed in the "Global Compact for Migration" (GCM), the global UN process currently taking place, which will culminate in a final outcome agreement by the UN General Assembly further to intergovernmental negotiations in 2018. The working group – composed of representatives from WHO and IOM in close cooperation with ILO, OHCHR, UNFPA, UNAIDS[1], the World Bank and other stakeholders including the International Federation of the Red Cross (IFRC), the Platform for International Cooperation on Undocumented Migrants (PICUM) and WMA - met in September and agreed on a Proposed Health Component, which should feed the discussion around the zero draft GCM. The Proposed Health Component for the GCM is available on the GCM website for Member States and partners.

3.4 Social determinants of health (SDH) and Universal Health Coverage (UHC)

The WMA is actively engaged with the WHO Department of Health Workforce and is participating in a Steering Committee to develop an **eBook on the Social Determinants of Health** Approach to health workforce education and training. The project is part of the WHO's work to implement the guidelines on "Transforming and scaling up health professionals' education and training", launched in Recife in 2013. The project also supports World Health Assembly Resolution WHA66.23 "Transforming health workforce education in support of universal health coverage". The collaboration involves participation in meetings organized by WHO and providing technical assistance and guidance for the eBook.

During the Universal Health Coverage Forum in December 2017 in Tokyo, Japan Dr. Yokokura, WMA president, spoke at the opening session. The goal of the Forum was to mobilize broad political support for accelerating progress towards UHC and the SDGs, including health security and pandemic preparedness. This forum brought together over 300 participants, including heads of government, ministers of finance and health, and senior representatives from bi- and multi-lateral institutions, civil society organizations, think tanks, and academia. At the forum WHO Director General Dr Tedros Adhanom Ghebreyesus and WMA President Dr Yoshitake Yokokura agreed to strengthen the collaboration of both organizations on Universal Health Coverage and Emergency preparedness. A Memorandum of Understanding is planned to be signed on 5th April 2018 in Geneva.

3.5 Counterfeit medical products

[1] ILO: International Labour Organisation – OHCHR: Office of the High Commissioner for Human Rights – UNFPA: United Nations Population Funds – UNAIDS: United Nations Programme on HIV/AIDS

Counterfeit medicines are manufactured below established standards of safety, quality and efficacy. They are deliberately and fraudulently mislabelled with respect to identity and/or source. Counterfeiting can apply to both brand name and generic products, and counterfeit medicines may include products with the correct ingredients but fake packaging, products with the wrong ingredients, products without active ingredients, or products with insufficient active ingredients. Counterfeit medical products threaten patient safety, endanger public health, e.g. by increasing the risk of antimicrobial resistance, and undermine patients' trust in health professionals and health systems. The involvement of health professionals is crucial to combating counterfeit medical products.

The WMA has joined the Fight the Fakes campaign that aims to raise awareness about the dangers of fake medicines. Coordination among all actors involved in the manufacturing and distribution of medicines is vital to tackle this public health threat. The website also serves as a resource for organisations and individuals who are looking to support this effort by outlining opportunities for action and sharing what others are doing to fight fake medicines.

3.6 Food security and nutrition

The Food and Agriculture Organization of the United Nations (FAO) and the World Health Organization (WHO) have received a mandate to develop a **Declaration on Nutrition** and an accompanying Framework for Action (FFA) to guide its implementation. They will organise several preparatory meetings and conferences during the development process. The WMA is observing this process. One main criticism is the short timeline and the low involvement of civil society in the process. NGOs also complain that problems concerning the use of antibiotics in foodstuffs are not well addressed in the current discussion.

The focus so far is on: Social protection to protect and promote nutrition, nutrition-enhancing agriculture and food systems and the contribution of the private sector and civil society to improving nutrition.

3.7 Health and the environment

3.7.1 Climate change

The WMA continues to be involved in the UN climate change negotiations, particularly the implementation of the Paris agreement adopted at COP21 in December 2015. For this purpose, a WMA delegation followed the two weeks of negotiations during the COP 23, which took place from 6-17 November 2017 in Bonn, Germany. The Secretariat liaised with WHO and the Global Climate and Health Alliance (GCHA) to ensure coordinated actions during these negotiations. The WMA made a public statement (https://www.wma.net/wp-content/uploads/2017/05/3.5-Health-environment-and-climate-change-WMA.pdf) at the 142nd session of the WHO Executive Board on the global strategy on health, environment and climate change.

During the reporting period, discussions were started with WHO and the GCHA on setting up a regular mechanism of cooperation in the area of climate change.

The WHO's First Global Conference on Air Pollution and Health is scheduled from 30th October to 1st November in Geneva. It will bring together global, national and local partners to share knowledge and mobilize action for cleaner air and better health. The WMA is in contact with WHO to discuss its involvement in the event.

3.7.2 Chemicals safety

In December 2009, the WMA joined the Strategic Approach to International Chemicals Management (SAICM) of the Chemicals Branch of the United Nations Environment Programme (UNEP), which aims to develop a strategy for **strengthening the engagement of the health sector in the implementation of the Strategic Approach**.

Further to the 2016 World Health Assembly Resolution on the **Role of the Health Sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond**, the 70th World Health Assembly last May approved the **Chemicals Roadmap** (http://www.who.int/ipcs/saicm/roadmap/en/) which identifies actions where the health sector has either a lead or important supporting role to play, recognizing the need for multi-sectoral and multi-stakeholder cooperation. The roadmap was developed in consultation with Member States, United Nations agencies, and other relevant stakeholders. The WMA participated in the consultation phase through electronic consultation and meetings.

3.7.3 WMA Green Page

The WMA is partnered with the Florida Medical Association (FMA) on a joint project "**My Green Doctor**". This project is a medical office environmental management service offered free of charge to members of the World Medical Association (WMA) and the Florida Medical Association (FMA). The initial version of My Green Doctor was launched by the FMA on World Earth Day 2010. In June 2014, the WMA and FMA agreed to work together on this project. My Green Doctor provides a free practice management tool designed by doctors to make medical offices more environmentally friendly. It provides everything needed to assist practice or clinic managers in establishing their own environmental sustainability programme: office policies, PowerPoints, a step-by-step guide for your Green Teams, and even free advice by telephone. The My Green Doctor website is now available in the "What we do - Education" section of the WMA website.

4. Health Systems

4.1 Patient safety

To address the global problems of **unsafe medication practices**, the WHO has launched a Global Patient Safety Challenge on Medication Safety with the overall goal to "reduce the avoidable harm due to unsafe medication practices by 50% worldwide by 2020". In order to develop this initiative, the WHO invited the WMA and other relevant stakeholders to several consultations this year.

Under this overarching topic the WMA was invited by the WHO to participate in a **Global Consultation for Setting Priorities for Global Patient Safety** in collaboration with the Centre for Clinical Risk Management and Patient Safety, Department of Health. This high-level global event brought together key international experts and senior policy makers from ministries of health from both developed and developing countries. The objective of this consultation was to identify the main challenges and barriers to improving patient safety for patients, health-care providers and the environment of care, and define priorities for future action by the WHO and countries.

Some years ago, the WMA, together with the WHO and the other health professions, wrote the **'Patient Safety Curriculum Guide- Multi Professional Edition',** and also participated in its update a few years later. Now the WHO would like to carry out a second revision of this curriculum guide in several steps. As the first step, the chapter 'Improving Medication Safety' should be updated in such a way that it can also stand alone as a single document. At a first meeting in December 2017 we discussed the topics, order and priorities of this chapter. Based on this discussion the WHO will develop a first revised version to be commented on by the WMA and other health professionals.

4.2 One Health

In May 2015, the World Veterinary Association (WVA) and the World Medical Association (WMA) in collaboration with the Spanish medical (SMA) and veterinary (SVA) associations organized the Global Conference on 'One Health' Concept with the theme: "Drivers towards One Health - Strengthening collaboration between Physicians and Veterinarians". The Global Conference brought together 330 delegates from 40 countries around the world. Veterinarians, physicians, students, public health officials and NGO representatives listened to presentations by high-level speakers and had the opportunity to learn, discuss and address critical aspects of the One Health concept. The main objectives of the conference were to strengthen links and communications between the professions and to achieve closer collaboration between physicians, veterinarians and all relevant stakeholders to improve different aspects of the health and welfare of humans, animals and the environment. A summary of the conference is available on the WMA website.

The second conference was hosted by the Japan Medical Association and the Japan Veterinary Association together with the World Veterinary and the World Medical Association in Kitakyushu City, Fukuoka Prefecture, Japan on 10-11 November 2016. The conference was attended by more than 600 participants from 44 countries around the world with approximately 30 lectures covering different One Health issues. A summary of the conference is available on the WMA website.

4.3 Antimicrobial resistance

Antimicrobial Resistance (AMR) is a growing concern and an important challenge to public health. It has various aspects and different actors contribute to the problem.

The WHO developed the **Global Action Plan on Antimicrobial Resistance**, which articulated five main objectives, with the healthcare workforce being a key player in their attainment. Most notably, Objective 1 strives to "improve awareness and understanding of antimicrobial resistance through effective communication, education and training.'' The WHO established an AMR secretariat whose purpose is to link the various

stakeholders, get them involved and coordinate the activities of the Action Plan. One emphasis will be on the education of medical students and physicians.

The WMA participated in a WHO expert consultation meeting on health workforce education and AMR. The outcome of this meeting was the development of the first draft of the **Global Interprofessional AMR Competency Framework for Health Workers' Education**. This tool will assist health policy planners and decision makers in countries to work towards achieving the first objective of the WHO Global Action plan on AMR, which aims to improve awareness and understanding of AMR through effective communication, education and training. It is also intended to serve as the basis for the development of a global prototype AMR curriculum for health workers' education and scheduled training. The WMA commented on the first draft version together with the World Federation for Medical Education. Our comments included the knowledge and training aspects required to carry out a proper diagnosis and the importance of differentiating between different origins and severity of infections, i.e. it is of utmost importance to have a deep knowledge of diagnosis before prescribing an antibiotic in order to reduce the burden of AMR. Together with the School for Public Policy at the George Mason University, the WMA has been providing a free online learning tool on Antimicrobial Resistance for nearly a decade now.

The WMA participated in the ninth **Meeting of the Strategic and Technical Advisory Group on Antimicrobial Resistance** (STAG - AMR) and the Meeting of the Technical Coordination Group (TCG) in February 2018 in Geneva.

4.4 Health workforce

In May 2016, the World Health Assembly adopted the Global Strategy on Human Resources for Health. One new and important statement in the WHO strategy is the emphasis that investment in HRH has a growth-inducing effect and health care itself is a large pillar of the economy. The argument that the health sector has a growth inducing effect on the economy is now being adopted by more and more UN agencies. As a result, the UN Secretary General appointed a High Level Commission on Health Employment and Economic Growth, which launched its report 'Working for Health and Growth - Investing in the health workforce' in September 2016. The report gives 10 recommendations on areas such as job creation, gender and women's rights, education technology and crisis and humanitarian settings. The Commission's goal is to stimulate and guide the creation of at least 40 million new jobs in the health and social sectors and to reduce the projected shortfall of 18 million health workers, primarily in low and lower middle income countries, by 2030.

Following the conclusion of its 10 year mandate, the Global Health Workforce Alliance has transitioned into the Global Health Workforce Network (GHWN). The Global Health Workforce Network aims to facilitate evidence generation and exchange, foster intersectoral and multilateral policy dialogue, including providing a forum for multi-sector and multi-stakeholder agenda setting, sharing of best practices, and harmonization and alignment of international support for human resources for health. The overall goal is to enable the implementation of Universal Health Coverage and the Sustainable Development Goals. The WHO, together with the GHWN and Ireland, organised the **Fourth Global Forum on Human Resources for Health in November 2017** and adopted the outcome document Dublin Declaration on Human Resources for Health.

During this forum the WMA and the International Federation of Pharmacists (FIP) organised a side session on: **How can regulation ensure quality health care, professional autonomy and protect the public's interest?**
Commercialised health care models may affect professional autonomy and the delivered quality of care. The purpose of health care regulation is to protect the public's interest and ensure patient-centred quality care based on ethical principles, as opposed to profit-oriented models of care. Professional autonomy through self-regulation defines standards and ensures quality for health care models. Therefore, regulation has an important role in the implementation of strategies such as the WHO Global Strategy on Human Resources for Health to accelerate UHC and ensure a sustainable health workforce.
Dr Julia Tainijoki, WMA Medical Advisor, spoke at another side event during this forum entitled: "**Addressing discrimination in health care settings through a focus on the rights, roles and responsibilities of health workers**" and presented the physician's perspective and WMA policies on this issue.

4.5 Violence in the health sector

Building on the success of the previous conference in Dublin, preparatory work has started for the sixth International Conference on violence in the health sector, which will take place in Toronto, Canada on 24 - 26 October 2018. The WMA is a member of the organisation and scientific committees in charge of the preparations for the event. Two meetings of the organisation committee took place during the reporting period. C. Delorme, as member of the Committee, liaised with the ICRC so that a representative of the Health Care in Danger initiative will be invited to the conference as a keynote speaker.

4.6 Caring Physicians of the World Initiative Leadership Course

The CPW Project began with the Caring Physicians of the World book, published in English in October 2005 and in Spanish in March 2007. Some hard copies (English and Spanish) are still available from the WMA Secretariat upon request.

Regional conferences were held in Latin America, the Asia-Pacific region, Europe and Africa between 2005 and 2007. The CPW Project was extended to include a leadership course organised by the INSEAD Business School in Fontainebleau, France in December 2007, in which 32 medical leaders from a wide range of countries participated. The curriculum included training in decision-making, policy work, negotiating and coalition building, intercultural relations and media relations. Please visit the WMA website for more readings and videos which reflect some experiences of previous course alumni.

The eighth course was held at the Mayo Clinic in Jacksonville, Florida, USA from 3 - 8 December 2017. The courses were made possible by educational grants provided by Bayer HealthCare and Pfizer, Inc. This work, including the preparation and evaluation of the course, is supported by the WMA Cooperating Center, the Center for Global Health and Medical Diplomacy at the University of North Florida.

5. Health Policy & Education

5.1 Medical and health policy development and education

In recent years, the Center for the Study of International Medical Policies and Practices at George Mason University, which is one of the WMA's Cooperating Centers, has studied the need for educational support in the field of policy creation. Surveys performed in cooperation with the WMA found a demand for education and exchange. The Center invited the WMA to participate in the creation of a scientific platform for international exchange on medical and health policy development. In autumn 2009, the first issue of a scientific journal, World Medical & Health Policy, was published by Berkeley Electronic Press as an online journal. It has now been moved to the Wiley Press. The World Medical & Health Policy Journal can be accessed at: http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1948-4682

5.2 Support for national constituent members

See item 2.2.1

CHAPTER II PARTNERSHIP & COLLABORATION

During the reporting period, the WMA Secretariat held bilateral meetings with the WHO and staff of other UN agencies on the following areas: Prevention of alcohol abuse, mental health, violence against women, the environment, the migration of health professionals and the prevention of torture. In addition, the Secretariat voiced the WMA's concerns in various public settings as follows[2]:

1. World Health Organization (WHO)

WHO Governance
WHO Executive Board, January 2018: The 142nd session of the WHO Executive Board took place in January 2018 in Geneva, Switzerland. The WMA made public statements on a series of issues. For more information (agenda, working documents and resolutions), see http://apps.who.int/gb/e/e_eb142.html
WHO Public Health Events
Fourth Global Forum on Human Resources for Health in November 2017 organised by WHO, GHWN and Ireland in November 2017
WHO Meeting of the Strategic and Technical Advisory Group on Antimicrobial Resistance (STAG - AMR) and Meeting of the Technical Coordination Group (TCG) in February 2018 in Geneva
WHO Global Consultation for Setting Priorities for Global Patient Safety in collaboration with the Centre for Clinical Risk Management and Patient Safety, Department of Health
WHO workshop "investing in healthy cities: "insuring prevention" at the 20th European Health Forum Gastein, Austria in October 2017
WHO GCM/NCD Working Group on Health Education and Health Literacy for NCDs, in February in Geneva

2. UNESCO Conference on Bioethics, Medical Ethics and Health Law

In recent years, the WMA has supported the "UNESCO Chair in Bioethics World Conference on Bioethics, Medical Ethics and Health Law" organised by the UNESCO Bioethics Chair, Prof. Dr Amnon Carmi. In October 2015, the conference convened in Naples, Italy. The WMA participated again by structuring sessions on end-of-life issues and the (at that time) draft of a new policy on Ethical Guidelines for Health Databases and Biobanks. WMA Past-Presidents, Dr Yoram Blachar and Dr Jon Snædal, WMA Ethics Advisor Prof. Vivienne Nathanson, WMA Legal Counsel, Ms Annabel Seebohm and the Secretary General served in preparing these sessions. Immediate Past President, Dr Xavier Deau, held a keynote speech at the opening of the conference.

The WMA was again invited to arrange two scientific sessions at the 12th UNESCO Chair of Bioethics Conference held in Limassol, Cyprus from 21-23 March 2017. The first discussed the

[2] More information on the activities mentioned is set out under the relevant section of the report.

ongoing revision process of the "Declaration of Geneva, the physicians' oath". This session was moderated by Dr Ramin Parsa-Parsi, Chair of the WMA work group, and Prof. Urban Wiesing, Director at our cooperating institute, the University of Tübingen. The second session was moderated by WMA Past President Dr Jon Snædal and Dr Otmar Kloiber, with contributions by Dr Emmanuell Rial-Sibag from our cooperating Center at the University of Neuchatel and Ms Annabel Seebohm, Secretary General of the Standing Committee of European Doctors (CPME).

The WMA is invited to the 13th World Conference on Bioethics, Medical Ethics and Health Law, which will take place from 27-29 November 2018 in Jerusalem, Israel. Please visit the conference page for more details.

3. Other UN agencies

AGENCY	ACTIVITIES
Human Rights Council of the United Nations, in particular:	
UN Special Rapporteur (SR) on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Dr D. Puras)	Monitoring the SRs' activities Ongoing exchange of information Meeting with the SR in September 2017 further to WMA written contribution to SR's report on mental health
Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (Dr Nils Melzer)	Monitoring the SR's activities Contact to be made with new SR
Special Rapporteur on the Rights of Persons with Disabilities (Ms Catalina Devandas Aguilar)	Monitoring the SR's activities Contact made late 2016
High Commissioner for Human Rights (Mr Zeid Ra'ad Al Hussein)	The WMA is part of the consultation process within the framework of the UN Resolution on mental health and human rights adopted in September 2016
UNAIDS	Campaign on Zero HIV-related stigma & discrimination in health care settings day *See item 3.3.3*
OECD	Meeting with Mrs Francesca Colombo, Head of the Health Section, and her team. Discussion about the new work strategy on health system reporting and the use of Patient Reported Outcome Measurements (PROMS). November 2016 (see also item 6.1 and 10)
International Organisation for Migration (IOM)	The WMA is part of the IOMWHO working Group on Migrants' Health. (see point 3.3)
WHO and World Bank	Dr Yokokura gave one of the keynote speeches at the Universal Health Coverage Forum December 2017 in Tokyo, Japan

4. World Health Professions Alliance (WHPA)

After over ten years, the World Federation of Dentists FDI took over the secretariat of the World Health Professions Alliance Leadership from the WMA at the beginning of 2018.

World Health Professions Regulation Conference
Save the date: 19-20 May 2018 in Geneva, prior to the World Health Assembly

Health professional regulation faces many challenges in a world characterised by political, social, economic and technological change. Widespread reform of health professional regulation reflects policy initiatives by many governments to ensure sustainable, efficient and effective health service delivery. But what are the implications of these challenges, and how do we ensure the public's best interests are met?

Scheduled to run over one-and-a-half days immediately before the World Health Assembly in May 2018, the 6th World Health Professions Regulation Conference (WHPRC) will provide participants with insights, perspectives and discussion on current challenges in health professional regulation.

There are three main themes that will be addressed during the conference:
1. A call to set the right standards in regulation
Topics will include: setting the right standards, who is regulating the regulators, ethics and professional autonomy, barriers to implementation, and reimbursement.
2. Safety, quality and compliance: Benefiting patients, communities and populations
Topics will include: best practice guidelines, the role of regulation in sustainable prevention, facilitation of migration, the cost of maintaining licenses, use of big data and case studies of outcome-oriented models.
3. Supporting the quality of lifelong learning
Topics will include: continuing professional development (CPD) and a discussion on the need for global standards, fostering innovation, improving patient treatment, the shift in CPD of assessment vs independence, and regulation of specialization.

5. WMA Cooperating Centers

The WMA is now proud to enjoy the support of five academic cooperating centres. The WMA Cooperating Centers bring specific scientific expertise to our projects and/or policy work, improving our professional profile and outreach.

WMA Cooperating Center	Areas of cooperation
Center for the Study of International Medical Policies and Practices, George-Mason-University, Fairfax, Virginia, USA	Policy development, microbial resistance, public health issues (tobacco), publishing the World Medical and Health Policy Journal.
Center for Global Health and Medical Diplomacy, University of North Florida, USA	Leadership development, medical diplomacy
Institute of Ethics and History of Medicine, University of Tübingen, Germany	Revising the Declaration of Geneva, medical ethics
Institut de droit de la santé, Université de	International health law, developing and

Neuchâtel, Switzerland	promoting the Declaration of Taipei, medical ethics, deontology, sports medicine
Steve Biko Center for Bioethics, University of Witwatersrand, Johannesburg, South Africa	Revising the Declaration of Helsinki, medical ethics, bioethics
Institute for Environmental Research, Yonsei University College of Medicine, South Korea	Environmental health, climate change and health issues

6. World Continuing Education Alliance (WCEA)

The World Medical Association signed an agreement with the WCEA to provide an online education portal that will not only enable the WMA to host its online education, but also offers an opportunity for member associations to develop their own portals and online content. This offer is directed specifically at medical associations and societies that wish to engage in providing online education. Interested groups, medical schools or academies are invited to contact the WMA Secretary General (secretariat@wma.net) for more information. This educational platform will be launched in May 2018.

7. Other partnerships or collaborations with Health and Human Rights Organizations

Organisation	Activity
Amnesty International	Ongoing contacts (exchange of information and support) during the reporting period, in particular on the situations in Turkey, Ethiopia and Iran.
Human Rights Watch	Regular contact on issues of common interest.
Global Alliance on Alcohol Policy (GAPA) and its members	Regular exchange of information.
International Committee of the Red Cross (ICRC)	Partners on the Health Care in Danger (HCiD) project since September 2011. Permanent cooperation with the Health in Detention and HCiD Departments. Memorandum of understanding between the ICRC and the WMA signed in November 2016.
International Council of Military Medicine (ICMM)	A Memorandum of Understanding between the ICMM and the WMA was signed at the WMA General Assembly in October 2017 (Chicago).
Council for International Organizations of Medical Sciences (CIOMS)	Development of guidance for the scientific community in medicine and health care in general. The WMA is a member and currently represented on the Executive Board.
International Federation of Health and Human Rights Organisations (IFHHRO)	Regular exchange of information on human rights and health matters.
International Federation of Medical Students Associations (IFMSA)	Internship program since 2013 (3 students in 2013 and 2 students in 2014). Regular collaboration, mostly in relation to WHO statutory meetings. Participation of WMA officers and officials in the pre-World Health Assembly conference of IFMSA in Geneva.

International Federation of Associations of Pharmaceutical Physicians (IFAPP)	Cooperation on issues of human experimentation and pharmaceutical development, the role of physicians in that process. A memorandum of understanding has been signed at the WMA General Assembly, October 2017 (Chicago).
University of Pennsylvania International Internship Program	Annual Internship program on health policy, public health, human rights, project management. Usually 2-3 students come as interns to our office for the summer. The programme has been running since 2014.
International Rehabilitation Council for Torture Victims (IRCT)	Regular exchange of information and joint actions on specific cases or situations.
Global Climate & Health Alliance (GCHA)	Regular exchange of information and ad hoc collaboration within the context of the UN climate change negotiations.
New Jersey Medical School Global TB Institute	The WMA is working with the New Jersey Medical School Global TB Institute and the University Research Company (URC) to update its online TB refresher course for physicians with the support of the US Agency for International Development (USAID).
Safeguarding Health in Conflict Coalition	Observer status in the coalition. Regular exchange of information.
World Coalition Against The Death Penalty	Regular exchange of information, in particular regarding individual cases requiring international support.
World Veterinary Association	Co-organisation of the Global Conference on One Health, 21-22 May 2015 in Madrid, Spain in collaboration with the Spanish medical and veterinary associations. 2nd Global Conference on One Health, Kitakyushu City, Fukuoka Prefecture, Japan, 10-11 November 2016.
US Defense Health Board – Ethics Subcommittee	WMA Past President, Dr Cecil Wilson, represented the WMA at two sessions of the Defense Health Board – Ethics Subcommittee in 2014 and 2015 advocating for always allowing physicians in military service to respect medical ethics, even in conflict. The report of the Board is available on our website.
Association for the Prevention of Torture	Exchange of information on the implementation of the Convention against Torture with regard to the role of physicians in preventing torture and ill treatment.
Physicians for Human Rights	Regular exchange of information and joint actions on specific cases or situations.
International Physicians for the Prevention of Nuclear War (IPPN)	Exchange of information and joint actions, in particular in the context of the UN Treaty on the Prohibition of Nuclear Weapons.

CHAPTER III COMMUNICATION & OUTREACH

In July 2017 a new member of staff joined the WMA Secretariat. Ms Magda Mihaila is a journalist and communications specialist who is now helping our team improve the way we get out messages to our members and into our social media stream.

1. WMA Newsletter

In April 2012, the WMA Secretariat started a bi-monthly e-newsletter for its members. The Secretariat appreciates any comments and suggestions for developing this service and making it as useful for members as possible.

2. WMA social media (Twitter and Facebook)

In 2013, the WMA launched its official Facebook and Twitter accounts (@medwma). The Secretariat encourages members to spread the word within their associations that they can follow the WMA's activities on Twitter and via Facebook.

3. The World Medical Journal

The World Medical Journal (WMJ) is issued every 3 months and includes articles on WMA activities and feature articles by members and partners. The 60th anniversary edition was published as a final printed copy in 2014. It transferred to an electronic format in 2015, which is available on the WMA website.

4. WMA African Initiative

WMA President 2013-2014, Dr Margaret Mungherera, started an initiative to bring African medical associations closer to the WMA. The idea was that stronger inclusion of organised medicine in international cooperation should not only help to get the African voice better heard, but would also leverage national visibility and standing.

Dr Mungherera brought together medical associations from various parts of Africa in small regional meetings to discuss issues around their current work, what obstacles they face and where they have had success. Invitations are open to all African medical associations, regardless of whether they are already members of the WMA.

Dr Mungherera set up regional consultative meetings with African NMAs in Kenya, South Africa, Tunisia and Nigeria. This initiative has been supported by the medical associations of South Africa and Tunisia, WMA President 2014-2015, Dr Xavier Deau, Past Chair of Council, Dr Mukesh Haikerwal, as well as the Chairman of the Past-Presidents and Chairs of Council Network, Dr Dana Hanson.

Immediate Past-President Dr Mungherera delivered presentations at the 4th International Conference on Violence in the Health Sector in Miami from 22-24 October 2014, the African Health Conference in London from 27-28 February 2015, and at the 6th World Congress on Women's Mental Health in Tokyo from 22-25 March 2015, among others.

Sadly, Dr Mungherera passed away on 4 February 2017 after a brave battle with cancer over recent years. As a psychiatrist by education, a public health activist by nature, and a determined

advocate for the people of Africa by conviction she was a marvellous physician leader on the global stage. For many of us she was more than a colleague, she became a friend, teacher and companion.

Margaret was with us for every meeting she could arrange for. The WMA remains grateful for her service to our community.

5. Meeting with Arab Medical Union leaders

Upon the invitation of the President of the Kuwait Medical Association, who at the time also chaired the Arab Medical Union, the WMA Chair of Council, Dr Ardis Hoven, and the Secretary General had an opportunity to attend the Scientific Conference of the Kuwait Medical Association and the coinciding meeting of Arab Medical Union leaders. The Chair delivered a presentation on the WMA to the leaders of the Arab Medical Union, most of which are not members of the WMA, and invited them to join. Later the Chair was given the opportunity to participate in a panel discussion about End-of-Life issues, which mainly dealt with the provision of palliative care, the withdrawal or withholding of futile treatment and the respect for patient will (denial of treatment).
In another section, the Secretary General presented the WMA Declarations of Taipei and Geneva.

6. Secondments / internships

The Danish Medical Association seconded Ms Eva Rahbek to the WMA Secretariat at the Council Session in Riga. We have been running an internship programme with the IFMSA since 2013 (3 Interns in 2017 from Poland, Spain and Rwanda), with the University of Pennsylvania since 2014 (2 Interns in 2017) and last year we started an internship programme with the Palack University Olomouc in the Czech Republic (1 intern in 2017).

A call was sent out to IFMSA members in February for two interns for the 2018 spring/summer period and 2 UPENN interns have been accepted for the period from May to August 2018.

CHAPTER IV OPERATIONAL EXCELLENCE

1. Advocacy

In April 2017, the Council decided to discontinue the Advocacy Workgroup and to replace it with a new Advocacy and Communications Advisory Panel with the mission to provide input and guidance to:

- Enhance the promotion of WMA policies and positions among the NMAs and to relevant external organisations, associations, and institutions; and
- Recommend advocacy and communications strategies to increase the visibility and positive impact of WMA policies and activities.

The Panel is chaired by Dr Ashok Zachariah Philip, Malaysian Medical Association and composed of the following members: Israel Medical Association (IsMA), South African Medical Association (SAMA), Spanish Medical Association (CGCoM), American Medical Association (AMA), Japanese Medical Association (JMA), French Medical Association (CNOM), Junior Doctors Network (JDN).

2. Paperless meetings

At its 188th meeting, the WMA Council expressed its desire to reduce its environmental impact by going paperless. Since the 189th Council meeting, documents posted on the website before the meeting have no longer been provided at the venue in print. Council members and officials are responsible for downloading documents from the members' area of the WMA website and bringing them to the meeting via electronic media or on paper, if desired. Documents developed on site during the meeting are available online via a WiFi connection or in print. The Secretariat introduced box.com at the 197th Council meeting as a parallel sharing and synchronizing tool for official WMA documents. In October 2016, the WMA General Assembly in Taipei decided to introduce entirely paperless meetings provided a suitable WiFi connection is available.

3. Governance

A Workgroup on Governance Review was set up at the Council Session in Moscow in 2015 under the chair of Dr Rutger Jan van der Gaag. The Workgroup delivered its final report to the 207th Council in Chicago after extended discussions with Constituent Members. Based on this report, the Secretary General drafted a discussion document for a new Strategic Plan to be considered at the Council Session in Riga.

CHAPTER V ACKNOWLEDGEMENT

The Secretariat wishes to record its appreciation of member associations and individual members for their interest in, and cooperation with, the World Medical Association and its Council during the past year. We thank all those who have represented the WMA at various meetings and gratefully acknowledge the collaboration and guidance received from the officers, as well as the association's editors, its legal, public relations and financial advisors, staff of constituent members, council advisors, associate members, friends of the association, cooperating centres, partner organizations and officials.

We wish to mention the excellent working relationships we have with colleagues and experts in international, regional and national organizations, be they (inter-)governmental or private. We highly appreciate their willingness and efforts to enable our cooperation.

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09.04.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**Council 209/Chair of Council Report/Apr2018** **Report of the Chair of Council (October 2017 – March 2018)**	Original: English
Destination:	209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **To be received**

As we approach the Council meeting in Riga this month, I pause to reflect on the considerable amount of work that has been accomplished by our members and by the WMA. Most recently at the WHO headquarters in Geneva, a Memorandum of Understanding between the WHO and the WMA was signed confirming co-operation on topics of mutual interest including action of the social determinants of health, universal health coverage and the improvement of emergency preparedness. My special thanks to our President, Dr. Yokokura and our Secretary General Dr. Otmar Kloiber on bringing this to fruition.

A very important accomplishment regarding regional meetings on End of Life Care has been achieved, and let me express my personal thanks to those countries who hosted and organized these events. We will be discussing the outcomes of these meetings in Riga and I look forward to this. On a more personal note, I was privileged to be able to attend the meeting at the Vatican and being the beneficiary of the hospitality and kindness afforded to those in attendance by Archbishop Vincenzo Paglia, President of the Pontifical Academy for Life. The diversity of knowledge as presented by medical professionals, legal authorities, experts in palliative care and theologians provided for all of us an extra ordinary experience. A special thank you to the German Medical Association for providing leadership and support for this very important activity.

During the latter part of November, I was the recipient of an invitation to attend the Second Kuwait Medical Association (KMA) Scientific conference. Both Dr. Kloiber and I had the opportunity of meeting with the leadership of the KMA and discussing the value of the WMA thanks to the invitation of Dr. Mohammad Al-Mutairi, President of the Kuwait Medical Association. This was an excellent opportunity to represent the WMA in a part of the world where our representation has been limited.

Of a more local nature, I was invited to speak at a regional Global Health meeting in Ohio, discussing the work of the WMA as related to global health issues. The audience included academics, public health organizations, and medical and dental students many of whom had been engaged in work in a variety of places related to public health and prevention. I had an opportunity to address antimicrobial resistance, the role of the entire medical and veterinarian community in preparedness, the need for educational and training programs in One Health that are multidisciplinary, and a focus on environmental health is necessary. The role that WMA plays in such global work is indeed a challenge but absolutely necessary.

On a final note, in recently writing a publication Foreword on Women's Health in Global Perspective, I was reminded of the barriers to health care and clinical needs that constitute threats to adequate health care for women. With increasing migrant streams caused by war, climate change and economic disruption, women have become targets of abuse, violence and deprivation. Gender based health disparities intensify the need for our role in the Social Determinants of Health globally.

As leaders in Medicine, we have the opportunity and responsibility to lay aside politics and concentrate on the needs of patients and our health care colleagues. As we enjoy the hospitality of Riga, I encourage dialogue around even what we might consider difficult topics. Respect for and encouraging the minority opinion is very desirable. We are diverse in many ways and that we must celebrate.

Respectfully submitted by Ardis Dee Hoven, MD, Chair of Council

06.04.18

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**MEC 209/Agenda/Apr2018/Rev**	Original: English
Title:	**Agenda of the Medical Ethics Committee**	
Destination:	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note:	This agenda is revised on item 3.4 only.	

Thursday, 26 April 2018

Membership of the Committee

Dr Andrew W. GURMAN
Dr David O. BARBE
Dr Michael Bryant GANNON
Dr Thomas SZEKERS
Dr Andrew DEARDEN
Dr Mark PORTER
Dr Shuyang ZHANG
Dr Serafin ROMERO
Dr Heidi STENSMYREN (Chair)
Dr Andreas RUDKJOEBING
Dr Frank-Ulrich MONTGOMERY
Dr Ramin PARSA-PARSI
Dr Ajay KUMAR
Dr Kenji MATSUBARA
Dr Mari MICHINAGA
Dr René HÉMAN
Dr Mzukisi GROOTBOOM

Ex-officio (with voting rights)

Dr Ardis Dee Hoven, *Chair of Council*
Dr Frank Ulrich Montgomery, *Vice-Chair of Council*
Dr Andrew Dearden, *Treasurer*

Ex-officio (without voting rights)

Dr Yoshitake Yokokura, *President*
Dr Leonid Eidelman, *President-Elect*
Dr Ketan Desai, *Immediate Past President*
Dr Otmar Kloiber, *Secretary General*
Ms Marie Colegrave-Juge, *Legal Advisor*
Mr Adolf Hällmayr, *Financial Advisor*
Ms Joelle Balfe, *Facilitator*
Dr Julia Tainijoki, *Medical Advisor*

1. GENERAL BUSINESS

1.1 Call to order by the Chair of Council

1.2 Report of the previous meeting held in Chicago, USA, 11-14 October 2017

Approve: Report of the Medical Ethics Committee (MEC 207/Report/Oct2017)

1.3 Chair's Opening Remark

2. MONITORING REPORT (ORAL)

3. BUSINESS IN PROGRESS

3.1 Declaration of Therapeutic Abortion

Consider: Oral report from the working group.
Proposed revision of WMA Declaration of Therapeutic Abortion
(MEC 209/Therapeutic Abortion COM REV3/Apr2018)

3.2 Ethics of Telemedicine

Consider: Proposed revision of the WMA Statement on the Ethics of Telemedicine
(MEC 209/Ethics of Telemedicine COM REV/Apr2018)

3.3 Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences

Consider: Proposed revision of the WMA Statement Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences
(MEC 209/Licensing Physicians Fleeing Prosecution COM REV/Apr2018)

3.4 Regional Meeting on End-of-Life Question (EoL workshops):

Receive: Oral report from the Secretary General

Report of the Symposium on End-of-Life Questions in Japan, September 2017 (MEC 209/End of Life Japan/Apr2018)

Report of the WMA African region meeting on End-of-Life Questions in Nigeria, September 2017 (MEC 209/End of Life Nigeria/Apr2018)

Report of the WMA South American region meeting on End-of-Life Questions in Brazil 2017 (MEC 209/End of Life Brazil/Apr2018)

Report on the WMA European Region Conference on End-of-Life Questions 2017 (MEC 209/End of Life Europe/Apr2018)

4. NEW BUSINESS

4.1 Genetics and Medicine

Consider: Proposal for a major revision of the WMA Statement on Genetics and Medicine
(MEC 209/Genetic and Medicine/Apr2018)

4.2 Biosimilar Medicinal Products

Consider: Proposed WMA Statement on Biosimilar Medicinal Products
(MEC 209/Biosimilar Medicinal Products/Apr2018)

5. CLASSIFICATION OF 2008 POLICIES

Consider: Recommendations received on MEC Document
(MEC 209/Policy Review 2008/Apr2018)

6. WMA HUMAN RIGHTS

Receive: Oral Report from the WMA Secretariat

7. ANY OTHER BUSINESS

8. ADJOURNMENT

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05.04.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**MEC 207/Report/Oct2017**	Original: English
Title:	**Report of the Medical Ethics Committee**	
Destination:	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**

Wednesday, 11 October 2017

Membership of the Committee

Dr. Andrew W. GURMAN
Dr. David O. BARBE
Dr. Michael Bryant GANNON
Dr. Thomas SZEKERS
Dr. Andrew DEARDEN
Dr. Mark PORTER
Dr. Shuyang ZHANG
Dr. Serafin ROMERO
Dr. Heidi STENSMYREN (Chair)
Dr. Andreas RUDKJOEBING
Dr. Frank-Ulrich MONTGOMERY
Dr. Ramin PARSA-PARSI
Dr. Ajay KUMAR
Prof. Leonid EIDELMAN
Dr. Kenji MATSUBARA
Dr. Mari MICHINAGA
Dr. René HÉMAN
Dr. Mzukisi GROOTBOOM

Ex-officio (with voting rights)

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Prof. Dr. Frank Ulrich Montgomery, *Vice-Chair of Council*
Dr. Andrew Dearden, *Treasurer*

Ex-officio (without voting rights)

Dr Ketan Desai, *President*
Dr. Yoshitake Yokokura, *President-Elect*
Sir Michael Marmot, *Immediate Past President*
Dr Otmar Kloiber, *Secretary General*
Ms. Marie Colegrave-Juge , *Legal Advisor*
Mr. Adolf Hällmayr, *Financial Advisor*
Prof. Vivienne Nathanson, *Facilitator*

1. GENERAL BUSINESS

1.1 The Chair of the Council called the meeting to order at 08:45 on Wednesday October 11, 2017.
1.2 The Committee approved the report of the previous meeting held in Livingstone, Zambia, 20-22 April 2017 (MEC 206/Report/Apr2017).
1.3 Dr Thomas SZEKERES was replaced by Dr Herwig LINDNER**.**

2. MONITORING REPORT (ORAL)

The General Secretary highlighted the importance of including all members in discussions of ethical issues at WMA, especially those who do not regularly attend WMA Council or General Assembly meetings. The recently held regional meetings are a good way to involve these members.

Dr Kloiber noted that there are a number of important issues emerging that impact the medical profession and encouraged members to submit proposed policies on the following topics: clinical independence, commercialisation of health care, artificial intelligence, and new technologies to modify the genome of humans and nano-technology.

3. BUSINESS IN PROGRESS

3.1 Declaration of Geneva

The Committee received an oral report from the Chair of the Workgroup on the Declaration of Geneva, Dr Ramin PARSA-PARSI. He reported on the open consultation in May/June this year and the workgroup meeting in Sweden in September. WMA ethics advisor, Prof Urban WIESING, gave an overview of the history of the declaration and explained the changes proposed by the workgroup.

RECOMMENDATION

3.2.1 That the proposed WMA Declaration of Geneva (MEC 207/ Declaration of Geneva/Oct2017) be approved by Council and forwarded to the General Assembly for adoption.

On the recommendation of the Committee, the Chair of Council agreed to read the Declaration of Geneva at the beginning of each ceremonial session of future General Assemblies. For this year, it will be read at the conclusion of the General Assembly, following adoption of the revision during the plenary session. Further it was decided to present the new version in the conference UNESCO Chair in Bioethics World Conference Bioethics, Medical Ethics & Health Law and 14th World Congress of Bioethics.

3.2 Declaration of Therapeutic Abortion

The Committee received the oral report of Dr Selealo MAMETJA, the chair of the workgroup, and considered the Proposed WMA Declaration of Therapeutic Abortion (MEC 207/Therapeutic Abortion REV2/Oct2017). The workgroup had a meeting shortly before the committee meeting and proposed some additional adjustments to the

document and also that the name of the document be changed from "therapeutic abortion" to "medically indicated abortion".

RECOMMENDATION

3.2.1 That the proposed WMA Declaration of Therapeutic Abortion (MEC 207/Therapeutic Abortion REV2/Oct2017), be circulated to constituent members for comments

3.3 Person Centered Medicine

The Committee considered the proposed WMA Statement on Person Centered Medicine and comments (MEC 207/Person Centered Medicine COM REV/Oct2017)

RECOMMENDATION

3.3.1 That the Council recognize the work on the topic of person centered medicine but that the policy not be pursued at this time.

3.4 Child Abuse

The Committee considered the proposed WMA Statement on Child Abuse and comments (MEC 207/Child Abuse COM REV/Oct2017)

RECOMMENDATION

3.4.1 That the revision of the proposed WMA Statement on Child Abuse and comments (MEC 207/Child Abuse COM REV/Oct2017) be approved by Council and forwarded to the General Assembly for adoption.

3.5 Organ and Tissue Donation

The Committee considered the proposed revision of the WMA Statement on Organ and Tissue and comments (MEC 207/Organ and Tissue Donation COM REV/Oct2017). The Committee will present the statement to the Council for consideration, with an additional proposed amendment to paragraph 17 to clarify language regarding donor consent.

RECOMMENDATION

3.5.1 That the proposed WMA Statement on Organ and Tissue and comments (MEC 207/Organ and Tissue Donation REV2/Oct2017) be approved by Council and forwarded to the General Assembly for adoption, pending agreement of the Council on language in paragraph 17 regarding donor consent.

3.6 Declaration of Hamburg

The Committee considered the proposed minor revision of the WMA Declaration of Hamburg (MEC 207/Declaration of Hamburg/Oct2017)

RECOMMENDATION

3.6.1 That the proposed WMA Declaration of Hamburg (MEC 207/Declaration of Hamburg/Oct2017), be approved by Council and forwarded to the General Assembly for information.

3.7 United Nations Rapporteur on the Independence and Integrity of Health Professionals

The Committee considered the proposed WMA Proposal for a United Nations Rapporteur on the Independence and Integrity of Health Professionals (MEC 207/UN Rapporteur/Oct2017) and the oral report of Ms Clarisse DELORME, WMA Advocacy Advisor, who had met with the ICRC to discuss the relevance of the existing statement.

RECOMMENDATION

3.7.1 That the revision of the proposed WMA Proposal for a United Nations Rapporteur on the Independence and Integrity of Health Professionals (MEC 207/UN Rapporteur/Oct2017) be rescinded and achieved.

3.8 Ethics of Telemedicine

The Committee considered the proposed WMA Statement on the Ethics of Telemedicine (MEC 207/Ethics of Telemedicine/Oct2017)

RECOMMENDATION

3.8.1 That the revision of the proposed WMA Statement on the Ethics of Telemedicine (MEC 207/Ethics of Telemedicine/Oct2017) be circulated to constituent members for comments.

3.9 Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences

The Committee considered the proposed WMA Statement Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences (MEC 207/Licensing Physicians Fleeing Prosecution/Oct2017)

RECOMMENDATION

3.9.1 That the revision of the proposed WMA Statement Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences (MEC 207/Licensing Physicians Fleeing Prosecution/Oct2017) be circulated to constituent members for comments.

3.10 Regional meetings on End-of-Life Question (EoL workshop)

The Committee received an oral report from the Secretary General on the regional meeting in Japan held in September 2017 in conjunction with the CMAAO meeting and with the support of the JMA. He reported that the appetite for discussing euthanasia and physician assisted suicide in the Asia region is very low among most countries, with the exception of Australia and New Zealand. He noted that no medical association attending the meeting has policy that supports euthanasia or physician assisted suicide. He also noted that discussion of unwanted or futile treatment is a topic that is often discussed regionally.
Prof. Ulrich MONTGOMERY informed the Committee about the upcoming End of Life conference in the Vatican in November this year. He stressed that the conference is nearly full and that members interested in attending should contact the German Medical Association immediately.

4. WMA HUMAN RIGHTS

The WMA Advocacy Advisor referred to the Council report (Council 207/SecGen Report/Oct2017) and highlighted the meeting with the UN Special Rapporteur on Health, Dr Dainius PURAS, regarding his latest report on mental health, human rights, and attacks on health professionals. The Executive Committee recommends to invite him to either the next Council meeting or General Assembly in 2018.

In July 2017, the Treaty on the Prohibition of Nuclear Weapons, the first multilateral legally-binding instrument for nuclear disarmament, was adopted. On the occasion of the opening for signature of the Treaty, the IPPN together with the WMA, the International Council of Nurses and the World Federation of Public Health Associations, adopted a joint Statement urging Member States to sign the Treaty and to ratify it as soon as possible so that it can enter into force.

5. ANY OTHER BUISNESS

5.1 The Secretary General reminded the committee that WMA has three policies related to capital punishment:

- WMA Resolution on Physician Participation in Capital Punishment
- WMA Resolution to Reaffirm the WMA's Prohibition of Physician Participation in Capital Punishment
- WMA Statement on the United Nations Resolution for a Moratorium on the Use of the Death Penalty

6. ADJOURNMENT

The meeting was adjourned at 11:40 on Wednesday 11th October to report back to the Council.

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12.10.2017

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**MEC 209/Therapeutic Abortion COM REV3/Apr2018** **Proposed revision of WMA Declaration on Therapeutic Abortion**	Original: English
Destination:	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**
Note:	As part of the annual policy review process, the Council in Buenos Aires (April 2016) decided that the WMA Declaration on Therapeutic Abortion should be reaffirmed with minor revision. The WMA secretariat submitted a revision to the 204th Council session in Taipei (October 2016). The Council decided to circulate this version to WMA members for comments. Given the controversies of opinions reflected in the comments from members, the Council appointed a workgroup with South Africa as the chair. This version is the compilation from the working group. The 207th Council session in Chicago (October 2017) considered the version proposed by the workgroup and decided to circulate it within WMA membership for comments.	

Abbreviation key:

AM	Associate Members
AMA	American Medical Association
AMV	Associazione Medica del Vaticano
BMA	British Medical Association

CGCM	Consejo General de Colegios Médicos de Espana
CMA	Canadian Medical Association
CNOM	Conseil National de l'Ordre des Médecins, France
DMA	Danish Medical Association
FMA	Finnish Medical Association
GMA	Bundesärztekammer (German Medical Association)
IsMA	Israeli Medical Association
NMA	Norwegian Medical Association
PCPD	Polish Chamber of Physicians and Dentists (Naczelna Izba Lekarska)
RDMA	Royal Dutch Medical Association
SwMA	Swedish Medical Association
TuMA	Turkish Medical Association

GENERAL COMMENTS	
AM	The Associate Members had a lively and respectful discussion about this difficult topic. We believe limiting it to medically-indicated abortion may make it easier to come to a satisfactory conclusion. The Associate Members are divided about a single issue in this document. It is the issue about referral. All of us believe physicians who are not comfortable or capable performing abortions should not have to do so. Some physicians feel that it is against their personal moral convictions to have to refer someone for a procedure the referring physician feels is immoral. Alternative language acceptable to these physicians is proposed as an alternative paragraph 8 (1). We are also including an additional alternative (2) that further defines medically-induced abortions using the terms “direct” and “indirect”. Other AMs feel just as strongly that these physicians, with a moral objection to medically-indicated abortion, should still have to help the patient get the necessary medical treatment. Those physicians feel the alternative language allows physicians to behave unethically to their patients because of their personal moral beliefs, not necessarily shared by the patient. They feel that the disagreeing physician has to help the patient find needed care. We do not endorse either version of paragraph 8, but leave it to the rest of the process to make the final decision on how to word paragraph 8. Other minor suggestions are included for consistency and clarity.
AMV	As we have previously stressed, the medical establishment should work towards protecting and promoting every human life (born and unborn). Considering the importance of the mother’s interests, we cannot accept the interruption of pregnancy before viability outside the case of a risk for the woman’s life or a grave health problem. This declaration also undermines the physician’s right to conscientious objection by forcing referrals to other physicians.
BMA	We welcome this revision of the declaration which addresses our previous comments on MEC 204. We have reservations regarding the changed title of the declaration to ‘medically-indicated abortion’ which is potentially ambiguous and value laden in terms of grounds for an abortion. For example, some might argue that abortion is rarely and only in extremis ‘medically-indicated’ when the health risks of pregnancy and childbirth are over and above that which would normally be expected; not taking into account the inherent risks of pregnancy and childbirth for women, and/or the particular circumstances of a woman and her family (for example, the pregnancy is a consequence of rape). The BMA currently refers to ‘induced abortion’, and would suggest this becomes the title.

	Keywords: Abortion, Pregnancy, ~~Mother,~~ Respect, Autonomy, Fundamental Right [*Within the context of abortion, the term 'mother' can be seen as emotive. A pregnant woman is not a mother until she gives birth.]*
CNOM	The CNOM (French Medical Council) thanks the working group for this new version but cannot support it as it is.
DMA	The Danish Medical Association supports the revised version of this declaration. We have two minor suggestions: In section 2, we would suggest deleting "between the patient and the physician" so that the sentence ends after "matter". And, in light of the change in title, in section 9 we would suggest changing "therapeutic abortion" to "medically indicated abortion". *[Note: those comments have been added in the table below]*
FMA	FMA can accept the revised document. We have one minor comment to the text: Para 9: to change wording to medically-indicated instead of therapeutic. *[Note: this comment has been added in the table below]*
GMA	The GMA has incorporated a small number of suggested editorial revisions below. *[Note: those comments have been added in the table below]*
NMA	NMA supports this document, but suggest one new item under Recommendations
PCPD	The Polish Chamber of Physicians and Dentists is of the opinion that physicians have a right to conscientious objection to providing certain medical services and those medical doctors who do not provide certain services may not be disciplined or discriminated against which should be safeguarded by national laws by the so called "conscience clause". Abortion is one of the medical procedures that is most often associated with the issue of conscientious objection. The Polish Chamber, therefore welcomes clear reference to the physicians' right to conscientious objection to providing abortion. As the Polish Constitutional Court stated in its judgment of 7 October 2015 in the proceedings initiated by the Polish Chamber it is not only the physician's right but it is the physician's duty to act according to his / her conscience. Acting against physician's conscience may be required only in cases where a delay in providing medical assistance would result in posing danger to life or serious harm. At the same time the Constitutional Court said that it is against the Polish constitution to require that a doctor who objects to provide abortion has to refer the woman to another easily accessible physician or health facility willing to perform abortion. As the Court indicated this would unproportionally infringe the physician's conscience. Also it is not a duty of a physician to gather and provide information about other physicians who do not object to perform abortion – in fact gathering such information by a physician could constitute a breach of other laws. This kind of information should be provided to patients by those who are in charge of running the healthcare system (public authorities, healthcare facility management, National Health Fund) and not by individual doctors whose conscience does not allow them to participate in abortion. The reasoning of this verdict should be fully supported, therefore the Polish Chamber proposes to amend points 8 and 9 by deleting second sentence in point 8, rephrasing the third sentence in point 8 and deleting point 9 which puts an obligation on all doctors despite their ethical convictions. In those cases where medically-indicated abortion is legally allowed it should be performed by a competent physician in approved healthcare facilities – these procedures should not be delegated to other health care professions. Therefore the Polish Chamber proposes to amend point 5 of the draft by deleting the part "or other health care worker". *[Note: this specific comment about paragraphs 5, 8 and 9 have been added in the table below]*
RDMA	Preliminary question: How does this declaration relate to the declaration on the WMA-website, WMA Declaration of Oslo on Therapeutic Abortion Adopted by the 24th World Medical Assembly, Oslo, Norway, August 1970 and amended by the 35th World Medical Assembly, Venice, Italy, October 1983 and the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006 1. The WMA requires the physician to maintain respect for human life.

	2. Circumstances bringing the interests of a mother into conflict with the interests of her unborn child create a dilemma and raise the question as to whether or not the pregnancy should be deliberately terminated. 3. Diversity of responses to such situations is due in part to the diversity of attitudes towards the life of the unborn child. This is a matter of individual conviction and conscience that must be respected. 4. It is not the role of the medical profession to determine the attitudes and rules of any particular state or community in this matter, but it is our duty to attempt both to ensure the protection of our patients and to safeguard the rights of the physician within society. 5. Therefore, where the law allows therapeutic abortion to be performed, the procedure should be performed by a physician competent to do so in premises approved by the appropriate authority. 6. If the physician's convictions do not allow him or her to advise or perform an abortion, he or she may withdraw while ensuring the continuity of medical care by a qualified colleague. Is there a more recent version? Otherwise we don't understand the changes made to this declaration being 'reaffirmed with minor revision'.
SwMA	This is a proposed revision of the existing *WMA Declaration on therapeutic abortion*. The existing policy is not entirely clear as to whether its scope is only abortions performed due to medical reasons or if it also covers other situations where a pregnancy is terminated following a request by the pregnant woman. The SMA would like to stress that it is of utmost importance that the change of terminology – from "therapeutic abortion" to "medically-indicated abortion" – in the revised version must not in any way be interpreted as if the WMA opposes other abortions than strictly medically-indicated ones.

*Numbering will be deleted (or adjusted) when the revised text is adopted.

No	**Proposed Text:** **MEC 207/Therapeutic Abortion REV2/Oct2017**	**Specific Comments** **Additions: <u>bold/underlined</u>** **Deletions: ~~lined-out~~** **Comments only: *[italic]***	**Proposed Revised Text by: Rapporteur** **MEC 209/ Therapeutic Abortion REV3/Apr2018**
Title	WMA Declaration on Medically-Indicated Abortion	WMA Declaration on ~~therapeutic~~ **<u>Medically-Indicated Termination</u>** [CNOM]	**Medically-Indicated Termination of Pregnancy**: (*most of peer-review literature around medical indications uses the term*)
	PREAMBLE		
		[New paragraph]: **<u>The doctor should always bear in mind that the first moral principle imposed upon him is to respect human life (born and unborn)</u>** [AMV]	
1.	Medically-indicated abortion refers to interruption of pregnancy due to health reasons, in accordance with evidence-	Medically-indicated abortion refers to interruption of pregnancy due to **<u>serious</u>** health reasons, in accordance with evidence-based medicine principles and ~~good~~ **<u>current</u>**	Medically-indicated termination of pregnancy refers to interruption of pregnancy due to health reasons, in

	based medicine principles and good clinical practice.	clinical practice. [AMV] **<u>For the purpose of this declaration m</u>**edically-indicated abortion refers to interruption of pregnancy due to health reasons, in accordance with evidence-based medicine principles and good clinical practice. [SwMA] Medically-indicated abortion refers to interruption of pregnancy due to health reasons [*It is necessary to explain the term 'medically indicated abortion' (the same holds for therapeutic abortion, since that term is unclear also). Does 'medically indicated' include: abortion induced because of the mother's physical or mental health, of social reasons and to prevent the birth of an affected child?*] … [RDMA] Medically-indicated abortion refers to interruption of pregnancy due to health reasons, in accordance with evidence-based ~~medicine~~ **<u>medical</u>** principles and good clinical practice. [CMA] Medically-indicated abortion refers to interruption of pregnancy due to health reasons, in accordance with **<u>principles of</u>** evidence-based medicine ~~principles~~ and good clinical practice. [GMA] Medically-indicated abortion refers to interruption of pregnancy due to health reasons **<u>for the mother</u>**, in accordance with evidence-based medicine principles ~~and good clinical practice.~~ [CGCM] Medically-indicated abortion refers to interruption of pregnancy due to health reasons … [IsMA*: are you referring to the health of the fetus, mother or both ?*]	accordance with principles of evidence-based medicine and good clinical practice

2.	Abortion is a medical matter between the patient and the physician. Attitudes toward abortion are a matter of individual conviction and conscience that must be respected.	*[Delete paragraph]* [SwMA] *[Delete paragraph; abortion is not only about "individual conviction and conscience". Medicine has a lot to say concerning fetal life]* [AMV] **Medically-indicated** ~~A~~**a**bortion is a medical matter between the patient and the physician …[AM] Abortion is a medical matter ~~between the patient and the physician~~ … [DMA] … Attitudes toward abortion are a matter of individual conviction and conscience that ~~must~~**should** be respected. [BMA] [*The BMA supports the right of doctors to have a conscientious objection to abortion and believes that such doctors should not be marginalised because of their beliefs. This is, however, a qualified right with some specific limitations. As noted in the new paragraph 8 - to save a woman's life – and, therefore, the term 'should' rather than 'must' would be preferable.]* [BMA] ~~Abortion~~**Medically-indicated abortion** is a medical matter between the patient and the physician. Attitudes toward abortion are a matter of individual ~~conviction and conscience~~**values** that must be respected. [CGCM] Abortion is a medical matter between the patient and the physician~~. Attitudes toward abortion are a matter of individual conviction and conscience that must be respected~~. [CNOM]	Termination of pregnancy is a medical matter between the patient and the physician. Attitudes toward termination of pregnancy are a matter of individual conviction and conscience that should be respected.

3.	Circumstances where the interest of a woman is in conflict with the interests of her unborn fetus may create a dilemma as to whether or not the pregnancy should be deliberately terminated. The diversity of responses to such situations is due in part to the diversity of attitudes towards the life of the fetus, for various reasons including cultural, religious and traditional.	Circumstances where the interest of a woman is in conflict with the interests of her unborn fetus ~~may create a dilemma~~ **raise the question** as to whether or not the pregnancy should be deliberately terminated. The diversity of ~~responses~~ **attitudes** to such situations is due in part to ~~the diversity of attitudes~~ **differing views** towards **the woman´s autonomy and** the life of the fetus~~, for various reasons including cultural, religious and traditional~~. [SwMA] Circumstances where the ~~interest~~ **life** of a woman is in conflict with the ~~interests~~**life** of her unborn fetus may create a dilemma as to whether or not the pregnancy should be deliberately terminated. The diversity of responses to such situations is due in part to the diversity of attitudes towards the life of the fetus, for various reasons including cultural, religious and traditional. [AMV] Circumstances - where the interest **in pursuing a pregnancy which puts the woman's life at risk** ~~of a woman is in conflict with the interests of her unborn fetus~~ - may create a dilemma as to whether or not the pregnancy should be deliberately terminated. The diversity of responses to such situations is due in part to the diversity of attitudes towards the life of the fetus, for various reasons including **medical,** cultural, religious and traditional. [CNOM]	A circumstance where the patient may be harmed by carrying the pregnancy to term presents a conflict between the life of the foetus and the health of the pregnant woman. Diverse responses to resolve this dilemma ~~situation~~ reflect the diverse cultural, legal, traditional, and regional standards of medical care throughout the world
	RECOMMENDATIONS		**RECOMMENDATIONS**

4.	Doctors should be aware of local abortion laws, regulations and reporting requirements. National laws, norms, standards, and clinical practice related to abortion should promote and protect women's health and their human rights, voluntary informed consent, and autonomy in decision-making, confidentiality and privacy. National medical associations should advocate that national health policy upholds these principles.	Doctors ~~should~~ **need to** be aware of local abortion laws, regulations and reporting requirements. National laws, norms, standards, and clinical practice related to abortion ~~should~~ **must** promote and protect women's health and their human rights, voluntary informed consent, ~~and~~ autonomy in decision-making, confidentiality and privacy. National **M**~~m~~edical **A**~~a~~ssociations should advocate that national health policy upholds these principles. [SwMA] Doctors should be aware of local abortion laws, regulations and reporting requirements. National laws, norms, standards, and clinical practice **should promote and protect every person's health** ~~related to abortion should promote and protect women~~'s health and their human rights, voluntary informed consent, and autonomy in decision-making, confidentiality and privacy. National medical associations should advocate that national health policy upholds these principles. [AMV] ~~Doctors~~ **Physicians** should be aware of local abortion laws, regulations and reporting requirements. National laws, norms, standards, and clinical practice related to abortion should ~~promote and~~ protect women's health**, dignity,** ~~and~~ their human rights, voluntary informed consent, and autonomy in decision-making, confidentiality and privacy… [AM] Doctors should be aware of local abortion laws **and ethical norms**, regulations and reporting requirements **thereof**. National laws, norms, standards, and clinical practice related to abortion should promote and protect women's health and their ~~human~~ rights, **as well as respect** voluntary informed consent, and autonomy in decision-making,	Physicians should be aware of local termination of pregnancy laws, regulations and reporting requirements. National laws, norms, standards, and clinical practice related to ~~termination~~ of pregnancy should promote and protect women's health, dignity and their human rights, voluntary informed consent, and autonomy in decision-making, confidentiality and privacy. National medical associations should advocate that national health policy upholds these principles.

		maintaining medical confidentiality and privacy. National medical associations should advocate that national health policy upholds**, promotes and complies with** these principles. [CGCM] Doctors should be aware of local abortion laws, regulations and reporting requirements **relating to medically-indicated termination**. National laws, norms, standards, and clinical practice related to **medically-indicated termination** should promote and protect women's health and their human rights, voluntary informed consent, and autonomy in decision-making, confidentiality and privacy. … [CNOM]	
		[Added paragraph:] **Women who decide to terminate pregnancy should not be punished. National Medical Associations and physicians should speak out against legislation and practices that are in opposition to this fundamental right.** *[It is important that women are not punished if they decide to terminate pregnancy]* [NMA]	
5.	Where the law allows medically-indicated abortion to be performed, the procedure should be performed by a competent physician or other health care worker in accordance with evidence-based medicine principles and good medical practice in an approved facility that meets necessary medical standards	Where the law allows ~~medically-indicated~~ abortion to be performed, the procedure should be performed by a competent physician or other health care worker in accordance with evidence-based medicine principles and good medical practice in an approved facility that meets necessary medical standards. [SwMA] Where the law allows medically-indicated abortion to be performed, the procedure should be performed by a competent physician or other health care worker in accordance with evidence-based medicine principles and ~~good~~ **current** medical practice in an approved facility that	Where the law allows medically-indicated termination of pregnancy to be performed, the procedure should be performed by a competent physician or other health care worker in accordance with evidence-based medicine principles and good medical practice in an approved facility that meets required medical standards

		meets necessary medical standards. [AMV] Where the law allows medically-indicated abortion to be performed, the procedure should be performed by a competent physician ~~or other health care worker~~ in accordance with … [PCPD] Where the law allows medically-indicated abortion to be performed, the procedure should be performed by a competent physician or other health care worker in accordance with **principles of** evidence-based medicine ~~principles~~ and good medical practice in an approved facility that meets necessary medical standards**.** [GMA] Where the law allows medically-indicated abortion to be performed, the procedure should be performed by a competent physician or other health care worker in accordance with evidence-based medicine principles and good medical practice in an ~~approved facility~~**appropriate health centre** that meets necessary medical standards. [CGCM] Where the law allows medically indicated abortion to be performed, the procedure should be performed by a competent physician or other health care worker in accordance with evidence-based medicine principles and good ~~medical~~ **clinical** practice in an approved facility that meets ~~necessary~~ **required** medical standards. [AMA]	
6.	The convictions of both the doctors and the patient must be respected.	*[Delete paragraph]* [SwMA] The convictions of both ~~the doctors and~~ the patient **and physician** must be respected. [AM]	The convictions of both the physician and the patient should be respected

		The convictions of both the doctors and the patient ~~must~~**should** be respected. [BMA] *[See note on para 2.]* [BMA] The convictions **and values** of both the doctors and the patient must be respected. [CGCM] *[Delete paragraph; combined with 7]* [AMA]	
7.	Patients with moral convictions must be supported appropriately and provided with necessary medical and psychological treatment.	*[Delete paragraph]* [SwMA] Patients ~~with moral convictions~~ must be supported appropriately and provided with necessary medical and psychological treatment **along with appropriate counselling and spiritual support if desired**. [AM] Patients ~~with moral convictions~~ must be supported appropriately and **offered** ~~provided with~~ necessary medical and psychological treatment. [BMA] Patients with moral convictions *[Is meant: moral convictions against abortion?]* must be supported appropriately and provided with necessary medical and psychological treatment. [RDMA] Patients with moral ~~convictions~~ **conflicts** must be supported appropriately and provided with necessary medical and psychological treatment. [GMA] Patients with moral ~~convictions~~ **objections against abortion that need to undergo this treatment** must be supported appropriately and provided with ~~necessary~~**the**	Patients with moral convictions against medically-indicated abortion must be supported appropriately and provided with necessary medical and psychological treatment along with appropriate spiritual support if desired

		appropriate medical and psychological treatment. [CGCM] Patients **and physicians** with moral convictions must be **respected,** supported appropriately and provided with necessary ~~medical and psychological~~ treatment**s, including psychological support**. [AMA] Patients with moral convictions must be supported appropriately and provided with **the** necessary medical and psychological treatment. [CNOM]	
		The doctor must provide pregnant women with adequate, reliable and complete information on the evolution of pregnancy and fetal development. It is not in accordance with medical ethics to deny, hide or manipulate information to influence the mother's decision about the continuity of her pregnancy. [CGCM]	*Covered under no.4 voluntary consent*
8.	Individual doctors have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. In such cases, the physician must refer the woman to a willing and trained health professional in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the physician who objects, must provide safe abortion or perform whatever	~~Individual doctors have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny~~ **Physicians who, for reasons of conscience, will not perform abortions must never in any way let their personal convictions interfere with or delay a woman´s** access to lawful abortion services ~~because it delays care for women, putting their health and life at risk~~. In such cases, the physician must **without delay** refer the woman to a willing and trained health professional in the same~~,~~ or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the physician who objects, must provide safe abortion or perform whatever procedure is necessary to ~~save the woman's life and to~~ prevent serious injury to ~~her~~	Physicians have a right to conscientious objection to advising or performing an abortion; therefore, they may withdraw while ensuring the continuity of medical care by a qualified colleague. In all cases, ~~doctors~~ physician must perform those procedures necessary to save the woman's life and to prevent serious injury to her health

	procedure is necessary to save the woman's life and to prevent serious injury to her health[1].	**the woman´s** health[1]. [SwMA] Individual ~~doctors~~**physicians** have a right to conscientious objection to providing **medically-indicated** abortion, but that right does not entitle them to impede or deny access to lawful **medically-indicated** abortion services because it delays care for women, putting their health and life at risk…Where referral is not possible, the physician who objects**, if capable,** must provide safe abortion or perfom whatever procedure is necessary to save the woman's life and to prevent serious injury to her health. [AM] [*Alternative language (1) also proposed for this paragraph, see the general comments at the top of the document:*] **Individual physicians have a right to conscientious objection to providing medically-indicated abortion, but that right does not entitle those physicians to impede or deny access to lawful medically-indicated abortion services. In such cases, the physician must make the objection known to their patient and leave her free to consult another physician or other health professional. The physician may withdraw while ensuring the continuity of medical care by a qualified colleague. The objecting physician may also announce publically the refusal to participate in abortion, warning women not to seek abortion services where they are not provided.** [AM] [*Alternative language (2)*]: **Individual physicians have a right to conscientious objection to providing elective abortions while supporting medically indicated**	

[1] Safe abortion: technical and policy guidance for health systems. Second Ed. World Health Organization; 2012

		indirect abortions to save the life of mother. However, that right does not entitle those physicians to impede or deny access to lawful elective abortion services. In such cases, the physician must make the objection known to their patient and leave her free to consult another physician or other health professional. The physician may withdraw while ensuring the continuity of medical care by a qualified colleague. The objecting physician may also announce publically the refusal to participate in elective abortions, warning women not to seek abortion services where they are not provided. [AM] Individual doctors have a right to conscientious objection **to advising or performing an abortion; therefore, they may withdraw while ensuring the continuity of medical care by a qualified colleague. In all cases, doctors must perform those procedures necessary to save the woman's life and to prevent serious injury to her health** ~~to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. In such cases, the physician must refer the woman to a willing and trained health professional in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the physician who objects, must provide safe abortion or perfom whatever procedure is necessary to save the woman's life and to prevent serious injury to her health~~[2]. [AMV] … Where *[Does this mean that if abortion is necessary to*	

[2] Safe abortion: technical and policy guidance for health systems. Second Ed. World Health Organization; 2012

		save the woman's life or health, that in that case the physician has to perform the abortion nonetheless? If so, it may be better in that situation not to speak of 'abortion', since the aim is not to terminate the pregnancy, but to save the woman's life or to prevent serious injury to her. The abortion is than a consequence of that procedure. A proposal to redefine this therefore is: If, in order to save the woman's life or to prevent serious injury to her health (maternal indication), it is necessary to perform a procedure that results in terminating the pregnancy, the physician who objects to providing abortion has to perform this procedure if referral to another physician is not possible.] … [RDMA] … ~~In such cases, the physician must refer the woman to a willing and trained health professional in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, t~~**T**he physician ~~who objects, must~~ **may not refuse to provide medical care, including to** provide safe abortion or perform whatever procedure is necessary, **only when a delay would result in posing danger to life or serious harm** ~~to save the woman's life and to prevent serious injury to her~~ health[3]. [PCPD] *[Alternatively, the second sentence of point 8 may be amended as follows:]* … In such cases, the physician **should inform in due time the patient as well as the physician's employer of the objection to perform abortion,**~~must refer the woman to a willing and trained health professional in the same, or another easily accessible~~	

[3] Safe abortion: technical and policy guidance for health systems. Second Ed. World Health Organization; 2012

		~~health-care facility,~~ in accordance with national law… [PCPD] Individual doctors have a right to conscientious objection to providing abortion, *[If the abortion is a medical necessity, then physician should provide that service, so there should be no right to refuse in this case]* … [TuMA] Individual doctors have a right to conscientious objection to providing abortion, but ~~that right does not entitle them to~~**they may not under any circumstances** impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. *[Second and third sentences of this paragraph deleted and replaced by:]* **If the physician's convictions do not allow him or her to advise or perform an abortion, he or she may withdraw while ensuring the continuity of medical care by a qualified colleague.** *[*CMA*: The CMA does not support mandatory referral, as recommended in this draft. We are unaware of any empirical evidence that such an approach is required in order to ensure equitable access to care. However, many physicians will see the obligation to refer to a willing provider as being morally equivalent to the act of performing the procedure itself.]* Individual doctors have a right to conscientious objection ~~to providing~~ **regarding** abortion, but that right does not entitle them to impede or deny access to ~~lawful abortion services~~**healthcare services and professionals equipped to carry out the legal abortion** because it delays care for women, putting their health and life at risk. ... Where referral is not possible, the **objecting** physician ~~who objects~~, must provide safe abortion or perfom whatever	

		procedure is necessary to save the woman's life and to prevent serious injury to her health[4]. [CGCM] *[Delete paragraph and replace by:]* **Neither physician or hospital personnel shall be required to perform any act that violates personally held moral principles. In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer.** [AMA] … In such cases, the physician ~~must~~ **should** refer the woman … [IsMA] Individual doctors have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to **medically-indicated termination** ~~lawful abortion~~ services because it delays care for women, putting their health and life at risk. In such cases, the physician must refer the woman to a willing and trained health professional ~~in the same, or another easily accessible health-care facility~~, in accordance with national law. Where referral is not possible, the physician who objects, must provide safe abortion or perfom whatever procedure is necessary to save the woman's life and to prevent serious injury to her health[5]. *[Comment about this last sentence: This is not the case in France: French Medical Ethics Code: Article 18 (article R.4127-18 of the CSP): A doctor may only perform a voluntary termination of pregnancy in accordance with the law. He is always free to refuse to do so and, if so, must inform the person*	

[4] Safe abortion: technical and policy guidance for health systems. Second Ed. World Health Organization; 2012

[5] Safe abortion: technical and policy guidance for health systems. Second Ed. World Health Organization; 2012

		concerned of his decision in accordance with the law and within the timeframe required by law.] [CNOM]	
9.	Physicians must work with society to seek to ensure that no woman loses her life because therapeutic abortion services are unavailable, even in extreme circumstances.	Physicians must work with society to seek to ensure that no woman ~~loses her life~~ **suffers harm** because ~~therapeutic~~ abortion services are unavailable~~, even in extreme circumstances~~. [SwMA] Physicians must work with society to seek to ensure that no woman loses her life because ~~therapeutic~~ **medically-indicated** abortion **and pregnancy** services are unavailable~~, even in extreme circumstances~~. [AM] Physicians must work with society to seek to ensure that ~~no woman loses her life because therapeutic abortion services~~ **no person loses his/her life because healthcare centers** are unavailable, even in extreme circumstances. [AMV] Physicians must work with society to seek to ensure that no woman loses her life because ~~therapeutic~~ **medically-indicated** abortion services are unavailable, even in extreme circumstances. [RDMA, FMA, CGCM, DMA] *[Delete paragraph]* [PCPD] Physicians must work with **the relevant institutions and authorities**~~society to seek~~ to ensure that no woman loses her life because ~~therapeutic~~ **medically-indicated** abortion services are unavailable, even in extreme circumstances. [GMA] Physicians must work with society ~~to seek~~ to ensure that no woman loses her life because ~~therapeutic~~ **medically**	Physicians must work with relevant institutions and authorities to ensure that no woman is harmed because medically-indicated termination of pregnancy services are unavailable.

		indicated abortion services are unavailable, even in extreme circumstances. [AMA]	
		[Added paragraph:] **Public health systems must develop medical care systems that enable medically-indicated abortion in order to avoid putting the pregnant woman's health at risk in cases where this treatment is indicated.** [CGCM]	*Covered above*
		[Added paragraph:] **In all his/her actions the doctor is obliged to safeguard the dignity and integrity of the women under his/her care.** [CGCM]	*Covered in number 4*

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08.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**MEC 209/Ethics of Telemedicine COM REV/Apr2018** **Proposed revision of WMA Statement on the Ethics of Telemedicine**	Original: English
Destination	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**
Note:	As part of the annual policy review process, the Council in Livingstone (April 2017) decided that the WMA Statement on the Ethics of Telemedicine should undergo a major revision. The South African Medical Association (SAMA) volunteered to undertake that work. The 207th Council session in Chicago (October 2017) considered the proposal and decided to circulate it within WMA membership for comments.	
Related WMA statements	• WMA Statement on Guiding Principles for the Use of Telehealth for the Provision of Health Care. *Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009* • WMA Statement on Mobile Health *Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015*	

Abbreviation key:

AM	Associate Members
AMA	American Medical Association

AMV	Associazione Medica del Vaticano
BMA	British Medical Association
CGCM	Consejo General de Colegios Médicos de Espana
CMA	Canadian Medical Association
CNOM	Conseil National de l'Ordre des Médecins, France
DMA	Danish Medical Association
FMA	Finnish Medical Association
IsMA	Israel Medical Association
KMA	Korean Medical Association
NMA	Norwegian Medical Association
NZMA	New Zealand Medical Association
RDMA	Royal Dutch Medical Association
SAMA	South African Medical Association
SwMA	Swedish Medical Association

GENERAL COMMENTS	
BMA	It could be helpful if the document specified more clearly what kind of doctor-patient interaction it covers, for example does it include the range of phone apps for video consultations? If so, the document arguably limits the potential scope of circumstances in which teleservices services could be beneficial to patients and the wider health system. *[Comments on specific paragraphs below]*
CNOM	The CNOM (French Medical Council) supports this proposal and thanks the SAMA for its excellent work
DMA	The DMA supports this very relevant statement. We have two specific suggestions: Firstly, in section 4.1 – at the very end of that section – we would suggest adding the phrase "and increase social inequality on medicine". So that it read: "Telemedicine technologies could be unaffordable to patients and hence impede access and increase social inequality on medicine. Secondly, in section 7 – we would like to add "patient competencies". So that it reads: Telemedicine should be tailor-made to patient competencies and local contexts, including regulatory frameworks. *[Note: those comments have been added in the table below]*
FMA	FMA thanks SAMA for the draft revision of this statement. We understand that countries are in different stages in utilizing telemedicine. However, we see that the use of telemedicine will increase in the future and it will provide viable and cost-effective options in patient care. Therefore, we propose some minor amendments to the text that would recognize this gradual change in health care practices.
KMA	Regarding the liability of physicians, it is not realistic to impose the duty of confirming the use of telecommunication system and necessary instruments for telemedicine application by a patient, a medical expert, or family members caring for the patient on physicians since it is not their field of expertise. Therefore, it is necessary to amend the contents.
NMA	The Norwegian Medical Association supports this document with one amendment in item 4.1.
NZMA	We are generally supportive of the content in this revised statement and have no specific amendments. However, we note that the statement does not address consultations across jurisdictions. We believe it would be useful for the next iteration to attempt to address the

	complexities and potential pitfalls of the long-distance provision of health care and advice when patient and doctor are in different countries.
RDMA	Preliminary question: The RDMA does not see ANY changes in this Statement compared to the one that is adopted in 2007 and available on the WMA-website. It seems to be exactly the same. Is this the right version? General comment: This statement does not differentiate between 1) the situation that telemedicine is the one and only possible practice of medicine in a certain case, and 2) the situation that telemedicine is a choice/preference of the physician, whereas a face-to-face is still possible / available. This makes the Statement unclear with regard to wat CAN be done and what SHOULD be done.
SwMA	We would like to suggest adding a reference to related WMA policies in the preamble (WMA Statement on mobile health, WMA Statement on guiding principles for the use of telehealth for the provision of health care). Regarding terminology, we are a bit unsure if telemedicine is the best and most up-to-date term. If not, perhaps it could be substituted for "digital medicine", "tele- and digital techniques in health care" or something similar?

Numbering will be deleted (or adjusted) when the revised text is adopted.

No	**Proposed Text:** **MEC 207/Ethics of Telemedicine/Oct2017**	**Specific Comments** **Additions: bold/underlined** **Deletions: ~~lined-out~~** **Comments only: *[italic]***	**Proposed Revised Text by:** **Rapporteur** **MEC 209/Ethics of Telemedicine REV/Apr2018**
Title	**WMA Statement on the Ethics of Telemedicine**		**WMA Statement on the Ethics of Telemedicine**
	DEFINITION		**DEFINITION**
1.	Telemedicine is the practice of medicine over a distance, in which interventions, diagnostic and treatment decisions and recommendations are based on data, documents and other information transmitted through telecommunication systems.	Telemedicine is the practice of medicine over a distance **and a new patient - physician relation instrument**, in which ~~interventions,~~ diagnostic and treatment **interventions**~~decisions~~ and **medical** recommendations are based on data, documents and other information transmitted through telecommunication systems **such as the internet, information networks, mobile telephones, social media or other media not requiring a personal presence of a similar nature as telemedicine refers to both the transfer of data between the physician and**	Telemedicine is the practice of medicine over a distance, in which interventions, diagnoses, therapeutic decisions, and subsequent treatment recommendations are based on patient data, documents and other information transmitted through telecommunication systems. Telemedicine can take place between a physician and a patient or between two or more physicians including other healthcare professionals.

		the patient and the transfer of data between physicians. [CGCM] Telemedicine is the practice of medicine over a distance, in which interventions, diagno**ses**,~~tic~~ ~~and~~ ~~treatment~~ **therapeutic** decisions**,** and **subsequent treatment** recommendations are based on **patient** data, documents and other information transmitted through telecommunication systems. [AMA]	
	PREAMBLE		**PREAMBLE**
2.	The development and implementation of information and communication technology are creating new modalities for providing care for patients. These enabling tools offer different ways of practising medicine. The adoption of telemedicine is justified because of its speed, and its capacity to reach patients with limited access to medical assistance, in addition to its power to improve health care.	*[WE SUGGEST ANOTHER PARAGRAPH HERE:]* **The face to face clinical encounter is the paradigm for good Medicine. Doctors will try to protect this important aspect of the patient-doctor relationship.** [AMV] *[Added text:]…* **It is used for patients who cannot see an appropriate physician because of inaccessibility due to distance, physical disability, employment, family commitments (including caring for others), cost, and physician schedules.** [AM] The development and implementation of information and communication technology are creating new modalities for providing care for patients. These **new methods of communication with** enabling tools **that provide new** ~~offer different~~ ways of practising medicine. The adoption of telemedicine **and other telematic media** is justified because of its speed, and its capacity to ~~reach~~**contact** patients with limited access to medical assistance, in addition to ~~its power to improve~~**the possibility of improving** health care. [CGCM] The development and implementation of information and communication technology are creating new **ways**	The development and implementation of information and communication technology are creating new and different ways for of practicing medicine. Telemedicine is used for patients who cannot see an appropriate physician timeously because of inaccessibility due to distance, physical disability, employment, family commitments (including caring for others), patients' cost and physician schedules. It has capacity to reach patients with limited access to medical assistance and have potential to improve health care.

		~~modalities~~ for providing **patient care.** ~~care for patients~~. ~~These enabling tools~~ **This continuum of technologies** offer**s new and** different ways of practising medicine. The adoption of telemedicine ~~is justified~~ **should be encouraged** because of its speed, and its capacity to reach patients with limited access to medical assistance, **Telemedicine has the potential to** ~~in addition to its power to~~ improve health care. [AMA]	
New			Face-to -face consultation between physician and patient remains the gold standard of clinical care. Telemedicine may hinder the ability of a physician to physically examine and may result in unintended harm.
NEW			The delivery of telemedicine services must be consistent with in-person services and supported by evidence.
New		*[Added paragraph:]* **Telemedicine is not only a patient - physician communication tool but also a patient - physician relationship tool, therefore distance medicine is a medical action with the same ethical considerations and demands as a medical action in person.** [CGCM]	The principles of medical ethics that are mandatory for the profession must also be respected in the practice of telemedicine
		*[Added paragraph:]***.** [CGCM]	*(Combined the two new added paragraphs)*
3.	Physicians must respect the following ethical guidelines when practising telemedicine.	Physicians must respect the following ethical guidelines when ~~practising~~**practicing** telemedicine. [RDMA]	.
	PRINCIPLES		**PRINCIPLES**
4.	Patient-physician Relationship and Confidentiality		Physicians must respect the following ethical guidelines when practising telemedicine.
4.1	The patient-physician relationship must be based on a personal encounter and	The patient-physician relationship ~~must~~ **should ideally** be based on a personal encounter and sufficient knowledge of	The patient-physician relationship must be based on a prior personal examination and sufficient

	sufficient knowledge of the patient's personal history. Telemedicine should be employed primarily in situations in which a physician cannot be physically present within a safe and acceptable time period. Physicians must be aware that certain telemedicine technologies could be unaffordable to patients and hence impede access.	the patient's personal history. [SwMA] … Physicians must be aware **that not all patients are data literate and** that certain telemedicine technologies could be unaffordable to patients and hence impede access. [NMA] *[Not all patients have the competence to handle the technology needed for performing telemedicine]* [NMA] **4.1** The patient-physician relationship must be based on a personal encounter and sufficient knowledge of the patient's personal history. **Telemedicine must assure that the elements of this personal encounter include the ability to interview, examine, and test, in an appropriately comprehensive manner. It should also provide for the diagnosis and treatment of the identified medical condition.** [AM] **4.2** Telemedicine should be employed ~~primarily~~ in situations in which a**n appropriate** physician cannot be physically ~~present~~**available** within a safe and acceptable time period. Physicians must be aware that certain telemedicine technologies could be unaffordable to patients and hence impede access. [AM] … Physicians must be aware that certain telemedicine technologies could be unaffordable to patients and hence impede access **and increase social inequality on medicine**. [DMA] The patient-physician relationship must be based on a personal encounter and sufficient knowledge of the patient's personal history. *[Why is that necessary? What in case this personal encounter has not yet taken place? I would say: is preferably based on a former personal*	knowledge of the patient's medical history. Telemedicine should be employed primarily in situations in which a physician cannot be physically present within a safe and acceptable time period. It could also be used in management of chronic conditions or follow-up after initial treatment where it has been proven to be safe and effective**.**

		encounter] … [RDMA] … Telemedicine should be employed primarily in situations in which a physician cannot be physically present within a safe and acceptable time period… *[This statement does not take account of the other circumstances in which telemedicine could be beneficial. For example, the long-term management of specific conditions where a face to face consultation would not be necessary or where attending for an appointment in person may be difficult for a patient because of reduced mobility.]* [BMA] … Telemedicine ~~should be employed primarily~~**can be employed in increasing number of situations, although in many settings it is primarily used** in situations in which a physician cannot be physically present within a safe and acceptable time period … [FMA] The patient-physician relationship **must** be based on ~~a personal encounter~~ **a previous examination** and sufficient knowledge of the patient's **medical records** ~~personal history~~. Telemedicine should be employed ~~primarily~~ **above all** in situations in which a physician cannot be physically present within a safe and acceptable time period. Physicians **and medical institutions** must be aware that certain telemedicine technologies could be ~~unaffordable to patients and hence impede access~~ **inaccessible and therefore ineffective for certain patients.** [CGCM] The patient-physician relationship must be based on a**n** ~~personal~~ encounter **established through a prior in-personal relationship that provides** ~~and~~ sufficient knowledge of the patient's personal history …[AMA]	*(Evidence-based)*

		…. Physicians must be aware that certain telemedicine technologies **can generate too important costs for** ~~could be unaffordable to~~ patients ~~and hence impede access~~. [CNOM]	
4.2	The patient-physician relationship must be based on mutual trust and respect. It is therefore essential that the physician and patient be able to identify each other reliably when telemedicine is employed.	The patient-physician relationship must be based on mutual trust and respect. ~~It is therefore essential that the physician and patient be able to identify each other reliably when telemedicine is employed.~~ *[Added text]* **This should be governed by the same ethical principles that regulate the practise of face-to-face medicine, with the defense of patient rights as well as due respect for healthcare professionals being guaranteed and in the event that the practice of telemedicine refers to a medical team, there must be a physician identified as responsible for the distance medical care.** [CGCM]	The patient-physician relationship must be based on mutual trust and respect. It is therefore essential that the physician and patient be able to identify each other reliably when telemedicine is employed. In case of consultation between two or more professionals within or between different jurisdictions, the primary physician remains responsible for the care and coordination of the patient with the distant medical team.
		[Added paragraph:] **The use of telemedicine should always be preceded by the express consent of the patient, or, in the case of relatives or close friends with the prior identification of all the persons involved.** [CGCM]	*(Consent has been addressed elsewhere)*
New		*[Added paragraph:]* **In the practice of telemedicine, it is essential to preserve patient confidentiality and privacy. For this, the physician providing telemedicine services must adopt the appropriate technical and management measures to preserve the security of their services and patient rights. These measures must guarantee an appropriate level of the existing risk, in addition to the strictest protection of patient data and compliance with legal regulations on this matter. In any case, the use of telemedicine should guarantee the patient the same levels of protection as face-to-face medicine.** [CGCM]	*(Covered in 4.4)*

		[Added paragraph:] **The physician will exercise caution to maintain his attitude and image in the use of new social media, especially on the internet and social networks, with language that is appropriate in form and content.** [CGCM]	*(This topic could be appropriately tended to under social media)*
		[Added paragraph:] **When telemedicine is implemented by the patient or by their relatives or close friends, they will always be attended and supervised by the physician responsible for their care.** [CGCM]	
4.3	Ideally, telemedicine should be employed only in cases in which a prior in-person relationship exists between the patient and the physician involved in arranging or providing the telemedicine service.	~~Ideally~~**Originally**, telemedicine ~~should be~~**ideally was** employed only in cases in which a prior in-person relationship ~~exists~~**existed** between the patient and the physician involved in arranging or providing the telemedicine service. **With changes in technology, this requirement is less necessary.** [AM] *[This will depend on the needs of a patient, there are some interactions for which there is no specific need for a prior in-person relationship to exist or where a patient may prefer greater anonymity, without this engaging ethical issues.]* [BMA] ~~Ideally,~~**In many cases the use of** telemedicine ~~should be employed only in cases in which~~**benefits from** a prior in-person relationship ~~exists~~ between the patient and the physician involved in arranging or providing the telemedicine service. [FMA] *… [Added text:]* **In emergencies, the use of telemedicine is ethically acceptable.** [CGCM] *[Delete paragraph; this is now in the first paragraph of*	*(Remove, this issue has been discussed earlier in the statement)*

		this section] [AMA] Ideally, **but not necessarily,** telemedicine should be employed ~~only~~ in cases in which … [CNOM]	
4.4	The physician must aim to ensure that patient confidentiality and data integrity are not compromised. Data obtained during a telemedical consultation must be secured through encryption and other security precautions must be taken to prevent access by unauthorized persons.	The physician must aim to ensure that patient confidentiality and data integrity are not compromised. Data obtained during a telemedical consultation must be secured through encryption and other security precautions ~~must be taken~~ to prevent ~~access by unauthorized persons~~ **unauthorized access and breaches of identifiable patient data.** [AM] *[Delete paragraph and replace by:]* **The physician and the health institutions where the medicine is practised must take extreme measures to ensure patient confidentiality, secrecy and safety, with special attention to the privacy configuration of the telematic media and encryption of files, personal access codes and security measures of a similar nature.** [CGCM] … Data obtained during a telemedical consultation must be secured through encryption and other **appropriate security protocols**~~security precautions~~ must be taken to prevent access by unauthorized persons. [AMA] The physician must aim to ensure that ~~patient~~ confidentiality **of the information exchanged during the consultation** and data integrity are not compromised. [CNOM]	The physician must aim to ensure that patient confidentiality, privacy and data integrity are not compromised. Data obtained during a telemedicine consultation must be secured to prevent unauthorized access and breaches of identifiable patient information through appropriate and up to date security measures in accordance with local legislation. Electronic transmission of information must also be safeguarded against unauthorized access.
4.5		*[Added paragraph:]* **The physician who practices telemedicine must always consider the principle of patient autonomy and have their informed consent.** [CGCM]	Proper informed consent requires that all necessary information regarding the distinctive features of telemedicine visit be explained fully to patients including, but not limited to:

			• explaining how telemedicine works, • how to schedule appointments, • privacy concerns, • the possibility of technological failure including confidentiality breaches, • protocols for contact during virtual visits, • prescribing policies, and • coordinating care with other health professionals in a clear and understandable manner, without influencing the patient's choices.
		[Added paragraph:] **When patient information is transmitted by telecommunication systems between physicians, the principles of confidentiality and medical secrecy in face-to-face patient-physician relationships must be maintained.** [CGCM]	*Addressed elsewhere*
			Physicians must be aware that certain telemedicine technologies could be unaffordable to patients and hence impede access. Inequitable access to telemedicine can further widen the health outcomes gap between the poor and the rich.
New 5		**5. Autonomy of the Physician** **5.1 A physician is not obligated to provide treatment or counseling via telemedicine.** **5.2 Telemedicine can potentially infringe on the physician's autonomy owing to 24/7 virtual availability. The physician's autonomy must take into consideration the limitations of the physician's ability to advise; provide care remotely; availability and the extent of his or her**	5. Autonomy and privacy of the Physician 5.1 A physician should not to participate in telemedicine if it violates the legal or ethical framework of the country. 5.2 Telemedicine can potentially infringe on the physician privacy due to 24/7 virtual availability. The physician need to inform patients about availability and recommend services such as emergency when inaccessible. 5.3 The physician should exercise their

		referrals. **5.3 The physician will exercise discretion regarding whether cases brought for consultation are appropriate for telemedicine. In this context, the physician should consider the degree of prior acquaintance with the patient and his or her medical history. In certain cases, the physician may choose to refer the patient to in-person medical treatment.** **5.4 A physician may discontinue treatment via telemedicine, at his or her discretion, if he/she believes that the treatment or remote consultation harms the quality of care provided to the patient**. [IsMA]	professional autonomy in deciding whether a telemedicine versus face-to-face consultation is appropriate. 5.4 A physicians should exercise autonomy and discretion in selecting the telemedicine platform to be used
(new 6)	Responsibilities of the Physician		**6. Responsibilities of the Physician**
5.1 (start 6.1)	A physician whose advice is sought through the use of telemedicine should keep a detailed record of the advice he/she delivers as well as the information he/she received and on which the advice was based.	A physician whose advice is sought through the use of telemedicine ~~should~~**must** keep a detailed record of the advice he/she delivers as well as the information he/she received and on which the advice was based. [SwMA] A physician whose advice is sought through ~~the use of~~ telemedicine **systems** should keep a detailed record of the advice he/she delivers as well as the information he/she received and on which the advice was based. [CGCM] A physician whose advice is sought through the use of telemedicine should keep a detailed record of the advice he/she delivers as well as the information he/she received and on which the advice was based **in order to ensure traceability**. [CNOM]	A physician whose advice is sought through the use of telemedicine should keep a detailed record of the advice he/she delivers as well as the information he/she received and on which the advice was based in order to ensure traceability.

5.2	It is the obligation of the physician to ensure that the patient and the health professionals or family members caring for the patient are able to use the necessary telecommunication system and necessary instruments. The physician must seek to ensure that the patient has understood the advice and treatment suggestions given and that the continuity of care is guaranteed.	~~It is the obligation of~~**T**he physician **need** to ensure that the patient and the health professionals or family members caring for the patient are able to use the necessary telecommunication system and necessary instruments… [SwMA] … The physician**, as in any other patient-physician encounter,** must seek to ensure that the patient has understood the advice and treatment suggestions given and that the continuity of care is guaranteed. [AM] It is the obligation of the physician to ensure *[Only in case that this patient is his/her responsibility and that the physician exclusively is reachable trough telecommunication.* *Part from that: what does this obligation actually mean? It seems unreasonable and impossible that the physician has to buy / provide for the telecommunication system and necessary instruments for the patient.]* … [RDMA] … The physician must seek to ensure that the patient has understood the advice and treatment suggestions given and that the continuity of **health**care is guaranteed. [CGCM] … The physician must seek to ensure that the patient has understood the advice and treatment suggestions given and **take steps to promote continuity of care.** ~~that the continuity of care is guaranteed.~~ [AMA]	If a decision is made to use telemedicine it is necessary to ensure that the users (patients and healthcare professionals) are able to use the necessary telecommunication system. The physician must seek to ensure that the patient has understood the advice and treatment suggestions given and take steps in so far as possible to promote continuity of care.
		[Added paragraph:] **The physician must always inform the patient of the risks of telemedicine services regarding the security of their data, their privacy and the measures adopted to protect them. He/She will also inform the patient about the data stored in his/her**	

		medical records and the security measures for protection and custody thereof. Likewise, the circumstances and deadlines for deleting this data must be foreseen. [CGCM]	
5.3	The physician asking for another physician's advice or second opinion remains responsible for treatment and other decisions and recommendations given to the patient.	*[Delete paragraph]* [SwMA] … *[Added text:]* **If the second opinion is requested of another physician through a telecommunications system, the privacy and confidentiality of the patient's clinical and personal details should also be safeguarded in this system.** [CGCM]	The physician asking for another physician's advice or second opinion remains responsible for treatment and other decisions and recommendations given to the patient.
		[Added paragraph:] **The physician must adopt measures to prevent unauthorised access to communications in telemedicine in order to protect confidentiality and contents.** [CGCM]	*(Covered elsewhere)*
5.4	A physician should be aware of and respect the special difficulties and uncertainties that may arise when he/she is in contact with the patient through means of tele-communication. A physician must be prepared to recommend direct patient-doctor contact when he/she feels that the situation calls for it.	~~A~~ **The** physician should be aware of and respect the special difficulties and uncertainties that may arise when he/she is in contact with the patient through means of tele-communication. ~~A~~ **The** physician must be prepared to recommend direct patient-doctor contact when ~~he/she feels that~~ the situation calls for it. [SwMA] … A physician must be prepared to recommend direct patient-doctor contact when ~~he/she feels that the situation calls for it~~**appropriate and necessary.** [AM] A physician should be aware of and respect the special difficulties and uncertainties that may arise when **using telemedicine technologies.** ~~he/she is in contact with the patient through means of tele-communication.~~ A physician must be prepared to recommend direct patient-doctor contact when he/she **believes it is in the patient's**	The physician should be aware of and respect the special difficulties and uncertainties that may arise when he/she is in contact with the patient through means of tele-communication. A physician must be prepared to recommend direct patient-doctor contact when he/she believes it is in the patient's best interests

		best interests. ~~feels that the situation calls for it.~~ [AMA]	
		[Added paragraph]: **The physician must make sure that they are aware of, and meet, any relevant licensing requirements that may exist under the circumstances. This might include those in the jurisdiction where the physician is located, as well as the jurisdiction where the patient is located.** [CMA]	Physicians should only practise telemedicine in countries/jurisdictions where they are licenced to practise. Cross-jurisdiction consultations should only be allowed between two physicians.
			Physicians should ensure that their medical indemnity cover include cover for telemedicine.
6. *(new 7)*	Quality of Care		**6. Quality of Care**
6.1 *(start 7.1)*	Quality assessment measures must be used regularly to ensure the best possible diagnostic and treatment practices in telemedicine.	~~Quality~~**Healthcare quality** assessment measures must be used regularly to ensure **patient security and** the best possible diagnostic and treatment practices ~~in~~**during** telemedicine **procedures. Quality must be the cornerstone of communications in telemedicine. Information regarding professional practice should always be clear and understandable and should be disseminated respecting the deontological principles that should prevail in all areas.** [CGCM] *... [Added text]:* **The delivery of telemedicine services must follow evidence-based practice guidelines to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.** [AMA]	Healthcare quality assessment measures must be used regularly to ensure patient security and the best possible diagnostic and treatment practices during telemedicine procedures. The delivery of telemedicine services must follow evidence-based practice guidelines to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. Like all health care interventions, telemedicine must be tested for its effectiveness, efficiency, safety, feasibility and cost-effectiveness.
6.2	The possibilities and weaknesses of telemedicine in emergencies must be acknowledged. If it is necessary to use telemedicine in an emergency situation, the advice and treatment suggestions are	… If it is necessary to use telemedicine in an emergency situation, the advice and treatment suggestions are influenced by the ~~level of threat to~~**severity of** the patient**´s medical condition** and the know-how and capacity of the persons who are with the patient**.** [SwMA]	The possibilities and weaknesses of telemedicine in emergencies must be duly identified. If it is necessary to use telemedicine in an emergency situation, the advice and treatment suggestions are influenced by the severity of the patient´s medical

	influenced by the level of threat to the patient and the know-how and capacity of the persons who are with the patient	… are influenced by the level of threat to the patient and the know-how and capacity of the persons who are with the patient. *[What does this mean for the physician's responsibility?]* [RDMA] The possibilities and weaknesses of telemedicine in emergencies must be **duly identified**~~acknowledged~~. If it is necessary to use telemedicine in an emergency situation, the advice and treatment suggestions **must be proportional.** ~~are influenced by the level of threat to the patient and the know-how and capacity of the persons who are with the patient~~ **They will be adapted both to the patient's level of vital risk and to the knowledge and healthcare capabilities of the people with the patient.** [CGCM] … If it is necessary to use telemedicine in an emergency situation, the advice and treatment suggestions are influenced by the level of threat to the patient and the **competencies** ~~know-how~~ ~~and capacity~~ of the persons who are with the patient. *[Added text]:* **Entities that deliver telemedicine services must establish protocols for referrals for emergency services.** [AMA]	condition and the competency of the persons who are with the patient. Entities that deliver telemedicine services must establish protocols for referrals for emergency services.
	RECOMMENDATION	**RECOMMENDATIONS** [AMA]	**RECOMMENDATIONS**
7.	Telemedicine should be tailor-made to local contexts including regulatory frameworks.	Telemedicine should be ~~tailor-made~~ **appropriately adapted** to local contexts including regulatory frameworks. [SwMA] *[Added paragraph:]* **Physicians and other health care professionals should be involved in the development of telemedicine tools, to ensure usability and that the tools meet health care needs. Physicians and other health care professionals should also receive sufficient education to ensure appropriate and efficient use of**	Telemedicine should be appropriately adapted to local regulatory frameworks, which may include licencing of telemedicine platforms in the best interest of patients.

		telemedicine tools. [SwMA] *[Delete paragraph and replace by:]* **Telemedicine should accommodate local cultures and traditions with international, national and regional regulatory controls to assure standards of quality medical care.** [AM] Telemedicine should be tailor-made to **patient competencies and** local contexts**,** including regulatory frameworks. [DMA] Telemedicine should be tailor-made to local contexts ~~including~~**and should include** regulatory frameworks. [CGCM] *[This paragraph with the following changes should be the third item (currently numbered 9.) of the section "RECOMMENDATIONS"; see below about the next items:]* Telemedicine should **adhere** ~~be tailor-made~~ to local **medical practice laws and** ~~contexts including~~ regulatory frameworks. [AMA]	
		[Added paragraph]: **NMAs will guarantee disciplinary procedures against physicians who violate the ethical and deontological norms of the place where they exercise remote, electronic communications regardless of the place and country in which the patient with whom they are related is located.** [CGCM]	
8.	The WMA and National Medical Associations should encourage the development of national legislation and international agreements on subjects related to the practice of telemedicine.	The WMA and National Medical Associations should encourage the development of national legislation and international agreements on subjects related to the practice of telemedicine~~.~~**, while protecting the patient-physician relationship, confidentiality, and quality of medical care.** [AM]	Where appropriate the WMA and National Medical Associations should encourage the development of ethical norms, practice guidelines, national legislation and international agreements on subjects related to the practice of telemedicine, while protecting the patient-physician relationship,

		Where appropriate, ~~T~~**t**he WMA and National Medical Associations should encourage the development of national legislation and international agreements on subjects related to the practice of telemedicine. [FMA] *[FMA notes that separate legislation for the practice of telemedicine is not always necessary since it is covered by general legislation on practice of medicine.]* *[This paragraph with the following changes should be the fourth item (currently numbered 10.) of the section "RECOMMENDATIONS"; see below about the next items:]* The WMA and National Medical Associations should encourage the development of national legislation**, practice guidelines,** and international agreements on ~~subjects related to~~ the practice of telemedicine. [AMA]	confidentiality, and quality of medical care.
		[Added paragraph:] **National Medical Associations should urge prevention of outside agencies limiting patient and physician choice of the specific technology utilized, as long as it complies with national and regional regulation and law.** [AM]	
9.	Similar to all other medical practices, telemedicine must be backed up by evidence.	*[Delete paragraph]* [SwMA] *[This paragraph with the following changes should be the fifth item (currently numbered 11.) of the section "RECOMMENDATIONS"; see below about the next items:]* **The delivery of telemedicine services must be consistent with in-person services and** ~~Similar to all other medical practices, telemedicine~~ must be ~~backed up~~ **supported** by evidence. [AMA]	*(Move it into pre-amble and recommendations)*
10.	Telemedicine must not be viewed as a cost-effective substitute for face-to-face healthcare.	Telemedicine ~~must~~**should** not be viewed as ~~a cost-effective substitute for~~**equal to** face-to-face healthcare **and should not be introduced solely to cut costs**.	Telemedicine should not be viewed as equal to face-to-face healthcare and should not be introduced solely to cut costs or as a perverse

		[SwMA] *[Delete paragraph and replace by:]* **While physicians and supporting institutions need adequate compensation, telemedicine should not be used as an intentional way to increase earnings and thereby increase cost to the medical system.** [AM] *[This statement presumably seeks to protect against inappropriate substitutions of telemedicine for face-to-face healthcare on cost grounds alone. As currently drafted however, it could also be interpreted as ruling out switching the method of delivery where it might be cost-effective and either have no substantive impact on the quality of care offered or be beneficial to the patient.]* [BMA] Telemedicine ~~must not be viewed as~~**can be** a cost-effective ~~substitute~~**option but it must not hinder patient's access to** ~~for~~ face-to-face healthcare **where needed**. [FMA] Telemedicine must not be viewed **solely** as a cost-effective substitute for face-to-face healthcare. [CGCM, AMA] *[This paragraph with the above change should be the sixth item (currently numbered 12.) of the section "RECOMMENDATIONS"; see below about the next items]* *[Added text:]* **In addition to enabling immediate access to certain patients, it makes it possible to cut waiting times for healthcare.** [CGCM]	incentive to over-service and increase earnings for doctors.
		[Added paragraph:] **Physician relationships and collegiality depend upon educational changes**	Use of telemedicine requires the profession to explicitly identify and manage adverse

		addressing the appropriate use of telemedicine and the courtesies surrounding referrals. [AM]	consequences on collegial relationships and referral patterns**.**
		[Added paragraph:] **New technologies and styles of practice integration may require new guidelines and standards.** [AM]	New technologies and styles of practice integration may require new guidelines and standards.
11.	Physicians should lobby for ethical telemedicine strategies in the best interest of patients.	Physicians should ~~lobby for~~ **also maintain the principles of medical ethics when practicing** ethical telemedicine ~~strategies~~ in the best interest of patients. [CGCM] *[Move this paragraph with the following changes to the first item (currently numbered 7.) of the section "RECOMMENDATIONS":]* Physicians should lobby for ethical telemedicine ~~strategies~~ **practices that are** in the best interest**s** of patients. [AMA]	Physicians should lobby for ethical telemedicine practices that are in the best interests of patients.
12.	Proper informed consent requires that all necessary information regarding the telemedicine visit be explained fully to patients including explaining how telemedicine works, how to schedule appointments, privacy concerns, the possibility of technological failure including confidentiality breaches, protocols for contact during virtual visits, prescribing policies, and coordinating care with other health professionals in a clear and understandable manner, without influencing the patient's choices.	**The patient must consent to the use of telemedicine.** Proper informed consent requires that all necessary information regarding the telemedicine visit be explained fully **and in a clear and understandable manner,** ~~to patients~~ including ~~explaining~~ how telemedicine works, how to schedule appointments, privacy concerns, the possibility of technological failure including confidentiality breaches, protocols for contact during virtual visits, prescribing policies, and coordinating care with other health professionals ~~in a clear and understandable manner, without influencing the patient's choices~~. [SwMA] … confidentiality breaches *[Why? What does this mean for the physician if this is beyond his control (as it in fact often is…)?]* … [RDMA] … without influencing the patient's choices *[And if the patient does not agree, does the physician have the obligation to offer a face-to-face consult?]* … [RDMA]	*(Move between 4 and 5)*

		[Added text:] … **<u>This information may be provided by physicians, technology providers, hospitals, academic centers, medical practice administrators and others involved in providing care to the patient.</u>** [AM] *[Delete paragraph and replace by:]* **<u>The use of telemedicine should always be conditional based on the existence of adequate information and patient consent. The functioning of telecommunication systems, the means to request medical attention, the possible risks of their use, the contact protocols during virtual visits, the means of prescription and the coordination of care with other health professionals should always be transmitted in a clear and understandable way without influencing patient decisions.</u>** [CGCM] *[Move this paragraph with the following changes to the second item (currently numbered 8.) of the section "RECOMMENDATIONS":]* Proper informed consent requires that all necessary information regarding the **<u>distinctive features of</u>** telemedicine ~~visit~~ be explained fully to patients including**<u>, but not limited to:</u>** • explaining how telemedicine works, • how to schedule appointments, • privacy concerns, • the possibility of technological failure including confidentiality breaches, • protocols for contact during virtual visits, • prescribing policies, and • coordinating care with other health professionals in a clear and understandable manner, without influencing the patient's choices. [AMA]	

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08.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**MEC 209/Licensing of Physicians Fleeing Prosecution COM REV/Apr2018** **Proposed revision of WMA Statement on Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences**	Original: English
Destination:	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**
Note:	As part of the annual policy review process, the Council in Livingstone (April 2017) decided that the WMA Statement on Licensing of Physicians Fleeing prosecution for Serious Criminal Offence should undergo a major revision. The French Medical Association (CNOM) volunteered to undertake that work. The 207th Council session in Chicago (October 2017) considered the proposal and decided to circulate it within WMA membership for comments.	

Legend:
Abbreviation key:

AM	Associate Members
AMA	American Medical Association
AMV	Associazione Medica del Vaticano
BMA	British Medical Association

CGCM	Consejo General de Colegios Médicos de Espana
CMA	Canadian Medical Association
DMA	Danish Medical Association
FMA	Finnish Medical Association
GMA	Bundesärztekammer (German Medical Association)
NMA	Norwegian Medical Association
RDMA	Royal Dutch Medical Association
SAMA	The South African Medical Association
SwMA	Swedish Medical Association

GENERAL COMMENTS	
AM	There appears to be an inconsistency between paragraph 3 and paragraph 5. Paragraph 3 discusses those physicians who have been found guilty as opposed to paragraph 5, which deals with those who have been alleged to have committed offenses. This inconsistency either must be made consistent, or be further explained. The new country should have the ability to independently evaluate the charges against the physician to be sure they were not politically invented, and that they are valid. We support this document after the inconsistency between paragraphs 3 and 5 is clarified.
AMA	The statement as written contains too many undefined concepts and terms. The statement uses terms "allegations" and "convictions" interchangeably even though they refer to different concepts. To focus the statement, we have eliminated the concepts related to war crimes and to allegations of crimes. If desired, a separate statement on licensure of physicians convicted of war crimes or crimes against humanity could be undertaken, but it should not co-exist with a statement on convictions for other crimes. We also propose changing the title of the statement: **WMA Statement on Licensure of Physicians with Criminal Convictions**
AMV	This document is accepted as it is.
BMA	Overall we would support the main thrust of this document. From a UK perspective though, the responsibilities for licensing, and, for ensuring that a doctor from overseas is fit to practice in the UK, falls on the regulatory body, the GMC, not the national medical association. This statement should be strengthened: it should be an obligation on any licensing authority to make reasonable and appropriate enquiries with regards to the former countries in which the doctor has been registered to practice medicine.
DMA	The DMA has no comments to this document
FMA	FMA supports the revision of this document. We have a few comments to the text. *[Note: those comments have been added in the table*

	below]
GMA	The GMA has incorporated a small number of suggested editorial revisions below. *[Note: those comments have been added in the table below]* *Keywords:* Crime, Licen**c**~~s~~e, Medical Associations, Medical Licensure, Prosecution, Regulation
NMA	NMA supports this document as it is.
RDMA	1) This Declaration is not consistent with regard to the question what kind of offences it addresses: sometimes the Declaration mentions "serious criminal offences", other times it mentions 'war crimes or crimes against humanity'. It is preferable to be consistent. 2) There is a difference between being accused of something (not sure if a person is guilty yet) and being convicted for something. Is it justifiable to deny physicians to practice if it is still unclear if they are really guilty of what they have been accused of?
SAMA	SAMA supports the statement in current format.

Numbering will be deleted (or adjusted) when the revised text is adopted.

No	**Proposed Text:** **MEC 208/Licensing of Physicians Fleeing Prosecution/Oct2017**	**Specific Comments** **Additions: bold/underlined** **Deletions: ~~lined-out~~** **Comments only: *[italic]***	**Proposed Revised Text by:** **Rapporteur** **MEC 209/Licensing of Physicians Fleeing Prosecution REV/Apr2018**
Title	**WMA Statement on Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences**	**WMA Statement on Licens~~ing~~ure of Physicians ~~Fleeing Prosecution for Serious~~ with Criminal ~~Offences~~Convictions** [AMA]	WMA Statement on Licensure of Physicians with Serious Criminal Convictions.
	PREAMBULE	**PREAMB~~U~~LE** [SwMA, AMA]	PREAMBLE
1.	Physicians are bound by medical ethics to dedicate themselves to the good of their patients. Physicians who are prosecuted for serious criminal offences or who have participated in war crimes or crimes against humanity are engaged in a practice that violates medical ethics,	Physicians are bound ~~by medical ethics~~ to dedicate themselves to the good of their patients. Physicians who are ~~prosecuted for~~ **involved in** serious criminal offences or who have participated in war crimes or crimes against humanity are engaged in a practice that violates medical ethics, human	Physicians are bound by medical ethics to dedicate themselves to the good of their patients. Physicians who have been convicted of serious criminal offences in particular genocide, war crimes or crimes against humanity* have violated medical ethics, human rights and international law and are therefore unworthy of practising medicine.

	human rights and international law. Physicians in such situations are unworthy of practicing medicine.	rights and international law. Physicians in such situations are unworthy of practicing medicine. [AM] Physicians are bound by medical ethics to dedicate themselves to the good of their patients. Physicians who ~~are prosecuted for~~ **have committed** serious criminal offences**, including** ~~or who have participated in~~ war crimes ~~or~~ **and** crimes against humanity**, have** ~~are~~ engaged in ~~a~~ practice**s** that violate~~s~~ medical ethics~~, human rights and international law. Physicians in such situations are unworthy of practicing~~ **and are unfit to practice** medicine. [SwMA] Physicians are bound by medical ethics to dedicate themselves to the good of their patients. Physicians who are ~~prosecuted for~~**engaged in** *[That they are prosecuted does not mean that they are guilty of doing so. Therefore, we prefer the other formulation]* serious criminal offences *[What are 'serious criminal offences'?]* or ~~who have participated~~ in war crimes or crimes against humanity are engaged in a practice that violates medical ethics, human rights and international law… [RDMA] … Physicians in such situations are ~~unworthy~~**ineligible** of practicing medicine. [FMA]	In accordance with the principle of the presumption of innocence, only physicians who have been convicted should be declared unworthy of practising medicine. Foot note: *as defined by the Rome Statute of the International Criminal Court

		… Physicians in such situations are unworthy of practi**s**eing medicine. [GMA] *[Paragraph not numbered:]*… Physicians who are **convicted of** ~~prosecuted for serious~~ criminal offences ~~or who have participated in war crimes or crimes against humanity~~ **or** are engaged in a practice that violates medical ethics~~,~~ **or** human rights **should not be allowed to practice medicine** ~~and international law. Physicians in such situations are unworthy of practicing medicine.~~ [AMA]	
	REFLECTION	~~**REFLECTION**~~ [GMA] ~~**REFLECTION**~~ **DISCUSSION** [AMA]	DISCUSSION
2.	Physicians seeking to work in any country are subject to the licensing arrangements of that country. Physicians applying for a license to practice must demonstrate their professional competence, both technical and moral, to the approved licensing bodies.	Physicians seeking to work in any country are subject to the licensing arrangements of that country. **The duty to demonstrate suitability to practice medicine rests with the person seeking registration.** ~~Physicians applying for a license to practice must demonstrate their professional competence, both technical and moral, to the approved licensing bodies.~~ [SwMA] … Physicians applying for a license to practice must demonstrate their professional competence, both technical and moral *[To prove that you did NOT do something is very difficult. How does the working group think this should be*	Physicians seeking to work in any country are subject to the licensing arrangements of that country. The duty to demonstrate suitability to practice medicine rests with the person seeking registration.

		done?]... [RDMA] Physicians seeking to work in any country are subject to the licensing ~~arrangements~~**requirements** of that country… [CMA] … Physicians applying for a licen**c**~~c~~e to practi**s**~~e~~e must demonstrate their professional competence, both technical and moral, to the approved licensing bodies. [GMA] Physicians seeking to **practice medicine** ~~work in any country~~ are subject to the licensing arrangements of **their local jurisdiction.** ~~that country.~~ Physicians applying for a license to practice must demonstrate their professional competence **and compliance with relevant ethical standards as required by** ~~both technical and moral,~~ ~~to~~ **the** approved licensing bodies **of the physician's country or jurisdiction of origin.** [AMA]	
3.	Physicians whose licences are revoked by their licensing body after being found guilty of serious professional misconduct, or following a criminal conviction, cannot be allowed to practise in a second country. The relevant licensing authorities must require not only proof of qualification	Physicians whose licences ~~are~~ **have been** revoked **because of** ~~by their licensing body after being found guilty of~~ serious professional misconduct, or following a criminal conviction, ~~cannot~~ **should not** be allowed to practise in a second country. The relevant licensing authorities ~~must~~ **in all countries should** require not only proof of	Physicians who have been convicted of serious criminal offences must not be allowed to practise in another country. The relevant licensing authorities must ensure both that physicians have the required qualifications and that they have not been convicted of a serious criminal offence.

	but also proof that the applicant continues to be in good professional standing in his or her country of origin.	qualification but also proof that the applicant ~~continues to be~~ **is** in good professional standing in his or her country of origin. [SwMA] Physicians whose licences are revoked by their licensing body after being found guilty of serious professional misconduct~~,~~ or following a criminal conviction **related to their profession** *[Not any crime does make a physician unsuitable for his/her job, does it?]*, cannot be allowed to practise in a second country …[RDMA] Physicians whose licences are revoked by their licensing body after being found guilty of serious professional misconduct, or following a criminal conviction, cannot be allowed to practise in ~~a second~~**any other** country… [CMA] *[Move this paragraph with the following changes to next item (currently numbered 4.):]* Physicians whose **original licenses** ~~licences~~ are revoked by the~~ir~~ licensing body **in their country or jurisdiction of origin** ~~after being found guilty of serious professional misconduct, or~~ following a criminal conviction~~, cannot~~ **should not** be allowed to practise **in another country or jurisdiction.** ~~in a second country~~. ~~The relevant~~ **Relevant** licensing **bodies in the new country or jurisdiction** ~~authorities~~ must require not only ~~proof~~ **verification** of	

		initial qualification**s** **for licensure,** but also ~~proof~~ **verification** that the applicant continues to be in good professional standing in his or her country **or jurisdiction** of origin. [AMA]	
4.	Yet physicians who have been prosecuted for serious criminal offences or accused by international agencies of war crimes or crimes against humanity have sometimes been able to leave their country and to obtain a licence to practice medicine in a host country from the relevant licensing authority. This practice is contrary to the public interest and is detrimental to patient safety.	~~Yet~~ **However, p**hysicians who have been prosecuted for serious criminal offences or accused by international agencies of war crimes or crimes against humanity have sometimes been able to leave the~~ir~~ country **in which these suspected crimes were committed** and ~~to~~ obtain a licence to practice medicine ~~in a host country~~ from the relevant licensing authority **in another country**. This ~~practice~~ is contrary to ~~the~~ public interest**,** ~~and is~~ detrimental to patient safety **and damaging the reputation of and trust in physicians**. [SwMA] ~~Yet~~ physicians who have been prosecuted for serious criminal offences ... [BMA] Yet physicians who have been prosecuted for serious criminal offences *[Sometimes physicians are in their countries prosecuted for criminal offences (e.g. the member of the Council of the Turkish Medical Association right now), while the WMA thinks this is not right. How to handle these cases?]* … [RDMA] ~~Yet p~~**P**hysicians who have been prosecuted	Physicians who have been convicted of serious criminal offences, in particular of genocide, war crimes or crimes against humanity, have sometimes been able to leave the country in which these crimes were committed and obtain a licence to practise medicine from the relevant licensing authority in another country. This practice is contrary to the public interest, damaging to the reputation of medical profession, and may be detrimental to patient safety

		for serious criminal offences …[CMA] … This practice is contrary to the public interest**, damaging to the reputation of medical profession,** and ~~is~~**may be** detrimental to patient safety. [FMA] … and to obtain a licence to practi**s**~~e~~e medicine in a host country from the relevant licensing authority… [GMA] *[Move this paragraph with the following changes to previous item (currently numbered 3.):]* ~~Yet physicians~~ **Physicians** who have been ~~prosecuted for serious criminal offences or accused by international agencies of war crimes or crimes against humanity~~ **convicted of a crime** ~~have~~ **are** sometimes ~~been~~ able ~~to leave their country and~~ to **relocate and** obtain a **new** ~~licence~~ **license** to practice medicine **in another country or jurisdiction.** ~~in a host country from the relevant licensing authority~~. This practice is contrary to the public interest and **puts patients at risk.** ~~is detrimental to patient safety~~. [AMA]	
		[Added paragraph:]… **Sometimes allegations against physicians are politically motivated and do not reflect actual misconduct.** [AM]	
	RECOMMENDATION	**RECOMMENDATION**S [AMA]	**RECOMMENDATIONS**

NEW		*[Added paragraph:]* **The WMA recommends that physicians who have been involved in serious criminal offences or who have participated in war crimes or crimes against humanity be denied membership in national medical organizations.** [AM]	The WMA recommends that physicians who have been convicted of serious criminal offences, in particular of genocide, war crimes or crimes against humanity, be denied membership to national medical associations.
		[Added paragraph]: **Where possible, national medical organizations should be granted powers to revoke the licenses of physicians who have been involved in serious criminal offences or who have participated in war crimes or crimes against humanity.** [AM]	
5.	The WMA recommends that national medical associations use their own powers to ensure that physicians against whom serious allegations of participation in war crimes or crimes against humanity have been made, are not able to obtain licences to practise until they have satisfactorily responded to these allegations. The WMA reminds the national medical associations of their duty to ensure efficient communications amongst themselves and to inform the relevant national authorities of serious offences in order for the latter to be able to take appropriate action.	The WMA recommends that national medical associations ~~use their own powers to~~ ensure that physicians against whom serious allegations of participation in war crimes or crimes against humanity have been made, are not able to obtain licences to practise until they have satisfactorily responded to these allegations. The WMA reminds the national medical associations of their duty to ensure efficient communications amongst themselves and to inform the relevant ~~national~~ **licensing** authorities of serious offences in order for the latter to be able to take appropriate action. [AM] The WMA recommends that national	The WMA recommends that national medical associations use their own authority to be informed, in so far as is possible, if serious allegations of participation in war crimes or crimes against humanity have been made against physicians, while at the same time respecting the presumption of innocence.

		medical associations ~~use their own powers~~ **work** to ensure that physicians against whom serious **and credible** allegations of participation in war crimes or crimes against humanity have been made, are not able to obtain licences to practise until they have satisfactorily responded to the~~se~~ allegations. **Where evidence of involvement in such abuses is compelling, the evidence should be drawn to the attention of appropriate authorities.** ~~The WMA reminds the national medical associations of their duty to ensure efficient communications amongst themselves and to inform the relevant national authorities of serious offences in order for the latter to be able to take appropriate action.~~ [SwMA] The WMA recommends that national medical associations**, or relevant regulatory bodies,** use … [BMA] *[Added text:]* **It should be an obligation on any licensing authority to make reasonable and appropriate enquiries with regards to the former countries in which the doctor has been registered to practice medicine.** [BMA] The WMA recommends that national medical associations use their own powers to ensure that physicians against whom serious allegations of participation in war crimes or crimes against humanity have	

		been made, are not able to obtain licences to practise until they have satisfactorily responded to these allegations *[What about 'criminal offences'? What is the difference between 'allegations' and 'serious allegations'? Is there a difference between allegations and prosecution? If not, please be consistent in formulating. Who has to decide that an allegation has been satisfactorily responded to? Is an allegation enough? Shouldn't it be a conviction?]* … [RDMA] The WMA recommends that ~~n~~**N**ational ~~m~~**M**edical ~~a~~**A**ssociations use their own powers to ensure that physicians against whom serious allegations of participation in war crimes or crimes against humanity have been made, are not able to obtain licences to practise until they have satisfactorily responded to these allegations. The WMA reminds ~~the n~~National ~~m~~**M**edical ~~a~~**A**ssociations of their duty to ensure efficient communications amongst themselves and to inform the relevant national **regulatory and legal** authorities of serious offences in order for the latter to be able to take appropriate action. [CMA] The WMA recommends that national medical associations use their own powers to ensure that physicians **who are prosecuted for serious criminal offences or** against whom serious allegations of	

		participation in war crimes or crimes against humanity have been made, … [FMA] The WMA recommends that national medical associations use their own **influence and, where applicable, authority**~~powers~~ to ensure that physicians against whom serious allegations of participation in war crimes or crimes against humanity have been made, are not able to obtain licences to practise until they have satisfactorily responded to these allegations. … [GMA] The WMA recommends that national medical associations use their own powers to ensure that physicians against whom serious allegations of participation in war crimes or crimes against humanity have been made, are not able to obtain licences to practise until they have satisfactorily responded to these allegations **or have a final exculpatory sentence**. … [CGCM] The WMA recommends that **all** national medical associations **and relevant licensing bodies** ~~use their own powers to~~ ensure that **all** physicians ~~against whom serious allegations of participation in war crimes or crimes against humanity have been made,~~ **who have been convicted of a criminal offense, either locally or from another jurisdiction, be unable** ~~are not~~	

		~~able~~ to obtain licences to practise **medicine.** ~~until they have satisfactorily responded to these allegations.~~ *[Modify and move the next sentence of the original text to a new paragraph as shown below:]* [AMA]	
		The WMA ~~reminds~~ **recommends that** ~~the~~ **national medical associations** ~~of their duty to~~ ensure efficient communications amongst themselves and ~~to~~ **that they** inform ~~the~~ relevant national **licensing authorities of physicians' criminal convictions.** ~~serious offences in order for the latter to be able to take appropriate action.~~ [AMA]	The WMA recommends that national medical associations ensure that there is efficient communication amongst themselves and that they inform relevant national licensing authorities of physicians' criminal convictions.

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April 2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**MEC 209/End of Life Japan/Apr2018** **Report of the Symposium on End-of-Life Questions in Japan 2017**	Original: English
Destination:	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note	The Symposium on End-of-Life Questions was held in Japan on September 14 and 15, 2017, with participation of the Confederation of Medical Associations in Asia and Oceania (CMAAO) members and the two World Medical Association (WMA) Asian regional members, namely, the Chinese Medical Association and the Israel Medical Association. This report was prepared by Professor Tatsuo Kuroyanagi, lawyer and the legal adviser of the Japan Medical Association (JMA).	

Symposium on End-of-Life Questions Result Report

The Symposium on End-of-Life Questions was held on September 14 and 15, 2017, with participation of the Confederation of Medical Associations in Asia and Oceania (CMAAO) members and the two World Medical Association (WMA) Asian regional members, namely, the Chinese Medical Association and the Israel Medical Association. The symposium generated certain achievements, and the following is the report of its results.

1. Introduction

The main purpose of this symposium was to investigate different opinions that exist among the WMA Asia-Pacific members and their home countries/jurisdictions with regard to the three WMA policies, namely WMA Declaration on Euthanasia, WMA Statement on Physician-Assisted Suicide, and WMA Resolution on Euthanasia.

The Japan Medical Association (JMA) planned this symposium because the WMA Executive Committee referred the investigation to the JMA. The JMA also carried out a questionnaire survey on five items of "End-of-Life Questions" in July 2017 to ensure fruitful discussion at the symposium and asked the member National Medical associations (NMAs) to present their views based on their answers to the questionnaire survey.

The JMA sent the questionnaire to 21 NMAs, and 19 submitted their answers. At the symposium, 17 NMAs presented their reports by further elaborating or partially modifying their answers.

This report of the questionnaire survey results was prepared based on the answers that the JMA received and the presentations made by each NMA during the symposium.

2. Target NMAs for the questionnaire survey

21 WMA members in the Asia-Pacific region were the target of the questionnaire survey, namely, 19 CMAAO members, the Chinese Medical Association and the Israel Medical Association. The JMA sent out the questionnaire to these 21 NMAs via e-mail, and asked them to submit their answers.[1]

The 19 NMAs that submitted their answers in writing were; Australia, Bangladesh, Cambodia (absent), Hong Kong, India, Indonesia, Japan, Korea, Malaysia, Myanmar, Nepal, New Zealand (absent), Pakistan, Philippines, Singapore, Taiwan, and Thailand, which are CMAAO members, and China and Israel, which are non-CMAAO members. Two CMAAO members, Macau and Sri Lanka, did not submit their answers. New Zealand and Cambodia were unfortunately unable to attend the symposium but had submitted detailed answers via e-mail.

3. Background

The WMA has made it clear that it is against euthanasia and physician-assisted-suicide (PAS). However, legislations allowing these procedures have been enacted in Switzerland in the past and in the Netherlands, Belgium, Luxemburg, and some states in the United States in recent years. In Switzerland legislation has allowed PAS, but not euthanasia. In addition, on February 6, 2015, the Supreme Court of Canada ruled that the crime of aiding suicide as stipulated in the Penal Code is unconstitutional in view of respecting the patients' right of self-determination, and this ruling has led to a legislation that approves PAS.

During the Meeting in Oslo in 2015, the WMA Council re-confirmed the opinions on the issue of active euthanasia and PAS. The overwhelming majority of the members wished to maintain the current position of opposing such practice. The Council Meeting in Taipei in 2016 decided to hold regional discussions on this issue especially in the Asian, African and Latin American regions.

4. Questions addressed in the symposium (questionnaire items)

As mentioned in the Introduction, the core purpose of the investigation and deliberation of this symposium was to study the reality concerning "Euthanasia and Physician-assisted-suicide" among the WMA Asia-Pacific members and their home countries/jurisdictions. Upon consulting with the WMA Secretariat in advance, the following four categories of questions were prepared.

Q-1 Questions regarding Euthanasia and Physician-assisted Suicide
Q-2 Questions regarding Advance directive (Living Will)
Q-3 Questions regarding Withholding or Withdrawing of Life-sustaining Treatment
Q-4 Questions regarding Palliative Care including End-of-life Care

In order to prevent confusion due to different understandings of the terminology, the titles of WMA policy documents related to each question were listed in marginal notes when preparing the

[1] It should be noted that the JMA also sent out the questionnaire to three other NMAs that are also the WMA members in the Asia-Pacific region, namely, Fiji, Samoa, and Vietnam, and requested to submit their answers. However, the JMA received no confirmation of reception nor any answers from them, so they were excluded from the survey.

text of the questions; respondents were asked to follow the definitions provided in these policy documents, if any. In referring to the policy documents, the Powerpoint file created and provided by WMA General Secretary Otmar Kloiber, which he used at the Latin American symposium in March 2017, was used as a reference, and some relevant texts of the policy documents that were mentioned in this Powerpoint file were extracted and noted in the questionnaire text as needed.

After these four questions were sent out, Question 5 that concerns the adult guardianship program with the right of medical consent and other legal measures was added later, in light of poor legal interventions available in Japan in case of providing highly invasive treatment in daily medical practice for extremely aged patients with dementia who lost the ability of self-determination or providing critical procedure involved in the end-of-life care.

5. Grouping at the symposium

The original plan was to divide the participating NMAs alphabetically and have them orally discuss the written opinions of each in groups. However, after examining the pre-submitted answers and receiving considerably delayed answers from two NMAs, the JMA decided to divide the NMAs into four groups based on the similarities in legal systems and religions. CMAAO Council Chair Dr. Yeh Woei Chon (Singapore), Vice Chair Dr. Kar Chai Koh (Malaysia), and advisor Dr. Dong-Chun Shin (Korea) were asked to serve as the symposium chairs (facilitators), and they reviewed all the answers of NMAs the night before the symposium.

The names and titles of the rapporteurs of the four groups are shown in the table in Attachment 2.

Stakeholders of the participating NMAs and other experts also joined the groups, including WMA Secretary General Otmar Kloiber, German Medical Association President Prof. Dr. Frank Ulrich Montgomery, International Manager Dr. Ramin Parsa-Parsi, and the immediate past American Medical Association President Dr. Andrew Gurman. They had lively discussion during this 2-day symposium.

On the second day of the symposium, a summary table of all answers by question, which the JMA had prepared based on the submitted responses, was distributed to everyone involved so that each could verify and/or modify the answers by question item. The sorting (or classification) contained in the summary shown in Attachment 1 was produced through such a process.

6. Answers

The answers to the above five questions are summarized below. Please refer to the report in Attachment 1 for details.

6-1. Answer to Question 1

Question 1 asked if there is any law or court ruling that tolerates a physician's involvement in euthanasia and/or assisted suicide.

All member associations answered "No" to this question.

However, we learned from the Australian Medical Association that the State of Victoria will be voting on a euthanasia bill in coming months. There is an appetite for euthanasia and PAS in numerous Australian states and New Zealand where several parliamentary bills have been defeated.

6-2. Answer to Question 2

Question 2 asked whether legislation on Advanced Directive exists or not.

We also asked about "Orders Not to Attempt Resuscitation (DNAR)" and the practice of appointing a legal representative in relation to this question.

As for the existence of legislation, the result showed half of the member countries and participating countries have such legislation. It is worth noting that the practice of "advanced care planning" with physicians at its core is becoming popular.

6-3. Answer to Question 3

Question 3 asked about withholding or withdrawing of a life support system. This question also concerns the WMA Declaration of Lisbon on Patient's Rights, in which death with dignity is endorsed as a form of practicing the right of self-determination by a patient. We observed a subtle difference in opinion on the ideas of "withholding" and "withdrawing," so we should carefully examine each answer over time.

6-4. Answer to Question 4

Question 4 asked about "palliative care." Enriched palliative care is expected to improve the pain management in the end-of-life care, which may resolve the issue raised in Question 1. However, the uses of narcotic drugs such as morphine and opioids, which are commonly used in palliative care, are strictly regulated by the authorities in many countries, and it appeared that this area of medical care is still being developed.

The involvement of religion was also asked in relation to this question, and the response in general implied that religion plays a role in most countries and jurisdictions.

6-5. Answer to Question 5

The responses from several member associations, namely Australia, Korea, New Zealand and Taiwan, suggest that this problem is being addressed.

7. Summary

At the CMAAO General Assembly Tokyo in 2017, all of the NMAs have opposed euthanasia and PAS. With the exception of Australia and New Zealand, there is no significant desire in the civil society of the Asia/Oceania region to discuss the concept of euthanasia and PAS. All the NMAs support the creation of Advanced Directive and advanced care planning with physicians for the terminally-ill patients.

Additional Note 1. Observations as the symposium organizer

The main purpose of this symposium was not about consolidating opinions but finding facts. The core of the questions concerns the life or death at the end of life. Naturally, the natural environment, culture, religion, and social structure of different countries/jurisdiction are deeply involved in the NMAs' answers in the survey. In terms of religion alone, there are Judaism, Christianity (Catholicism and Protestantism), Islam, Hinduism, Buddhism (Hinayana and Mahayana), Taoism, Confucianism, etc.—some accept reincarnation, some believe in the absolute being, and their beliefs in life and death are very variable. When asked about the role of religion in the questions relating to palliative care, the NMAs' answers and explanations suggested strong influence of religion. The Bangladesh's answer was "Most of the people believe one God and it helps." Indonesia answered "Belief in One and Only God," "Life is given by God and cannot be taken away except by Him or His permission," and "Important to save the soul, to be prepared for life after death." Pakistan, which adapts the Talqueen practice for every terminal Moslem patients (Pukovisa 2017), answered "Pakistan, an orthodox religious country–this issue not only can be discussed but presently there is no room to make any kind of legislation in this regards." Cambodia's answer was "Buddhism is major religion and any act to prolong survival is a good thing." Nepal answered "Dominated by Hindu and Buddhist religion, people believe in afterlife in hell or heaven." Thailand answered "Buddhism plays an important role. Buddhists in Thailand claim suicide as sin." Again, these answers indicate that the answers to Question 1 are also strongly influenced by religion.

In addition, the oral reports and the Powerpoint slides used during presentation suggested that the family and community bonds are extremely firm in the island regions in Oceania such as Indonesia, Philippines, Malaysia and the countries/jurisdictions in the Southeast Asian region such

as Pakistan, India, Bangladesh, Myanmar, Thailand, and Cambodia. It was also indicated that the idea of self-determination that developed in the Western countries has not necessarily fully infiltrated in these areas.

In relation to Question 1, which was the main theme of this survey, a voice of question was raised about the use of the word "(active) euthanasia" and the fact that the Supreme Court of India used the word "passive euthanasia," which the Indian Medical Association quoted in their answers. The definitions and implications of the words "euthanasia = die Euthanasie" and "physician-assisted-suicide" are often interpreted differently depending on the users, which suggests that they need to be set straight within the WMA to avoid confusion in future discussions. The WMA Resolution on Euthanasia that was adapted by the 2002 Washington General Assembly states "The World Medical Association has noted that the practice of active euthanasia with physician assistance, has been adopted into law in some countries" in its third sentence. On this point, the well-established law dictionary in America, the Black's Law Dictionary, lists "active euthanasia" and "passive euthanasia" as the antonym in its 7th edition (1999) and the latest edition (10th edition; 2014) (Attachment 3). It should also be noted that although the word "physician-assisted-suicide" was used in the questionnaire this time, a criminal type of 'murder at the victim's request' separately from 'physician-assisted-suicide' exists in many jurisdictions including Japan. In the present wording of the policy documents, however, this criminal type is supposed to be excluded. If this type is to be included, perhaps the word "physician-assisted-dying" could be introduced and listed together with "physician-assisted-suicide" to indicate ascertainment. To note, putting its propriety aside, the aforementioned dictionary by Black is using the word "passive euthanasia" to mean "the act of allowing a terminally ill person to die by either withholding or withdrawing life sustaining support such as a respirator or feeding tube," as the Supreme Court of India did.

Lastly, we are deeply grateful to Dr. Otmar Kloiber for his support throughout the planning and holding of the symposium. We also thank Dr. Yeh Woei Chon, Chair of CMAAO, Dr. Kar Chai Koh, Vice-Chair and Dr. Dong Chun Shin, Advisor for overseeing the proceedings of the symposium and consolidating opinions.

This report was prepared by JMA Legal Advisor Professor Tatsuo Kuroyanagi in cooperation with the International Affairs Division staff of JMA, Mr. Yuji Noto, Mr. Hisashi Tsuruoka, Ms. Mieko Hamamoto, Ms. Rei Kobayashi and Ms. Michiyo Takano. It should be noted that Kuroyanagi solely bears the responsibility for wording and content of this report.

Additional Note 2. Conflict of Interest Statement

The author of this report is Professor Tatsuo Kuroyanagi, Legal Adviser of the Japan Medical Association. There is no financial or commercial interest connected to this work.

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09.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**MEC 209/End of Life Nigeria/Apr2018** **Report of the WMA African region meeting on End-of-Life Questions in Nigeria 2017**	Original: English
Destination:	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note	The Symposium on End-of-Life Questions was hosted by the Nigerian Medical Association in Abuja, Nigeria on 1st and 2nd February 2018. This report was prepared by Nigerian Medical Association.	

REPORT OF THE WMA AFRICAN REGION MEETING ON END OF LIFE ISSUES

PREAMBLE

As part of the efforts of the World Medical Association (WMA) to generate open regional discussions on the dilemmas related to End of Life issues, particularly with respect to Palliative care, Euthanasia and Physician assisted suicide, the WMA Council meeting held in Livingstone, Zambia in the month of April 2017, encouraged the African region of the WMA to organize an African Region meeting on End of Life issues.

Arising from the foregoing, the Coalition of African Medical Associations gave the nod to the Nigerian Medical Association to host the WMA African Region Meeting on End of Life issues. Accordingly, the WMA African Region meeting on End of Life issues (Palliative care, Euthanasia and Physician assisted suicide) was hosted by the Nigerian Medical Association in Abuja, Nigeria on the 1st and 2nd of February 2018.

The End of Life meeting which held at the Transcorp Hilton Hotel and Towers, Abuja, had as its theme 'An Excursion into the End of Life Spectrum: Defining the boundaries between Palliative care, Euthanasia and Physician assisted suicide'. It was graced by some invited dignitaries as well as the Secretary General of WMA (Dr. Otmar Kloiber) who made a presentation on WMA policy on End of Life issues. It also had in attendance Presidents and delegates of National Medical Associations from Nigeria, Zambia, Kenya, South Africa, Cote D'Ivoire and Botswana.

Activities conducted during the meeting included Welcome cocktail, formal opening ceremony, Scientific sessions with presentations by various Guest speakers on End of Life issues, Breakout technical sessions, sight-seeing/visitations and a closing dinner.

The formal opening ceremony was chaired by the Senate President, Senator Dr. Bukola Saraki (who was represented by Senator Dr. Lanre Tejuosho), while the Minister of Health, Prof. I.F. Adewole (who was also in attendance) represented both Nigeria's President (Muhammadu Buhari GCFR) and Nigeria's Vice President (Prof. Yemi Osinbajo).

OBSERVATIONS

The meeting made the following observations:

1) There is no specific policy or legislation on Euthanasia and Physician assisted suicide in Africa.

2) Aside from countries such as Nigeria, Zambia, Kenya, Uganda, South Africa and Botswana with some initiatives, policies, guidelines and practices on palliative care, there is a dearth of policy guidelines and legislation on palliative care in most African countries.

3) In African culture, tradition and religion, life is held sacred and families never abandon their loved ones at the end of life.

4) Palliative care is generally accepted in African culture, tradition, and religion.
5) Involvement of Physicians in Euthanasia and Physician assisted suicide flies in the face of the Physicians' Pledge and ethics governing the medical profession.

6) There is a low level of awareness on End of Life issues among African populations and medical/health professionals.

7) There is a dearth of standard health care systems and medical personnel equipped to deliver palliative care.

8) There is a high poverty rate; poor access to affordable, equitable and quality health care; and poor access to palliative care in most African countries.

RESOLUTIONS

1) National Medical Associations in Africa are unanimously opposed to Euthanasia and Physician assisted suicide in any form.

2) National Medical Associations in Africa support policies and legislations permitting and strengthening palliative care.

3) There is need for improved political will and commitment to palliative care by African Governments.

4) African National Medical Associations (NMAs), Non-Governmental Organizations (NGOs), etc. need to embark on enlightenment and advocacy campaigns to orientate various arms of government and policy makers, as well as the general public on the importance and availability of palliative care.

5) There is need for increased awareness amongst care givers, patients and other stakeholders, with the capacity of Physicians and other relevant health professionals to deliver palliative care continuously built.

6) There is great need for strengthening of African healthcare systems, universal health coverage, improved budgetary allocation to health, and integration of palliative care and other chronic medical conditions into the health care financing/health insurance schemes of African countries.

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09.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**MEC 209/End of Life Brazil/Apr2018** **Report of the WMA South American region meeting on End-of-Life Questions in Brazil 2017**	Original: English
Destination:	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note	The Symposium on End-of-Life Questions was hosted by the Brazilian Medical Association in Rio de Janeiro in 2017. This report was prepared by Brazilian Medical Association.	

Latin American Meeting on End-of-Life Ethical Dilemmas

CONCLUSIONS

Medicine in recent decades has had and continues to enjoy dizzying advances. However, they are not all successes. On the one hand, the life expectancy is greatly advanced, but on the other hand, the times of suffering, the trials and useless treatments, the solitude of the patient, the lack of answers, and in an endless way the suffering of the agony.

Human dignity is linked to the life of each individual and the radical equality of all human beings from the beginning, regardless of their concrete conditions. Life is always dignified, unworthy are the conditions in which many human beings live and are unworthy the decisions and behaviors that provoke them, produce or cause them.

The medical science put at the service of suffering and sick who are no longer cured, is where palliative care is developed when trying to give the technical and human attention that the patients need in terminal situation, with the best possible quality and looking for the professional excellence.

After palliative medicine emerges with force, it does not seek to lengthen or shorten life, it only seeks the patient's greater well-being respecting the moment of death, but accompanying to the end. Today its services must be a right or at least an attainable service for all patients.

It is well known that hope is energy to live, on the contrary, contempt, lack of affection, marginality annul the interest in life, are the prelude to death that especially affects the most disadvantaged and weakest on which often society, far from offering comfort and understanding, multiplies the feelings of uselessness, incapacity, dependence and, consequently, it worsens its state and now offers the way out to end up in an organized manner with life.

Death occurs at a certain moment in life, so it can neither be worthy nor unworthy, what can be worthy or unworthy are the conditions of life that have preceded it.

Volunteering is not enough to guarantee the freedom and dignity of the person. The human being will often find himself in situations of vulnerability where he can manifest his will, but he does not do it freely. That is why his dignity must be defended against third parties and even against their own decisions.

Pity and compassion must be the engine for all lives to make sense, that no one dies in solitude, or mobilize so that no one suffers avoidable pains. However, if the doctor is prepared not only to cure but also to kill, the ethics of medical practice and the trust that the patient must have in his doctor will be very battered.

With euthanasia, a social message is sent to the most severely disabled patients, who can be morally coerced, even if it is silent and indirectly, to request a faster end, since they are considered a useless burden for their families and for society. In such a way that patients weaker or in worse circumstances would be the most pressured to request euthanasia.

The request for euthanasia by the patients is reduced by improving the training of professionals in the treatment of pain and in palliative care. A permissive legislation with euthanasia would restrain the involvement, both scientific and care, of some doctors and health professionals in the care of patients with no possibility of cure that require a considerable dedication in time and human resources.

Societies should be aware of the risks of legislation allowing euthanasia where the social climate can lead doctors and family members to slip into its application in cases of unconscious or incapable patients who have not expressed their authorization, this is the phenomenon of the "slippery slope" that has led in the Netherlands to its application in people who had not requested it or did not meet the legal requirements.

At present it is not that there is a legal vacuum in relation to the regulation of this matter, but what is regulated is the duty of the physician to preserve life, as correlative to the fundamental right of all citizens. That duty of the physician must be exercised in accordance with the rules that indirectly regulate the Lex Artis, which refers to the laws that order the health professions and the rigorous fulfillment of the ethical obligations.

The medical profession faced to the social debate on euthanasia has agreed to recognize that cases of petition for euthanasia are exceptional when providing quality medical care and that the debate on the decriminalization of euthanasia revolves around the social consequences of legislating for these cases.

By vocation, training and mentalization, he or she who chooses medicine as a reason for being knows that all his/her efforts, all the knowledge, are to save the lives of their patients and save as much suffering as possible, cannot be dedicated simultaneously to end someone's life for whose life he/she has fought. Euthanasia in any case should be a medical activity.

The sick at the end of life need a helping hand not to precipitate their death, nor to prolong their agony with the therapeutic obstinacy, but to be with them and relieve their suffering with palliative care while their death arrives.

Rio de Janeiro, 18 March 2017

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THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**MEC 209/End of Life Europe/Apr2018** **Report on the WMA European Region Conference on End-of-Life Questions 2017**	Original: English
Destination:	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note	The WMA together with the German Medical Association and the Pontifical Academy for Life organized a two-day WMA European Region Conference on End-of-Life Questions, which took place in the Vatican's Aula Vecchia del Sinodo on 16 and 17 November 2017	

Report on the WMA European Region Conference on End-of-Life Questions

The two-day WMA European Region Conference on End-of-Life Questions took place in the Vatican's Aula Vecchia del Sinodo on 16 and 17 November 2017. Around 150 participants gathered from Europe and beyond, including WMA leaders and members, experts in palliative care, ethicists, lawyers and religious leaders. The presentations on euthanasia and physician assisted suicide (PAS) and the views expressed covered the full spectrum of opinion. The purpose of the event, which was co-organised by the WMA, the German Medical Association and the Pontifical Academy for Life, was to explore ethical dilemmas relating to end-of-life issues to assist the WMA in deciding whether or not to amend its policy on these issues.

In an address prepared by Pope Francis and read by Cardinal Peter Turkson, the Pope said it was clear that not adopting, or else suspending, disproportionate measures, meant avoiding overzealous treatment. From an ethical standpoint, this was completely different from euthanasia, which was always wrong, in that the intent of euthanasia was to end life and cause death.

In his introductory remarks, Professor Dr. Frank Ulrich Montgomery, President of the German Medical Association, explained that the WMA had always had a very clear position on end-of-life issues – it condemned euthanasia and PAS as unethical. He later added that he found none of the arguments in favour of PAS compelling. Like euthanasia, PAS was unethical and must be condemned by the medical profession. Medical ethics should not simply follow public opinion.

Archbishop Vincenzo Paglia, President of the Pontifical Academy for Life, reiterated that Pope Francis's message reaffirmed and added precision to previous papal texts about end-of-life care.

WMA President Dr. Yoshitake Yokokura referred to the symposium on end-of-life held by the Confederation of Medical Associations in Asia and Oceania in Tokyo in September, where most national medical associations had opposed euthanasia and PAS.

But Dr. René Héman, Chairman of the Royal Dutch Medical Association, took a different view. He quoted the recently revised Declaration of Geneva and the pledge that 'I will respect the autonomy and dignity of my patient'. He explained the situation in the Netherlands, where euthanasia was still a punishable offence and was forbidden unless specific requirements were met. These include instances where there has been a voluntary and well considered request, where there is unbearable suffering and no prospect of improvement and where one other independent physician has been consulted. Also, there has to be a conviction that no other reasonable solution for the patient's situation is available and that the termination of life or assisted suicide are performed with due care. Dr Héman said it would never be good to end a person's life, but sometimes it would be worse not to. He argued that euthanasia was based on the principles of respect for a patient's autonomy and on compassion.

Dr. Yvonne Gilli, from the Swiss Medical Association, outlined the situation in Switzerland, where there had been an increase in the rate of assisted suicides in the last ten years. She referred to revised guidelines just issued by the Swiss Academies of Arts and Sciences, which included more focus on guiding physicians through a professional dialogue with a dying patient. They made more specific recommendations on palliative sedation and on assisted suicide.

A discussion on theological approaches, featuring representatives of the Catholic, Jewish, Islamic and Orthodox Christian faiths, all of whom expressed opposition to euthanasia and PAS, was followed by presentations on the legal aspects of end-of-life issues.

Prof. John Keown, Professor of Christian Ethics at the Kennedy Institute of Ethics, Georgetown University, explained the common and criminal law relating to euthanasia and PAS and relating to withholding and withdrawing life-preserving treatment for competent and incompetent patients. Prof. Dr. Volker Lipp, Professor of Civil Law, Procedural Law, Medical Law and Comparative Law, at Georg-August-Universität, Göttingen spoke about the diversity in various legal systems. He examined the various definitions of the term "euthanasia" and said care should be taken about using it as it was an ambiguous concept.

Dr. Laurence Lwoff, Head of the Bioethics Unit, Human Rights Directorate, Council of Europe, talked about the Council of Europe Guide on the decision-making process regarding medical treatment in end-of-life situations. This gave rise to complex situations relating to equity of access to health care, professional obligations, free and informed consent and previously expressed wishes.

Presentations were followed by lively panel discussions and robust question and answer sessions. Dr. Jeff Blackmer, from the Canadian Medical Association, defended the role of doctors in Canada, where medically assisted dying became legal in 2016.

The first day concluded with speeches from Prof. Dr. Leonid Eidelman, President of the Israeli Medical Association and President elect of the WMA, and Prof. Pablo Requena, Professor of Moral Theology at the Pontifical University of the Holy Cross, and the delegate of the Vatican Medical Association at the WMA.

Dr. Eidelman referred to the experience of the Netherlands and said that one of the most important factors separating physicians who did or did not accept PAS and euthanasia was whether they saw their actions as similar to or different from other regular medical treatments they gave their patients. Was it a regular medical intervention like treatment with antibiotics or was it something extraordinary demanding a different attitude? In his view physicians should not be involved in PAS or euthanasia for several reasons. Many requests disappeared with symptom control and psychological support.

Prof. Requena said that compassion was not a good reason for euthanasia and unbearable suffering was not a medical reason. He said he doubted that society had the moral sense to protect physicians on this issue. That was why it was important that physicians protected themselves and that medical societies and the WMA continued to oppose euthanasia as a medical aid. Finally, he quoted the Hippocratic Oath, which stated 'I will not give a lethal drug to anyone if I am asked nor will I advise such a plan'.

The second day began with the question 'Is there a right to determine one's own death?' The opening speaker was Prof. Dr. Urban Wiesing, from the Institute for Ethics and History of Medicine at the University of Tuebingen in Germany, who argued for the concept of plurality, saying that there was no consensus on end-of-life issues from an ethical point of view. He said the answer to ethical plurality was a political one. He argued that there was no slippery slope involved as a result of PAS. Nor was there any loss of trust in physicians.

Prof. Dr. Christiane Druml, Chairperson of the Austrian Bioethics Commission and UNESCO Chair of Bioethics at the Medical University of Vienna, said it was a clear and undisputed principle that treatments which were not or no longer indicated or treatments which the patient refused must not be performed. But there were still cases where disproportionate treatment was initiated. Medical interventions which provided no benefit for the patient or which were more burdensome than potentially beneficial to the patient were ethically and medically unjustified because they came at a disproportionate burden.

Dr. Anne de la Tour, President of the French Society of Palliative Care spoke about end stage decisions on medication, feeding and terminal sedation, and the differences between sedation and euthanasia.

Dr. Gunnar Eckerdal, from the Department of Oncology at Sahlgrenska University Hospital in Sweden, talked in more detail about the role of nutrition. He said that treatment without clinical indication should be stopped. Treatment that was not going to give effect should not be started. He argued that PAS and euthanasia were not secure and involved wrong diagnoses and wrong prognoses, as well as underdiagnosed and undertreated depression.

Dr. Marco Greco, President of the European Patients' Forum, said his organisation did not have an official position on euthanasia and PAS. But empowerment was a multi-dimensional process that helped people gain control over their own lives and increased their capacity to act on issues that they themselves defined as important. He emphasised the importance of the partnership between patients and those caring for them. Shared decision-making was absolutely fundamental.

Dr. Heikki Pälve, former CEO of the Finnish Medical Association, spoke about dealing with public opinion from his recent experience in Finland. He said that public opinion had been strongly in favour of euthanasia as were 46 per cent of physicians. But the national medical association was opposed. This created difficulties. He believed that euthanasia fundamentally changed and to some degree also damaged trust in the health care system and said that the slippery slope argument was a fact, and a very undesirable one.

The conference concluded with a lively panel discussion on whether there was a need to change WMA policy, featuring speakers on both sides of the argument and questions from the audience.

Summary

Throughout the meeting, proponents of right-to-die policies emphasised that their intention was to protect physicians in their own countries who are acting within the law, not to change or influence policies in other countries. They based their arguments on the concepts of patient self-determination, dignity and compassion. Those who were opposed to euthanasia and PAS, representing the majority of attendees, rejected these procedures as being diametrically opposed to the ethical principles of medicine and expressed concern that they could lead to misuse or abuse, e.g. in the case of mentally or psychologically incapacitated people. They also expressed concern that these procedures could cause damage to the complete trust which characterises the patient-physician relationship or lead to social pressure for the elderly or those with chronic illness to end their lives.

The majority of attendees ultimately advocated for the retention of the existing policies of the WMA on euthanasia and PAS.

Despite disagreements during the many intentionally transparent and open debates held throughout the event, participants were united in their support for high-quality, accessible palliative care and their belief that PAS and euthanasia should never be seen as a cost-saving measure.

This report is based on an article by Nigel Duncan, which originally appeared in the December 2017 issue of the World Medical Journal, and contains supplementary material.

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THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**MEC 209/Genetic and Medicine/Apr2018**	Original: English
Title:	**Proposal for a major revision of the WMA statement on Genetics and Medicine**	
Destination:	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**

The Danish Medical Association believes that it would be timely for the WMA to initiate a major revision of the WMA Statement on Genetics and Medicine. The main reason for our proposal is that the current version of the statement does not deal sufficiently with the ethical issues that arise through the development and use of NGS in personalized medicine.

The goal of a major revision would be to develop the statement to:

- include a thorough treatment of the ethical implications of using NGS for personalized medicine
- be up-to-date with regards to the ethical issues of genetics and medicine that are included in the current statement
- be aligned with the principles of the WMA Declaration of Taipei on Ethical Considerations regarding Health Databases and Biobanks

Ethically relevant features of personalized medicine

There is no universally recognized definition of personalized medicine[1] but the salient feature is that it aims to adapt treatment to individual patients. This is often done by identifying genetic characteristics of either the patient or the illness and then adapting the treatment in accordance with the significance of those characteristics. The goal is to improve our ability to diagnose and classify illnesses in order to prevent or treat them more precisely, effectively and with fewer, less severe side effects.[2]

Personalized medicine entails ethical issues both through its development and in its use. The key reason for this is that both the development and application of personalized medicine often involves extensive genome sequencing.

[1] Sometimes also referred to as precision medicine or genomic medicine.

[2] Personalizing medicine can also be sought by adapting the treatment to other relevant person-specific features than genetic ones. In this context, we will however attention on the relevance of genetic features as is it is mainly increased attention to those features that generates the ethically relevant issues.

A key feature in relation to developing personalized medicine is that large groups of participants have their whole genomes sequenced and that data from that process is analyzed exploratively in combination with other types of health care data to identify correlations and patterns that might be of clinical relevance.

The information generated by extensive genome sequencing, including whole genome sequencing, often has the following characteristics:

- Very large volumes of health care data are generated about each participating person and the development of personalized medicine requires the sequencing genomes from large number of persons
- The full significance of the data is not known at the time of the sequencing, which means that, at a later time, the data could be used to generate much more information about the individual
- There is a significant risk of secondary or incidental findings which might include information about health care risks
- The data generated from the sequencing of one person's genome contains information about other genetically related persons
- Due to the nature of the data generated by genome sequencing, the data cannot be fully anonymized
- The genetic information generated by the sequencing is permanent for each participating person

Individually, each of these characteristics could also be found in other types of health care information. For example, incidental findings regularly occur in relation to radiological examinations.

However, the combination of the characteristics makes data from extensive genome sequencing particularly sensitive and therefore detailed ethical guidelines are appropriate.

A working group to revise the current statement

In light of this – and that the development and use of personalized medicine is expected to accelerate in the coming years – we believe that it would be relevant to initiate a major revision of the WMA-Statement on Genetics and Medicine. Specifically, we propose that the WMA establishes a working group to be responsible for the revision and the DMA would be happy to responsible for such a working group.

We are aware that the current statement is up for review in 2019 but given the speed of the development of personalized medicine and the use of NGS, we believe that a revision should be initiated now.

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19.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**MEC 209/Biosimilar Medicinal product/Apr2018** **Proposed WMA Statement on Biosimilar Medicinal Products**	Original: English
Destination:	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note	This WMA Statement is proposed to the Committee by the Israeli Medical Association.	

PREAMBLE

1. The expiry of patents for the first original biotherapeutics has led to the development and authorization of copy versions, called 'similar biological medicinal products'' or biosimilars. that are highly similar to an already approved biological medicine, known as the reference medicine.

2. In light of the fact that biosimilars are made in living organisms, there may be some minor differences from the reference medicine. The manufacture of biosimilars tends to be more complex than for chemically derived molecules. Therefore, the active substance in the final biosimilar can have an inherent degree of minor variability. Biosimilars are not always interchangeable with the reference products even after regulatory approval.

3. Biosimilars are not the same as generics. A generic drug is an identical copy of a currently licenced pharmaceutical product that has an expired patent protection and must contain the 'same active ingredients as the original formulation'. A biosimilar is a different product with a similar, but not identical, structure that elicits a similar clinical response. As a result, biosimilars medicines have the potential to cause an unwanted immune response. Whereas generics are interchangeable, biosimilars are not.

4. Biosimilars have been available in Europe for almost a decade following their approval by the European Medicines Agency (EMA) in 2005. The first biosimilar was approved by the FDA for use in the U.S. during 2015.

5. Biosimilar medicines have transformed the outlook for patients with chronic and debilitating conditions, as similar efficacy as that of the innovator product can be obtained at a lower cost.

6. Biosimilars will also increase access for patients without access to the bio-originator. Greater global access to effective biopharmaceuticals can reduce disability, morbidity, and mortality associated with various chronic diseases.

7. Nonetheless, the potentially lower cost of biosimilars raises the risk that insurers may favor them over the original reference medicine, even when they may not be appropriate for an individual patient.

RECOMMENDATIONS

8. National medical associations should work with their governments to cultivate national guidance on safety of biosimilars.

9. National medical associations should advocate for delivering biosimilar therapies that are as safe and effective as their reference products.

10. National medical associations should lobby against allowing insurers and health funds to promote biosimilar and reference medicine's interchangeability and automatic substitution, that can be to the detriment of patients.

11. Physicians must ensure that patient medical records accurately reflect the biosimilar medicine that is being taken.

12. Physicians shouldn't prescribe a biosimilar to patients already showing success with the reference medicine.

13. Physicians should raise awareness of the issues surrounding biosimilars and promote clearly delineated labelling of biosimilars.

19.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**MEC 209/Policy Review 2008/Apr2018** **Annual Policy Review 2008: Recommendations received on MEC documents**	Original: English
Destination:	Medical Ethics Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**

The ongoing policy review process adopted by the WMA requires a review of every policy for which it had been ten years since adoption or last revision.

The first step in the review process is to survey Constituent Members for their advice on whether a policy requires (a) reaffirmation, (b) minor or editorial changes before reaffirmation (c) a major revision, or (d) rescinding and archiving. On 6 February 2018, a memo was sent to Constituent Members asking them to recommend the classifications of the 2008 policies. The result of this consultation is as follows:

1) List of Respondents (26):

Australian Medical Association (AuMA)	Norway Medical Association (NMA)
Bangladesh Medical Association (BMA)	Netherlands medical Association(RDMA)
Canadian Medical Association (CMA)	Consejo General de Colegios Medicos de España (CGCM)
Conseil National de l´Ordre des Médecins France (CNOM)	Swedish Medical Association (SwMA)
Danish Medical Association (DMA)	Taiwan Medical Association (TMA)
Israeli Medical Association (IsMA)	Medical Association of Thailand (MAT)
Japan Medical Association (JMA)	Turkish Medical Association (TuMA)
Korean Medical Association (KMA)	British Medical Association (BMA)
Kuwait Medical Association (KuMA)	Vatican Medical Association (AMV)
German Medical Association (GMA)	Pakistan Medical Association (PkMA)
Austrian Medical Chamber (AMC)	Finnish Medical Association (FMA)
Rwanda Medical Association (RMA)	American Medical Association (AMA)
Colegio Medico de Mexico (CMM)	South African Medical Association (SAMA)

2) Policies abbreviations:

Capital punishment: Resolution on Physician Participation in Capital Punishment
Torture : Resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel, Inhuman or Degrading Treatment of Which They are Aware
Code of ethics: International Code of Medical Ethics (MEC)

3) Specific comments from NMAs:

Capital punishment · (JMA) JMA believes that "Resolutions" should not undergo a major revision because they are supposed to have been adopted reflecting the times when they were adopted. This resolution should be also reaffirmed without changes. (KMA) Merging this resolution with the WMA Resolution to reaffirm the WMA's Prohibition of Physician Participation in Capital Punishment. (SwMA) We agree with the Secretariat´s suggestion to merge this resolution with the "WMA Resolution to reaffirm the WMAs prohibition of physician participation in capital punishment". (BMA) We agree that is makes little sense to have two documents saying much the same thing.
Torture (JMA) Citing the other related documents will lead to an endless, unnecessary procedure. (KMA) If a doctor recognizes that a patient has been under torture and other cruel, inhuman or degrading treatment, it should be accurately recorded and kept with the ethical obligation to report to an authorized institution. However, since there are concerns about patients and doctors being under retaliation, or the infringement of personal information, it is necessary to take extra caution. (SwMA) This resolution has a long introduction, in which a large number of declarations, conventions and resolutions are mentioned. To put greater focus on the actual recommendations, perhaps the introduction could be shortened and, if necessary, reference to the different documents placed in an annex or footnotes? (RDMA) We also think that it is important to qualify in this Resolution the relation with the other ones. More in general should the WMA be careful to have several resolutions, statements and Declarations on the same subject (DMA) The DMA recommends a *major revision* for this resolution. While the document contains many important messages, these messages are not well communicated. For example, the documents should not open with 15 references to other documents without a clear statement on the relevance of those messages. (AMA) We recommend a major revision. The policy would benefit from re-formatting to the customary WMA style and has too many extraneous references at the beginning of the document.
Code of Ethics

(JMA) agrees to the viewpoints of the WMA Secretariat. It is true that ICME is now complemented by the other ethics policies, and requires a thorough review. WMA should start working on this review process internally while paying due consideration to the DoG.

(RDMA) At first glance we don't see a need for complete re-writing. We do however think it is very useful to compare all the different documents of the WMA dealing with medical ethics and conduct of physicians. Maybe it is possible to merge some of them? Also it is very important that they contain consistent messages. Therefore, we suggest that a broader project, comparing the WMA-documents may, may be useful. Apart from that and because of that we do agree with postponing the revision process of this particular Code of Medical Ethics, with the implementation of the DoG still going on.

(DMA) The WMA-secretariat recommends that decision on this document be postponed to avoid confusion during the ongoing reception of the DoG. While the DMA certainly agrees that such confusion must be avoided, we do believe that a decision to start a major revision is appropriate - and that the revision process could be initiated after the meeting in Riga. The revision of this important document must be very thorough indeed and will require a substantial internal WMA process. By the time a public consultation may be appropriate, we believe that the risk of confusion with the DoG will be minimal. The DMA would be proud to participate in the reviewing process as we have just finalized a reviewing process of our own ethical principles.

(TuMA) It could be useful to review it thoroughly after updating DoGeneva.

(FMA) Agree with postponing by one year. Internal work could start even earlier.

4) Constituent Members' classification

Name of Policy / Constituent Members	Capital Punishment	Torture	Code of ethics
AMA	Merge	C	Postpone
AMC	Merge	B	Postpone
AMV	Merge	B	Postpone
AuMA	C	B	Postpone
BaMA	A	A	A
CMA	A	B	Postpone
CGCM		B	Postpone
CMM		B	Postpone
CNOM	C	B	Postpone
DMA	B	C	C
FMA	Merge	B	Postpone
GMA	A	B	C
IsMA	Merge	B	Postpone
JMA	A	A	Postpone
KMA	Merge	B	Postpone
KuMA	Merge	A	C
NMA	Merge	B	
PkMA	A	B	Postpone
RDMA	Merge	B	Postpone
RMA	A	B	B

SAMA	B	A	
SwMA	Merge	B	Postpone
TMA	A	B	
MAT	A	A	A
TuMA	Merge	B	C
BMA	Merge	B	C
TOTAL	**24**	**26**	**23**

5) Summary of classification

Name of Policy / Classification	**Capital Punishment**	**Torture**	**Code of Ethics**
Reaffirm (a)	8	5	2
Reaffirm with minor revision (b)	1	19	1
Major revision (c)	2	2	5
Rescind and archive (d)			
	12 (merge)		15 (postpone decision)
Proposed classification based on members' recommendations	**Merge with WMA Resolution to reaffirm the WMA's Prohibition of Physician Participation in Capital Punishment ***	**B**	**Postpone decision**

In the light of this response, the Committee is asked to recommend to Council a classification for this policy in MEC.

The Secretariat can take care of a policy requiring minor revision, which will be circulated to the member associations for comment and considered at the October 2018 Committee and Council meetings. Constituent Members are invited to volunteer, either individually or in workgroups, to undertake any major policy revision. Recommendations for rescinding and archiving will go to the Assembly in October 2018 for final decision.

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09.04.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**FPL 209/Agenda/Apr2018/Rev**	Original: English
Title:	**Agenda of the Finance and Planning Committee**	
Destination:	Finance and Planning Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note:	This agenda has been revised on the items 3.1, 3.3 and 5.2.	

Thursday, 26 April 2018

Membership of the Committee

Dr Moojin Choo
Dr Louis Francescutti
Dr Andrew W. Gurman
Dr René Héman (Chair)
Dr Miguel Roberto Jorge
Dr Toru Kakuta
Dr Mari Michinaga
Dr Andreas Rudkjoebing
Dr Julio Trostchansky
Dr Walter Vorhauer

Ex-officio (with voting rights)

Dr Ardis Dee Hoven, *Chair of Council*
Dr Frank Ulrich Montgomery, *Vice-Chair of Council*
Dr Andrew Dearden, *Treasurer*

Ex-officio (without voting rights)

Dr Yoshitake Yokokura, *President*
Dr Leonid Eidelman, *President-Elect*
Dr Ketan Desai, *Immediate Past President*
Dr Otmar Kloiber, *Secretary General*
Ms Marie Collegrave-Juge, *Legal Advisor*
Mr Adolf Hällmayr, *Financial Advisor*
Ms Joelle Balfe, *Facilitator*
Ms Sunny Park, *Head of Operations*

1. GENERAL BUSINESS

1.1 Call to order by the Chair of the Council

1.2 Report of the previous meeting held in Chicago, United States, 11-14 October 2017

Approve: Report of the Finance and Planning Committee
(FPL 207/Report/Oct2017)

1.3 Chair's Opening Remarks

2. FINANCE

2.1 Membership Dues Payments

Consider: Report on Membership Dues Payments for 2018
(FPL 209/Dues Report/Apr2018)

Receive: Oral Report on Dues Arrears

2.2 Financial Statement

Consider: Pre-audited Financial Statement for 2017
(FPL 209/FinStat 2017/Apr2018)

3. PLANNING

3.1 WMA Strategic Plan

Consider: Oral report by the Secretary General on the Draft Strategic Plan 2020

3.2 WMA Statutory Meetings

Consider: Planning of Future WMA Meetings
(FPL 209/WMA Future Meetings/Apr2018)

3.3 WMA Special Meetings

Receive: Oral Report
1) WMA Meetings in Geneva during WHA, 21-26 May 2018
2) Icelandic Medical Association / WMA Medical Ethics Conference October 1-4, 2018 in Reykjavik, Iceland
3) 13th UNESCO World Conference on Bioethics, Medical Ethics and Health Law in Jerusalem, Israel, 27-29 November 2018
4) 14th World Congress of Bioethics and 7th National Bioethics Conference, Bangalore, India, December 3-7, 2018, Potential WMA participation

4. MEMBERSHIP

4.1 Constituent membership

Consider: Applications for Constituent members, if any

4.2 Associate Membership

Consider: Report of the WMA Associate Membership for 2017
(FPL 209/AM Membership/Apr2018)
Receive: Report of Chair of Associate Members
(FPL 209/Chair of AM Report/Apr2018)
Receive: Report of the Junior Doctors Network (JDN)
(FPL 209/JDN Report/Apr2018)
Receive: Report of the Past Presidents and Chairs of Council Network (PPCN)
(FPL 209/PPCN Report/Apr2018)

5. GOVERNANCE

5.1 Review Committee

Receive: Oral report of the Chair of Review Committee

5.2 Nominating process for senior posts

Consider: Proposal to introduce a self-declaration statement to the nominating process for WMA Presidency (FPL 209/Nominating process/Apr2018)

6. OUTREACH

6.1 World Medical Journal

Receive: Report of WMJ Editor
(FPL 209/WMJ Report/Apr2018)

6.2 Public Relations

Receive: Public Relations Report for October 2017 – March 2018
(FPL 209/PR Report/Apr2018)

7. ANY OTHER BUSINESS

8. ADJOURNMENT

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THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**FPL 207/Report/Oct2017**	Original: English
Title:	**Report of the Finance and Planning Committee**	
Destination:	Finance and Planning Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**

Wednesday, 11 October 2017

Membership of the Committee

Dr Moojin Choo
Dr Louis Francescutti
Dr Andrew W. Gurman
Dr René Héman (Chair)
Dr Miguel Roberto Jorge
Dr Toru Kakuta
Dr Mari Michinaga
Dr Andreas Rudkjoebing
Dr Julio Trostchansky
Dr Walter Vorhauer

Ex-officio (with voting rights)

Dr Ardis Dee Hoven, *Chair of Council*
Prof. Dr med. Frank Ulrich Montgomery, *Vice-Chair of Council*
Dr Andrew Dearden, *Treasurer*

Ex-officio (without voting rights)

Dr Ketan Desai, *President*
Sir Michael Marmot, *Immediate Past President*
Dr Yoshitake Yokokura, *President-Elect*
Dr Otmar Kloiber, *Secretary General*
Ms Marie Colegrave-Juge, *Legal Advisor*
Mr Adolf Hällmayr, *Financial Advisor*
Prof Vivienne Nathanson, *Facilitator*

1. GENERAL BUSINESS

1.1 The Chair of the Council called the meeting to order at 11:40 am.

1.2 The Committee **approved** the report of the previous meeting held in Livingstone from 20-22 April 201 (FPL 206/Report/Apr2017).

1.3 The Chair thanked the American Medical Association for hosting the meeting. He noted the very full agenda and the fact that the work of the Finance and Planning Committee enables the health of the organization and its ability to pursue its mission.

2. FINANCE

2.1 Financial Statement

2.1.1 The Committee **considered** the Audited Financial Statement for 2016 (FPL 207/FinStat 2016/Oct2017). The WMA Treasurer, Dr Andrew DEARDEN, highlighted several key points from the Statement.

The Treasurer also addressed concerns about accepting funding from the pharmaceutical industry. He stressed that we must be transparent about where all funding comes from, the amounts, and the projects or activities to which they are applied. The Secretary General stated that it is WMA's policy to avoid any undue influence on the work of the WMA and that information about sponsorship is available in the Secretary General Report to the Council. According to US law, it is also published on the websites of the donors. The Treasurer stressed that funding from outside sources is not used for the core work of the WMA, including the cost of statutory meetings. This funding is used exclusively for special projects, including educational efforts and other meetings.

RECOMMENDATION

2.1.1.1 That the Audited Financial Statement for 2016 (FPL 207/FinStat 2016/Oct2017) be approved by the Council and be forwarded to the General Assembly for approval and adoption.

2.1.2 The Committee **received** the oral report on 2016 Dues Arrears. The Treasurer announced that 99.35 % of 2016 contributions had been received.

2.2 WMA Budget and Membership Dues Payments

2.2.1 The Committee **considered** the Proposed WMA Budget for 2018 vs. Actual 2016 Expenditures (FPL 207/Budget 2018/Oct2017).

The Treasurer reviewed the details of the report, including some of the new proposed activities that would be possible due to the WMA's strong financial situation. The Canadian Medical Association asked the Treasurer to clarify whether the proposed new projects would be accomplished within the existing staff resources or would require hiring additional staff at the WMA Secretariat. The Secretary General responded that some of the activities would be accomplished by existing staff, but that there was a plan to add new staff to support the expanded work. He introduced the newest WMA Staff member, Communication and Information Manager Ms. Magda MIHAILA.

RECOMMENDATION

2.2.1.1 That the Proposed WMA Budget for 2018 (FPL 207/Budget 2018/Oct2017) be approved by the Council and be forwarded to the General Assembly for adoption.

2.2.2 The Committee **received** the Report on Membership Dues Payments for 2017 (FPL 207/Dues Report/Oct2017) including the dues in arrears. This document will be forwarded to the General Assembly for information.

2.2.3 The Committee **received** WMA Dues Categories 2018 (FPL 207/Dues Categories 2018/Oct2017). This document will be forwarded to the General Assembly for information.

2.2.4 The Committee **received** the oral report of Finance Workgroup. The Treasurer reported that the workgroup would review the WMA sponsorship policy, which should be done periodically to ensure that it is clear and current. He noted the launch of the educational platform that would occur late in 2017 or early 2018, which was possible due to the accumulated financial surplus.

The Secretary General reported on the situation in Venezuela and asked the Committee to support the Finance Group's request that the WMA waive the dues for the Venezuelan Medical Association for 2017 and consider them in good standing.

RECOMMENDATION

2.2.4.1 That the Council waive the membership dues of the Venezuela Medical Association.

2.3 Auditor

The Committee **considered** an oral report and the recommendation of the Treasurer to reappoint KPMG as the auditor for the 2017 WMA Financial Statement.

RECOMMENDATION

2.3.1 That the Council appoint KPMG as auditor of the 2017 WMA Financial Statement.

3. PLANNING

3.1 WMA Strategic Plan

The Secretary General reported that he had been instructed by Council to delay development of the next Strategic Plan, pending the outcomes from the Governance workgroup, which has now concluded its mandate. The recommendations in the workgroup's final report will be integrated into the next Strategic Plan. The draft Strategic plan will be presented at the Council Session in April 2018.

3.2 WMA Statutory Meetings

The Committee **considered** the planning and arrangements for future WMA meetings (FPL 207/WMA Future Meetings/Oct2017).

3.2.1 The Secretary General informed the committee that the recent unrest and the treatment of physicians, human rights defenders, and persons critical of the government in Turkey has led to a recommendation by the ExCo that WMA reverse last year's decision to hold the 2019 General Assembly in Istanbul. The Secretary General recognized that this is unfortunate, as it was WMA's hope to be able to support the TMA by holding the meeting there. Several members echoed their regret at the situation. He proceeded to explain that the Georgian Medical Association had agreed to host the General Assembly in 2019 instead of 2020. Therefore, the ExCo is recommending that WMA postpone indefinitely the invitation of the Turkish Medical Association and accept the Georgian Medical Association's offer to host the 2019 General Assembly.

The Secretary General clarified that this postponement will be reconsidered when the situation in Turkey stabilizes. He added that the WMA would release a press statement explaining the WMA's decision not to go to Istanbul in 2019 and expressing our continued strong support for the TMA.

RECOMMENDATION

3.2.1.1 That the Council recommend to the Assembly that the WMA postpone indefinitely the invitation of the Turkish Medical Association to host a meeting in 2019 and accept the Georgian Medical Association's offer to host the 2019 General Assembly.

3.2.2 The Committee **considered** the invitation of the Portuguese Medical Association to host the 215th Council session in 2020.

RECOMMENDATION

3.2.2.1 That the invitation of the Portuguese Medical Association to host the 215th Council Session in Porto in April 2020 be accepted.

3.2.3 The Committee considered the invitation of the German Medical Association to host the 73rd General Assembly in 2022.

RECOMMENDATION

3.2.3.1 That the invitation of the German Medical Association to host the 73rd General Assembly in Berlin in October 2022 be accepted.

3.2.4 Regarding the Council's decision in April 2017 to recommend that the 2021 General Assembly be held in China, the Secretary General informed the Committee that he had remaining concerns regarding free access by the press during the meeting as well as issues related to electronic communications, the method by which WMA organizes and shares documents. He noted that he

believed both concerns could be resolved but that they currently represented issues that need to be addressed.

At the direction of the ExCo, the Secretary General informed the Committee that the World Heart Federation had been denied permission at the last minute to hold a meeting in China unless its member from Taiwan agreed to change its name. If this happened to the WMA, both the WMA and participants would risk losing money spent on the meeting, travel arrangements, and registration fees, which could amount to more than 500,000 Euros. In discussion, it was clear that the divergence of positions between the Chinese Medical Association and the Taiwan Medical Association regarding the name of the Taiwan Medical Association remained unresolved. The Secretary General reminded the Committee that the WMA has previously made a decision not to interfere in this internal political situation and stressed that the WMA has no mandate or statute that gives us the right to make any demands regarding the name of a member. Several members supported this decision in their comments during discussion. The Secretary General informed the Committee of the ExCo's recommendation that the two medical associations, possibly with help from the WMA providing a moderator, use the next year to reach an agreement on this matter and that the Committee wait until 2018 to consider any changes to our plan to hold the 2021 General Assembly in China.

The medical associations from China and Taiwan agreed to discuss the issue of the name of the Taiwan Medical Association between themselves, possibly with support from the WMA.

The April 2017 decision of the Council to recommend to the 2017 General Assembly that WMA accept the invitation of the Chinese Medical Association to host the meeting in 2021 remains on the agenda (GA Council Report-Provisional Annex/Oct2017, Item 4.1) and will be presented to the Assembly during the plenary session.

3.3 WMA Special Meetings

The Committee **received** the oral report from the Secretary General concerning two meetings:

3.3.1 Dr Jon SNÆDAL informed the Committee that the Icelandic Medical Association and the WMA will hold a Medical Ethics Conference October in conjunction with the WMA General Assembly in Reykjavik, Iceland, 1-4 October, 2018 in Reykjavik, Iceland

3.3.2 13th UNESCO World Conference on Bioethics, Medical Ethics and Health Law in Jerusalem, Israel, 27-29 November 2018.

3.3.3 Nominations are closed for the WMA CPW Leadership course, which will be held from 3-8 December 2017. This meeting will be held in cooperation with the Mayo Clinic and receives financial support from Bayer and Pfizer.

4. MEMBERSHIP

4.1 Constituent membership

4.1.1 The Committee **considered** the Application from the Czech Medical Chamber (FPL 207/Apply-Czech/Oct2017). The Secretary General explained that the Czech Medical Association, a longtime WMA member, recently terminated its membership in WMA in recognition of the fact that the Czech Medical Chamber is a more representative of physicians in the country and more appropriate organization to be the WMA member from the Czech Republic.

RECOMMENDATION

4.1.1.1 That the Czech Medical Chamber be admitted to the WMA Constituent Membership.

4.1.2 The Committee **considered** the Application from the Belarusian Association of Physicians (FPL 207/Apply-Belarus/Oct2017). The Secretary General explained that WMA has been in contact with this Association for many years and now welcomes their application for membership in WMA. The organization does have a legal advisor who is a member of their board and therefore a member of their association, but this does not create an issue with our bylaws and should not preclude their membership in WMA.

RECOMMENDATION

4.1.2.1 That the Belarusian Association of Physicians be admitted to the WMA Constituent Membership.

4.1.3 The Committee **considered** the Application from the Pakistan Medical Association (FPL 207/Apply-Pakistan/Oct2017). The Secretary General informed the Committee that the Pakistan Medical Association was previously a WMA member. Thanks to the work of WMA President, Dr. Ketan Desai, they have been persuaded to re-join WMA. The Pakistan Medical Association does have six non-physician "honorary members" for specific merits, but we do not believe this creates any conflict with our ability to support their application for WMA membership.

RECOMMENDATION

4.1.3.1 That the Pakistan Medical Association be admitted to the WMA Constituent Membership.

4.1.4 The Committee **considered** the Application from the National Medical Chamber of Russia (NMC) (FPL 207/Apply-Russia/Oct2017)

The Secretary General explained that the Russian Medical Chamber includes organizations from 79 of the 82 regions in Russia, with the remaining three scheduled to join the NMC later this year. He considered the NMC the most representative of the national-level physician organizations in Russia, with a strong focus on self-governance, aiming to steer and supervise physician

conduct and develop ethical standards. Following careful review of their application by the WMA Legal Advisor, Mr. Marie COLEGRAVE, it was his recommendation that WMA approve their application. In response to a request from the Danish Medical Association, the Secretary General provided an overview of the assessments WMA had done to learn about the NMC and the reasons the NMC appears to be the most representative association in Russia. In response to a question from the Canadian Medical Association, the Secretary General explained that the amount of dues paid by the NMC would be low at first. He had made it clear to the President of the NMC that he expected the dues payments to increase incrementally as the financial strength of the organization grows. Dr. Peteris Apinis, President of the Latvian Medical Association, stated that he was familiar with the organization and its very well-respected leader.

The Secretary General noted that there remains an issue of former WMA member, the Russian Medical Society (RMS), which apparently believes it still has standing in WMA, despite being automatically terminated early in 2017 for non-payment of the subscription due. The RMS had sent a letter to WMA, essentially threatening legal action if the WMA accepts another member from Russia. The ExCo discussed this in depth and concluded that this should not interfere with the decision to admit the NMC into membership.

RECOMMENDATION

4.1.4.1 That the National Medical Chamber of Russia be admitted to the WMA Constituent Membership.

5. GOVERNANCE

5.1 Governance Review

The Committee **received** the Report of the Governance Review Workgroup (FPL 207/Governance Review/Oct2017) by Prof. Dr Rutger J. van der GAAG, the Chair of Workgroup.

Prof. van der GAAG reported that the mandate and the work of the workgroup had concluded. He reviewed some additional recommendations resulting from the workgroup meeting the previous day that are not contained in the written report. Several NMAs and the Chair of Council commended the workgroup Chair for his exceptional leadership of the group, noting the progress made and trust built over time as the workgroup considered numerous difficult issues.

The Chair recognized that there remains work to do in order to implement the changes recommended by the workgroup. She informed the Committee that she would take the Workgroup report to the ExCo to discuss and develop a plan for moving forward, deciding what incremental, short term, and long-term activities WMA should undertake to continue to make progress on the topics and issues identified. She stressed the importance of tying this work to the Strategic Plan and to be creative, forward thinking, and deliberative about enacting change. The Chair of Council thanked the Workgroup Chair and its members for their hard work.

RECOMMENDATION

5.1.1 That the Council accept the report of the Workgroup and that it be presented to the General Assembly for information and discussion.

5.2 Review Committee

The Chair of the Review Committee, Dr. Mark PORTER, reported that, following the formation of the Committee in Livingstone, the Committee had reviewed the new proposed policies for this meeting and was beginning cooperation with the Secretariat in the 10-year policy review process.

5.3 Revision of WMA Articles and Bylaws / Rules

5.3.1 The Committee **considered** the Proposed Revision of the Rules Applicable to WMA Associate Membership (FPL 207/AM Rules/Oct2017).

The Secretary General recommended that Medical Students and Junior Doctors be granted free Associate Membership for a period of five years, with the understanding that they would not receive any products other than online access to the WMA members area and would not have voting rights in the Associate Members meeting.

RECOMMENDATION

5.3.1.1 That the Proposed Revision of the Rules Applicable to WMA Associate Membership (FPL 207/AM Rules/Oct2017) be approved by the Council and be forwarded to the General Assembly for approval.

5.3.2 The Committee **considered** the Appendix of the JDN Terms of Reference (FPL 207/JDN ToR Appendix/Oct2017), which addressed election procedures necessitated by the increased membership of the group.

RECOMMENDATION

5.3.2.1 That the Appendix of the JDN Terms of Reference (FPL 207/JDN ToR Appendix/Oct2017) be approved by the Council.

6. OUTREACH

6.1 Associate Members Report

The Committee **deferred** the Report of the Chair of Associate Members (FPL 207/Chair of AM Report/Oct2017) by Dr. Joseph HEYMAN, to the Council.

6.2 Past Presidents' and Chairs' Network

The Committee **deferred** the Report of the Past Presidents and Chairs of Council Network (PPCN) (FPL 207/PPCN Report/Oct2017) to the Council.

6.3 JDN Report

The Committee **deferred** the Report of the Junior Doctors Network (JDN) (FPL 207/JDN Report/Oct2017) by Dr. Caline MATTAR, to the Council.

6.4 World Medical Journal

The Committee **deferred** the Report by the WMJ Editor (FPL 207/WMJ/Oct2017) by Dr. Peteris APINIS, to the Council.

6.5 Public Relations

The Committee **deferred** the Public Relations Report for May – September 2017 (FPL 207/PR Report/Oct2017) by WMA Press Officer Mr. Nigel DUNCAN, to the Council.

7. ANY OTHER BUSINESS

No other business was raised.

8. ADJOURNMENT

The meeting was adjourned at 14:55.

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12.10.2017

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**FPL 209/Dues Report/Apr2018** **Report on Membership Dues Payment for 2018**	Original: English
Destination:	Finance and Planning Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Information**
Note:	This document is composed of two parts, comparison of membership dues paid and number of declared members paid (Annex 1) for 2016, 2017 and 2018 as of 5 April 2018.	

COMPARISON OF MEMBERSHIP DUES PAID IN 2018, 2017 AND 2016

CONSTITUENT MEMBERS - COUNTRY

Membership rate per member

Category A -	**0,40**		**2018**		**2017**		**2018/2017**		**2016**
Category B -	**0,95**		Euro		Euro		Euro		Euro
Category C -	**1,60**		Rate Classes		Rate Classes				Rate Classes
Category D -	**2,15**		A-D/member		A-D/member				A-D/member

1. Current year

AFRICA

ANGOLA			B	-	C	-	-	C
CABO-VERDE			B	-	B	-	-	B
CAMEROON			B	-	B	-	-	B
CONGO			A	6 000	A	-6 000	-	A
CÔTE D'IVOIRE			B	95	B	-95	95	B
EGYPT			B	-	B	-	-	B
ETHIOPIA			A	-	A	-	-	A
GHANA		1 055	B	1 055	B	-	1 055	B
GUINEA			A	120	A		-	A
KENYA			B	713	B		-	B
LESOTHO			B	-	B		-	B
MALAWI			A	-	A	-	40	A
MALI			A	-	A	-	-	A
MOZAMBIQUE			A	-	A	-	-	A
NAMIBIA			C	-	C	-	-	C
NIGERIA		14 250	B	14 250	B	-	1 285	B
RWANDA		80	A		A		-	A
SÉNÉGAL			A	544	A	-544	-	B
SOMALIA	***		A	-	A	-	-	A
SOUTH AFRICA		14 040	C	14 040	C	-	14 040	C
SUDAN			B	-	B	-	-	B

Membership rate per member

		2018		**2017**		**2018/2017**	**2016**	
Category A -	**0,40**	Euro		Euro		Euro	Euro	
Category B -	**0,95**	Rate Classes		Rate Classes			Rate Classes	
Category C -	**1,60**	A-D/member		A-D/member			A-D/member	
Category D -	**2,15**							
TANZANIA			A	-	A	-	-	A
TUNISIA		433	B	633	B	-200	-	C
UGANDA			A	40	A	-40	40	A
ZAMBIA		950	B	950	B		950	B
ZIMBABWE	***	-	A	-	A	-	-	A
Sub-total		**30 809**		**38 440**		**-6 879**	**17 505**	
ASIA								
BANGLADESH		570	B	570	B	-	412	B
CHINA	***	20 000	C	80 000	C	-60 000	3 555	C
INDIA		71 250	B	71 250	B	-	71 250	B
ISRAEL		53 750	D	52 500	D	1 250	52 500	D
KUWEIT		2 150	D	2 100	D	50	2 102	D
MYANMAR		380	B	285	B	95	285	B
NEPAL			A	163	A	-163	163	A
PAKISTAN		475	B	**		475	**	
SRI LANKA			B	-	B	-	-	B
VIETNAM			B	422	B	-422	-	B
Sub-total		**148 575**		**207 290**		**-58 715**	**130 267**	
EUROPE								
ALBANIA		3 200	C	3 200	C	-	1 920	C
ANDORRA			D	-	D	-	-	D
ARMENIA			B	-	B	-	-	B
AUSTRIA		15 093	D	14 742	D	351	14 742	D
AZERBAIJAN			C	-	C	-	-	C
BELARUS			C	**				
BELGIUM		4 934	D	4 820	D	115	4 820	D
BULGARIA			C	-	C	-	-	C
CROATIA		1 500	D	-	D	1 500	1 575	D
CYPRUS			D	-	D	-	-	D
CZECH REP.	***	12 900	D	**	D	12 900	1 680	D
DENMARK		32 250	D	31 500	D	750	31 500	D
ESTONIA		1 075	D	1 050	D	25	1 050	D
FINLAND		27 950	D	27 300	D	650	27 300	D
FRANCE		107 715	D	105 210	D	2 505	105 210	D
GEORGIA		259	B	437	C	-177	272	B
GERMANY	***	112 875	D	220 500	D	-107 625	220 500	D
GREECE		10 750	D	10 500	D	250	10 500	D
HUNGARY		6 450	D	6 300	D	150	6 300	D
ICELAND		1 828	D	1 785	D	43	1 785	D
IRELAND		1 505	D	1 470	D	35	1 470	D
ITALY			D	12 600	D	-12 600	12 600	D
KAZAKHSTAN			C	240	C	-240	240	C
LATVIA		3 118	D	3 045	D	73	3 045	D

Membership rate per member

		2018		2017		2018/2017	2016	
Category A -	**0,40**	Euro		Euro		Euro	Euro	
Category B -	**0,95**	Rate Classes		Rate Classes			Rate Classes	
Category C -	**1,60**	A-D/member		A-D/member			A-D/member	
Category D -	**2,15**							
LIECHTENSTEIN			D	-	D	-	-	D
LITHUANIA			D	-	D	-	-	D
LUXEMBOURG			D	1 275	D	-1 275	1 296	D
MACEDONIA			C	-	C	-	-	C
MALTA		1 075	D	1 050	D	25	1 050	D
MONTENEGRO			C	-	C	-	-	C
NETHERLANDS		128 153	D	124 121	D	4 032	33 128	D
NORWAY		32 250	D	31 500	D	750	31 500	D
POLAND		897	D	876	D	21	876	D
PORTUGAL			D	5 250	D	-5 250	5 250	D
ROMANIA		16 000	C	15 040	C	960	14 400	C
RUSSIA	***		C	11 200	C	-11 200	-	D
SERBIA			C	16 002	C	-16 002	-	C
SLOVAKIA			D	479	D	-479	479	D
SLOVENIA		6 927	D	6 829	D	98	-	D
SPAIN	***		D	105 000	D	-105 000	105 000	D
SWEDEN		43 215	D	42 210	D	1 005	42 210	D
SWITZERLAND		38 732	D	36 863	D	1 869	36 863	D
TURKEY		1 600	C	1 600	C	-	1 600	C
UKRAINE		95	B	95	B	-		B
UNITED KINGDOM		219 300	D	214 200	D	5 100	214 200	D
UZBEKISTAN			B	-	B	-	67	B
VATICAN		108	D	105	D	3	105	D
Sub-total		**831 753**		**1 058 392**		**-226 639**	**934 531**	
LATIN AMERICA								
ARGENTINA			D	700	D	-700	4 200	D
BAHAMAS			D	-	D	-	-	D
BELIZE		160	C	**				
BOLIVIA			B	422	B	-422	422	B
BRAZIL		80 800	C	80 800	C	-	80 800	C
CHILE		4 504	D	4 400	D	105	4 400	D
COLOMBIA			C	-	C	-	-	C
COSTA RICA			C	600	C	-600	1 609	C
EL SALVADOR			B	-	B	-	-	B
HAITI			A	-	A	-	100	A
MEXICO			C	533	C	-533	533	C
PANAMA		566	C	803	C	-237	-	C
PERU			C	-	C	-	-	C
TRINIDAD AND TOBAGO			D	420	D	-420	420	D
URUGUAY			D	4 110	D	-4 110	5 273	D
VENEZUELA	***		C	-	C	-	-	D
Sub-total		**86 030**		**92 788**		**-6 917**	**97 757**	
NORTH AMERICA								

Membership rate per member

		2018		2017		2018/2017	2016	
Category A -	**0,40**	Euro		Euro		Euro	Euro	
Category B -	**0,95**	Rate Classes		Rate Classes			Rate Classes	
Category C -	**1,60**	A-D/member		A-D/member			A-D/member	
Category D -	**2,15**							
CANADA		64 715	D	63 210	D	1 505	63 210	D
USA		260 150	D	254 100	D	6 050	254 100	D
Sub-total		**324 865**		**317 310**		**7 555**	**317 310**	
PACIFIC								
AUSTRALIA		44 406	D	45 555	D	-1 149	39 297	D
FIJI			C	-	C	-	-	C
HONG KONG		2 043	D	1 995	D	48	1 995	D
INDONESIA			B	-	B	-	-	B
JAPAN	***		D	317 100	D	-317 100	317 100	D
KOREA		37 625	D	36 750	D	875	36 750	D
MALAYSIA		2 400	C	2 400	C	-	2 400	C
NEW ZEALAND		400	D	2 100	D	-1 700	2 100	D
PHILIPPINES			B	713	B	-713	661	B
SAMOA			B	-	B	-	-	B
SINGAPORE		516	D	504	D	12	504	D
TAIWAN			D	23 125	D	-23 125	23 125	D
THAILAND		1 066	C	1 066	C	-	1 066	C
Sub-total		**88 455**		**431 307**		**-342 852**	**424 998**	
TOTAL		**1 510 487**		**2 145 527**		**-634 447**	**1 922 369**	
2. Previous years								
Belgium (2006-2012)		2 002	D	2 002	D		2 002	D
Panama (2015-2016)				1 556	C			
Russia (2015)							5 250	D
Rwanda (2015-2017)		44	A					
Tunisia (2015-2016)				2 066	B			
Ukraine (2015, 2016)				185	B			
Uzbekistan (2013-2015)							189	D
Vietnam (2016)				422	B			
Sub-total		**2 046**		**6 231**			**7 441**	
TOTAL		**1 512 533**		**2 151 758**		**-639 225**	**1 929 810**	

** Not member at that time

***** Note by the Secretary General:**

The following statutory members have formal special arrangements with the WMA:

• Due to the current impossibility to transfer money out of Zimbabwe, the technical inability to collect our dues, the extreme inflation rate in the country and after having consulted with the Zimbabwe Medical Association the Secretary General considers the Zimbabwe Medical Association in Good Standing without having received dues so far but considers that ZiMA pays its annual dues (20 EUR) till the financial situation changes.

Membership rate per member

		2018	2017	2018/2017	2016
Category A -	**0,40**	Euro	Euro	Euro	Euro
Category B -	**0,95**	Rate Classes	Rate Classes		Rate Classes
Category C -	**1,60**	A-D/member	A-D/member		A-D/member
Category D -	**2,15**				

- Due to the war in Somalia, the Secretary General considers the Somalia Medical Association is in good standing and waived the membership dues since 2011.
- German Medical Association pays its dues in two equal parts on January 1st and July 1st.
- Japan Medical Association pays its dues in with its new business year in April.
- Spanish Medical Association pays its dues in two equal parts on February 1st and August 1st.
- The Czech Medical Association resigned in April 2017 and the Czech Medical Chamber joined the membership in October2017.
- The membership of the Russian Medical Society was terminated in April 2017 following procedure accroding to WMA Bylaws, Chapter 1, Section 5B and the National Medical Chamber of Russia joined the membership in Octboer 2017.
- Due to the financial crises in Venezuela, the membership dues of Venezuela Medical Association was waived for the years 2013 to 2017.
- Chinese Medical Association pays its dues by three installments. 1st installment was received on 4 April 2018.

ANNEX

COMPARISON OF DECLARED MEMBERS IN 2018, 2017 AND 2016

CONSTITUENT MEMBERS - COUNTRY

	2018	2017	2018/2017	2016
1. Current year				
AFRICA				
ANGOLA	-	-	-	-
CABO-VERDE	-	-	-	-
CAMEROON	-	-	-	-
CONGO	-	15 000	-15 000	-
CÔTE D'IVOIRE	-	100	-100	100
EGYPT	-	-	-	-
ETHIOPIA	-	-	-	-
GHANA	1 111	1 111	-	1 111
GUINEA	-	300	-300	-
KENYA	-	750	-750	-
LESOTHO	-	-	-	-
MALAWI	-	-	-	100
MALI	-	-	-	-
MOZAMBIQUE	-	-	-	-
NAMIBIA	-	-	-	-
NIGERIA	15 000	15 000	-	1 352
RWANDA	200	-	200	-
SÉNÉGAL	-	1 360	-1 360	-
SOMALIA	-	-	-	-
SOUTH AFRICA	8 775	8 775	-	8 775
SUDAN	-	-	-	-
TANZANIA	-	-	-	-
TUNISIA	456	666	-210	-
UGANDA	-	100	-100	100
ZAMBIA	1 000	1 000	-	1 000
ZIMBABWE	50	50	-	50
Sub-total	**26 592**	**44 212**	**-17 620**	**12 588**
ASIA				
BANGLADESH	600	600	-	434
CHINA	12 500	50 000	-37 500	2 222
INDIA	75 000	75 000	-	75 000
ISRAEL	25 000	25 000	-	25 000
KUWEIT	1 000	1 000	-	1 000
MYANMAR	400	300	100	300
NEPAL	-	407	-407	407
PAKISTAN	500	**	500	**
SRI LANKA	-	-	-	-
VIETNAM	-	444	-444	-
Sub-total	**115 000**	**152 751**	**-37 751**	**104 363**
EUROPE				

ANNEX

	2018	2017	2018/2017	2016
ALBANIA	2 000	2 000	-	1 200
ANDORRA	-	-	-	-
ARMENIA	-	-	-	-
AUSTRIA	7 020	7 020	-	7 020
AZERBAIJAN	-	-	-	-
BELARUS	-	**		**
BELGIUM	2 295	2 295	-	2 295
BULGARIA	-	-	-	-
CROATIA	697	-	697	750
CYPRUS	-	-	-	-
CZECH REP.	6 000	**	6 000	800
DENMARK	15 000	15 000	-	15 000
ESTONIA	500	500	-	500
FINLAND	13 000	13 000	-	13 000
FRANCE	50 100	50 100	-	50 100
GEORGIA	273	273	-	286
GERMANY	52 500	105 000	-52 500	105 000
GREECE	5 000	5 000		5 000
HUNGARY	3 000	3 000	-	3 000
ICELAND	850	850	-	850
IRELAND	700	700	-	700
ITALY	-	6 000	-6 000	6 000
KAZAKSTAN	-	150	-150	150
LATVIA	1 450	1 450	-	1 450
LIECHTENSTEIN	-	-	-	-
LITHUANIA	-	-	-	-
LUXEMBOURG	-	607	-607	617
MACEDONIA	-	-	-	-
MALTA	500	500	-	500
MONTENEGRO	-	-	-	-
NETHERLANDS	59 606	59 105	501	15 775
NORWAY	15 000	15 000	-	15 000
POLAND	417	417	-	417
PORTUGAL	-	2 500	-2 500	2 500
ROMANIA	10 000	9 400	600	9 000
RUSSIA	-	7 000	-7 000	-
SERBIA	-	10 001	-10 001	-
SLOVAKIA	-	228	-228	228
SLOVENIA	3 222	3 252	-30	-
SPAIN	-	50 000	-50 000	50 000
SWEDEN	20 100	20 100	-	20 100
SWITZERLAND	18 015	17 554	461	17 554
TURKEY	1 000	1 000	-	1 000
UKRAINE	100	100	-	-
UNITED KINGDOM	102 000	102 000	-	102 000
UZBEKISTAN	-	-	-	70
VATICAN	50	50	-	50
Sub-total	**390 395**	**511 152**	**-120 757**	**447 912**
LATIN AMERICA				

ANNEX

	2018	2017	2018/2017	2016
ARGENTINA	-	333	-333	2 000
BAHAMAS	-	-	-	-
BELIZE	100	**	100	**
BOLIVIA	-	444	-444	444
BRAZIL	50 500	50 500	-	50 500
CHILE	2 095	2 095	-	2 095
COLOMBIA	-	-	-	-
COSTA RICA	-	375	-375	1 005
CUBA	-	-	-	-
EL SALVADOR	-	-	-	-
HAITI	-	-	-	250
MEXICO	-	333	-333	333
PANAMA	353	502	-149	-
PERU	-	-	-	-
TRINIDAD AND TOBAGO	-	200	-200	200
URUGUAY	-	1 957	-1 957	2 522
VENEZUELA	-	-	-	-
Sub-total	**53 048**	**56 739**	**-3 691**	**59 349**
NORTH AMERICA				
CANADA	30 100	30 100	-	30 100
USA	121 000	121 000	-	121 000
Sub-total	**151 100**	**151 100**	**-**	**151 100**
PACIFIC				
AUSTRALIA	20 653	21 692	-1 039	18 712
FIJI	-	-	-	-
HONG KONG	950	950	-	950
INDONESIA	-	-	-	-
JAPAN	-	151 000	-151 000	151 000
KOREA	17 500	17 500	-	17 500
MALAYSIA	1 500	1 500	-	1 500
NEW ZEALAND	186	1 000	-814	1 000
PHILIPPINES	-	750	-750	696
SAMOA	-	-	-	-
SINGAPORE	240	240	-	240
TAIWAN	-	11 011	-11 011	11 011
THAILAND	666	666	-	666
Sub-total	**41 695**	**206 309**	**-164 614**	**203 275**
TOTAL	**777 830**	**1 122 263**	**-344 433**	**978 587**

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**FPL 209/WMA Future Meetings/Apr2018**	Original: English
Title:	**Planning and Arrangements for future WMA Meetings**	
Destination:	Finance and Planning Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**

1. ITEMS TO BE CONSIDERED

1.1 Meeting dates

Survey was sent out to the members in January 2018 and the following dates are most preferable dates for upcoming meetings in 2021/2022:

1.1.1 218th Council session (venue is not decided): **22-24 April 2021**
1.1.2 72nd General Assembly (venue is not decided): **13-16 October 2021**
1.1.3 221st Council session (venue is not decided): **7-9 April 2022**

1.2 New invitations received from

1.2.1 Rwanda Medical Association (RMA) in **Kigali**[1]
- Preferably for the **71st General Assembly in October 2020**
- or nearby future vacant years for Council Session, i.e. April 2021 or 2022

1.2.2 British Medical Association (BMA) in **London**[2]
- for the **71st General Assembly in October 2020**
- or future years including 2021 and 2022

1.2.3 Ordre National des Medecins Conseil National de l'Ordre (CNOM France) in **Paris**[3]
- for the **221st Council Session in April 2022**

[1] Secretariat received a completed questionnaire and see the city Kigali is eligible as a venue for the WMA Council Session or General Assembly.
[2] Secretariat received a completed questionnaire and see the city London is eligible as a venue for the WMA General Assembly. Only concern would be that there may be some difficulty for Russian representatives for visa issuing due to the recent political situation.
[3] Secretariat received a completed questionnaire and see the city Paris is eligible as a venue for the WMA Council Session.

The Secretariat will proceed an on-going survey on meeting dates and call for invitation of future meetings during July 2018. For consideration by the 210th Council Session in Reykjavik in October 2018, invitations shall be submitted to the secretariat until 31 August 2018.

1.3 GA Beijing (or Shanghai) 2021

Following to the decision made by the General Assembly in October 2017, the invitation of the Chinese Medical Association was postponed until the 2018 General Assembly.

2. DATES/VENUES OF WMA ASSEMBLIES AND COUNCIL SESSIONS 2005-2021

The venues of WMA General Assembly meetings are determined by a global rotation system ideally, whereby the WMA General Assembly is held in each of the six regions of the WMA over a period of six years.

Year	Dates	Region	Venue	Note
2005	12-15 October	Latin America	Santiago, Chile	
2006	12-15 October	Africa	Sun City, South Africa	
2007	3-6 October	Europe	Copenhagen, Denmark	150th Anniversary
2008	15-18 October	Pacific	Seoul, Korea	100th Anniversary
2009	13-15 May	Asia	Tel Aviv, Israel	
	14-17 October	Asia	New Delhi, India	
2010	20-22 May	Europe	Evian-les-Bains, France	
	13-16 October	North America	Vancouver, Canada	
2011	7-9 April	Pacific	Sydney, Australia	
	12-15 October	Latin America	Montevideo, Uruguay	
2012	26-28 April	Europe	Prague, Czech Republic	
	10-13 October	Pacific	Bangkok, Thailand	
2013	4-6 April	Pacific	Bali, Indonesia	
	16-19 October	Latin America	Fortaleza, Brazil	
2014	24-26 April	Pacific	Tokyo, Japan	
	8-11 October	Africa	Durban, South Africa	
2015	16-18 April	Europe	Oslo, Norway	
	14-17 October	Europe	Moscow, Russia	
2016	28-30 April	Latin America	Buenos Aires, Argentina	
	19-22 October	Pacific	Taipei, Taiwan	
2017	20-22 April	Africa	Livingston, Zambia	
	11-14 October	North America	Chicago, United States	
2018	26-28 April	Europe	Riga, Latvia	
	3-6 October	Europe	Reykjavik, Iceland	100th Anniversary
2019	25-27 April	Latin America	Santiago, Chile	
	23-26 October	Europe	Tbilisi, Georgia	30th Anniversary in 2019
2020	16-18 April	Europe	Porto, Portugal	
	21-24 October			

2021	22-24 April[4]			
	13-16 October[5]	Asia	Beijing, China[6]	106th Anniversary in 2021
2022	7-9 April[7]			
	5-8 or 12-15 October[8]	Europe	Berlin, Germany	75th Anniversary in 2022

- All future meetings are listed in the WMA website.

3. ARRANGEMENTS OF STATUTORY MEETINGS

3.1 General Assembly, Reykjavik 2018

- Dates: Wednesday 3 to Saturday 6 October 2018
- Venue for meeting rooms: Harpa conference center
- Hotel for accommodation: Hilton Reykjavik Nordica
- Preliminary schedule
  - The pre-meetings of Executive Committee, workgroups and JDN meeting will be held on Monday 1 October and/or Tuesday 2 October, prior to the meeting.
  - The three **Standing Committees** and the **Credentials Committee** will meet on Wednesday 3 October.
  - **Scientific Session**: **Icelandic Medical Association/WMA Medical Ethics Conference** will take place in Harpa conference center from 1- 4 October. The scientific session on 4 October will be replaced by joining the Medical Ethics Conference.
  - There will be a half-day **Tour** for accompanying persons on Thursday 4 October.
  - The main meeting of the **Council** will take place on Friday 5 October.
  - The Assembly **Ceremonial Session** will take place after the Council Session on Friday 5 October.
  - There will be a half-day **Tour** for all participants on Friday 5 October.
  - The Assembly **Plenary Session** will be held on Saturday 6 October.

1 Oct	2 Oct	3 Oct	4 Oct	5 Oct	6 Oct
Mon	Tue	Wed	Thu	Fri	Sat
IcMA Conference on Medical Ethics	1st day of conference	2nd day of conference	3rd day of conference (full day)		
WMA pre-meetings (ExCo and other possible WGs)	WMA pre-meetings (Open WG meetings are planned in conjunction	WMA Council	WMA Scientific session	WMA GA and social	WMA GA plenary

[4] Pending Council's approval
[5] Pending Council's and GA's approval
[6] Pending GA's approval (see consideration item 1.3)
[7] Pending Council's approval
[8] Pending Council's and GA's approval: The German Medical Association has requested to hold off the decision until October 2018 for them to have some time to search the most preferable venue.

	with the Ethics conference)				

- Interpretation
  Simultaneous Interpretations in English, Spanish, French and Japanese will be provided.

- Social events
  - The Welcome reception for all participants will be offered by the Icelandic Medical Association on Wednesday 3 October.
  - The Icelandic Medical Association will offer the dinner to all participants on Friday 5 October.
  - The WMA Assembly dinner for all participants will be offered by the World Medical Association on Saturday 6 October.

- More details will be available on the WMA website and the registration will be open in May 2018.

3.2 212th Council Session, April 2019

- Dates: Thursday 25 to Saturday 27 April 2018

- Hotel: Hotel Santiago (Mandarin Oriental) in Santiago, Chile

- Preliminary schedule
  - The **pre-meetings of Executive Committee, workgroups and JDN meeting** will be held on Wednesday 24 April, one day prior to the meeting.
  - The meeting will begin with the **Opening Plenary Session of the Council** on Thursday 25 April.
  - The **three Standing Committees** will meet on Thursday 25 April and Friday 26 April.
  - The **Council Plenary Session** will take place on Saturday 27 April.

- Interpretation
  Simultaneous interpretation in English, Spanish, French and Japanese will be provided.

- Social events
  - The Welcome reception for all participants will be offered by the Colegio Médico de Chile on Thursday 25 April.
  - The Council dinner will be offered by the World Medical Association on Friday 26 April.
  - The Half-day tour and dinner for all participants will be offered by the Colegio Médico de Chile on Saturday 27 April.

- More details will be available on the WMA website and the registration will be open in October 2018.

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THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**FPL 209/AM Membership/Apr2018** **Report on the Associate Membership for 2017**	Original: English
Destination:	Finance and Planning Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **To be received**

1. This report covers the period up to 31 December 2017.

2. The total number of Associate Members who are in good standing is 1,115. The regional breakdown of the 1,115 Associate Members (including 25 as life members) is:

Japan:	647 in good standing
All other countries:	468 members in good standing in the other regions, including 25 life members and 137 IFMSA/JDN members in free membership

3. Applications for Associate Membership shall be obtained only from the WMA directly, or from a National Medical Association that is a Constituent Member of the WMA. The application should be returned, with the proper amount of membership dues to the WMA General Secretariat.

4. Medical students and junior doctors (on graduation as physicians for a period of five years) will be granted Associate Membership of the WMA. No membership fee will be charged, but no products, services or publications (except electronic publications) will be provided to these members. In addition, these members will not have the right to vote.

5. Online applications for the different member types have been implemented on the WMA website.

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16.04.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**FPL 209/Chair of AM Report/Apr2018**	Original: English
Title:	**Report of the Chair of the Associate Members (October 2017 – March 2018)**	
Destination:	Finance and Planning Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **To be received**

While in Chicago we had a very successful "Meet the Associate Members" informal dinner sponsored by the American Medical Association. We will be enjoying another informal get-together in Riga on the evening of April 25th which was open to all attending the council meeting. Registration was required in advance. Special thanks to the Latvian Medical Association for making this possible.

At the end of our meeting in Chicago, there were 85 members of our active Google group. We have more than doubled in size to 195 members of this wonderful discussion platform. We had a very robust discussion of each of the circulated documents for this meeting. One document alone had over fifty comments. The discussions are respectful and enlightening and are open to all associate members. A summary of our comments appears on each document.

We held a conference call on March 26 for the leaders of the Junior Doctors Network, the Past Presidents and Chairs Network and the Chair of the AMs along with the Secretary General. We wanted to connect to look for ideas for coordination of the three parts of the AMs and to make the AM experience more valuable to the WMA and to the AMS themselves. A summary of the meeting follows:

Attendees:
Dana Hanson, Chair, Past Presidents and Chairs Network (PPCN)
Jon Snædal, PPCN Secretary
Caline Mattar, Chair, Junior Doctors Network (JDN)
Yassen Tcholakov, JDN Socio-Medical Affairs
Otmar Kloiber, Secretary General, World Medical Association (WMA)
Joe Heyman, Chair, WMA Associate Members

1) There was a discussion about how to get more recognition for WMA policies among the rank and file membership of national medical associations (NMAs). It would be great if an NMA introduced a resolution at the Council Meeting that suggested that NMAs review WMA policy when considering new policy or reviewing existing policy.
2) We will try to come up with an agenda for a meeting in Iceland of all AMs with possible broadcast.

3) We discussed a voluntary effort to include other associate members when a particular policy is being developed among one of the groups in the AMs. We may have leadership communicate with each other between meetings briefly to keep everybody in the loop.
4) We may wish to bring subjects that are not policy, or are not policy currently under review, to the AMs at large for discussion in the Google Group.
5) We discussed the barriers to broadcast the Scientific Session to the AMs who cannot attend. At least for the time being we cannot broadcast it for everyone since speakers speak in several languages and because there are software and financial barriers.
6) We discussed the relationships between the WMA and the international specialty societies. It is healthy.
7) We discussed recruiting associate members. We have three types of members right now, a) those involved in international medicine, b) those involved in Public Health, and c) those who are interested for other reasons. We should focus on recruiting people who are interested in public health and/or medical ethics.
8) We discussed efforts to broadcast meetings with GoToMeeting, Zoom, and Adobe Connect in the hope we can more easily involve those members who can not attend in person.
9) We considered adding an additional hour or another meeting time for AMs where a panel discussion might be possible.
10) We would like to find a periodic formal way in which the AM Chair could meet with the executive committee to bring them up to date on what has happened with the AMs and for the AM chair to learn more about the WMA activities and concerns.
11) We discussed a role for medical students that would not compete with the International Federation of Medical Student Associations (IFMSA).
12) We discussed how we might interest Council members to join the AMs.
13) We ruled out regional meetings of AMs for now.

Respectfully submitted by Joe Heyman, MD, Chair of the Associate Members

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03.04.18

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**FPL 209/JDN Report/Apr2018**	Original: English
Title:	**Report of the Junior Doctors Network (JDN) (October 2017 – March 2018)**	
Destination:	Finance and Planning Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **To be received**

During the reporting period, the JDN working groups (WG) have continued their activities, those including Working conditions, and Medical care for the psychiatric patient.

Additionally, the WG Global Medical Exchanges on surveying the membership on interest and mapping existing initiatives. The survey is currently at its pilot stage.

The working group on Antimicrobial Resistance (AMR) is gearing up towards another AMR social media campaign in collaboration with the WMA secretariat to promote the WMA policy and AMR course during Antibiotic Awareness Week in November, and is looking forward to the policy revision coming up.

As part of a revision of the internal processes of the network, new terms of reference are now proposed to regulate the JDN WGs. This will be presented for discussion at the Meeting in Riga.

JDN members participated in the 4th Global Forum on Human Resources for Health which was held in Dublin and contributed to the organization of the Youth forum portion of the event.

We continue to have monthly management team meetings in addition to the general membership teleconference to ensure coordination of activities and appropriate follow up. We continue to have a reporting system with half yearly reports submitted by the JDN officers in April, and end of year reports submitted in September. JDN working groups as well will start reporting on their activities twice yearly. The next report is due prior to the start of the Riga meeting.

We have planned our JDN meeting in Riga and we are implementing a new format which includes capacity building. We will be having a climate change workshop as part of the meeting, as well as a leadership in healthcare workshop in collaboration with the Alumni of the WMA Caring Physicians of the World course.

JDN continues to support regional collaborations. There is an active group of Junior Doctors in Latin America which continues to evolve and new members from the Eastern Mediterranean are joining the network. JDN is also working on establishing close collaboration with the European Junior Doctors EJD, on several topics of mutual interest.

With regards to Medical Education, JDN continues its collaboration with the World Federation for Medical Education, and the network will be represented at the WFME meeting by the JDN Chair, Dr Caline Mattar and the JDN Education Officer Dr Audrey Fontaine.

The JDN continues to foster its partnership with the IFMSA through continued collaboration and coordination.

Since the last meeting, we have seen an increasing number of Junior Doctor representatives of National Associations join the network. We highly value close collaboration with NMAs in order to continue to increase participation of young physicians from the national organizations.

This report was prepared by Dr Caline Mattar, Chair of the Junior Doctors Network.

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03.04.18

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**FPL 209/PPCN Report/Apr2018**	Original: English
Title:	**Report of the Past Presidents and Chairs of Council Network (October 2017 – March 2018)**	
Destination:	Finance and Planning Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **To be received**

The PPCN has continued its work this year.

Dr Dana Hanson has participated in the WMA AM Leadership conference call on 26 March with Dr Jón Snaedal, PPCN Secretary. (see FPL 209/Chair of AM Report/Apr2018)

Dr Yank Coble has continued supporting and organising the WMA Leadership Course with Mayo Clinic Jacksonville campus for the course in December 2017.

Dr Yoram Blachar has continued to engage to the UNESCO World conference on Bioethics, Medical Ethics and Health Law in Limassol and next meeting (13th) will be held in Jerusalem, Israel, 27-29 November 2018.

Dr Jón Snaedal has been taking a lead to organise the Icelandic Medical Association/WMA Medical Ethics Conference to be held in conjunction with the WMA General Assembly in Reikjavik in 2018. He has served as President of the International College for Person Centered Medicine (ICPCM) which has been cooperating with the WMA on organising its annual Geneva conference on person centered medicine since 2006. The ICPCM conference was held on 8-11 April 2018.

Dr Mukesh Haikerwal AC is continuing to raise WMA's profile in social media networks. He is actively supporting our outreach to our African members and non-member Medical Associations. Dr. Haikerwal AC represented the WMA at the World Self-Medication Industry Assembly in Sydney October 2017.

Advise on current questions has been and is being provided by members of the PPCN upon request of the secretariat.

We would thank Dr. Kloiber and staff for their support.

Submitted by Dr. Dana Hanson, Chair of PPCN

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THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**FPL 209/Nominating process/Apr2018** **Proposal to introduce a self-declaration statement to the nominating process for WMA Presidency**	Original: English
Destination:	Finance and Planning Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note:	This is submitted by the British Medical Association.	

Summary:	This proposal is to introduce a self-declaration statement to the nominating process for WMA Presidency. It is necessary to conduct due diligence to establish whether the candidate may bring the Association into disrepute. Performing this exercise, ensures reputational assurances for the Association and nominating constituent member, by exercising principles of transparency and openness. The proposal must consider capacity, resources and system capability to ensure it is not unduly burdensome on the Association, nor the nominating body, and therefore must be proportionate.
Related WMA policies:	WMA Articles and Bylaws WMA Nomination Form for the Election to the Office of President

Current mechanism for appointment for President:

1. Extract from WMA articles & bylaws

B) Method of Nomination A Constituent Member of the World Medical Association may nominate any qualified candidate for the office of President by submitting the said nomination in writing to the WMA Secretariat, together with the candidate's written acceptance of nomination. ***Such nomination shall include a certification that the candidate is a member of the Constituent Member making the nomination, and that the candidate's character,***

integrity and competence are beyond reproach, thus qualifying the candidate to be nominated for the office of President. Such assurance shall be made on forms provided by the Secretary General over the signature of the responsible officer of the Constituent Member and the seal of the National Medical Association. *Such nomination must reach the Secretariat at least 3 weeks prior to the opening of the General Assembly at which the election is to be held. (see Annex 1; current declaration form for a constituent member of the WMA to nominate candidate)*

2. Mechanism for early termination/dismal; extract from WMA articles & bylaws

F) *Termination*

i) The Council shall be empowered to take action to preserve the integrity and reputation of the World Medical Association, including, but not limited to, suspending the authority of the President, President-Elect, or Immediate Past President to act as an officer of the WMA for cause. A decision to suspend the authority of the individual to act as an officer of the WMA shall require a 2/3 majority of the Council members present and voting. Before voting on a proposal to suspend the authority of the individual to act as an officer, the Council must:

a) Provide an opportunity for the concerned individual to address the Council, in person and/or in writing

b) Consult with the Constituent Member of which the individual is a member

ii) An affirmative vote to suspend the authority of the President, President-Elect, or Immediate Past President from acting as an officer must be based on substantial evidence and a reasonable degree of certainty that the individual no longer meets the criteria established in section B) and D)(iv) to serve in the office or has neglected the duties of the office.

iii) Between Council meetings, the Executive Committee shall be empowered to investigate accusations made against the President, President-Elect, or Immediate Past President and shall communicate with the Council, as appropriate, regarding the situation. The accused individual shall be excluded from participating in this process but shall be afforded the opportunity to respond to the accusation(s). The Chair of Council shall report the findings of the Executive Committee to the Council at its next meeting. The Executive Committee shall not have the authority to suspend the authority of the individual to act as an officer.

iv) In the event of the suspension of the authority of the President to act as an officer, the Council, if it deems necessary, may make such appointment or provisions for the discharge of duties of the office until the next meeting of the General Assembly.

v) Following the suspension by the Council of the authority of the President-elect or President to act as an officer, at the next meeting of the General Assembly, the Council shall provide a recommendation to the General Assembly regarding permanent termination from office. The General Assembly may accept the Council's recommendation or reject it and take such other action as it deems appropriate. Permanent termination from office shall require a 2/3 majority of the delegates present and voting.

3. Proposed mechanism:

The following proposal draws on discussions with HR professionals and employment lawyers with extensive experience in conducting and advising on appointments processes.

To include following declaration to the nomination form for WMA constituents:
'I declare that the information given in this form and in any accompanying documentation is true to the best of my knowledge and belief and permission is granted for enquiries to be made to confirm qualifications, experience, dates of employment/ membership, for the release by other people or organisations of necessary information to verify the content. I understand that the declaration of any conflict will not necessarily prevent the nominee being offered this position, however the nominee may be dismissed following appointment if any of information given is false, misleading or if I, the nominating body, have withheld any relevant details'.

The nominating body will also have to declare any personal interests within the written acceptance declaration.

If the nominee is successfully appointed, are there any conflicts that can be transported to the WMA ***Y/N***   *If you have answered yes, please provide details in the space below:*   *[allow space for free text]*

It is expected that the 'vetting' and 'screening' exercise will be conducted by the proposing constituent member, who will then be expected to sign a declaration. This process will establish the candidate's suitability to the role, in terms of skills and experience.

4. Further considerations:

-Public announcement to all WMA constituent members, of the proposed future mechanism.
-Include a role profile; therefore, candidate needs to demonstrate effective leadership through:

[Example; extract from BMA Council chair appointment form]

1. The ability to command confidence and respect and exercise influence
2. Excellent communication skills, written and verbal with all potential audiences
3. Strategic leadership, chairing skills and negotiation capability
4. Promotion of effective relationships and open communication
5. Teamwork, influencing people and resources, and diplomacy
6. Personal integrity and a commitment to maintaining the highest standards of integrity and probity

The above list of principles will need to be adapted to suit the requirements of the WMA, for example, principle 2 as it is currently written may discourage nominations from non-anglophone countries. In addition, principle 3, is not applicable for the role of the WMA President.

Within the WMA articles and bylaws under 'Procedure & Schedule', you will find a list of principles scattered throughout the section. This could simply be pulled into one place, in the form of a role profile.

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29.03.2018
Annex 1;

THE WORLD MEDICAL ASSOCIATION, INC.
NOMINATION FORM FOR THE ELECTION TO THE
OFFICE OF PRESIDENT FOR 2017-2018

We, the undersigned, on behalf of the _____
(Name of the Constituent Member)

do hereby place in nomination for the office of President of the World Medical Association for 2017-2018 the name of Dr./Prof. _____. The
(Physician's name)

nominee has been endorsed for this office of President by our Association, of which he/she has been a member for _____ years.
(number)

Dr./Prof. _____ has demonstrated total commitment to the highest standards of medical ethics throughout his/her professional life.
(Physician's name)

He/she is a _____who has served as _____
(G.P./Specialty) (Office held)

of the _____. In all ways, Dr./Prof. _____ has been exemplary in professional and personal conduct. Based on the personal knowledge of our colleagues, this Association believes that Dr./Prof. _____ is an individual of impeccable integrity who will serve the World Medical Association with honor and distinction.
(Name of the Constituent Member) (Physician's name) (Physician's name)

Signed and sealed on _____
(Date)

_____ _____
President or Chairperson Secretary General

Candidate's curriculum vitae and written acceptance are enclosed herewith.

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**FPL 209/WMJ Report/Apr2018**	Original: English
Title:	**Report of WMJ Editor**	
Destination:	Finance and Planning Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **To be received**

The World Medical Journal turns 64 this year. The majority of the leaders of the World Medical Association and national medical associations are a little older or a little younger than the WMJ itself. Over this period of time the world has changed; these years have seen several wars and epidemics, the discovery of new medications, fantastic developments in medical technologies and, ultimately, people are now able to live their lives on this earth 20 years longer thanks to the efforts of medical and public health professionals. Both for a journal and a person, 64 years of age have connotations of maturity, experience, stability, and also difficulties making changes. On the other hand, 64 years is a perfect age to look back at past developments and make long-term forecasts for the future.

I have had the pleasure of being Editor in Chief of the WMJ since 2008 and year by year I am preparing to leave this position. The maximum term for the President of the Latvian Medical Association is running out for me and I will simply no longer belong to the WMA community.

It was a great honour to take over the Journal from Mr Alan Rowe. This unique man was the leader of our journal for many years and managed to unite doctors all over the globe, setting a great example writing excellent articles and through his fantastic mastery of the English language. I think it is unlikely that our journal will again experience such English language skills combined with a deep sense of both medical and ethical issues anytime soon.

During all these years Professor Elmar Doppelfeld has been by my side to support me with ideas, opinions and experience. I would like to thank my assistants, Maira Sudraba and Velta Pozņaka, who worked on the journal with great devotion. It is they who do most of the work. And I am grateful to Otmar Kloiber who can be counted on for an opinion and a critical view on every single article. If it were not for him, we would have a much more cumbersome journal; it would be a much lesser WMA journal. And, of course, I thank Nigel Duncan who prepares excellent materials about WMA activities.

The World Medical Journal is essentially a newsletter meant for the leaders of medical associations all over the world. The primary goal of the journal, as I see it, is to inform these leaders about key events, documents, movements and the direction in which the WMA is going, as well as to deliver information about the events of different national medical associations. After all, the earth is small and we can be proud that our people are represented in every country.

Not only does every country in the world have its own medical association, it also has a national medical journal. We are clearly very different. In large countries with hundreds of thousands of working doctors these journals are thick, issued weekly and pharmaceutical companies gladly place illustrative information on their products in them, thus maintaining the journals' financial well-being and allowing them to reach every doctor free of charge. In smaller countries and those with tighter healthcare budgets the journals are published less frequently, they are thinner and not available to every doctor.

The World Medical Journal is an excellent brand; it is the journal of the WMA. We can think of the WMA as a country of the world's doctors, the global medical community, and the WMJ as the mouthpiece of this country, exactly as large and powerful as a country of this size deserves. Admittedly, the printed media is leaving the global information space. Views on received information differ around the globe, but most experts agree that more than 70% of this information comes from electronic sources (TV, video, internet etc.) and only 10-15% comes from printed media. A large part of the world's population sends the contents of their advertisement-stuffed mailboxes straight into the trashcan.

For a couple of years already the WMJ has also been prevailingly published in digital form. We only mail printed journals to the world's leading libraries. The articles are delivered to us in digital form and we send the journal to national medical associations in digital form. The World Medical Journal is issued four times per year. Each issue is supposed to contain forty pages, while issues no. 2 and no. 4 are thicker as we complement these with materials from the WMA Council Meeting and General Assembly.

The WMJ has a neuroprotective function: writing to a medical journal is an operation which increases the number of neuronal cells and the activity of synopsis in the central nervous system. The journal is also a record of history, which is the present day from a viewpoint in the future. I am not certain that in 4 years from now one will still be able to read about the World Medical Association via the wmj.net portal, whereas I am absolutely sure that all issues of the journal, starting from the 1950s, will be accessible in the University of Washington Library in Seattle. This is why I encourage the leaders of all national medical associations to contribute their articles to the WMJ. There may possibly remain no other historical evidence of the activities performed by your national association under your leadership at the global level.

19.04.18

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**FPL 209/PR Report/Apr2018** **Public Relations Report for October 2017 – April 2018**	Original: English
Destination:	Finance and Planning Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **To be received**

Fifteen press releases have been issued since the General Assembly in Chicago.

2017
Oct 13: President's inaugural speech
Oct 13: WMA Expresses Solidarity with Polish Doctors
Oct 14: Revised Physicians' Pledge Published
Oct 14: WMA Opposes Recreational Cannabis
Oct 15: WMA to Postpone Assembly in Istanbul
Oct 17: Chicago Assembly decisions
Oct 18: Quality Assurance guidance
Oct 19: Climate change funding called for
Oct 26: WMA opposes euthanasia bill
Nov 10: WMA calls for release of Iranian doctor

2018
Jan 29: Indian Government criticised over dismantling medical council
Jan 30: WMA condemns arrests of Turkish Medical Association leaders
Feb 1: Joint letter to Erdogan calls for release of TMA leaders
Feb 26: International community criticised over Syrian hospital bombing
Apr 5: WHO and WMA sign memorandum of understanding

General Publicity

There was a good response to the publication of the revised Declaration of Geneva following the Chicago Assembly. The Pledge was exclusively published by JAMA (the Journal of the American Medical Association) and in the weeks following publication media reports appeared all over the world. This prompted some constructive debate and was generally very well received. A number of national medical associations posted the revised Declaration on their website and there were many reports of the Pledge being adopted by various NMAs and being recited at the start of physician meetings. In the days immediately following the Assembly, there were literally hundreds of tweets posted from around the world.

Other policy statements from the Assembly that received good publicity included the statements on medical cannabis, bullying and harassment and climate change. A selection of media coverage can be found on the WMA website.

Several other topics have received considerable media publicity in the last six months. These include the issue of physician assisted suicide and in particular the end of life conference held in Rome, which was marked by a message from the Pope. This received extensive publicity around the world.

The other event that provoked considerable media attention was the arrest of leaders of the Turkish Medical Association. Following the arrests, the WMA led a mass campaign on twitter that drew worldwide attention to the issue. This demonstrated yet again that social media has become a powerful medium for instant, short term reaction to events.

Twitter

The number of followers on the WMA twitter account continues to grow and reached 9,000 in March. The total is increasing by around 2,000 a year. The average number of WMA tweets being posted over recent months has been more than 70 a month. Estimated statistics show that the largest group of followers come from the US, the UK, Canada and Australia. Not surprisingly, almost half of the followers are in the 25-34 age range, with very few above the age of 55.

The WMA has joined with other organisations to campaign on influenza and fake medicines. Some posts have been boosted as part of the official campaign.

Ms Magda Mihaila, the WMA Communication and Information manager, has now taken on full responsibility for twitter (*https://twitter.com/#!/medwma*) as well as Facebook.

Facebook

WMA Facebook postings are dealt with by the office in Ferney, led by Ms Mihaila. Items are now being posted regularly on the site and the number of Facebook followers has risen to over 10,700. Some posts reach as much as 8.5 k views. In the future, the office intends to increase the number of followers among the members of WMA. In the future, WMA intends to create more original content for social media.

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09.04.18

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**SMAC 209/Agenda/Apr2018/REV** **Agenda of the Socio-Medical Affairs Committee**	Original: English
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note	This revised agenda includes new items 4.3, 6.1 and 6.2.	

Thursday 26 April 2018

Membership of the Committee

Dr Miguel Roberto JORGE (Chair)
Dr David O. BARBE
Dr Michael Bryant GANNON
Dr Thomas SZEKERES
Dr Mark PORTER
Dr Louis FRANCESCUTTI
Dr Shuyang ZHANG
Dr Walter VORHAUER
Dr Serafín ROMERO
Dr Ramin PARSA-PARSI
Dr Ajay KUMAR
Dr Toru KAKUTA
Dr Kenji MATSUBARA
Dr MooJin CHOO
Dr René HÉMAN
Dr Mzukisi GROOTBOOM
Dr Heidi STENSMYREN
Dr Julio TROSTCHANSKY

Ex-officio (with voting rights)

Dr Ardis Dee Hoven, *Chair of Council*
Dr Frank Ulrich Montgomery, *Vice-Chair of Council*
Dr Andrew Dearden, *Treasurer*

Ex-officio (without voting rights)

Dr Yoshitake Yokokura, *President*
Dr Leonid Eidelman, *President-Elect*
Dr Ketan Desai, *Immediate Past President*
Dr Otmar Kloiber, *Secretary General*
Ms Marie Colegrave-Juge, *Legal Advisor*
Mr Adolf Hällmayr, *Financial Advisor*
Ms Joelle Balffe, *Facilitor*
Ms Clarisse Delorme, *Advocacy Advisor*

1. GENERAL BUSINESS

1.1 Call to order by the Chair of the SMAC

1.2 Report of the previous meeting held in Chicago, United-States, 11-14 October 2017

Approve: Report of the Socio-Medical Affairs Committee
(SMAC 207/Report/Oct2017)

1.3 Chair's Opening Remark

1.4 Health and Migration, Dr. Poonam Dhavan, Migration Health Programme Coordinator, International Organisation for Migration (IOM)

2. MONITORING REPORT (ORAL)

3. BUSINESS IN PROGRESS

3.1 Health and Environment

Receive: Oral Report of the Environment Caucus

3.2 Plastic Bags, Ecological Issues & Environmental Degradation

Consider: Proposed revision of the WMA Statement on Environmental Degradation and Sound Management of Chemicals
(SMAC 209/Environmental Degradation/Apr2018)

3.3 Medical Tourism

Consider: Proposal for a WMA Statement on Medical Tourism
(SMAC 209/Medical Tourism REV5/Apr2018)

3.4 Women in Medicine

Consider: Proposed WMA statement on Women in Medicine & Comments
(SMAC 209/Women in Medicine COM REV2/Apr2018)

3.5 Professional Autonomy of Physicians

Consider: Proposed revision of the WMA Declaration of Seoul on Professional Autonomy and Clinical Independence & comments
(SMAC 209/Declaration of Seoul COM REV/Apr2018)
Consider: Proposed revision of the WMA Declaration of Madrid on Professionally-led Regulation & comments
(SMAC 209/Declaration of Madrid COM REV/Apr2018)

3.6 Sustainable Development

Consider: Proposed WMA Statement on Sustainable Development & Comments (SMAC 209/Sustainable Development COM REV/Apr2018)

3.7 Avian & Pandemic Influenza

Consider: Proposed WMA Statement on Avian and Pandemic Influenza & Comments (SMAC 209/Pandemic Influenza COM REV/Apr2018)

4. NEW ITEMS

4.1 Nuclear Weapons

Consider: Proposed revision of WMA Statement on Nuclear Weapons (SMAC 209/Nuclear Weapons/Apr2018)

4.2 Development and Promotion of a Maternal and Child Health Handbook

Consider: Proposed WMA Statement on the Development and Promotion of a Maternal and Child Health Handbook (SMAC 209/Maternal and child Handbook/Apr2018)

4.3 Pseudoscience, pseudotherapies, intrusion and sects in the field of health

Consider: WMA Declaration on Pseudoscience, pseudotherapies, intrusion and sects in the field of health (SMAC 209/ Pseudoscience /Apr2018)

5. CLASSIFICATION OF 2008 POLICIES

Consider: Recommendations received on SMAC Documents (SMAC 209/Policy Review 2008/Apr2018)

6. ANY OTHER BUSINESS

6.1 Presentation and preliminary discussion on a proposal for a WMA Network on Disaster Medicine (Japanese Medical Association)

6.2 Presentation and preliminary discussion on a white paper on Artificial Intelligence (American Medical Association)

7. ADJOURNMENT

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10.04.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**SMAC 207/Report/Oct2017** **Report of the Socio-Medical Affairs Committee**	Original: English
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**

Wednesday, 11 October 2017

Membership of the Committee

Dr. Miguel Roberto JORGE (Chair)
Dr. David O. BARBE
Dr. Michael Bryant GANNON
Dr Thomas SZEKERES
Dr. Mark PORTER
Dr. Louis FRANCESCUTTI
Dr. Shuyang ZHANG
Dr. Walter VORHAUER
Dr. Serafín ROMERO
Dr. Ramin PARSA-PARSI
Dr. Ajay KUMAR
Prof. Leonid EIDELMAN
Dr. Toru KAKUTA
Dr. Kenji MATSUBARA
Dr. MooJin CHOO
Dr. René HÉMAN
Dr. Mzukisi GROOTBOOM
Dr. Heidi STENSMYREN
Dr. Julio TROSTCHANSKY

Ex-officio (with voting rights)

Dr Ardis Dee Hoven, *Chair of Council*
Prof. Dr med. Frank Ulrich Montgomery, *Vice-Chair of Council*
Dr Andrew Dearden, *Treasurer*

Ex-officio (without voting rights)

Dr Ketan Desai, *President*
Sir Michael Marmot, *Immediate Past President*
Dr Yoshitake Yokokura, *President-Elect*
Dr Otmar Kloiber, *Secretary General*
Ms Marie Colegrave-Juge, *Legal Advisor*
Mr Adolf Hällmayr, *Financial Advisor*
Prof Vivienne Nathanson, *Facilitator*

1. GENERAL BUSINESS

1.1 The meeting was called to order by the Chair of Council at 16:05 on 10 October 2017.

1.2 Apologies for absence: Dr. T. SZEKERES replaced by Dr H. LINDNER; Dr.J. TROSTCHANSKY replaced by Dr A. RODRIGUEZ.

1.3 The Committee approved the report of the previous meeting held in Livingstone, Zambia (SMAC 206/Report/Apr2017).

2. MONITORING REPORT (ORAL)

Dr. J. TAINIJOKI, WMA Medical Advisor, informed the Committee that a high-level Meeting on Non-Communicable Diseases is scheduled prior to the next United Nations General Assembly in September 2018. The Secretariat is involved in the preparation process, advocating for a holistic approach on NCDs, which should include Social Determinants of Health. She invited members interested to contact the secretariat.

3. BUSINESS IN PROGRESS

3.1 Health and Environment

The Chair of Council, Dr. A. HOVEN, reminded the Committee that Dr. D. SHIN, Co-Chair of the Health and Environment Caucus [Prof. V. NATHANSON is the other co-Chair], resigned from his position a few months ago. Dr. A. HOVEN announced that she would appoint a new Chair to the Caucus and asked for constituent members to volunteer for this position. Dr. A.HOVEN will appoint a new Chair from among the volunteers after the Chicago meetings.

3.2 Role of Physicians in Adoption Practices

The Committee considered the proposal for a WMA Statement on the Role of Physicians in Preventing Exploitation in Adoption Practices (SMAC 207/Trafficking with Minors COM REV3/Oct2017).

RECOMMENDATION

3.2.1 That the proposal for a WMA Statement on the Role of Physicians in Preventing Exploitation in Adoption Practices (SMAC 207/Trafficking with Minors REV3/Apr2017) be approved by the Council and forwarded to the General Assembly for adoption.

3.3 Medical Tourism

The Committee considered the proposal for a WMA Statement on Medical Tourism and comments (SMAC 207/Medical Tourism REV4/Oct2017) submitted by the Israel Medical Association, rapporteur.

RECOMMENDATION

3.3.1 That the proposal for a WMA Statement on Medical Tourism (SMAC 207/Medical Tourism REV4/Oct2017) be sent back to the rapporteur for further work.

3.4 Tuberculosis

The Committee considered the proposed revision of WMA Resolution on Tuberculosis and comments (SMAC 207/Tuberculosis COM REV2/Oct2017).

RECOMMENDATION

3.4.1 That the proposed revision of WMA Resolution on Tuberculosis (SMAC 207/Tuberculosis REV2/Oct2017) be approved by the Council and forwarded to the General Assembly for adoption.

3.5 Health and Climate Change

The Committee considered the proposed WMA Declaration on Health and Climate Change and comments (SMAC 207/Climate Change COM REV3/Oct2017)

RECOMMENDATION

3.5.1 That the proposed WMA Declaration on Health and Climate Change (SMAC 207/Climate Change REV3/Oct2017) be approved by the Council and forwarded to the General Assembly for adoption.

3.6 Women in Medicine

The Committee considered the proposed WMA statement on Women in Medicine & Comments (SMAC 207/Women in Medicine COM REV/Oct2017).

RECOMMENDATION

3.6.1 That the proposed WMA statement on Women in Medicine (SMAC 207/Women in Medicine REV/Oct2017) be re-circulated to constituent members for comments.

3.7 Fair Medical Trade

The Committee considered the proposed WMA Statement on Fair Medical Trade & Comments (SMAC 207/Fair Medical Trade COM REV/Oct2017).

RECOMMENDATION

3.7.1 That the proposed WMA Statement on Fair Medical Trade (SMAC 207/Fair Medical Trade REV2/Oct2017), as amended, be approved by the Council and forwarded to the General Assembly for adoption.

3.8 Plastic Bags & Ecological Issues

The Committee considered the proposed WMA Statement on Curbing Consumption of Plastic Bags to Address Growing Ecological Issues & Comments (SMAC 207/Plastic Bags COM REV/Oct2017).

RECOMMENDATION

3.8.1 To appoint a rapporteur to review the WMA Statement on environmental degradation and sound management of chemicals in order to incorporate the issue of plastic bags pollution. The Swedish Medical Association volunteered to undertake that work.

3.9 Professional Autonomy of Physicians

The Committee considered the proposed revision of the WMA Declaration of Seoul on Professional Autonomy and Clinical Independence (SMAC 207/Declaration of Seoul/Oct2017) and the proposed revision of the WMA Declaration on Professionally-led Regulation (SMAC 207/Declaration of Madrid/Oct2017).

RECOMMENDATION

3.9.1 That the proposed revision of the WMA Declaration of Seoul on Professional Autonomy and Clinical Independence (SMAC 207/Declaration of Seoul/Oct2017) be circulated to constituent members for comments.

3.9.2 That the proposed revision of the WMA Declaration of Madrid on Professionally-led Regulation (SMAC 207/Declaration of Madrid/Oct2017) be circulated to constituent members for comments.

3.10 Sustainable Development

The Committee received the oral report from the working group, chaired by Dr. M. MICHIGANA (Japan Medical Association), and then considered the Proposed WMA Statement on Sustainable Development (SMAC 207/Sustainable Development/Oct2017).

RECOMMENDATION

3.10.1 That the Proposed WMA Statement on Sustainable Development (SMAC 207/Sustainable Development/Oct2017) be circulated to constituent members for comments.

3.11 Avian & Pandemic Influenza

The Committee received the oral report from the Secretary General and then considered the proposed revision of WMA Statement on Avian and Pandemic Influenza (SMAC 207/Pandemic Influenza/Oct2017) prepared by Dr. Caline MATTAR, AMR specialist.

RECOMMENDATION

3.11.1 That the proposed revision of WMA Statement on Avian and Pandemic Influenza (SMAC 207/Pandemic Influenza/Oct2017) be circulated to constituent members for comments.

3.12 Family Planning and the Right of a Woman to Contraception

The Committee considered the proposed revision of WMA Statement on Family Planning and the Right of a Woman to Contraception (SMAC 207/Right to Contraception/Oct2017), which underwent a minor revision as part of the annual policy review process.

RECOMMENDATION

3.12.1 That the proposed revision of WMA Statement on Family Planning and the Right of a Woman to Contraception (SMAC 207/Right to Contraception/Oct2017) be approved by the Council and forwarded to the General Assembly for information.

3.13 Noise Pollution

The Committee considered the proposed revision of the Statement on noise pollution (SMAC 207/Noise Pollution/Oct2017), which underwent a minor revision as part of the annual policy review process.

RECOMMENDATION

3.13.1 That the proposed revision of the Statement on noise pollution (SMAC 207/Noise Pollution/Oct2017) be approved by the Council and forwarded to the General Assembly for information.

3.14 Support of the Medical Associations in Latin America and the Caribbean

The Committee considered the proposed revision of the Resolution on Support of the Medical Associations in Latin America and the Caribbean (SMAC 207/Latin America and Caribbean/Oct2017) which underwent a minor revision as part of the annual policy review process.

RECOMMENDATION

3.14.1 That the proposed revision of the Resolution on Support of the Medical Associations in Latin America and the Caribbean (SMAC 207/Latin America and Caribbean/Oct2017) be approved by the Council and forwarded to the General Assembly for information.

3.15 Economic Embargoes and Health

The Committee considered the proposed revision of WMA Resolution on Economic Embargoes and Health (SMAC 207/Economic Embargoes/Oct2017) which underwent a minor revision as part of the annual policy review process.

RECOMMENDATION

3.15.1 That the proposed revision of WMA Resolution on Economic Embargoes and Health (SMAC 207/Economic Embargoes/Oct2017) be approved by the Council and forwarded to the General Assembly for information.

4. ADJOURNMENT

The meeting was adjourned at 17.10.

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12.10.2017

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**SMAC 209/Environmental Degradation/Apr2018/REV** **Proposed revision of the WMA Statement on Environmental Degradation and Sound Management of Chemicals**	Original: English
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note	At the meeting in Chicago in October 2017 the Socio-Medical Affairs Committee considered a proposed *WMA Resolution on Curbing Consumption of Plastic Bags to Address Growing Ecological Issues*. Rather than adopting the proposed policy, it was decided to review the *WMA Statement on Environmental Degradation and Sound Management of Chemicals* in order to incorporate the issue of plastic bags pollution. The Swedish Medical Association was appointed rapporteur and submits this proposed revision of the existing WMA statement, with the support of Peter Orris. The proposed revision includes wording regarding plastic pollution. Amendments are highlighted in **bold**, underlined or ~~strikethrough~~. *This revised version includes an amendment under the section "National and International Actions" which was omitted in the original text.*	

PREAMBLE

This Statement focuses on one important aspect of environmental degradation, which is environmental contamination by ~~**harmful**~~ domestic and industrial substances. It emphasizes the harmful chemical contribution to environmental degradation and physicians' role in promoting sound management of chemicals as part of sustainable development, especially in the healthcare environment.

Most chemicals to which humans are exposed come from industrial sources and include, food additives, household consumer and cosmetic products, agrochemicals, and other substances (drugs; dietary supplements) used for therapeutic purposes. Recently, attention has been concentrated on the effects of human engineered (or synthetic) chemicals on the environment, including specific

industrial or agrochemicals and on new patterns of distribution of natural substances due to human activity. As the number of such compounds has multiplied, governments and international organizations have begun to develop a more comprehensive approach to their safe regulation. **The increasing amount of plastic waste in our environment is another serious concern, that needs to be addressed.**

While governments have the primary responsibility for establishing a framework to protect the public's health from chemical hazards, the World Medical Association, on behalf of its members, emphasizes the need to highlight the human health risks and make recommendations for further action.

BACKGROUND

Chemicals of Concern

During the last half-century, the use of chemical pesticides and fertilizers dominated agricultural practice and manufacturing industries rapidly expanded their use of synthetic chemicals in the production of consumer and industrial goods.

The greatest concern relates to chemicals, which persist in the environment, have low rates of degradation, bio-accumulate in human and animal tissue (concentrating as they move up the food chain), and which have significant harmful impacts on human health and the environment (particularly at low concentrations). Some naturally occurring metals including lead, mercury, and cadmium have industrial sources and are also of concern. Advances in environmental health research including environmental and human sampling and measuring techniques, and better information about the potential of low dose human health effects have helped to underscore emerging concerns.

Health effects from chemical emissions can be direct (occurring as an immediate effect of the emission) or indirect. Indirect health effects are caused by the emissions' effects on water, air and food quality as well as the alterations in regional and global systems, such as red tide in many oceans, and the ozone layer and the climate, to which the emissions may contribute.

National and International Actions

The model of regulation of chemicals varies widely both within and between countries, from voluntary controls to statutory legislation. It is important that all countries move to a coherent, standardized national legislated approach to regulatory control. Furthermore, international regulations must be coherent such that developing countries will not be forced by economic circumstances to **accept elevated toxic exposure levels** ~~circumvent potentially weak national regulations~~. An example of a legislative framework can be found at http://ec.europa.eu/environment/chemicals/index.htm.

Synthetic chemicals include all substances that are produced by, or result from, human activities including industrial and household chemicals, fertilizers, pesticides, chemicals contained in products and in wastes, prescription and over-the-counter drug products and dietary supplements, and unintentionally produced byproducts of industrial processes or incineration, like dioxins. Furthermore, nanomaterials, in some circumstances, can be regulated by synthetic chemicals regulations but in other cases, may need explicit regulation.

Notable International Agreements on Chemicals

Several notable agreements on chemicals exist. These were prompted by the first United Nations Conference on the Human Environment declaration in 1972 (Stockholm) on the discharge of toxic substances into the environment. These agreements include the 1989 Basel Convention to control/prevent trans-boundary movements of hazardous wastes, the 1992 Rio Declaration on Environment and Development, the 1998 Rotterdam Convention on informed consent and shipment of hazardous substances, and the 2001 Stockholm Convention on Persistent Organic Pollutants. It should be noted that little information is available on the efficacy of the controls.

Strategic approach to international chemicals management

Worldwide hazardous environmental contamination persists despite these agreements, making a more comprehensive approach to chemicals essential. Reasons for ongoing contamination include persistence of companies, absolute lack of controls in some countries, lack of awareness of the potential hazards, inability to apply the precautionary principle, non-adherence to the various conventions and treaties and lack of political will. The *Strategic Approach to International Chemicals Management* (SAICM) was adopted in Dubai, on February 6, 2006 by delegates from over 100 governments and representatives of civil society. This is a voluntary global plan of action designed to assure the sound management of chemicals throughout their life cycle so that, by 2020, chemicals are used and produced in ways that minimize significant adverse effects on human health and the environment. The SAICM addresses both agricultural and industrial chemicals, covers all stages of the chemical life cycle of manufacture, use and disposal, and includes chemicals in products and in wastes.

Plastic waste

Plastic has been part of life for more than 100 years and is regularly used in some form by nearly everyone. While some biodegradable varieties are being developed, most plastics break down very slowly with the decomposition process taking hundreds of years. This means that most plastics that have ever been manufactured are still on Earth, unless burnt polluting the atmosphere with poisonous smoke.

Concerns about the use of plastic include accumulation of waste in landfills and in natural habitats, physical problems for wildlife resulting from ingestion or entanglement in plastic, the leaching of chemicals from plastic products and the potential for plastics to transfer chemicals to wildlife and humans. Many plastics in use today are halogenated plastics or contain other additives used in production, that have potentially harmful effects on health (e.g. carcinogenic or promoting endocrine disruption).

Our current usage of plastic is not sustainable, accumulating waste and therefore contributing to environmental degradation and potentially harmful effects on health. Specific regulation is therefore needed to counter the harmful distribution of slowly degradable plastic waste into the environment and the incineration of such waste which often creates toxic byproducts.

WORLD MEDICAL ASSOCIATION (WMA) RECOMMENDATIONS

Despite these national and international initiatives, chemical contamination of the environment due to inadequately controlled ~~**chemical**~~ production and usage continues to exert harmful effects on global public health. Evidence linking some chemicals to some health issues is strong, but **far from** all chemicals **have been tested for their health or environmental impacts. This is** especially **true for** newer **chemicals** or nano materials, particularly at low doses over long periods of time. **Plastic**

contamination of our natural environment, including in the sea where plastic decomposes to minute particles, is an additional area of serious concern. Physicians and the healthcare sector are frequently required to make decisions concerning individual patient**s** and the public as a whole based on existing data. Physicians therefore caution that they, too, have a significant role to play in closing the gap between policy formation and chemicals management and in reducing risks to human health.

The World Medical Association recommends that:

ADVOCACY

- National Medical Associations (NMAs) advocate for legislation that reduces chemical pollution, reduces human exposure to chemicals, detects and monitors harmful chemicals in both humans and the environment, and mitigates the health effects of toxic exposures with special attention to vulnerability during pregnancy and early childhood.
- NMAs urge their governments to support international efforts to restrict chemical pollution through safe management, or phase out and safer substitution when unmanageable (e.g. asbestos), with particular attention to developed countries aiding developing countries to achieve a safe environment and good health for all.
- NMAs facilitate better communication between government ministries/departments responsible for the environment and public health.
- Physicians and their medical associations advocate for environmental protection, disclosure of product constituents, sustainable development, and green chemistry within their communities, countries and regions.
- Physicians and their medical associations should support the phase out of mercury and persistent bioaccumulative and toxic chemicals in health care devices and products **and avoid incineration of wastes from these products which may create further toxic pollution**.
- Physicians and their medical associations should support legislation to require an environmental and health impact assessment prior to the introduction of a new chemical or a new industrial facility.
- Physicians should encourage the publication of evidence of the effects of different chemicals **and plastics,** and dosages on human health and the environment. These publications should be accessible internationally and readily available to media, non-governmental organizations (NGOs) and concerned citizens locally.
- Physicians and their medical associations **should** advocate for the development of effective and safe systems to collect and dispose of pharmaceuticals that are not consumed. **They should also advocate for the introduction worldwide of efficient systems to collect and dispose of plastic waste.**
- **Physicians and their medical associations should encourage efforts to curb the manufacture and use of plastic packaging and plastic bags, and to halt the introduction of plastic waste into the environment. These efforts may include specific regulations limiting the use of plastic packaging and plastic bags.**
- Physicians and their medical associations should support efforts to rehabilitate or clean areas of environmental degradation based on a "polluter pays" and precautionary principles and ensure that moving forward, such principles are built into legislation.
- The WMA, NMAs and physicians should urge governments to collaborate within and between departments to ensure coherent regulations are developed.

LEADERSHIP

The WMA:

- Supports the goals of the Strategic Approach to International Chemicals Management (SAICM), which promotes best practices in the handling of chemicals by utilizing safer substitution, waste reduction, sustainable non-toxic building, recycling, as well as safe and sustainable waste handling in the health care sector.
- Cautions that these chemical practices must be coordinated with efforts to reduce greenhouse gas emissions from health care to mitigate its contribution to global warming.
- Urges physicians, medical associations and countries to work collaboratively to develop systems for event alerts to ensure that health care systems and physicians are aware of high-risk industrial accidents as they occur, and receive timely accurate information regarding the management of these emergencies.
- Urges local, national and international organizations to focus on sustainable production, safer substitution, green safe jobs, and consultation with the health care community to ensure that damaging health impacts of development are anticipated and minimized.
- Emphasizes the importance of the safe disposal of pharmaceuticals as one aspect of health care's responsibility and the need for collaborative work in developing best practice models to reduce this part of the chemical waste problem.
- Encourages environmental classification of pharmaceuticals in order to stimulate prescription of environmentally less harmful pharmaceuticals.
- **Encourages local, national and international efforts to reduce the use of plastic packaging and plastic bags.**
- Encourages ongoing outcomes research on the impact of regulations and monitoring of chemicals on human health and the environment.

The WMA recommends that Physicians;

- Work to reduce toxic medical waste and exposures within their professional settings as part of the World Health Professional Alliance's campaign for Positive Practice Environments.
- Work to provide information on the health impacts associated with exposure to toxic chemicals, how to reduce patient exposure to specific agents and encourage behaviors that improve overall health.
- Inform patients about the importance of safe disposal of pharmaceuticals that are not consumed.
- Work with others to help address the gaps in research regarding the environment and health (i.e., patterns and burden of disease attributed to environmental degradation; community and household impacts of industrial chemicals; **the effects, including on health, of distribution of plastic and of plastic waste into our natural environment;** the most vulnerable populations and protections for such populations).

PROFESSIONAL EDUCATION & CAPACITY BUILDING

The WMA recommends that:

- Physicians and their professional associations assist in building professional and public awareness of the importance of the environment and global chemical pollutants on personal health.
- National Medical Associations (NMAs) and physician professional associations develop tools for physicians to help assess their patients' risk from chemical exposures.

- Physicians and their professional associations develop locally appropriate continuing medical education on the clinical signs, diagnosis and treatment of diseases that are introduced into communities as a result of chemical pollution and exacerbated by climate change.
- Environmental health and occupational medicine should become a core theme in medical education. Medical schools should encourage ~~in~~ the training of sufficient specialists in environmental health and occupational medicine.

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18.04.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**SMAC 209/Medical Tourism REV5/Apr2018** **Proposal for a WMA Statement on Medical Tourism**	Original: English
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**
Note:	This was proposed by the Israeli Medical Association (IsMA) to the Council in Buenos Aires (April 2016) which decided to circulate it for comments. At its 205th session in Taipei (October 2016), the Council decided to re-circulate it for comments. The Council in Livingstone (April 2017) considered the comments from constituent members and the compromise version proposed by IsMA. After discussion, it was decided to send the proposal back to the rapporteur for further work. Last October in Chicago, the Council considered the revised version (REV4) and decided to send it again to the rapporteur for additional work. The changes are highlighted in **bold** and <u>underlined</u>.	
Suggested Keywords:	Medical Tourism, Foreign Patients, Guidelines, Ethics	

PREAMBLE

1. Medical tourism is an expanding phenomenon, although to date it has no agreed upon definition and, as a result, practices and protocols in different countries can vary substantially. For purposes of this statement, medical tourism is defined as a situation where patients travel voluntarily across international borders to receive medical treatment, most often at their own cost. Treatments span a range of medical services, and commonly include: dental care, cosmetic surgery, elective surgery, and fertility treatment (OECD, 2011).

2. This statement does not cover cases where a national health care system or treating hospital sends a patient abroad to receive treatment at its own cost or where, as in the European Union, patients are allowed to seek care in another EU Member State according to legally defined

criteria, and their home health system bears the costs. Also not covered is a situation in which people are in a foreign country when they become ill and need medical care.

3. If not regulated appropriately, medical tourism may have medico-legal and ethical ramifications and negative implications, including but not limited to: internal brain drain, establishment of a two-tiered health system, and the spread of antimicrobial resistance. Therefore, it is imperative that there are clear rules and regulation to govern this growing phenomenon.

4. Medical tourism is an emerging global industry, with health service providers in many countries competing for foreign patients, whose treatment represents a significant potential source of income. The awareness of health as a potential economic benefit and the willingness to invest in it rise with the economic welfare of countries, and billions of dollars are invested each year in medical tourism all over the world. The key stakeholders within this industry include patients, brokers, governments, health care providers, insurance providers, and travel agencies. The proliferation of medical tourism websites and related content raise concerns about unregulated and inaccurate on-line health information.

5. A medical tourist is in a more fragile and vulnerable situation than that of a patient in his or her home country. Therefore, extra sensitivity on the part of caretakers is needed at every stage of treatment and throughout the patient's care, including linguistic and cultural accommodation wherever possible. When medical treatment is sought abroad, the normal continuum of care may be interrupted and additional precautions should therefore be taken.

6. Medical tourism bears many ethical implications that should be considered by all stakeholders. **Medical tourists receive care in both state-funded and private medical institutions and regulations must be in place in both scenarios**. These recommendations are addressed primarily to physicians. The WMA encourages others who are involved in medical tourism to adopt these principles.

RECOMMENDATIONS

General

7. The WMA emphasises the importance of developing health care systems in each country in order to prevent excessive medical tourism resulting from limited treatment options in a patient´s home country. Financial incentives to travel outside a patient's home country for medical care should not inappropriately limit diagnostic and therapeutic alternatives in the patient's home country, or restrict treatment or referral options.

8. The WMA calls on governments to carefully consider all the implications of medical tourism to the healthcare system of a country by developing comprehensive, coordinated national protocols for medical tourism in consultation and cooperation with all relevant stakeholders. These protocols should assess the possibilities of each country to receive medical tourists, to agree on necessary procedures, and to prevent negative impacts to the country´s health care system.

9. The WMA calls on governments and service providers to ensure that medical tourism does not negatively affect the proper use of limited health care resources or the availability of appropriate care for local residents in hosting countries. Special attention should be paid to treatments with long waiting times or involving scarce medical resources. Medical tourism must not promote unethical or illegal practices, such as organ trafficking. Authorities, including

government, should be able to stop elective medical tourism where it is endangering the ability to treat the local population.

10. The acceptance of medical tourists should never be allowed to distort the normal assessment of clinical need and, where appropriate, the development of waiting lists, or priority lists for treatment. Once accepted to treatment by a health care provider, medical tourists should be treated in accordance with the urgency of their medical condition. Whenever possible patients should be referred to institutions that have been approved by national authorities or accredited by appropriately recognised accreditation bodies.

Prior to travel

11. Patients should be made aware that treatment practices and health care laws may be different than in their home country and that treatment is provided according to the laws and practices of the host country. Patients should be informed by the physician/service provider of their rights and legal recourse prior to travelling outside their home country for medical care, including information regarding legal recourse in case of patient injury and possible compensation mechanisms.

12. The physician in the host country should establish a treatment plan, including a cost estimate and payment plan, prior to the medical tourist's travel to the host country. In addition, the physician and the medical tourism company (if any) should collaborate in order to ensure that all arrangements are made in accordance with the patient´s medical needs. Patients should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities.

13. Medical tourists should be informed that privacy laws are not the same in all countries and, in the context of the supplementary services they receive, it is possible that their medical information will be exposed to individuals who are not medical professionals (such as interpreters). If a medical tourist nonetheless decides to avail him or herself of these services, he or she should be provided with documentation specifying the services provided by non-medical practitioners (including interpreters) and an explanation as to who will have access to his or her medical information, and the medical tourist should be asked to consent to the necessary disclosure.

14. All stakeholders (clinical and administrative) involved in the care of medical tourists must be made aware of their ethical obligations to protect confidentiality. Where possible, interpreters, and other administrative staff with access to health information of the medical tourist should sign confidentiality agreements.

15. The medical tourist should be informed that a change in his or her clinical condition might result in a change in the cost estimate and in associated travel plans and visa requirements.

16. If the treatment plan is altered because of a medical need that becomes clear after the initial plan has been established, the medical tourist should be notified of the change and why it was necessary. Consent should be obtained from the patient for any changes to the treatment plan.

17. When a patient is suffering from an incurable condition, the physician in the host country shall provide the patient with accurate information about his or her medical treatment options, including the limitations of the treatment, the ability of the treatment to alter the course of the disease in an appreciable manner, to increase life expectancy and to improve the quality of life.

If, after examining all the data, the physician concludes that it is not possible to improve the patient's medical condition, the physician should advise the patient of this and discourage the patient from travelling.

Treatment

18. Physicians are obligated to treat every individual accepted for treatment, both local and foreigner, without discrimination. All the obligations detailed in law and international medical ethical codes apply equally to the physician in his or her encounter with medical tourists.

19. Medical decisions concerning the medical tourist should be made by physicians, in cooperation with the patient, and not by non-medical personnel.

20. At the discretion of the treating physicians, and where information is available and of good quality, the patient should not be required to undergo tests previously performed, unless there is a clinical need to repeat tests.

21. The patient should receive information about his or her treatment in a language he or she understands. This includes the right to receive a summary of the treatment progress and termination by the treating physician and a translation of the documents, as needed.

22. Agreement should be reached before treatment begins, on the transfer of test results and X-rays, back to the home country of the patient.

23. Where possible, communication between the physicians in the host and home country should be established in order to ensure appropriate aftercare and clinical follow-up of the medical problems for which the patient was treated.

24. The physician who prepares the treatment plan for the patient should confirm the diagnosis, the prognosis and the treatments that the medical tourist has received.

25. The patient should receive a copy of his or her medical documents for the purpose of continuity of care and follow-up in his or her home country. Where necessary, the patient should be given a detailed list of medical instructions and recommendations for the period following his or her departure. This information should include a description of the expected recovery time and the time required before travelling back to his or her home is possible.

Advertising

26. Advertising for medical tourism services, whether via the internet or in any other manner, should comply with accepted principles of medical ethics and include detailed information regarding the services provided. Information should address the service provider's areas of specialty, the physicians to whom it refers the benefits of its services, and the risks that may accompany medical tourism. Access to licensing/accreditation status of physicians and facilities and the facility's outcomes data should be made readily available. Advertising material should note that all medical treatment carries risks and specific additional risks may apply in the context of medical tourism.

27. National Medical Associations should do everything in their power to prevent improper advertising or advertising that is in violation of medical ethical principles, including advertising

that contains incorrect or partial information and/or any information that is liable to mislead patients, such as overstatement of potential benefits.

28. Advertising that notes the positive attributes of a specific medical treatment should also present the risks inherent in such treatment and should not guarantee treatment results or foster unrealistic expectations of benefits or treatment results.

Transparency and the prevention of conflicts of interest

29. Possible conflicts of interest may be inevitable for physicians treating medical tourists, including at the behest of their employing institution. It is essential that all clinical circumstances and relationships are managed in an open and transparent manner.

30. A physician shall exercise transparency and shall disclose to the medical tourist any personal, financial, professional or other conflict of interest, whether real or perceived, that may be connected to his or her treatment.

31. A physician should not accept any benefit, other than remuneration for the treatment, in the context of the medical treatment, and should not offer the medical tourist nor accept from him or her any business or personal offer, as long as the physician-patient relationship exists. Where the physician is treating the medical tourist as another fee paying patient, the same rules should apply as with his/her other fee paying patients.

32. A physician should ensure that any contract with a medical tourism company or medical tourist does not constitute a conflict of interest with his or her current employment, or with his or her ethical and professional obligations towards other patients.

Transparency in payment and in the physician's fees

33. A treatment plan and estimate should include a detailed report of all costs, including a breakdown of physician's fees, such as: consultancy and surgery and additional fees the patient might incur, such as: hospital costs, surgical assistance, prosthesis (if separate), and costs for post-operative care.

34. The cost estimate may be changed after the treatment plan has been given only in the event that the clinical condition of the patient has changed, or where circumstances have changed in a way that it was impossible to anticipate or prevent. If the pricing was thus changed, the patient must be informed as to the reason for the change in costs in as timely a fashion as possible.

Medical Tourism: Treatments, Markets and Health System Implications: A Scoping Review, Paris: Organisation for Economic Co-operation and Development (2011)

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March 2017

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**SMAC 209/Women in Medicine COM REV2/Apr2018** **Proposed WMA Statement on Women in Medicine**	Original: English
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**
Note:	This is a proposal from the Israeli Medical Association (IsMA). The 206th Council session in Livingstone (April 2017) considered and decided to circulate it within WMA membership for comments. The Council session in Chicago (October 2017) considered the compromised version and decided to circulate it again within WMA membership for comments.	
Keywords	Women, Gender, Workforce, Male Physician, Female Physician, Pay, Employment Opportunities, Feminization, Work-Life Balance.	

Abbreviation key:

AM	Associate Members
AMA	American Medical Association
AMV	Associazione Medica del Vaticano (Vatican State)
BMA	British Medical Association
CMA	Canadian Medical Association

CGCM	Consejo General de Colegios Médicos de Espana (Spain)
CNOM	French National Medical Council
DMA	Danish Medical Association
FMA	Finnish Medical Association
GMA	German Medical Association
JDN	Junior Doctors Network
NZMA	New Zealand Medical Association
NMA	Norwegian Medical Association
SAMA	South African Medical Association
SwMA	Swedish Medical Association

GENERAL COMMENTS	
AM	The Associate Members support this document but feel it needs to be stronger emphasizing that the social and cultural changes, especially about harassment of women, need to be the first and most important part of what needs to happen. We have moved that to the forefront, emphasizing its importance especially in the current social environment. We have moved some paragraphs around to indicate their relative importance. We think "family friendliness" could be more specific. We support this document with or without our suggestions.
AMV	We appreciate the work done by the Israeli Medical Association and completely agree with this proposal.
BMA	Overall this statement is very comprehensive and identifies some important areas where greater support and enforcement of rights offer major benefit to women doctors. We would like to propose the following changes to ensure the statement has the maximum relevance and impact for women doctors.
CNOM	The CNOM (French Medical Council) thanks the IsMA for the quality and importance of this text and supports it apart from paragraphs 25 and 28.
DMA	The Danish Medical Association is still critical towards this draft. We believe that the statement should be adjusted to focus unambiguously on equal rights and opportunities – rather than on problems and solutions for women in particular. The authors have already to some extent moved the draft in this direction – but we believe that more needs to be done. For example, we believe that some of the wording about the increase of the number of women in medicine still has a pejorative ring to it - for example the use of the phrase "the feminization of medicine". Similarly, we believe that a change in title would be helpful. The title should reflect WMA's goal concerning gender equal rights and opportunities rather than pointing to women in medicine as a separate issue.

FMA	FMA would like to thank the IMA for their work and for a more balanced text. However, we would still like to raise a question, whether the document could be even further developed and titled as a Statement on Gender Equality in Medicine? Parts of the text already correspond to this title.
NZMA	We welcome the development of this statement and are generally supportive of the fundamental principles. We have proposed a few minor suggested wording changes as tracked changes in the draft statement (see below).
GMA	• The GMA suggests avoiding the term "feminization", which, according to female leaders in the medical profession, has a negative connotation in certain contexts and is sometimes used pejoratively. It has been replaced in most instances, but still appears in the preamble. • The GMA notes that there is some overlap between the section on Work-Life Balance and the section on Pregnancy and Parenthood (e.g., paragraph 10 could fit in both categories). • The GMA also suggests moving paragraph 13 to the Pregnancy and Parenthood section and combining it with paragraph 18. Paragraphs 19 and 20 are also covered elsewhere in the paper (e.g. in paragraph 18 "Parents should have the right to take maternity or parental leave without negative consequences…") • The GMA recommends that paragraphs 22 and 23 focused on breastfeeding be combined.
NMA	Thanks to the Israeli Medical Association for revising this document. The document is improved and it does not only deal with female physicians, but also with equal rights between the sexes and a family friendly profession. We think the document should be even more directed towards both sexes and suggest some additions and deletions in the document. We do not agree that certain measures have to be taken due to the increased number of female physicians in medicine. More female physicians should not be considered as a challenge or a problem, and the concept feminisation of medicine could be perceived as something negative. Physicians of both sexes have common interests in developing a working life with equal opportunities for both female and male physicians. The situation is therefore more complex, and measures and changes in attitudes are necessary to establish good working environments for both male and female physicians. It must be acceptable also for male physicians to leave at 4 pm to pick up children in the kindergarten and male physicians should have equal opportunities to take marital leave without any reprisals from the employer.
SAMA	SAMA feels that this is an important document, which raises important issues. Further comments have been made in the body of the document. The current document seems to have lost its emphasis on the issues that affect women in medicine and is now emphasising a general working environment.
SwMA	The SMA feels that this policy would benefit from focusing even more on equal opportunities and rights for female and male physicians, rather than on perceived challenges due to a larger proportion of women in the medical workforce. We have suggested some changes of wording throughout the document to try to achieve this.

Numbering will be deleted (or adjusted) when the revised text is adopted.

	Proposed Text: **SMAC 207/Women in Medicine REV/Oct2017**	**Specific Comments** **Additions: bold/underlined** **Deletions: ~~lined-out~~** **Comments only: *[italic]***	**Proposed Revised Text by:** **IsMA** **SMAC 209/ Women in Medicine REV2/Apr2018**
Title	**WMA Statement on Women in Medicine**		WMA Statement on Medicine in Medicine
	Preamble		
New		**The WMA notes the increasing trend around the world for women to enter medical schools and the medical profession, and believes that the study and the practice of medicine must be transformed to a greater or lesser extent in order to support all people who study to become or practice as physicians, of whatever gender. This is an essential process of modernization by which inclusiveness is promoted by gender neutrality. This statement proposes mechanisms to identify and address barriers causing discrimination between genders.** [BMA]	The WMA notes the increasing trend around the world for women to enter medical schools and the medical profession, and believes that the study and the practice of medicine must be transformed to a greater or lesser extent in order to support all people who study to become or practice as physicians, of whatever gender. This is an essential process of modernization by which inclusiveness is promoted by gender neutrality. This statement proposes mechanisms to identify and address barriers causing discrimination between genders.
1.	The statement highlights the rise in female physicians and with this the opportunities and challenges which arise. The statement recommends actions in the following areas: increased presence of women in academia and management roles, work-life balance, changes in	Delete parag. [NMA] and [SwMA] Parag. 1 and 2 to change places [SAMA] The statement highlights the **increase** ~~rise~~ in the **number of** female physicians and with this the **potential** opportunities and challenges which arise [CMA]. The statement recommends actions in the	

	organizational culture and long-term implications of the feminization of medicine.	following areas: increased presence of women in academia and management roles, work-life balance, changes in organizational culture and long-term implications of the ~~feminization~~ **increased proportion of women in** of medicine. [GMA] The statement highlights the rise in female physicians and with this the opportunities and challenges which arise. The statement recommends actions in the following areas: **changes in organizational culture including the elimination of harassment in training and the workplace**, increased presence of women in academia and management roles **(including leadership and partnership)**, work-life balance, ~~changes in organizational culture,~~ and long-term implications of ~~the feminization of medicine~~ **workforce changes in medicine**. [AM: *Please define the use of "the feminization of medicine" or use another term*] The statement highlights the rise in female physicians and with this the opportunities and challenges which arise. The statement recommends actions in the following areas: increased presence of women in academia and management roles, work-life balance, changes in organizational culture and long-term implications of the ~~feminization~~ **increased proportion of women in** ~~of~~ medicine. [GMA] The statement highlights the rise **in numbers of** female physicians and with this the opportunities and challenges ~~which~~ **that** arise. [NZMA] The statement highlights the ~~rise~~ **increase** in female physicians and with this the opportunities and	

		challenges which arise. The statement recommends actions in the following areas: increased presence of women in academia and management roles, work-life balance, changes in organizational culture and long-term implications of **workforce planning.** ~~the feminization of medicine.~~ [AMA] ….. The statement recommends actions in the following areas: increased presence of women in academia and management roles, work-life balance, changes in organizational culture and long-term implications of **gender neutrality in** ~~the feminization of~~ medicine~~.~~ [BMA]	
2.	In many countries around the world, the number of women studying and practicing medicine has steadily risen over the past decades, surpassing 50% in many places.	Parag. 1 and 2 to change places [SAMA] Moved after parag. 3 for better flow of the document [SwMA] In many countries around the world, the number of women studying and practicing medicine has steadily risen over the past decades, surpassing 50% in many places. **Both men and women must have the same opportunities to do a career in medicine.** [NMA]	In many countries around the world, the number of women studying and practicing medicine has steadily risen over the past decades, surpassing 50% in many places.
3.	This issue was previously recognized in the WMA Resolution on Access of Women and Children to Health Care and the Role of Women in the Medical Profession (1997 Hamburg, 2008 Seoul) which, among other things, called for increased representation and participation in the medical profession, especially in light of the growing enrolment of women in medical	Delete parag. [NMA] Parag. 3 and 4 to change places [SAMA] ~~This~~ **The** issue **of women in medicine** [SwMA] was previously recognized in the WMA Resolution on Access of Women and Children to Health Care and the Role of Women in the Medical Profession ~~(1997 Hamburg, 2008 Seoul)~~ [SwMA] ~~which~~ **that** [NZMA], among other things, called for increased representation	

	schools. It also called for a higher growth rate of membership of women in the NMA's through empowerment, career development, training and other strategic initiatives.	and participation in the medical profession, especially in light of the growing enrolment of women in medical schools. It also called for a higher growth rate of membership of women in ~~the NMA's~~ **National Medical Associations (NMAs)** through empowerment, career development, training and other strategic initiatives. [SwMA+AM+SAMA+AMA+BMA]	
		In many countries around the world, the number of women studying and practicing medicine has steadily risen over the past decades, surpassing 50% in many places. [SwMA: Moved from parag. 2 above for better flow of the document]	
4.	This development is in need of supportive measures including the following:	Parag. 3 and 4 to change places [SAMA] This development ~~is in need of supportive measures~~ **offers opportunities for action,** including **in** the following **areas**: [SwMA]	This development offers opportunities for action, including in the following areas:
New		• **Elimination of harassment against women in both training and the workplace**. [AM]	
	• Greater emphasis on a proper balance of work and family life, while supporting the professional development of an individual physician.	• Greater emphasis on a proper balance of work and family life, while supporting the professional development of ~~an individual~~ physician**s**. [SwMA]	Greater emphasis on a proper balance of work and family life, while supporting the professional development of individual physicians.
	• Encouragement and actualization of women in both academia, leadership and managerial roles.	• Encouragement and actualization of women in ~~both~~ [CMA] academia **and non-academic practice environments**, leadership, **partnership**, and managerial roles. [AM]	Encouragement and actualization of women in academia, leadership and managerial roles.

		• Encouragement and actualization of women in ~~both~~ academia, **senior /** leadership and managerial roles. [BMA]	
	• Equalization of pay and employment opportunities for men and women, the elimination of gender pay gaps in medicine, and the removal of barriers negatively affecting the advancement of female physicians.	Equalization of pay and employment opportunities for men and women, the elimination of **sex and** gender pay gaps [AMA] in medicine, ~~and the removal of barriers negatively affecting the advancement of female physicians~~. [NMA]	Equalization of pay and employment opportunities for men and women, the elimination of gender pay gaps in medicine, and the removal of barriers negatively affecting the advancement of female physicians.
			The issue of women in medicine was previously recognized in the WMA Resolution on Access of Women and Children to Health Care and the Role of Women in the Medical Profession which, among other things, called for increased representation and participation in the medical profession, especially in light of the growing enrolment of women in medical schools. It also called for a higher growth rate of membership of women in National Medical Associations (NMAs) through empowerment, career development, training and other strategic initiatives.
	RECOMMENDATIONS		**RECOMMENDATIONS**
		Moved from below, as amended (parag 24-26): **Changes in organizational culture** The medical profession and employers should ~~work to eliminate~~ not tolerate discrimination and harassment	

		on the basis of gender and create a supportive environment that allows for equal opportunities for training, employment and advancement. **Physicians and staff should be periodically trained to recognize, respond, and report signs of discrimination and harassment so that action can be taken to eliminate them from the workplace. Employers should have confidential, non-retaliatory protected programs for reporting discrimination and harassment. There should be a separate unbiased independent mechanism for addressing these reports on both an individual and systemic level.** Hospitals should recognise that female physicians have been found to face higher levels of mental illness and suicide than their male peers and should investigate and address structural issues within the workforce that may contribute to this, including but not limited to organisational culture. [AM comments: *This statement should be footnoted with data and source, if possible*] Family friendliness should be part of the organizational culture of hospitals and other places of employment **by providing paid family leave when indicated**. [AM]	
	Increased presence of women in academia, leadership and management roles.	Delete [NMA]	**Increased presence of women in academia, leadership and management roles**.

5.	National Medical Associations/Medical Schools/Employers should facilitate the establishment of mentoring programs, sponsorship, and active recruitment to provide female medical students and physicians, guidance and encouragement necessary to undertake leadership and management roles.	Delete parag. [NMA] National Medical Associations/Medical Schools/Employers ~~should~~ **are urged to** facilitate the establishment of mentoring programs, sponsorship, and active recruitment to provide ~~female~~ **all** medical students and physicians, guidance and encouragement necessary to undertake leadership and management roles. [SwMA] National Medical Associations/Medical Schools/Employers should facilitate the establishment of mentoring programs, sponsorship, and active recruitment to provide **both** female **and** male medical students and physicians, guidance and encouragement necessary to undertake leadership and management roles. [NZMA]	National Medical Associations/Medical Schools/Employers are urged to facilitate the establishment of mentoring programs, sponsorship, and active recruitment to provide medical students and physicians with the necessary guidance and encouragement necessary to undertake leadership and management roles.
6.	NMAs should explore opportunities and incentives to encourage both men and women to pursue diverse careers in medicine and apply for fellowships, academic, senior leadership and management positions.	NMAs should ~~explore~~ **support** opportunities and incentives to encourage both men and women to pursue diverse careers in medicine and apply for fellowships, academic, senior leadership and management positions. [SwMA] NMAs should explore opportunities and incentives to encourage ~~both men and~~ **more** women to pursue diverse careers in medicine. **NMAs should encourage** ~~and~~ **women to** apply for fellowships, academic, senior leadership and management positions. [AM]	NMAs should explore opportunities and incentives to encourage both men and women to pursue diverse careers in medicine and apply for fellowships, academic, senior leadership and management positions.
7.	NMAs should lobby for gender equal medical education and work policies.	Deleted paragraph. [SwMA] NMAs should lobby **pro-actively** [AM] for gender equal medical education, ~~and~~ work **and responsibility**	NMAs should lobby for gender equal medical education and work policies.

		policies [CGCM] NMAs should lobby for **equal** **sex and** gender ~~equal~~ medical education and work policies. [AMA]	
8.	Engagement of women in health policy organizations and professional medical organizations should be encouraged.	Engagement of **both** women **and men** in health policy organizations and professional medical organizations should be encouraged. [SwMA] **Equal** engagement of women **and men** in health policy organizations and professional medical organizations should be encouraged. [NZMA]	NMAs should encourage the engagement of both men and women in health policy organizations and professional medical organizations.
	Work-Life Balance		**Work-Life Balance**
9.	Physicians should recognize that an appropriate work-life balance is beneficial to all physicians, however that women may uniquely face challenges to work-life balance imposed by societal expectations that must be addressed to solve the issue.	Physicians should recognize that an appropriate work-life balance is beneficial to all physicians~~, however that women may uniquely face challenges to work-life balance imposed by societal expectations that must be addressed to solve the issue~~. [SwMA] Physicians should recognize that an appropriate work-life balance is beneficial to all physicians, ~~however~~ **and** [NZMA] that women may ~~uniquely~~ face **unique** challenges to work-life balance imposed by societal expectations that must be addressed to solve the issue. [GMA] Physicians should recognize that an appropriate work-life balance is beneficial to all physicians, however that women may uniquely face challenges to work-life balance imposed by societal expectations **concerning gender roles** that must be addressed to solve the issue. [CGCM]	Physicians should recognize that an appropriate work-life balance is beneficial to all physicians, but that women may face unique challenges to work-life balance imposed by societal expectations concerning gender roles that must be addressed to solve the issue.

10.	Hospitals and other places of employment should strive to provide and promote access to high quality, affordable, flexible childcare for working parents, including the provision of onsite housing and childcare where appropriate. These should be available to male and female physicians, recognizing the need for a better work-life balance. They should provide information on available services which support the compatibility of work and family.	Hospitals and other places of employment should strive to provide and promote access to high quality, affordable, flexible childcare for working parents, including the provision of onsite housing and childcare where appropriate. These **services** should be available to **both** male and female **working** physicians, recognizing the need for a better work-life balance. ~~They should provide information on available services which support the compatibility of work and family.~~ [SwMA] Hospitals and other places of employment should strive to provide and promote access to high quality, affordable, flexible childcare for working parents, including the provision of onsite housing and childcare where appropriate. These should be available to ~~male and female~~ **all** physicians [AM], recognizing the need for a better work-life balance. **As well as about co-responsibility in personal life**. They should provide **male and female physicians** information [CGCM] on available services ~~which~~ **that** support the compatibility of work and family. [NZMA] Hospitals and other places of employment should be receptive to the possibility of flexible and family-friendly working hours, including part-time residencies, posts, and professional appointments, where appropriate. ~~particularly in fields in which women are underrepresented.~~ [NMA]	Hospitals and other places of employment should strive to provide and promote access to high quality, affordable, flexible childcare for working parents, including the provision of onsite housing and childcare where appropriate. These services should be available to both male and female physicians, recognizing the need for a better work-life balance. Employers should provide information on available services which support the compatibility of work and family.
11.	Hospitals and other places of employment should be receptive to the possibility of flexible and family-friendly working hours, including	Hospitals and other places of employment should be receptive to the possibility of flexible and family-friendly working hours **where appropriate**, including part-time residencies, posts, and professional	Hospitals and other places of employment should be receptive to the possibility of flexible and family-friendly working hours, including part-time

	part-time residencies, posts, and professional appointments, where appropriate, particularly in fields in which women are underrepresented.	appointments, ~~where appropriate~~ [NZMA]. ~~particularly in fields in which women are underrepresented~~. [NMA + SwMA]	residencies, posts, and professional appointments, particularly in fields in which women are underrepresented.
12.	There is a need for increased research on alternative work schedules and telecommunication opportunities that will allow flexibility in balancing work-life demands.	There is a need for increased research on alternative work schedules and telecommunication opportunities that will allow flexibility in balancing work-life demand **of men and women**. [CGCM]	There is a need for increased research on alternative work schedules and telecommunication opportunities that will allow flexibility in balancing work-life demands.
13.	NMAs should advocate for the enforcement and, where necessary, the introduction of policy mandating appropriate paid maternity leave and parental leave in their respective countries.	NMAs should advocate for the ~~enforcement and, where necessary, the~~ [SwMA] introduction of policy mandating appropriate paid ~~maternity leave and~~ [CMA + SwMA] parental leave in their respective countries. **The policy should include options for flexible working hours.** [SwMA] NMAs should advocate for the enforcement and, where necessary, the introduction of policy mandating appropriate paid maternity leave and parental leave **and rights** in their respective countries. [BMA] Move to parag. 18.[GMA]	NMAs should advocate for the enforcement and, where necessary, the introduction of policy mandating appropriate paid parental leave and rights in their respective countries.
14.	Medical workplaces and professional organisations should have fair, impartial and transparent policies and practices to give female doctors and medical students equal access to employment, education and training opportunities in medicine.	Medical workplaces and professional organisations should have fair, impartial and transparent policies and practices to give female **and male** doctors and medical students equal access to employment, education and training opportunities in medicine. [SwMA] Medical workplaces and professional organisations should have fair, impartial and transparent policies and practices to give **all** [NZMA] female ~~doctors~~ **physicians** and medical students equal access to employment, education and training opportunities in	Medical workplaces and professional organisations should have fair, impartial and transparent policies and practices to give all physicians and medical students equal access to employment, education and training opportunities in medicine.

		medicine. [AMA]	
	Pregnancy and Parenthood		**Pregnancy and Parenthood**
15.	It should be inadmissible for employers to ask applicants about family planning in relation to work.	It should be **illegal** ~~inadmissible~~ for employers to ask applicants about **pregnancy and/or** family planning in relation to work. [BMA] It should be inadmissible for employers to ask applicants about family planning in relation to work **or when applying medical school or residency**. [JDN]	It should be illegal for employers to ask applicants about pregnancy and/or family planning in relation to work.
New		**Physicians should have the freedom to choose when they wish to have children and should not feel pressures against doing so at a time of their choosing**. [JDN]	
16.	A risk assessment should be made by the employer concerning the risks to pregnant physicians working shifts. The pregnant physician should have the right to not work night shifts or on-call shifts during pregnancy, especially during the last trimester, without negative consequences on salary or progression in residency.	A risk assessment should be made by the employer concerning the risks to pregnant physicians working shifts. The pregnant physician should have the right **not** to ~~not~~ work night shifts or on-call shifts during **the later part of** pregnancy~~, especially during the last trimester,~~ without **any** negative **employment** consequences ~~on salary or progression in residency~~. [SwMA] A risk assessment should be made by the employer concerning the risks to pregnant physicians working shifts. **Considerations for radiation exposure, hazardous chemicals, environmental exposures, lifting requirements, access to adequate food and water, and restroom access should be addressed and accommodations provided**. The pregnant physician, **whether in training or practicing**, should have the right to **make schedule accommodations in**	Employers should assess the risks to pregnant physicians and their unborn children, when a physician has recently given birth and when she is breastfeeding. Where it is found, or a medical practitioner considers, that an employee or her child would be at risk were she to continue with her normal duties, the employer should provide suitable alternative work for which the physician should receive her normal rate of pay. Physician should have the right to not work night shifts or on-call shifts during the later part of pregnancy, without negative consequences on salary, employment or progression in residency.

		order to avoid night shifts or on-call shifts **(if desired), and radiologic and infectious exposure** during pregnancy, especially during the last trimester, without negative consequences on salary or progression in residency. **Pregnant physicians should be able to choose which work or training accommodations best fit their personal and family needs**. [AM] A risk assessment **of the workplace** should be made by the employer concerning the risks to pregnant physicians **and their unborn children, when a physician has recently given birth and when she is breastfeeding. where it is found, or a medical practitioner considers, that an employee or her child would be at risk were she to continue with her normal duties, the employer should provide suitable alternative work for which the physician should receive her normal rate of pay** ~~working shifts.~~ The pregnant physician should have the right to not work night shifts or on-call shifts during pregnancy, especially during the last trimester, without negative consequences on salary or progression in residency. [BMA: *The statement on risk assessments for pregnant doctors working shifts should be widened to include the range of workplace activities that could put pregnant physicians and their unborn children at risk e.g. long periods of standing, lifting heavy items. It should also be broadened to include new mothers and those breastfeeding.*]	
17.	Pregnant physicians should have equal training opportunities in post-graduate training.		Pregnant physicians should have equal training opportunities in post-graduate training.
18.	Parents should have the right to take	Parents should have the right to take ~~maternity or~~	Parents should have the right to take

	maternity or parental leave without negative consequences on their employment, training or career opportunities.	parental leave without negative consequences on their employment, training or career opportunities [SwMA + CMA] Parents should have the right to take maternity or parental leave without negative consequences on their employment, training or career opportunities. **NMAs should advocate for the enforcement and, where necessary, the introduction of policy mandating appropriate paid maternity leave and parental leave in their respective countries**. [GMA]	adequate parental leave without negative consequences on their employment, training or career opportunities.
19.	Parents should have adequate parental leave with fair pay and options for flexible working.	Delete parag. [GMA + SwMA]	
20.	Parents should have the right to return to the same position after parental leave, without the fear of termination.	Delete parag. [GMA + SwMA]	Parents should have the right to return to the same position after parental leave, without the fear of termination.
21.	Employers and training bodies should provide necessary supports to any physician returning after a prolonged period of absence including inter alia for parental, maternity and elder-care leave.	Employers ~~and training bodies~~ should provide necessary supports ~~to any physician returning after a prolonged period of absence~~**,** including ~~inter alia for~~ **after** parental~~,~~ **or** maternity ~~and elder-care~~ leave. (SwMA) Employers and training bodies should provide necessary supports to any physician returning after a prolonged period of absence including inter alia for parental **and/or** maternity or **caring for older or disabled relatives** ~~and elder-care leave~~. [BMA]	Employers and training bodies should provide necessary support to any physician returning after a prolonged period of absence including parental, maternity and elder-care leave.

22.	Mothers should be able to breastfeed (or be given protected time for breast pumping) during work hours, within the current guidelines from the WHO.		Mothers should be able to breastfeed (or be given protected time for breast pumping) during work hours, within the current guidelines from the WHO.
23.	Workplaces should provide adequate accommodation for women who are breastfeeding including designated areas for breastfeeding, breast pumping, and milk storage.	Workplaces should provide adequate ~~accommodation~~ **areas** for women who are breastfeeding**,** including designated areas for breastfeeding, breast pumping, and milk storage. [SwMA]	Workplaces should provide adequate accommodation for women who are breastfeeding including designated areas for breastfeeding, breast pumping, and milk storage.
	Changes in organizational culture		**Changes in organisational culture**
24.	The medical profession and employers should work to eliminate discrimination and harassment on the basis of gender and create a supportive environment that allows for equal opportunities for training, employment and advancement.	The medical profession and employers should work to eliminate discrimination and harassment on the basis of **sex and** gender and create a supportive environment that allows for equal opportunities for training, employment and advancement. [AMA]	The medical profession and employers should work to eliminate discrimination and harassment on the basis of gender and create a supportive environment that allows equal opportunities for training, employment and advancement.
25.	Hospitals should recognise that female physicians have been found to face higher levels of mental illness and suicide than their male peers and should investigate and address structural issues within the workforce that may contribute to this, including but not limited to organisational culture.	Delete parag. [CNOM: *Unless we can back up this phenomenon with a reference to the scientific evidence, we would recommend deleting this paragraph*] Hospitals should recognise that female physicians have been found to ~~face~~ **be subject to** higher **risks** ~~levels~~ of mental illness and suicide than their male peers and should investigate and address structural issues within the workforce that may contribute to this, including but not limited to organisational culture. [SwMA: *Please add reference to studies showing this*] Hospitals **and other primary care and work for women centers** should recognise that female physicians have been found to face higher levels of	

		mental illness and suicide than their male peers and should investigate and address structural issues **about hiring policies** ~~within~~ **for** the workforce that may contribute to this, including but not limited to organisational culture [CGCM] [SAMA: *Please provide a reference for this statement*] Replace parag. by: **Employers should recognise that female physicians have been found to face significant levels of mental illness, from mild to severe conditions, and suicide** [BMA: *The statement on hospitals addressing the issues associated with the higher risks of mental illness and suicide experienced by women needs qualification. Whilst there is some evidence that women doctors in some countries are at a higher risk of suicide compared to men, the evidence on mental health is more complex due to factors including underreporting of mental health issues by men. It is therefore preferable to highlight and address the specific mental health issues experienced by women doctors which are linked to career pathways, combining work with family and workplace discrimination. There is a role for all healthcare employers in tackling these issues, not just hospitals.*]	
26.	Family friendliness should be part of the organizational culture of hospitals and other places of employment.		Family friendliness should be part of the organizational culture of hospitals and other places of employment.
	Workforce planning and research		**Workforce planning and research**
		Move parag. 29 below here [AM]	
27.	Governments should take the increasing number of women entering	**NMA's should encourage** Governments ~~should~~ **to** take the increasing number of women entering	NMAs should encourage governments to take the increasing number of women

	medicine into consideration in the context of long-term workforce planning. A diverse workforce is beneficial to the system and to patients. Organizations delivering healthcare should focus on ensuring systems are appropriately resourced to ensure all those working within it are able to deliver safe care to patients and are appropriately and equitably rewarded. Governments should also work to counteract negative attitudes and behaviour, bias, and/or outdated norms and values from organizations and individuals.	medicine into consideration in the context of long-term workforce planning…. [SAMA] ~~Governments should take the increasing number of women entering medicine into consideration in the context of long-term workforce planning.~~ A diverse workforce is beneficial to ~~the system~~ **health care** and to patients. **Governments need to take this into account in the context of long-term workforce planning.** Organizations delivering healthcare should focus on ensuring systems are appropriately resourced to ensure **that** all those working within ~~it~~ **them** are able to deliver safe care to patients and are appropriately and equitably rewarded. Governments should also work to counteract negative attitudes and behaviour, bias, and/or outdated norms and values from organizations and individuals. [SwMA] Governments **and employers** should take the increasing number of women entering medicine into consideration in the context of long-term workforce planning. A diverse workforce is beneficial to the **health care** system and to patients…. [AM]	entering medicine into consideration in the context of long-term workforce planning. A diverse workforce is beneficial to the health care system and to patients. Organizations delivering healthcare should focus on ensuring systems are appropriately resourced to ensure that all those working within them are able to deliver safe care to patients and are appropriately and equitably rewarded. Governments should also work to counteract negative attitudes and behaviour, bias, and/or outdated norms and values from organizations and individuals.
28.	Governments should invest in research to evaluate the long-term implications associated with the different approaches of male and female physicians to patient care. They should work to identify those factors that drive women to choose certain career steps and fields of specialization early on in their medical education and training and strive to address barriers in order to	**NMA's should encourage** Governments ~~should~~ **to** invest in research…. [SAMA] Governments should invest in research to ~~evaluate the long-term implications associated with the different approaches of male and female physicians to patient care. They should work to~~ identify ~~those~~ factors that drive women **and men** [SwMA] to choose certain career steps and fields of specialization early on in their medical education and training and strive to address **any identified** barriers [CMA] in order to	NMAs should encourage governments to invest in research to identify those factors that drive women to choose certain fields of specialization early on in their medical education and training and strive to address any identified barriers in order to achieve equal representation of men and women in all fields of medicine.

	achieve equal representation of women in all fields of medicine.	achieve equal representation of women **and men** in all fields of medicine. [SwMA] Replace parag. by: **Research should be commissioned to identify those factors that drive women to choose certain fields of specialization early on in their medical education and training, so that women have a broader choice of career and specialty.** [BMA: *The statement on research required to evaluate the long-term implications associated with the different approaches of male and female physicians to patient care requires clarification. The key priority in research and policy focus should be the barriers which still prevent women being able to choose and continue their careers in certain specialties of medicine – e.g. because of a lack of flexibility, inability to work part time, long/unsocial hours culture*]. **Considering the data now available to us which would enable investigation into the question that gender could have an impact on the different approaches of male and female physicians to patient care or different care models,** governments should invest in research to evaluate the long-term implications ~~associated with the different approaches of male and female physicians to patient care~~.They should work to identify those factors that drive women to choose certain career steps and fields of specialization early on in their medical education and training and strive to address barriers in order to achieve equal representation of women in all fields of medicine. [CNOM]	
29.	Governments and employers should	**NMA's should encourage** Governments and	NMAs should encourage governments

	ensure that men and women receive equal compensation for commensurate work and work to eliminate the gender pay gap in medicine.	employers ~~should~~ **to** ensure that men and women receive equal compensation for commensurate work and work to eliminate the gender pay gap in medicine. [SAMA] Governments and employers should ensure that ~~men and~~ women **and men** receive equal compensation for commensurate work and work to eliminate the gender pay gap in medicine. [SwMA] Governments and employers should ensure that men and women receive equal compensation for commensurate work and work to eliminate the **sex and** gender pay gap in medicine. [AMA] Move above, before parag. 27 [AM]	and employers to ensure that men and women receive equal compensation for commensurate work and strive to eliminate the gender pay gap in medicine.

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06.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**SMAC 209/Declaration of Seoul COM REV/Apr2018** **Proposed revision of WMA Declaration of Seoul on Professional Autonomy and Clinical Independence**	Original: English
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**
Note:	As part of the annual policy review process, the Council in Buenos Aires (April 2016) decided that the Statement on Professional Responsibility for standards of Medical Care, under the 10-years policy review, be rescinded and archived, and that the WMA Declarations of Seoul and Madrid be merged in a single document, completed with the missing sections from that Statement. Prof. Vivienne Nathanson, British Medical Association (BMA), volunteered to complete that work. Further to the proposed revision submitted to the Council in Taipei (Oct. 2016) and then circulated for comments, the Council in Livingstone (April 2017) reversed its decision and decided that the Declarations of Seoul and Madrid be kept separate and revised individually to incorporate the relevant missing sections from the Statement on Professional Responsibility for standards of Medical Care, which will then be rescinded and archived.	

The text below presents the proposed revision of the Declaration of Seoul from prof. Nathanson. The 207th Council session in Chicago (October 2017) considered the proposal and decided to circulate it within WMA membership for comments.

Abbreviation key:

AM	Associate Members
AMA	American Medical Association
AMV	Associazione Medica del Vaticano (Vatican State
CMA	Canadian Medical Association
CNOM	French National Medical Council
FMA	Finnish Medical Association
DMA	Danish Medical Association
NZMA	New Zealand Medical Association
NMA	Norwegian Medical Association
RDMA	Royal Dutch Medical Association
SAMA	South African Medical Association
SwMA	Swedish Medical Association

GENERAL COMMENTS	
AMV	The proposed revision of WMA Declaration of Seoul on Professional Autonomy and Clinical Independence is accepted as it is.
CMA	The CMA supports this Declaration.
DMA	The DMA supports this important, clear and well-written document.
CNOM	The CNOM (French Medical Council) supports this text and would like professional autonomy to be defined throughout the text as the ability of physicians to organise their professional lives (which can be difficult for physicians working as employees), which helps to guarantee clinical independence. This definition would ensure consensus for all members of the WMA.
FMA	FMA can accept the amended document except for para 6 which we propose to be reworded.
JDN	No changes proposed
NMA	NMA supports this document, but suggests two minor changes.
NZMA	We are comfortable with this revised declaration and have no specific amendments.

Numbering will be deleted (or adjusted) when the revised text is adopted.

No	**Proposed Text:** **SMAC 207/Declaration of Seoul/Oct2017**	**Specific Comments** **Additions: bold/underlined** **Deletions: ~~lined-out~~** **Comments only: *[italic]***	**Proposed Revised Text by:** **Rapporteur** **SMAC 209/ Declaration of Seoul REV/Apr2018** *Rapporteur's comments are in italic*
Title	Declaration of Seoul on Professional Autonomy and Clinical Independence		Declaration of Seoul on Professional Autonomy and Clinical Independence
	The WMA reaffirms the Declaration of Madrid on professionally-led regulation.		The WMA reaffirms the Declaration of Madrid on professionally-led regulation
	The World Medical Association recognises the essential nature of professional autonomy and physician clinical independence, and states that:		The World Medical Association recognises the essential nature of professional autonomy and physician clinical independence, and states that:
1	Professional autonomy and clinical independence are essential elements in providing quality health care to all patients and populations.	Professional autonomy and clinical independence are essential elements in providing quality health care to all patients and populations. **The autonomy and professional independence of the physician are essential requirements for high quality health care and therefore it is a benefit for the patients whose rights it protects, and for the society, reason why they must be preserved.** [CGCM] [AMA: *Combined first two paragraphs]*	Professional autonomy and clinical independence are essential elements in providing quality health care to all patients and populations. **Professional autonomy and independence are essential for the delivery of high quality health care and therefore benefit patients and society.** *Question from compiler – should this be removed given the language in the final para?*
2	Professional autonomy and clinical independence describes the processes under which ~~is~~ individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue or inappropriate influence by outside parties or individuals.		Professional autonomy and clinical independence describes the processes under which ~~is~~ individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue or inappropriate influence by outside parties or individuals.

3	Medicine is a highly complex art and science. Through lengthy training and experience, physicians become medical experts and healers weighing evidence to formulate advice to patients. Whereas patients have the right to self-determination, deciding within certain constraints which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations.	Medicine is a highly complex art and science. Through lengthy training and experience, physicians become medical experts and ~~healers~~ **therapists** (NMA) weighing evidence to formulate advice to patients. Whereas patients have the right to self-determination, deciding within certain constraints which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations. (NMA comments: *In Norway "healer" is associated with persons not officially recognised as health care personnel*) Medicine is ~~a~~ highly complex art and science. Through lengthy training and experience, physicians become medical experts ~~and healers~~ weighing evidence to formulate advice to patients. Whereas patients have the right to self-determination, deciding within certain constraints which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations.[SwMA]	Medicine is ~~a~~ highly complex art and science. Through lengthy training and experience, physicians become medical experts ~~and healers~~ weighing evidence to formulate advice to patients. Whereas patients have the right to self-determination, deciding within certain constraints which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations.
New		**The professional service of the physician cannot be considered a commercial service because it is subject to specific ethical standards that allow it to provide professional, competent, qualified and respectful care with the professional standards and values that protect the patient** [CGCM: to link to parag.3]	*While there is a "higher calling" to medicine it is also commercially provided in many countries.*
4	Physicians recognize that they must take into account the structure of the	Physicians recognize that they must take into account the structure of the health system and	Physicians recognize that they must take into account the structure of the health system and

	health system and available resources. Unreasonable restraints on clinical independence imposed by governments and administrators are not in the best interests of patients, may not be evidence based and risk undermining the trust which is an essential component of the patient-physician relationship.	available resources **and prudent use of those resources**. ~~Unreasonable restraints on clinical independence imposed by governments and administrators are not in the best interests of patients, may not be evidence based and risk undermining the trust which is an essential component of the patient-physician relationship~~. [SAMA] Physicians recognize that they must take into account the structure of the health system and available resources **when making treatment decisions**. Unreasonable restraints on clinical independence imposed by governments and administrators are not in the best interests of patients~~,~~ **because they** may not be evidence based and risk undermining ~~the~~ trust which is an essential component of the patient-physician relationship. [AMA]	available resources **when making treatment decisions**. Unreasonable restraints on clinical independence imposed by governments and administrators are not in the best interests of patients~~,~~ **because they** may not be evidence based and risk undermining ~~the~~ trust which is an essential component of the patient-physician relationship
New		**Professional autonomy does not imply that the physician can deviate from the professional guidelines when he considers it necessary and he must be prepared to explain his performance and assume his responsibilities**. [CGCM: to link to parag. 4]	**Professional autonomy is limited by adherence to professional rules, standards and the evidence base.**
New		**Whilst there is need for priority setting and limitations on health care coverage due to limited resources, increasingly, governments, health care funders (third party payers), administrators and Managed Care organisations interfere with clinical autonomy**	**Priority setting and limitations on health care coverage are essential due to limited resources. Governments, health care funders (third party payers), administrators and Managed Care organisations may interfere with clinical autonomy by seeking to impose rules and**

		by imposing unreasonable rules and disease cover limitations. These rules do not take into considerations evidence-based medicine principle, cost-effectiveness and best interest of patients. Often, economic evaluation studies are undertaken from funder's perspective and not from users' perspective which put more emphasis on cost-savings than health outcomes. [SAMA: *Subject to editorial language changes*]	**limitations. These may not reflect evidence-based medicine principles, cost-effectiveness and the best interest of patients. Economic evaluation studies may be undertaken from a funder's not a users' perspective and emphasise cost-savings rather than health outcomes.**
New		**Furthermore, priority setting, funding decision making and resource allocation/limitations processes are not transparent. The lack of transparency further perpetuates health inequities.** [SAMA]	**Priority setting, funding decision making and resource allocation/limitations processes are frequently not transparent. A lack of transparency further perpetuates health inequities.**
5	Some hospital administrators and third-party payers consider physician professional autonomy to be incompatible with prudent management of health care costs. The reality is that professional autonomy is a major contributing factor to physicians assisting patients to make informed choices, and enables physicians to refuse demands by patients and family members for access to inappropriate treatments and services.	~~Some hospital administrators and third-party payers consider physician professional autonomy to be incompatible with prudent management of health care costs. The reality is that p~~ (NMA) **P**rofessional autonomy is a major contributing factor to physicians assisting patients to make informed choices, and enables physicians to refuse demands by patients and family members for access to inappropriate treatments and services. *(*NMA's comments*: WMA should avoid characterising other occupational groups negatively)* Some hospital administrators and third-party payers **may** [SwMA] consider physician professional autonomy to be incompatible with prudent management of health care costs. **When necessary, National Medical Associations (NMAs) should address these concerns** [AM].	Some hospital administrators and third-party payers consider physician professional autonomy to be incompatible with prudent management of health care costs. ~~The reality is that~~ **Professional** autonomy ~~is a major contributing factor to~~ **allows** physicians ~~assisting patients~~ to **help patients** make informed choices, and ~~enables~~ **supports** physicians ~~to~~ **if they** refuse demands by patients and family members for access to inappropriate treatments and services.

		The reality**, however** [SwMA], is that professional autonomy is a major contributing factor to physicians assisting patients to make informed choices, and enables physicians to refuse demands by patients and family members for access to inappropriate treatments and services. **When disagreements arise among physicians, patients and families, physicians should listen carefully to the patients' concerns, and try to arrive at a mutually satisfying solution**. [AM] Some hospital administrators and third-party payers consider physician professional autonomy to be incompatible with prudent management of health care costs. ~~The reality is that~~ **However,** professional autonomy ~~is a major contributing factor to~~ **allows** physicians ~~assisting patients~~ to **help patients** make informed choices, and ~~enables~~ **supports** physicians ~~to~~ **if they** refuse demands by patients and family members for access to inappropriate treatments and services. [AMA]	
6	Interference with the professional autonomy and clinical independence of physicians by other health care professionals can damage optimal patient care as fundamentally as interference by lay personnel.	Delete paragraph and replace by new paragraph below [AMA] Interference with the professional autonomy and clinical independence of physicians by other health care professionals **and others** can damage optimal patient care ~~as fundamentally as interference by lay personnel~~. **The physician must be guaranteed the freedom to express clinical and ethical opinion without any inappropriate external interference**. [CGCM]	*The AMA suggestion is taken, see new para below*

		Interference with the professional autonomy and clinical independence of physicians by other health care professionals **employed by funders, administrators and managed care organisations** can damage optimal patient care as fundamentally as interference by lay personnel. [SAMA] Interference with the professional autonomy and clinical independence of physicians by other health care professionals can damage optimal patient care ~~as fundamentally as interference by lay personnel~~. [SwMA] Interference with the professional autonomy and clinical independence of physicians by other health care professionals ~~can damage optimal patient care as fundamentally as interference by lay personnel.~~ **may create confusion in clinical settings and have negative effect on patient care, and should thus be avoided. This does not rule out the need for team work in patient care**. [FMA]	
New		**Care is given by teams of health care professionals, led by physicians. No member of the care team should interfere with the professional autonomy and clinical independence of the physician, who assumes the ultimate responsibility for the care of the patient. In situations where another team member has clinical concerns about the proposed course of treatment, a mechanism to**	**Care is given by teams of health care professionals, usually led by physicians. No member of the care team should interfere with the professional autonomy and clinical independence of the physician who assumes the ultimate responsibility for the care of the patient. In situations where another team member has clinical concerns about the proposed course of treatment, a mechanism to**

		voice those concerns without fear of reprisal should exist. [AMA]	**voice those concerns without fear of reprisal should exist.**
New		**The delivery of health care by physicians is governed by ethical rules, professional norms and by applicable law. Physicians contribute to the development of normative standards, recognizing that this both regulates their work as professionals and provides assurance to the public.** [AM]	**The delivery of health care by physicians is governed by ethical rules, professional norms and by applicable law. Physicians contribute to the development of normative standards, recognizing that this both regulates their work as professionals and provides assurance to the public.**
7	Ethics committees, credentials committees and other forms of peer review have been long established, recognised and accepted by organised medicine as ways to scrutinise physicians' professional conduct and, where appropriate, impose reasonable restrictions on the absolute professional freedom of physicians (*from paragraph 3 of the Statement on Professional Responsibility for standards of Medical Care*).	**As a guarantee of the autonomy and professional and clinical independence of the physician and of the patients and of compliance with their norms are the ethics committees** [CGCM]. ~~Ethics committees~~, credentials committees and other forms of peer review **that** [CGCM] have been long established, recognised and accepted by organised medicine as ways to scrutinise physicians' professional conduct and, where appropriate, impose reasonable restrictions on the ~~absolute~~ [SwMA] professional freedom of physicians. Ethics committees, credentials committees and other forms of peer review, **including regulating bodies**, have been long established …. [SAMA] Ethics committees, credentials committees and other forms of peer review have **long been** ~~been long~~ established, recognised and accepted by organised medicine as ways to scrutinise physicians' professional conduct and, where appropriate, impose reasonable restrictions on the	Ethics committees, credentials committees and other forms of peer review have **long been** ~~been long~~ established, recognised and accepted by organised medicine as ways ~~to scrutinise~~ **of scrutinizing** physicians' professional conduct and, where appropriate, **may** impose reasonable restrictions on the absolute professional freedom of physicians.

		absolute professional freedom of physicians. [AMA]	
8	The World Medical Association reaffirms the importance of professional autonomy and clinical independence as an essential component of high quality medical care and a benefit to the patient that must be preserved. The WMA also affirms that professional autonomy and clinical independence are core elements of medical professionalism.	The ~~World Medical Association~~ **WMA** [RDMA] reaffirms the importance of professional autonomy and clinical independence as an essential component of high quality medical care and a benefit to the patient that must be preserved. ~~The WMA also affirms that professional autonomy and clinical independence are core elements of medical professionalism~~. **The medical profession for the benefit of its patients and a professional exercise of the highest quality has a permanent obligation to protect, defend and support the autonomy and professional independence of the physician**. [CGCM] The World Medical Association reaffirms ~~the~~ ~~importance of~~ **that** professional autonomy and clinical independence ~~as an~~ **are** essential component**s** of high quality medical care and ~~a~~ ~~benefit to the patient~~ **the patient-physician relationship** that must be preserved. The WMA also affirms that professional autonomy and clinical independence are core elements of medical professionalism. [AMA]	The World Medical Association reaffirms ~~the~~ ~~importance of~~ **that** professional autonomy and clinical independence ~~as an~~ **are** essential component**s** of high quality medical care and ~~a~~ ~~benefit to the patient~~ **the patient-physician relationship** that must be preserved. The WMA also affirms that professional autonomy and clinical independence are core elements of medical professionalism. *See query in para before para 2*

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09.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**SMAC 209/ Declaration of Madrid COM REV/Apr2018** **Proposed revision of WMA Declaration of Madrid on Professionally-led Regulation**	Original: English
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**
Note:	As part of the annual policy review process, the Council in Buenos Aires (April 2016) decided that the Statement on Professional Responsibility for standards of Medical Care, under the 10-years policy review, be rescinded and archived, and that the WMA Declarations of Seoul and Madrid be merged in a single document, completed with the missing sections from that Statement. Prof. Vivienne Nathanson, British Medical Association (BMA), volunteered to complete that work. Further to the proposed revision submitted to the Council in Taipei (Oct. 2016) and then circulated for comments, the Council in Livingstone (April 2017) reversed its decision and decided that the Declarations of Seoul and Madrid be kept separate and revised individually to incorporate the relevant missing sections from the Statement on Professional Responsibility for standards of Medical Care, which will then be rescinded and archived. The 207th Council session in Chicago (October 2017) considered the proposed revision of	

the Declaration of Madrid and decided to circulate it within WMA membership for comments.

Abbreviation key:

AM	Associate Members
AMA	American Medical Association
AMV	Associazione Medica del Vaticano (Vatican State
BMA	British Medical Association
CMA	Canadian Medical Association
CNOM	French National Medical Council
CGCM	Consejo General de Colegios Médicos de Espana (Spain)
DMA	Danish Medical Association
FMA	Finnish Medical Association
JDN	Junior Doctors Network
NMA	Norwegian Medical Association
NZMA	New Zealand Medical Association
RDMA	Royal Dutch Medical Association
SwMA	Swedish Medical Association

GENERAL COMMENTS	
AM	The Associate Membership supports this document with or without our suggestions above.
BMA	While we can agree with the sentiment of the declaration – the system described does not apply to the UK. The statement, as it is currently written, assumes that all national regulatory systems are still 'professionally-led' and describes how this must be maintained/protected/ encouraged. Given that the UK has moved away from this model, it is very difficult for us to adhere to this.
DMA	The DMA supports this document. We have a few minor suggestions (see below in the text).
FMA	FMA supports the proposed amendments to the Declaration. We have a few comments to the text.
NZMA	We are broadly comfortable with this revised declaration and have no specific amendments. However, we received the following comment on clause 11 (last paragraph):

	This looks mostly fine, except that regulation in our part of the world is done by a body which is not directly elected by the profession, and involves political patronage, in that the MCNZ is approved by, and responsible to, the Minister of Health. A minority of the members are elected, and they are subject to ministerial approval. Most are appointed by the Minister. Not sure how this lies with the WMA position. The statement seems a bit naïve. Much of the regulation in NZ and Australia now happens between the colleges and regulatory bodies, whereas the NZMA contributes on a global level with policies and positions, especially the Code of Ethics, but does not really regulate despite being influential. Maybe the paper is being pragmatic and avoiding what it cannot directly influence.
NMA	Acknowledging that this document could be valuable for some of WMAs members, NMA experiences this document to be a little bit out of date. The medical profession must be open to the society and attentive to its surroundings and NMA has no regulatory responsibilities. Para 2 illustrates our concerns. It is too categorical to say that physicians are the best to judge the actions of their peers. The profession should in the spirit of the Geneva Declaration not close within itself, but be open also to be judged by others and learn from the society and the patients. We suggest that the document is rewritten to be less categorical and more inclusive.
SwMA	The SMA feels that the proposed wording is too strongly based on the concept that professionally-led regulation is the only acceptable solution to achieve high standard health care. We totally agree that the medical profession must be actively involved and have a strong voice in the development of rules and guidelines for health care. However, we do not believe that it is always absolutely necessary for the medical profession to have regulatory powers. If used appropriately, we believe that other systems can be accepted. We have suggested some changes of wording in order for the declaration to be a bit more flexible in this regard. In Sweden, for example, different authorities (The National Board of Health and Welfare, The Health and Social Care Inspectorate and The Medical Responsibility Board) develop rules and guidelines for and supervise health care and health professionals. In our opinion, this system works quite well.
AMV	We accept the Proposed revision of WMA Declaration of Madrid on Professionally-led Regulation as it is.

Numbering will be deleted (or adjusted) when the revised text is adopted.

No	**Proposed Text:** **SMAC 207/Declaration of Madrid/Oct2017**	**Specific Comments** **Additions: bold/underlined** **Deletions: ~~lined-out~~** **Comments only: *[italic]***	**Proposed Revised Text by:** **Rapporteur** **SMAC 209/ Declaration of Madrid REV/Apr2018** *Rapporteur's comments are in italic*
Title	Declaration of Madrid on Professionally-led Regulation		
	The WMA reaffirms the Declaration of Seoul on professional autonomy and clinical independence of physicians.		The WMA reaffirms the Declaration of Seoul on professional autonomy and clinical independence of physicians
New		**PREAMBLE** **The regulation of the medical profession is key to ensure social confidence in the profession, to ensure the qualification and registration of professionals, to control the profession and its responsibilities, to ensure the revalidation, maintenance and updating of professional competence, transparency and accountability, to respond professionally to the needs of citizens, to defend the professional autonomy of the physician, to develop medical ethics, deontology and disciplinary intervention and to promote articulation between the State, the profession and the health system.** **The performance of the profession and the social**	*This new preamble would appear to be unacceptable to Countries such as Australia, NZ, the UK, Sweden and Norway, from their general comments as it insists on wholly medical professional led regulation* *A shorter preamble is therefore suggested taking in some of these concepts* **The regulation of the medical profession plays an essential role in ensuring and maintaining public confidence in the standards of care and of behaviour that they can expect from the medical professionals who serve them. That regulation requires very strong**

		responsibility of physicians is framed in a system of values belonging to the profession. The fundamental purpose of medical regulation is to protect citizens, ensuring that the profession is exercised by qualified people with credentials that certify their professional competence and maintenance thereof over time, generating social confidence in medicine. **The medical profession must take the initiative in its regulation and lead the necessary changes in order to reach the highest levels of ethical and professional demands. An effective, committed, independent and transparent self-regulation is a key element to continue deserving the social legitimacy that sustains the medical profession.** (CGCM)	**independent professional involvement. This may be the leading voice or one amongst other caring and informed partners providing that regulation assures the highest possible standards within the medical profession.**
	Physicians aspire to the development or maintenance of systems of regulation that will best protect the highest possible standards of care for all patients. Physicians believe that professionally led models provide the optimum environment to enhance and assure the individual physician's right to treat patients without interference, based on his or her best clinical judgment. Therefore, the WMA urges its constituent members and all physicians to take actions to ensure such systems are in place. These actions should be informed	Physicians aspire to the development or maintenance of systems of regulation that will best protect the highest possible standards of care for all patients. ~~Physicians believe that~~ **P**rofessionally led models provide the optimum environment to enhance and assure the individual physician's right to treat patients without interference, based on his or her best clinical judgment…… (AM) Physicians aspire to the development or maintenance of systems of regulation that will best protect the highest possible standards of care for all patients. ~~Physicians believe that professionally led models provide the optimum environment to enhance and assure the individual physician's right to treat patients without interference, based on his or her best clinical judgment. Therefore, the WMA urges its constituent members and~~	Physicians aspire to the development or maintenance of systems of regulation that will best protect the highest possible standards of care for all patients. ~~Physicians believe that~~ professionally led models provide the optimum environment to enhance and assure the individual physician's right to treat patients without interference, based on his or her best clinical judgment. Therefore, the WMA urges its constituent members and all physicians to take actions to ensure **effective** ~~such~~ systems are in place. These actions should be informed by the following principles:

	by the following principles:	~~all physicians to take actions to ensure such systems are in place. These actions should be informed by the following principles.~~ (SwMA)	
1	Physicians have been granted by society a high degree of professional autonomy and clinical independence, whereby they are able to make recommendations based on their knowledge and experience, clinical evidence and their holistic understanding of the patient including his/her best interests without undue or inappropriate outside influence.	Physicians ~~have been granted by society~~ **enjoy** (AMA) a high degree of professional autonomy and clinical independence **that allows them to perform a qualified and responsible profession without undue external interference. Professional self-regulation shows the trust that society has placed in physicians**, whereby they are able to make recommendations based on their knowledge and experience, clinical evidence and their holistic understanding of the patient including his/her best interests without undue or inappropriate outside influence. (CGCM) Physicians have been granted by society a ~~high degree of~~ **complete** professional autonomy (CNOM) and clinical independence, whereby they are able to make recommendations based on their knowledge and experience, clinical evidence and ~~their holistic understanding of~~ the **best interest of the** patient ~~including his/her best interests~~ [RDMA: *Where does this 'holistic understanding' refer to?*] without undue ~~or inappropriate~~ outside influence (SwMA). Physicians have been granted by society a high degree of professional autonomy and clinical independence, whereby they are able to make recommendations based on their knowledge and experience, clinical evidence and ~~their holistic understanding of the patient including his/her best interests~~ **best interests of their patients** without undue or inappropriate outside influence. [FMA:	Physicians ~~have been granted by society~~ **enjoy** a high degree of professional autonomy and clinical independence, whereby they are able to make recommendations based on their knowledge and experience, clinical evidence and their holistic understanding of the patient including his/her best interests without undue or inappropriate outside influence. *Holistic would have the usual definition – physicians understand their patients within their family, environment, work etc*

		We prefer the current wording]	
2	The planning and delivery of all types of health care is based upon an ethical model by which all physicians are governed. This is an element of professionalism and protects patients. Physicians are best placed to judge the actions of their peers against such normative standards, bearing in mind relevant local circumstances.	**The professional self-regulation of physicians must be based on an ethical model that applies to everyone equally and develops the principles of professionalism that protects and benefits patients.** ~~The planning and delivery of all types of health care is based upon an ethical model by which all physicians are governed. This is an element of professionalism and protects patients~~. [CGCM] Physicians are best ~~placed~~ **qualified** to judge the actions of their peers against such normative standards, bearing in mind relevant local circumstances. [AMA] The planning and delivery of all types of health care is based upon an ethical model and **current evidence-based medical knowledge** by which all physicians are governed [CNOM]. This is an element of professionalism and protects patients. ~~Physicians are best placed to judge the actions of their peers against such normative standards, bearing in mind relevant local circumstances.~~ (SwMA)	**The professional self-regulation of physicians must be based on a model that applies to everyone equally and that protects and benefits patients** .The planning and delivery of all types of health care is based upon an ethical model **and current evidence-based medical knowledge** by which all physicians are governed. This is an element of professionalism and protects patients. Physicians are best ~~placed~~ **qualified** to judge the actions of their peers against such normative standards, bearing in mind relevant local circumstances.
3	The medical profession has a continuing responsibility to be self-regulating. Ultimate control and decision-making authority must rest with physicians, based on their specific medical training, knowledge, experience and expertise.	**Each country, in a collective, medical action will assume the responsibility of establishing and maintaining a system of self-regulation through its National Medical Association that ensures the professional autonomy of the physician to make decisions regarding the medical care of their patients, guaranteeing professional, responsible and appropriate conduct.** ~~The medical profession has a continuing responsibility to be self-regulating~~. Ultimate control and decision-making authority must rest with physicians, based on their specific medical training,	*The CGCM amendment would be unacceptable to those countries which accept a mixed model of regulation. The revised wording seeks to keep the concept of medical leadership without causing problems with these members.* The medical profession has a continuing responsibility to be **strongly involved in regulation or** self-regulating. Ultimate

		knowledge, experience and expertise. [CGCMC] The medical profession has a continuing responsibility to be self-regulating. ~~Ultimate control and decision-making authority must rest with physicians, based on their specific medical training, knowledge, experience and expertise~~. **Physicians in each country are urged to establish, maintain and actively participate in a transparent system of professionally-led regulation.** [SwMA]	control and decision-making authority must ~~rest with~~ **include** physicians, based on their specific medical training, knowledge, experience and expertise. **In countries where self-regulation remains physicians must ensure that this retains the confidence of the public. In countries that have a mixed regulation system physicians must ensure that it maintains professional confidence.**
4	Physicians in each country are urged to establish, maintain and actively participate in a legitimate rigorous and transparent system of professionally-led regulation.	Physicians in each country are urged to establish, maintain and actively participate in a ~~legitimate~~ **fair** (CGCM), ~~rigorous~~ (FMA+RDMA) and transparent system of professionally-led regulation, **though efforts such as national clinical guidelines developed by and for physicians** (DMA) (RDMA: *The term 'rigorous' seems to strict? Without this word the sentence is complete as well (legitimate and transparent system…). 'rigorous' suggests that regulation has always to be followed, but in the end it is always the physician who decides to follow a rule or not (comply or explain).)* Physicians in each country are urged to establish, maintain and actively participate in a legitimate rigorous and transparent system of professionally-led regulation. **Such systems are intended to balance physicians' rights to exercise medical judgment freely with the obligation to do so wisely and temperately**. (AMA)	Physicians in each country are urged to establish, maintain and actively participate in a **fair,** ~~legitimate~~ rigorous and transparent system of professionally-led regulation. **Such systems are intended to balance physicians' rights to exercise medical judgment freely with the obligation to do so wisely and temperately**. *Rigorous has been left in as it requires an evidence base to the system.*

		Move to the end of paragraph 3 with amendments (SwMA)	
5	National Medical Associations must do their utmost to promote and support the concept of professionally-led regulation amongst their membership and the public. To ensure that potential conflicts of interest between their representative and regulatory roles are avoided they must ensure separation of the two processes and rigorous attention to a transparent and fair system of regulation that will assure the public of its fairness.	National Medical Associations must do their utmost to promote and support the concept of professionally-led regulation amongst their membership and the public. To ensure that potential conflicts of interest between their representative and regulatory roles are avoided they must ensure separation of the two processes and **pay** rigorous attention (BMA) to a transparent and fair system of regulation that will assure the public of its **independence and** fairness (CMA). National Medical Associations must do their utmost to promote and support the concept of professionally-led regulation amongst their membership and the public. ~~To ensure that potential conflicts of interest between their representative and regulatory roles are avoided they must ensure separation of the two processes and rigorous attention to a transparent and fair system of regulation that will assure the public of its fairness.~~ **The regulator must be transparent and communicate the information available regarding ethical and professional norms on which their professional practice is based to society and its professionals**. (CGCM) ~~National Medical Associations must do their utmost to promote and support the concept of professionally-led regulation amongst their membership and the public.~~ To ~~ensure that~~ **avoid** potential conflicts of interest between their representative and regulatory roles ~~are avoided they~~	National Medical Associations must do their utmost to promote and support the concept of **well-informed and effective** ~~professionally-led~~ regulation amongst their membership and the public. To ensure that potential conflicts of interest between their representative and regulatory roles are avoided they must ensure separation of the two processes and **pay** rigorous attention to a transparent and fair system of regulation that will assure the public of its **independence and** fairness . *The new words near the beginning make it clear that regulation must be effective to be acceptable. The use of well informed allows those espousing professionally led to justify it by this phrase. For those espousing a mixed regulatory framework it gives strength to their arguments for considerable professional involvement.*

		National Medical Associations must ensure **appropriate transparency and a clear** separation of the two processes ~~and rigorous attention to a transparent and fair system of regulation that will assure the public of its fairness~~. (SwMA) ….. To ensure that potential conflicts of interest between their representative and regulatory roles are avoided they must ensure ~~separation of the two processes and rigorous attention to~~ a transparent and fair system of regulation that will assure the public of its fairness. (RDMA: *RDMA thinks it unnecessary to add this very strict instruction*) Switch parag. 5 and 10: Parag 10 replaces 5: "Whatever judicial or regulatory process a country has established, any judgement on a physician's professional conduct or performance must incorporate evaluation by the physician's professional peers who, by their training knowledge and experience, understand the complexity of the medical issues involved". (AMA)	
New		**Any system of professionally-led regulation must ensure the quality of care provided to patients, the competence of the physician providing that care and guarantee the professional conduct of all physicians, generating social confidence in medicine and in the physician.** (CGCM)	*This is covered in many other paras.*
6	Any system of professionally-led regulation must ensure:	Any system of professionally-led regulation must ensure **and enhance** (FMA): Any system of professionally-led regulation must ~~ensure~~:	Any system of professionally-led regulation must **enhance and** ensure:

		(BMA)	
	▪ the quality of the care provided to patients,	▪ **ensure** the **delivery of high** quality ~~of the~~ **safe** care ~~provided~~ to patients, (BMA)	▪ the **delivery of high** quality ~~of the~~ **safe** care ~~provided~~ to patients,
	▪ the competence of the physician providing that care	▪ **ensure** the competence of the physician providing that care (BMA)	▪ the competence of the physician providing that care
	▪ the professional conduct of all physicians, and	▪ **ensure** the professional conduct of all physicians, and (BMA) ▪ the professional conduct of all physicians, ~~and~~ (AM)	▪ the professional conduct of all physicians, and
New	▪	▪ **Protection of the society** (SAMA)	▪ **the protection of society**
	▪ Inspire the confidence of patients, their families and the public.	▪ ~~Inspire~~ (AM+FMA) the confidence of patients~~, their families~~ and the public. (SwMA) **and** (AM) ▪ ~~Inspire~~ the ~~confidence~~ **support** of patients, their families and the public. (AMA: *see also para. 11*) ▪ ~~Inspire~~ the confidence of patients, their families and the public **as far as possible in the case of a life-threatening emergency**. (CNOM) Replace last bullet by: **As such, the regulation should pursue the confidence of patients, their families and the public**. (RDMA: *Grammatically wrong. It is hard to understand how regulation can inspire confidence. RDMA thinks regulation needs to pursue confidence.*)	▪ **Promote Inspire** the **trust and** confidence of patients, their families and the public.
New		▪ **Ensure the regulation system itself is subject to**	**the regulation system itself is subject to**

		quality assurance (BMA)	**quality assurance**
New		▪ **The honour of the medical profession** (AM)	
7	To ensure that the patient is offered quality continuing care, physicians must be required to participate actively in the process of Continuing Professional Development in order to update and maintain their clinical knowledge, skills and competence.	To ensure that the patient is offered quality continuing care, physicians ~~must be required to~~ **should** (SwMA) participate actively in the process of Continuing Professional Development, **including reflection,** (BMA) in order to update and maintain their clinical knowledge, skills and competence. **Employers and management have a responsibility to enable physicians to meet this requirement** (DMA) To ensure that the patient is offered quality continuing care, physicians ~~must be required to~~ participate actively in the process of Continuing Professional Development in order to update and maintain their clinical knowledge, skills and competence. (RDMA: *Physicians should not only be required to do so, they should actually do so.)*	To ensure that the patient is offered quality continuing care, physicians ~~must be required to~~ **must** participate actively in the process of Continuing Professional Development, **including in reflective practice,** in order to update and maintain their clinical knowledge, skills and competence. **Employers and management have a responsibility to enable physicians to meet this requirement**.
8	The professional conduct of physicians must always be within the bounds of the Code of Ethics governing physicians in each country. National Medical Associations must promote professional and ethical conduct among physicians for the benefit of their patients. Ethical violations must be promptly recognized, reported and acted upon. Physicians who have erred must be appropriately disciplined and	The professional conduct of physicians must always be within the bounds of the Code of Ethics governing physicians in each country. National Medical Associations must promote professional and ethical conduct among physicians for the benefit of their patients. **Professional Associations should insist upon ethical consideration to be sure that physicians resist financial incentives to offer either too much or too little medical care** (AM). Ethical violations ~~must~~ **should** be promptly recognized~~, reported~~ and acted upon. ~~Physicians who have erred must be appropriately disciplined and where possible rehabilitated.~~ (SwMA)	The professional conduct of physicians must always be within the bounds of the Code of Ethics governing physicians in each country. National Medical Associations must promote professional and ethical conduct among physicians for the benefit of ~~their~~ patients, **and ethical** violations must be promptly recognized, reported **to the relevant regulatory authority** and acted upon. ~~Physicians who have erred must be appropriately disciplined and where possible rehabilitated.~~ **Physicians are obligated to**

	where possible rehabilitated.	The professional conduct of physicians must always be within the bounds of the Code of Ethics governing physicians in each country. National Medical Associations must promote professional and ethical conduct among physicians for the benefit of ~~their~~ patients, **and ethical** violations must be promptly recognized, reported and acted upon. ~~Physicians who have erred must be appropriately disciplined and where possible rehabilitated.~~ **Physicians are obligated to intervene in a timely manner to ensure that impaired colleagues cease practicing and receive appropriate assistance from a physician health program**. (AMA) Delete the last 2 sentences ("ethical violations" until end of parag.) (RDMA: *The RDMA is not sure if this is necessary to add. A first question is who should report and act upon it. A second consideration is that these 'actions' suggest a rather harsh regime of possibly 'naming and shaming'. RDMA thinks this is not the most effective way to promote professional conduct, since it may lead to defensive medicine and to attempts to hide mistakes. Both can work out contrarily to what is wanted.)*	**intervene in a timely manner to ensure that impaired colleagues cease practicing and receive appropriate assistance from a physician health program**. *To ensure clarity that this is not about naming and shaming the report must be to the appropriate regulatory authority*
New		**The professionally-led regulatory body should publish the outcomes of disciplinary hearings that identifies offending physicians who have been found responsible of violations while keeping patients anonymous. These include criminal charges, cautions, specified continuing education and remediation programs, and any fines paid. This establishes transparency and trust between the public and physicians, increases patient**	*While publication appears useful this is too broad, especially given that many cases go to successful appeals.* *A modified for of words has been included in case the members want to "require" some form of publication.*

		safety, and promotes just outcomes for offenses. (JDN)	**The regulatory body should, when the judicial or quasi-judicial processes are complete, and assuming the case is found against the physician, publish their findings and include details of the remedial action taken. Lessons learned from every case should, as possible, be extracted and used in professional education processes.**
9	National Medical Associations are urged to assist each other in coping with new and developing problems, including potential inappropriate threats to professionally-led regulation. The ongoing exchange of information and experiences between National Medical Associations is essential for the benefit of patients.	National Medical Associations are urged to assist each other in coping with new and developing ~~problems, including potential inappropriate threats to professionally-led regulation. The ongoing~~ **challenges. Such** exchange of information and experiences between National Medical Associations is essential for the benefit of patients (SwMA) National Medical Associations are urged to assist each other in coping with new and developing problems, including potential ~~inappropriate~~ threats to professionally-led regulation. The ongoing exchange of information and experiences between National Medical Associations is essential for the benefit of patients. (AMA) *(*DMA comments*: We would suggest adding examples of "inappropriate threats". Also, perhaps "inappropriate" is redundant here*.)	National Medical Associations are urged to assist each other in coping with new and developing problems, including potential ~~inappropriate~~ threats to professionally-led regulation. The ongoing exchange of information and experiences between National Medical Associations is essential for the benefit of patients.
10	Whatever judicial or regulatory process a country has established, any judgement on a physician's professional conduct or	Switch parag. 5 and 10: Parag 5 replaces 10, with amendments: "National Medical Associations must do their utmost to promote and support the concept of professionally-led	Whatever judicial or regulatory process a country has established, any judgment on a physician's professional conduct or

	performance must incorporate evaluation by the physician's professional peers who, by their training knowledge and experience, understand the complexity of the medical issues involved. (*from parag. 2 under « Position » of the Statement on Professional Responsibility for standards of Medical Care*)	regulation amongst their membership and the public. To ensure that potential conflicts of interest between their representative and regulatory roles are avoided**,** they must ensure separation of the two processes and rigorous ~~attention~~ **adherence** to a transparent and ~~fair~~ **equitable** system of regulation that will assure the public of its fairness". (AMA)	performance must incorporate evaluation by the physician's professional peers who, by their training knowledge and experience, understand the complexity of the medical issues involved. (*from parag. 2 under « Position » of the Statement on Professional Responsibility for standards of Medical Care*
New		**The World Medical Association and National Medical Associations advocate to both patients and the public that a system of professionally-led regulation is critical to ensure high quality medical care. (AM)**	*See comments from NZMA, BMA, NMA, SwMA above*
11	An effective and responsible system of professionally-led regulation by the medical profession in each country must not be self-serving or internally protective of the profession, and the process must be fair, reasonable and sufficiently transparent to ensure this. National Medical Associations should assist their members in understanding that self-regulation must not only be protective of physicians, but must maintain the safety, support and confidence of the general public as well as the honour of the	An effective and responsible system of professionally-led regulation by the medical profession in each country must not be self-serving or internally protective of the profession, and **to ensure this** the process must be fair, reasonable and sufficiently transparent **and offer guarantees regarding the benefits to patients, generating social confidence in the profession.** ~~to ensure this~~ (CGCM). **Consideration should be given to the addition of health care consumers as part of a non-professional minority on professionally-led regulatory bodies**(AM). National Medical Associations should assist their members in understanding that self-regulation must ~~not only be protective of physicians, but must~~ maintain the safety, support and confidence of the general public as well as the honour of the profession itself. (RDMA: *Why should it be protective of physicians at all?*	An effective and responsible system of professionally-led regulation by the medical profession in each country must not be self-serving or internally protective of the profession., ~~and the process must be fair, reasonable and sufficiently transparent to ensure this.~~ National Medical Associations should assist their members in understanding that self-regulation must not ~~only~~ be protective of physicians, but must maintain the safety, support and confidence of the general public as well as the honour of the profession itself.

	profession itself.	*See point above what regulation should aim for instead. Moreover 'be protective of physicians' here seems in contrast to 'not be self-serving or internally protective of the profession' as mentioned in the first sentence.*) An effective and responsible system of professionally-led regulation by the medical profession in each country must not be self-serving or internally protective of the profession, and the process must be fair, reasonable and sufficiently transparent to ensure this. ~~National Medical Associations should assist their members in understanding that self-regulation must not only be protective of physicians, but must maintain the safety, support and confidence of the general public as well as the honour of the profession itself~~. (SwMA) An effective and responsible system of professionally-led regulation by the medical profession in each country must not be self-serving or internally protective of the profession, and the process must be fair, reasonable and sufficiently transparent to ensure this. National Medical Associations should assist their members in understanding that self-regulation must not ~~only~~ be protective of physicians, but must maintain the safety, support and confidence of the general public as well as the honour of the profession itself. (CMA: *Unless "only" is removed, this sentence is in direct opposition to the one preceding it*). An effective and responsible system of professionally-led regulation by the medical profession in each country must not be self-serving or internally protective of the profession**.** ~~and the process must be fair, reasonable and~~	

		~~sufficiently transparent to ensure this.~~ **[note: previously stated.]**National Medical Associations should assist their members in understanding that self-regulation must not only **protect** ~~be protective of~~ physicians, but must maintain the safety, support and confidence of the general public ~~as well as~~ **and** the honour of the profession itself. (AMA)	
New		**Acting responsibly, the physician should always consider the economic dimension of their actions, regardless of who finances them. This consideration should not serve as a pretext to deny patients the necessary medical services.** (CGCM)	**While physicians must always consider the economic dimensions of their recommended care this must not be a pretext for denial of necessary medical services.** *Question – is this relevant to the topic of this document?*

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March 2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**SMAC 209/Sustainable Development COM REV/Apr2018** **Proposed WMA Statement on Sustainable Development**	Original: English
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**
Note:	The Council in Tapei (October 2016) decided to set up a working group on sustainable development with the mandate to develop a proposal for a WMA policy on sustainable development and to define a proposed strategy for sustainable development at international and national level. The WG is composed of constituent members from the following countries: Japan (Chair), Portugal, Brazil, the Netherlands, UK and the Junior Doctors Network. The WG appointed as rapporteur Agostinho Sousa (Portugal) and has submitted the below proposal to the Council in Chicago (October 2017). The Council considered the proposal and decided to circulate it within WMA membership for comments.	

Abbreviation key:

AM	Associate Members
AMA	American Medical Association

AMV	Associazione Medica del Vaticano
BMA	British Medical Association
CGCM	Consejo General de Colegios Médicos de Espana
CMA	Canadian Medical Association
DMA	Danish Medical Association
FMA	Finnish Medical Association
NMA	Norwegian Medical Association
RDMA	Royal Dutch Medical Association
SAMA	The South African Medical Association
SwMA	Swedish Medical Association

GENERAL COMMENTS	
AM	The Associate Membership supports this document with or without our suggestions.
AMV	Accepted as it is.
BMA	We fully support this paper and are pleased to see that the WG has gone beyond the SGDs by drawing together the various policy instruments that underpin the goals.
CMA	The CMA supports this Statement.
DMA	The DMA believes that this document needs further development with regards to both content and form. As the draft stands, the focus and the key messages in the document are unclear which leads the reader in doubt about the purpose of the statement.
FMA	FMA thanks the working group for the draft statement. In our view, the document would benefit from some rewriting, especially as regards paragraphs 8-12 *[Because of the issue on the paragraph numbering, those paragraphs are now numbered 7-11; see text below]*. It could be further clarified how these policy priorities link to SDGs and whose priorities they are. Furthermore, it could e.g. be explained how the implementation of Health in All Policies can help in the fulfillment of the SDGs. We also propose to shift paragraph 7 *[should be numbered 6 in the next version, see above]* to the recommendations.
NMA	The Norwegian Medical Association supports this document as it is.

Numbering will be deleted (or adjusted) when the revised text is adopted.

No	Proposed Text: SMAC 207/Sustainable Development/Oct2017	Specific Comments Additions: **bold/underlined** Deletions: ~~lined-out~~ Comments only: *[italic]*	Proposed Revised Text by: Rapporteur SMAC 209/ Sustainable Development REV/Apr2018
Title	WMA Statement on Sustainable Development		
	Preamble		
1.	The WMA believes that health and well-being are dependent upon social determinants of health (SDH), the circumstances in which people are born, grow, live, work and age. These social determinants will directly influence the achievement of the United Nations Sustainable Development Goals (SDGs). Many of the SDG goals, targets and the indicators that have been developed to measure progress towards them, will also be useful measures of the impact action is having on reducing the SDH and, in particular, health inequities.	… Many of the SDG goals, targets and ~~the~~ indicators that have been developed to measure progress towards them, will also be useful measures of the impact **of** action ~~is having~~ on ~~reducing the~~ SDH and, in particular, **on reducing** health inequities. [BMA] The WMA believes that health and well-being are dependent upon social determinants of health (SDH), the ~~circumstances~~**conditions** in which people are born, grow, live, work and age**; and the social influences on these conditions** … Many of the SDG goals, targets and the indicators that have been developed to measure progress towards them, will also be useful measures of the impact action is having on ~~reducing~~**improving** the SDH and, in particular, health inequities. [AM] The WMA believes that health and well-being are dependent upon social determinants of health (SDH**s**), the circumstances in which people are born, grow, live, work and age … Many of the SDG goals, targets and the indicators that have been developed to measure progress towards them, will also be useful measures of the impact action is having on reducing the SDH**s** and, in particular, health inequities. [SAMA]	The WMA believes that health and well-being are dependent upon social determinants of health (SDH**s**), the **conditions** ~~circumstance~~ in which people are born, grow, live, work and age. These social determinants will directly influence the achievement of the United Nations Sustainable Development Goals (SDGs). Many of the SDG goals, targets and ~~the~~ indicators that have been developed to measure progress towards them, will also be useful measures of the impact **of** action is having on ~~reducing~~ **improving** the SDH and, in particular, **on reducing** health inequities.

2.	This statement builds upon WMA policy on SDH as set out in the Declaration of Oslo, and upon the basic principles of medical ethics set out in the Declaration of Geneva. (1)	This statement builds upon WMA policy on SDH as set out in the Declaration of Oslo **on Social Determinants of Health**, and upon the basic principles of medical ethics set out in the Declaration of Geneva. (1) [SwMA]	This statement builds upon WMA policy on S**ocial Determinants of Health** ~~DH~~ as set out in the Declaration of Oslo, and upon the basic principles of medical ethics set out in the Declaration of Geneva. ~~(1)~~
3.	The WMA recognizes the important efforts undertaken by the United Nations with the adoption on 25 September 2015 of the resolution *"Transforming our world: the 2030 Agenda for Sustainable Development"* (2). The Sustainable Development Agenda is based upon five key themes: people, planet, prosperity, peace and partnership and the principle of leaving no one behind. The WMA supports the importance of global efforts on sustainable development and the impact that it could bring to humanity.	… The WMA **affirms**~~supports~~ the importance of global efforts on sustainable development and the impact that **they can**~~it could~~ bring to humanity. [BMA]	The WMA recognizes the important efforts undertaken by the United Nations with the adoption on 25 September 2015 of the resolution *"Transforming our world: the 2030 Agenda for Sustainable Development"* ~~(2)~~. The Sustainable Development Agenda is based upon five key themes: people, planet, prosperity, peace and partnership and the principle of leaving no one behind. The WMA ~~supports~~ **affirms** the importance of global efforts on sustainable development and the impact that **they can** ~~it could~~ bring to humanity.
4.	SDGs are built on the lessons learned from successes and failures in achieving the Millennium Development Goals (MDGs), including inequity in many areas of life. While there is no overarching concept unifying the SDGs, the WMA believes that inequity in health and wellbeing encapsulates much of the agenda. The WMA notes that while only	*[Comment:* WE NEED TO SAY EXACTLY WHAT GOAL #3 IS, AND POSSIBLY FOOTNOTE OR DESCRIBE ALL THE GOALS.*]* [AM] … The WMA notes that while only goal 3 is overtly about health**,** many of the goals have major health components. [SAMA]	SDGs are built on the lessons learned from successes and failures in achieving the Millennium Development Goals (MDGs), including inequity in many areas of life. While there is no overarching concept unifying the SDGs, the WMA believes that inequity in health and wellbeing encapsulates much of the **2030** Agenda. The WMA notes that while only **SDG 3**[1] ~~goal 3~~ is overtly about health**,** many of the goals have major health components.

[1] Sustainable Development Goal 3. Ensure healthy lives and promote well-being for all at all ages by 2030

	goal 3 is overtly about health many of the goals have major health components.		
5.	The WMA recognizes governments must commit and invest to fully implement the goals by 2030, in alignment with the Addis Ababa Action Agenda (3) (4). The WMA also recognizes the risk that the SDGs might be considered unaffordable due to their estimated potential cost of between US$ 3.3 and US$ 4.5 trillion a year. (5)	The WMA recognizes **that** governments must commit and invest to fully implement the goals by 2030, in alignment with the Addis Ababa Action Agenda (3) (4) … [SwMA]	The WMA recognizes **all** governments must commit and invest to fully implement the goals by 2030, in alignment with the Addis Ababa Action Agenda ~~(3) (4)~~. The WMA also recognizes the risk that the SDGs might be considered unaffordable due to their estimated potential cost of between US$ 3.3 and US$ 4.5 trillion a year.~~ (5)~~
6.	The WMA emphasises the need for cross and intersectoral work to achieve the goals and believes that health must be addressed in all SDGs and not only under health specific goal number 3. (2) (6)		The WMA emphasises the need for cross and intersectoral work to achieve the goals and believes that health must be addressed in all SDGs and not only under health specific **SDG 3** ~~goal number 3~~. ~~(2) (6)~~
	Policy priorities:		**Policy priorities:**
7.	Recognition of Health in All Policies and the Social Determinants of Health.	Recognition of the Social Determinants of Health and the Health in All Policies **/ Multisectoral / Whole of Government / Whole of Society approach** *[rearranged sentence and made additions]* [SAMA]	Recognition of Health in All Policies and the Social Determinants of Health **/ Whole of Society approach**
8.	Other areas are essential to achieving the SDG3s. They include:	**Policy**~~Other~~ areas **that** are essential to achieving the SDG3s~~. They~~ include: [BMA] *[Comment: what is meant by SDG3s ?]* [RDMA]	~~Other~~ **Policy** areas **that** are essential to achieving the SDG 3 ~~s. They~~ include:

		Other ~~areas~~**considerations** are **also** essential to achieving the SDG~~3s~~ **targets**. They include: [SwMA] **Attention to** ~~O~~**o**ther areas **that** are essential to achieving the SDG3s**,** ~~they~~ **that** include: [SAMA]	
	• Patient Empowerment and Patient Safety • Continuous Quality Improvement in Health Care • Overcoming the Impact of Aging on Health Care • Addressing Antimicrobial Resistance • The safety and welfare of Health care staff		• Patient Empowerment and Patient Safety • Continuous Quality Improvement in Health Care • Overcoming the Impact of Aging on Health Care • Addressing Antimicrobial Resistance • The safety and welfare of Health care staff
		[Added paragraph:] **The AMM and NMAs should promote the principle of equity in health is an objective shared by society. It must also be ensured that the health sector does not increase inequalities in health and promote equitable provision of health services in all groups of society and in all stages of health care.** [CGCM]	
9.	Ensure policy alignment between all the UN Agencies and the work of regional governmental organizations such as EU, African Union, Arab League, ASEAN, and Organization of American States. (7)	~~Ensure~~**Ensuring** policy alignment … [SAMA] Ensure policy alignment ~~between~~**among** all the UN Agencies and the work of regional governmental organizations such as EU, African Union, Arab League, ASEAN, and Organization of American States. (7) [AMA]	Ensur**ing**~~e~~ policy alignment ~~between~~ **among** all the UN Agencies and the work of regional governmental organizations such as EU, African Union, Arab League, ASEAN, and Organization of American States. ~~(7)~~
10.	The WMA commits to working collaboratively with other stakeholders on the other global agreements that will	The WMA commits to working collaboratively with **a wide range of**~~other~~ stakeholders on the **various**~~other~~ global	~~The WMA commits to working collaboratively with other stakeholders on the other global~~

	underpin the SDG process and programme.	agreements that will underpin the SDG process and programme. [BMA] *[Delete paragraph:]* [SwMA] *[Comment: THIS FITS BETTER UNDER THE RECOMMENDATIONS SECTION. WE HAVE SUGGESTED ADDITIONAL WORDING IN THE FIRST PARAGRAPH OF THAT SECTION.]* [SwMA] The WMA**'s** ~~commits~~**commitment** to working collaboratively with other stakeholders on the other global agreements that will underpin the SDG process and programme. [SAMA]	~~agreements that will underpin the SDG process and programme.~~
11.	The implementation of the other three global agreements regarding the sustainable development process:	The **WMA commits to support** implementation of the other three global agreements regarding the sustainable development process: [BMA] The implementation of ~~the other three~~ global agreements regarding the sustainable development process: [AM] **The WMA supports t**~~T~~he implementation of ~~the other~~ three **additional** global agreements regarding the sustainable development process: [AMA]	The **WMA commits to support** implementation of the other three global agreements regarding the sustainable development process:
	• The Addis Ababa Action Agenda as the mechanism that will provide the financial support for the 2030 Agenda	• The Addis Ababa Action Agenda ~~a~~**i**s the mechanism that will provide the financial support for the 2030 Agenda [AM] • The Addis Ababa Action Agenda as the mechanism that will provide the financial support for the 2030 Agenda**.** [SAMA]	The Addis Ababa Action Agenda as the mechanism that will provide the financial support for the 2030 Agenda.

	• The Paris Agreement as the only binding mechanism of the sustainable development process that sets out a global action plan to put the world on track to avoid dangerous climate change by limiting global warming to well below 2°C above pre-industrial levels. (8) (9)	• The Paris Agreement ~~a~~**i**s the ~~only~~ binding mechanism of the sustainable development process that sets out a global action plan to put the world on track to avoid dangerous climate change by limiting global warming to well below 2°C above pre-industrial levels. (8) (9) [AM]	The Paris Agreement **is** the ~~only~~ binding mechanism of the sustainable development process that sets out a global action plan to put the world on track to avoid dangerous climate change by limiting global warming to well below 2°C above pre-industrial levels. ~~(8) (9)~~
	• The Sendai Framework for Disaster Risk Reduction as the agreement which recognizes that the State has the primary role to reduce disaster risk but that responsibility should be shared with other stakeholders including local government, the private sector and other stakeholders. (10)	• The Sendai Framework for Disaster Risk Reduction as the agreement which recognizes that the State has the primary role to reduce disaster risk but that responsibility should be shared with other stakeholders including local government~~,~~ **and** the private sector ~~and other stakeholders~~. (10) [BMA] • The Sendai Framework for Disaster Risk Reduction ~~a~~**i**s the agreement which recognizes that the State has the primary role to reduce disaster risk but that responsibility should be shared with ~~other stakeholders including~~ local government, the private sector and other stakeholders. (10) [AM]	The Sendai Framework for Disaster Risk Reduction as the agreement which recognizes that the State has the primary role to reduce disaster risk but that responsibility should be shared with ~~other stakeholders including~~ local government, the private sector and other stakeholders. ~~(10)~~
		[Added paragraph:] **Establish strategies for strengthening specific public health programs and national health systems to address the social determinants of health, redirecting health services, interventions and programs with the aim of reducing inequities and ensuring universal coverage and achieving that establishments, goods and services related to health are available to all, are acceptable, accessible, appropriate and of good quality.** [CGCM]	

	Recommendations and Commitments		
12.	The WMA commits to work with other intergovernmental organizations, including the UN and WHO, for the implementation and follow-up of this agenda and related international agreements. (11) (12) (13).	The WMA commits to work with other intergovernmental organizations, including the UN and **the** WHO, **and other stakeholders** for the implementation and follow-up of this agenda and related international agreements. (11) (12) (13). [SwMA] … The WMA commits to work**ing** with other intergovernmental organizations, including the UN and WHO, for the implementation and follow-up of this agenda and related international agreements. (11) (12) (13). *[Added sentence:]* **This should include putting pressure on States that have not committed to some of the binding international agreements, including the Paris Agreement.** [SAMA] The WMA commits to work with other **non-governmental and** intergovernmental organizations, including the UN and WHO, for the implementation and follow-up of this agenda, ~~and~~ related international agreements, **and for policy and advocacy alignment**. (11) (12) (13) [AMA]	The WMA commits to work with other intergovernmental organizations, including the UN**,** ~~and~~ **the** WHO**, healthcare professionals' organizations and other stakeholders**, for the implementation and follow-up of this Agenda and related international agreements**, and for policy and advocacy alignment.** ~~(11) (12) (13)~~.
13.	The WMA commits to collaborate with its constituent member Associations to support their work at national level and with governments on the 2030 Agenda implementation.	The WMA commits to collaborat~~e~~**ing** with its constituent member Associations to support their work at national **and regional** level**s,** and with governments on the 2030 Agenda implementation. [SAMA]	The WMA commits to collaborate with its constituent member Associations to support their work at **regional and** national level**s,** and with **their** governments on the 2030 Agenda implementation.
14.	The WMA recommends that NMAs create a strategy regarding data collection, implementation, capacity building and advocacy, to enhance policy coherence	The WMA recommends that NMAs create ~~a~~ strateg~~y~~**ies** regarding data collection, implementation, capacity building and advocacy, to enhance policy coherence and to	The WMA recommends that NMAs create ~~a~~ **strategies**~~y~~ regarding data collection, implementation, capacity building and advocacy, to enhance policy coherence and to

	and to maximise the impact of doctors at national and global levels.	maximise ~~the impact of doctors~~**Agenda implementation** at national and global levels. [SwMA]	maximise the ~~impact of doctors~~ **2030 Agenda implementation** at national and global levels.
15.	The WMA commits to work with other non-governmental organizations, including other healthcare professionals' organizations, to align policy and advocacy. (14)	The WMA commits to work**ing** with ~~other non-governmental organizations,~~ **a range of partners besides governments,** including **business,** ~~other~~ healthcare professionals~~'~~ organizations, **conservation agencies, donors, and community organisations,** to align policy and advocacy. (14) [SAMA] *[Delete paragraph; incorporated in #12]* [AMA]	~~The WMA commits to work with other non-governmental organizations, including other healthcare professionals' organizations, to align policy and advocacy. (14)~~
16.	The WMA also recommends that NMAs work with development banks, NGOs, intergovernmental organisations and other stakeholders that are also working for implementing of the 2030 Agenda, especially in their own countries (15) (16) (17) (18)	The WMA also recommends that NMAs work with development banks, NGOs, intergovernmental organisations and other stakeholders that are also working ~~for~~**to** implement~~ing of~~ the 2030 ~~a~~**A**genda, especially in their own countries (15) (16) (17) (18) [BMA] The WMA ~~also~~ recommends that NMAs ~~work~~**collaborate** with ~~development banks, NGOs, intergovernmental organisations and~~ other stakeholders that are also working ~~for~~**to** implement~~ing of~~ the 2030 Agenda, especially in their own countries (15) (16) (17) (18) [SwMA] The WMA also recommends that NMAs ~~work~~ **cooperate** with development banks, NGOs, intergovernmental organisations and other stakeholders that are also working ~~for implementing of~~ **to implement** the 2030 Agenda, especially in their own countries (15) (16) (17) (18) [AMA]	The WMA also recommends that NMAs ~~work~~ **collaborate** with development banks, NGOs, intergovernmental organisations and other stakeholders **who** ~~that~~ are also working ~~for~~ **to** implement~~ing~~ of the 2030 Agenda, especially in their own countries ~~(15) (16) (17) (18)~~
17.	WMA asks the UN and WHO to develop guidelines on how financing for health will be implemented to reach the targets established by the 2030 agenda and	WMA asks the UN and WHO to develop guidelines on how financing for health will be implemented to reach the targets established by the 2030 ~~a~~**A**genda**,** and **the** economic implications of NCDs, aging and antimicrobial resistance. (5) [BMA]	**The** WMA **encourages** ~~asks~~ the UN and **the** WHO to develop guidelines on how financing for health will be implemented to reach the targets established by the 2030 **A**~~a~~genda and

	economic implications of NCDs, aging and antimicrobial resistance. (5)	WMA ~~asks~~**encourages** the UN and **the** WHO to develop guidelines on how financing for health will be implemented to reach the targets established by the 2030 agenda and economic implications of NCDs, aging and antimicrobial resistance. (5) [SwMA] **The** WMA asks the UN and WHO to develop guidelines … [SAMA]	**the** economic implications of NCDs, aging and antimicrobial resistance. ~~(5)~~
		[Added paragraph:] **Physicians and their NMAs must assume the SDGs of sustainable development as their own and strive to achieve the specific objectives of the health field, promoting healthy lifestyles and the quality of life of individuals and communities, ensuring the sustainability of the systems that sustain life.** [CGCM]	

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February 2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**SMAC 209/Pandemic Influenza COM REV/Apr2018** **Proposed revision of WMA Statement on Avian and Pandemic Influenza**	Original: English
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**
Note:	As part of the annual policy review 2016, the Council in Buenos Aires (April 2016) decided that the WMA Statement on Avian and Pandemic influenza should undergo a minor revision. During its session in Taipei (October 2016) – on the request of Secretary General Dr Otmar Kloiber - the Council agreed to postpone the revision process given some concerns about the scientific content of the paper. At the Council in Livingstone (April 2017), Dr Kloiber informed the Council that a revised version of the Statement will be submitted in October in Chicago. The proposed revision was prepared by Dr Caline Mattar, AMR specialist. The 207th Council session in Chicago (October 2017) considered the proposal and decided to circulate it within WMA membership for comments.	

Abbreviation key:

AM	Associate Members
AMA	American Medical Association

AMV	Associazione Medica del Vaticano
BMA	British Medical Association
CGCM	Consejo General de Colegios Médicos de Espana
CNOM	Conseil National de l'Ordre des Médecins (France)
CMA	Canadian Medical Association
DMA	Danish Medical Association
FMA	Finnish Medical Association
NMA	Norwegian Medical Association
RDMA	Royal Dutch Medical Association
SAMA	The South African Medical Association
SwMA	Swedish Medical Association

GENERAL COMMENTS	
AM	Excellent document. We support it with or without our edits. We further suggest removing the word, "etc" from paragraphs 7c and 8c. If other items should be listed, we prefer listing the specifics. *[Note: this has been added in the table below]*
AMA	The discussion of mutation risks or co-existence with other viruses included in the 2006 version (paragraph 5) has been omitted. We believe this discussion is crucial to an understanding the genesis of pandemic strains of viruses and should be reinstated.
AMV	We think that the point 7.b ["Identify legal and ethical frameworks as well as governance in relation to the pandemic"] is a bit generic. It should be possible to find a more specific recommendation.
BMA	We overall support this paper and feel that it has been produced to a high technical standard. However, we have some concern that the language may be too technical throughout the piece and that the overall tone may not be widely accessible to an international audience.
DMA	The DMA has no comments to this document.
CNOM	There seems to be a crossover in the text between aviary influenza and seasonal influenza.
FMA	FMA can accept the revised document. However, we would like to point out that WMA now has a general statement on epidemics and pandemics, and we propose to refer to that in the preamble of this document.
NMA	The Norwegian Medical Association supports this document with some minor changes.

Numbering will be deleted (or adjusted) when the revised text is adopted.

No	Proposed Text: SMAC 207/Pandemic Influenza/Oct2017	Specific Comments Additions: **bold/underlined** Deletions: ~~lined-out~~ Comments only: *[italic]*	Proposed Revised Text by: Rapporteur SMAC 209/ Pandemic Influenza REV/Apr2018
Title	**WMA Statement on Avian and Pandemic Influenza**		**WMA Statement on Avian and Pandemic Influenza**
	Preamble		**Preamble**
1.	Pandemic influenza occurs approximately three or four times every century. It usually occurs when a novel influenza A virus emerges that can easily be transmitted from person-to-person, to which humans have little or no immunity. Infection control and social distancing practices can help slow down the spread of the virus. Vaccine development can be challenging as the pandemic strain may not be accurately predicted. Adequate supplies of antivirals are key for treatment of specific at risk population and possibly control further spread in certain settings.	*[Last sentence deleted]* [CGCM] … Adequate supplies of antivirals are key for treatment of specific at risk population**s** and possibly control further spread in certain settings. [SAMA] … Adequate supplies of antivirals are key ~~for treatment of specific at risk population and possibly control~~ **in controlling** further spread **of the outbreak.** ~~in certain settings~~. [AMA]	Pandemic influenza occurs approximately three or four times every century. It usually occurs when a novel influenza A virus emerges that can easily be transmitted from person-to-person, to which humans have little or no immunity. Infection control and social distancing practices can help slow down the spread of the virus. Vaccine development can be challenging as the pandemic strain may not be accurately predicted. Adequate supplies of antivirals are key for treatment of specific at risk population and **controlling** further spread **of the outbreak**.
2.	Avian influenza is a zoonotic infection of birds and poultry, and can cause sporadic human infections. Birds act as reservoir and shed the virus in their feces, mucous and saliva. Humans are infected if they are exposed through the mouth, eyes, or inhalation of virus particles. There may have been evidence of a non-sustained human to	… There may **also** have been ~~evidence of a non-sustained~~**limited** human to human ~~limited~~transmission ~~reported as well~~. [BMA] … ~~There may have been evidence of a n~~**N**on-sustained human to human limited transmission **has been** reported as well. [SwMA]	Avian influenza is a zoonotic infection of birds and poultry, and can cause sporadic human infections. Birds act as reservoir and shed the virus in their feces, mucous and saliva. Humans are infected if they are exposed through the mouth, eyes, or **from the** inhalation of virus particles. **Limited evidence of** human to human transmission

	human limited transmission reported as well.	… Humans are infected if they are exposed through the mouth, eyes, or **from the** inhalation of virus particles. There ~~may have~~ **has** been evidence of a non-sustained human to human limited transmission reported as well. [CMA] … Birds act as **a** reservoir and shed the virus in their feces, mucous and saliva. Humans ~~are~~**may be** infected if they are exposed through the mouth, eyes, or inhalation of virus particles. ~~There may have been evidence of a non-sustained~~ **Limited evidence of** human to human ~~limited~~ transmission **has been** reported as well. [AMA]	**has been** reported as well
3.	This statement provides guidance to National Medical Associations and physicians on how they should be involved in their respective country's pandemic influenza planning process in addition to responding to Avian Influenza or pandemic influenza should it occur. It also delineates the requirements for government preparedness and response. Finally, it provides recommendations about activities that physicians should consider in preparing themselves for pandemic influenza.	This statement **alongside with WMA Statement on Epidemics and Pandemics** provides guidance to National Medical Associations and physicians on how they should be involved in their respective country's pandemic influenza planning process in addition to responding to Avian Influenza or pandemic influenza should it occur… [FMA] This statement provides guidance to National Medical Associations and physicians on how they should be involved in their respective country's pandemic influenza planning **and how to respond** ~~process in addition to responding~~ to Avian Influenza or pandemic influenza ~~should it occur~~**.** … [AMA]	This statement **alongside with WMA Statement on Epidemics and Pandemics** provides guidance to National Medical Associations and physicians on how they should be involved in their respective country's pandemic influenza planning **and how to respond** to Avian Influenza or pandemic influenza
	Recommendations		**Recommendations**
	Avian Influenza		**Avian Influenza**
4.	In the event that an Avian Influenza strain transmission to humans increases, the following measures should be taken:	In the event **of an avian influenza outbreak,** ~~that an Avian Influenza strain transmission to humans increases,~~ the following measures should be taken: [AMA]	In the event **of an avian influenza outbreak,** ~~the~~ following measures should be taken

a	Sources of exposure should be avoided when possible as this is the most effective prevention measure	Sources of exposure should be avoided when possible as this is the most effective prevention measure**.** [CMA, SAMA]	Sources of exposure should be avoided when possible as this is the most effective prevention measure**.**
b	Personal protective equipment should be used and hand hygiene practices emphasized for personnel handling poultry as well as the healthcare team	Personal protective equipment should be used and hand hygiene practices emphasized for personnel handling poultry as well as ~~the~~ **for** healthcare team**s** [SwMA] Personal protective equipment should be used and hand hygiene practices emphasized for personnel handling poultry as well as **members of** the healthcare team**.** [CMA] … as well as the healthcare team**.** [SAMA]	Personal protective equipment should be used and hand hygiene practices emphasized for personnel handling poultry as well as **members of** the healthcare team.
c	All infected/exposed birds should be destroyed with proper disposal of carcasses, and rigorous disinfection of farms	All infected/exposed birds should be destroyed with proper disposal of carcasses, and rigorous disinfection of farms**.** [CMA, SAMA] All infected/exposed birds**, and other potentially infected animals** should be destroyed with proper disposal of carcasses, and rigorous disinfection of farms **and markets** [AM] All infected/exposed birds should be destroyed with proper disposal of carcasses~~,~~ and rigorous disinfection **or quarantine** of farms [AMA]	All infected/exposed birds should be destroyed with proper disposal of carcasses~~,~~ and rigorous disinfection **or quarantine** of farms.
d	Stockpiles of vaccines should be maintained for use during an outbreak	Stockpiles of vaccines should be maintained for use during an outbreak**.** [CMA, SAMA] Stockpiles of vaccines **and antivirals** should be maintained for use during an outbreak [AMA]	Stockpiles of vaccines **and antivirals** should be maintained for use during an outbreak.
e	Antiviral medications such as neuraminidase inhibitors can be used	Antiviral medications such as neuraminidase inhibitors can be used for treatment**.** [CMA, SAMA]	Antiviral medications such as neuraminidase inhibitors **may**~~can~~ be used

	for treatment	Antiviral medications such as neuraminidase inhibitors **may**~~can~~ be used for treatment [AMA]	for treatment.
		[Added paragraph:] **f. Surveillance should be increased** [AM]	
	Pandemic Influenza Preparedness		**Pandemic Influenza Preparedness**
5.	WHO and National Public Health Officials:		WHO and National Public Health Officials:
	The coordination of the international response to an influenza pandemic is the responsibility of the World Health Organization (WHO). The WHO currently uses an all-hazards risk based approach, to allow for a coordinated response based on varying degrees of severity of the pandemic.		The coordination of the international response to an influenza pandemic is the responsibility of the World Health Organization (WHO). The WHO currently uses an all-hazards risk based approach, to allow for a coordinated response based on varying degrees of severity of the pandemic.
6.	The WHO must:	~~The~~ WHO ~~must:~~ [BMA] The WHO ~~must~~**should**: [SwMA, CMA]	The WHO **should:**
a	Offer technical and laboratory assistance to affected countries if the need arises and monitor activity levels of potential pandemic influenza strains continuously, ensuring the designation of "Public Health Emergency of International Concern" is done in a timely manner if needed.	**The WHO must** ~~O~~offer technical and laboratory assistance to affected countries if the need arises and monitor activity levels of potential pandemic influenza strains continuously, ensuring the designation of "Public Health Emergency of International Concern" is done in a timely manner if needed. [BMA] Offer technical and laboratory assistance to affected countries if the need arises and **continuously** monitor activity levels of potential pandemic influenza strains ~~continuously~~, ensuring the designation of "Public Health Emergency of International Concern" is done in	a. Offer technical and laboratory assistance to affected countries if **needed** ~~the need arises~~ and **continuously** monitor activity levels of potential pandemic influenza strains continuously, ensuring **that** the designation of "Public Health Emergency of International Concern" is done in a timely manner if needed

		a timely manner if needed. [SwMA] Offer technical and laboratory assistance to affected countries if **needed** ~~the need arises~~ and monitor activity levels of potential pandemic influenza strains continuously, ensuring **that** the designation of "Public Health Emergency of International Concern" is done in a timely manner if needed. [AMA]	
		[Added paragraph, from text of 7.e. modified and moved here:] **The WHO should monitor and coordinate processes by which** ~~G~~**g**overnments ~~are also urged to~~ share biological materials ~~namely~~**including** virus strains ~~and others~~, to facilitate the production **of** and ensure access to vaccines globally~~, this process should be monitored and coordinated by the WHO~~. [AMA]	b. **Monitor and coordinate processes by which g**overnments share biological materials **including** virus strains, to facilitate the production **of** and ensure access to vaccines globally
b	The WHO should communicate available information on influenza activity of concern as early as possible to allow for a timely response.	~~The WHO should c~~**C**ommunicate available information on influenza activity of concern as early as possible to allow for a timely response. [SwMA, CMA] ~~The WHO should~~ **C**ommunicate ~~available~~ **critical** information on influenza activity of concern as early as possible to allow for a timely response. [AMA]	c. **C**ommunicate available information on influenza activity of concern as early as possible to allow for a timely response
7.	National governments are urged to develop National Action plans to address the following points:	National governments are urged to develop National Action plans ~~to~~**that** address the following ~~points~~: [SwMA] National governments are urged to develop National Action plans **in coordination with physicians and./or medical organizations. As planning proceeds, timely and clear information and the rationale**	National governments are urged to develop National Action plans to address the following points:

		behind decisions, should be available to public health authorities, the medical establishment and the public. Plans should be shared with the WHO and ~~to~~ address the following points: [AM] National governments **or designated government agencies** are urged to develop National Action plans to address the following points: [SAMA] National governments are urged to develop National **pandemic**~~Action~~ plans to address the following points: [AMA]	
a	Ensure that there is local capacity for diagnostics and surveillance to allow continuous surveying of influenza activity around the country;	Ensure that there is local capacity for diagnostics and surveillance to allow continuous surveying of influenza activity around the country~~;~~**.** [CMA, SAMA] Ensure that there is **adequate** local capacity for **diagnosis**~~tics~~ and surveillance to allow continuous **monitoring**~~surveying~~ of influenza activity around the country [AMA]	Ensure that there is **adequate** local capacity for **diagnosis** and surveillance to allow continuous **monitoring** of influenza activity around the country
		[Added paragraph] **Consider the surge capacity of hospitals, laboratories, and public health infrastructure and improve them if necessary.** [AMA]	**Consider the surge capacity of hospitals, laboratories, and public health infrastructure and improve them if necessary.**
b	Identify legal and ethical frameworks as well as governance in relation to the pandemic;	Identify legal and ethical frameworks as well as governance **structures** in relation to ~~the~~ pandemic **planning**~~;~~**.** [CMA] **Develop and i**~~I~~dentify legal and ethical frameworks as well as governance in relation to the pandemic. [AM]	Identify legal and ethical frameworks as well as governance **structures** in relation to ~~the~~ pandemic **planning.**

c	Identify the mechanisms and the relevant authorities to escalate interventions to slow the spread of the virus in the community such as school closures, quarantine, border closures etc;	Identify ~~the~~ **appropriate** mechanisms**, such as school closures, quarantine, border closures etc,** and the relevant authorities to escalate interventions **in order** to slow the spread of the virus in the community ~~such as school closures, quarantine, border closures etc~~ [SwMA] Identify the mechanisms and the relevant authorities to escalate interventions to slow the spread of the virus in the community such as school closures, quarantine, border closures etc~~;~~**.** [CMA, SAMA] **Develop and i**~~I~~dentify the mechanisms … such as school closures, quarantine, border closures**.** ~~etc;~~ *[If other items should be listed, we prefer listing the specifics.]* [AM] Identify the mechanisms and the relevant authorities to **initiate and** escalate interventions to slow the spread of the virus in the community such as school closures, quarantine, border closures etc [AMA]	Identify the mechanisms and the relevant authorities to **initiate and** escalate interventions to slow the spread of the virus in the community such as school closures, quarantine, border closures etc.
d	Prepare risk communication and crisis communication strategies and messages in anticipation of public and media fear and anxiety;	Prepare risk ~~communication~~and crisis communication strategies and messages in anticipation of public and media fear and anxiety [SwMA] Prepare risk communication and crisis communication strategies and messages in anticipation of public and media fear and anxiety~~;~~**.** [CMA]	Prepare risk ~~communication~~ and crisis communication strategies and messages in anticipation of public and media fear and anxiety.
e	Governments are also urged to share biological materials namely virus strains and others, to facilitate the	~~Governments are also urged to s~~**S**hare biological materials namely virus strains and others, to facilitate the production and ensure access to vaccines globally,	Governments are also urged to share biological materials namely virus strains and others, to facilitate the production and

	production and ensure access to vaccines globally, this process should be monitored and coordinated by the WHO;	this process should be monitored and coordinated by the WHO. [BMA] ~~Governments are also urged to s~~**S**hare biological materials namely virus strains and others, to facilitate the production and ensure access to vaccines globally~~,~~**.** ~~;~~ this process should be monitored and coordinated by the WHO. [CMA] ~~Governments are also urged to share~~ **Processes that ensure appropriate sharing of** biological materials namely virus strains and others, to facilitate the production **of** and ensure access to vaccines globally~~,~~ ~~this~~**. These** process**es** should be monitored and coordinated by the WHO~~;~~**.** [SwMA] Governments are also urged to share biological materials namely virus strains and others, to facilitate the production and ensure access to vaccines globally~~,~~**.** **T**~~t~~his process should be monitored and coordinated by the WHO. [SAMA] Governments are also urged to share biological materials namely virus strains and others, to facilitate the production and ensure access to vaccines globally~~.~~**,** ~~this process should be monitored and coordinated by the WHO~~. *[This text has been modified and moved to an added paragraph after 6.a]* [AMA]	ensure access to vaccines globally~~.~~**,**
f	Ensure that diagnostics and surveillance efforts are continued and that enough vaccine stockpiles are established;	Ensure that diagnostic~~s~~ and surveillance efforts are continued and that **adequate** ~~enough~~ vaccine **and antiviral** stockpiles are established. [AMA]	Ensure that diagnostic~~s~~ and surveillance efforts are continued and that **adequate** ~~enough~~ vaccine **and antiviral** stockpiles are established.

g	Protocols should be in place to manage patients in the community, triage in healthcare facilities, ventilation management, as well as handling of infectious waste;	Protocols should be in place to manage patients in the community, triage in healthcare facilities, **and for** ventilation management, as well as handling of infectious waste [BMA] Protocols ~~should be in place~~ to manage patients in the community, triage in healthcare facilities, ventilation management, as well as handling of infectious waste [SwMA] … as well as handling of infectious waste~~;~~**.** [CMA, SAMA] **Establish p**~~P~~rotocols ~~should be in place~~ to manage patients in the community, **carry out** triage in healthcare facilities, **provide** ventilation management, ~~as well as~~ **and handleing** ~~of~~ infectious waste [AMA]	**Establish p**~~P~~rotocols ~~should be in place~~ to manage patients in the community, **carry out** triage in healthcare facilities, **provide** ventilation management, ~~as well as~~ **and handleing** ~~of~~ infectious waste.
h	The allocation of vaccine doses, antivirals and hospital beds should be coordinated with experts;	~~The a~~**A**llocation of vaccine doses, antivirals and hospital beds should be coordinated with experts. [SwMA]	~~a~~**A**llocation of vaccine doses, antivirals and hospital beds should be coordinated with experts.
i	Priority for vaccination should be given to the highest risk groups including those required to maintain essential services;	Priority for vaccination should be given to the highest risk groups including those required to maintain essential services~~;~~**, including health care services.** [CMA]	Priority for vaccination should be given to the highest risk groups including those required to maintain essential services~~;~~**, including health care services.**
j	Provide guidance and timely information to regional health departments, health care organizations, and physicians;	~~Provide g~~**G**uidance and timely information to regional health departments, health care organizations, and physicians. [SwMA]	~~g~~**G**uidance and timely information to regional health departments, health care organizations, and physicians
k	Prepare for an increase in demand for healthcare services especially if clinical severity of the illness is high. In this case prioritization and	~~Prepare~~**Preparation** for an increase in demand for healthcare services especially if clinical severity of the illness is high. In ~~this~~**such** case**s** prioritization and	~~Prepare~~**Preparation** for an increase in demand for healthcare services **and absences of health care providers**

	coordination of available resources is essential;	coordination of available resources is essential. [SwMA] … In this case prioritization and coordination of available resources is essential. **This may include tapping into private sector capacity where state resources are insufficient.** [SAMA] Prepare for an increase in demand for healthcare services **and absences of health care providers.** ~~especially if clinical severity of the illness is high. In this case prioritization and coordination of available resources is essential.~~ [AMA]	especially if clinical severity of the illness is high. In ~~this~~**such** case**s** prioritization and coordination of available resources is essential. **This may include tapping into private sector capacity where state resources are insufficient.**
l	Ensure adequate funding is allocated for preparedness and response;	~~Ensure a~~**A**dequate funding ~~is allocated~~ for preparedness and response [SwMA] Ensure adequate funding is allocated for preparedness and response~~;~~**.** [CMA, SAMA] Ensure adequate funding is allocated for preparedness and response **of pandemics and their health and social consequences.** [CGCM] Ensure adequate funding ~~is allocated~~ for **pandemic** preparedness and response [AMA]	Ensure adequate funding is allocated for **pandemic** preparedness and response **as well as its health and social consequences**.
m	Make sure that mechanisms are in place to ensure the safety of healthcare facilities, personnel and protection for supply chains for vaccines and antivirals if needed.	~~Make sure that m~~**M**echanisms ~~are in place~~ to ensure the safety of healthcare facilities, **and** personnel and protection for **vaccines and antivirals** supply chains ~~for vaccines and antivirals if needed~~. [SwMA] Make sure that mechanisms are in place to ensure the safety of healthcare facilities, personnel and ~~protection~~	Make sure that mechanisms are in place to ensure the safety of healthcare facilities, personnel and ~~protection for~~ **the** supply chains for vaccines and antivirals

		~~for~~ **the** supply chains for vaccines and antivirals ~~if needed~~. [AMA]	
		[Added paragraph:] **n. Promote and finance research to develop vaccines and effective treatments with lasting effects against the viruses that produce these pandemics**. [CGCM]	**n. Promote and fund research to develop vaccines and effective treatments with lasting effects against influenza.**
		[Added paragraph:] **o. Encourage collaboration between human and veterinary medicine in the prevention, approach and research of bird flu to achieve control of this and any other pandemic.** [CGCM]	**o. Encourage collaboration between human and veterinary medicine in the prevention, research and control of avian influenza**
8.	National Medical Associations are urged to:	**National governments or, if necessary,** National Medical Associations are urged to: [RDMA] *[In some countries, including the Netherlands, the actions mentioned below are performed by governmental organisations and not the NMA. Therefore RDMA would like to change the title as above] [RDMA]* National Medical Associations **should have their own organization-specific business contingency plan in place to ensure continued support of their members, and** are urged to: [AM]	National Medical Associations are urged to:
a	Delineate their involvement in the national pandemic influenza preparedness plan which can include increasing capacity building amongst the physician communities, participating in guideline development and communication with healthcare	Delineate their involvement in the national pandemic influenza preparedness plan which can include increasing capacity building amongst ~~the~~ physician ~~communities~~, participating in guideline development and communication with healthcare professionals. [BMA]	Delineate their involvement in the national pandemic influenza preparedness plan**,** which ~~can~~ **may** include increasing capacity building amongst physicians, participating in guideline development and communication with healthcare professionals.

	professionals.	Delineate their involvement in the national pandemic influenza preparedness plan**,** which ~~can~~ **may** include increasing capacity building amongst the physician communit**y**, participating in guideline development and communication with healthcare professionals. [SwMA] Delineate their involvement in the national pandemic influenza preparedness plan which ~~can~~**may** include increasing capacity building amongst the physician communities, … [AMA]	
b	Help educate the public through the media and official channels of communication.	Help educate the public **about avian and pandemic influenza** ~~through the media and official channels of communication~~ [SwMA]	Help educate the public **about avian and pandemic influenza**
c	Promote infection control practices amongst the public to slow the spread of influenza, including home confinement of infected patients, hand hygiene, cough etiquette etc;	… hand hygiene, cough etiquette etc~~;~~**.** [CMA] … of infected patients, hand hygiene, cough etiquette**.** ~~etc;~~ *[If other items should be listed, we prefer listing the specifics.]* [AM] … of infected patients, hand hygiene, cough etiquette etc**.** [SAMA]	
d	When feasible, NMAs should coordinate with other healthcare professionals' organizations as well as other NMAs to identify common issues and congruent policies regarding to pandemic influenza preparedness and response;	When feasible, NMAs should coordinate with other healthcare professionals' organizations as well as other NMAs to identify common issues and congruent policies regarding ~~to~~ pandemic influenza preparedness and response [BMA] When feasible, ~~NMAs should~~ coordinate with other **NMAs as well as other** healthcare professionals' organizations ~~as well as other NMAs to identify common issues and~~ **promote** congruent policies	When feasible, ~~NMAs should~~ coordinate with other healthcare professionals' organizations as well as other NMAs to identify common issues and congruent policies ~~regarding~~**related** to pandemic influenza preparedness and response~~;~~**.**

		regarding ~~to~~ pandemic influenza preparedness and response [SwMA] When feasible, ~~NMAs should~~ coordinate with other healthcare professionals' organizations as well as other NMAs to identify common issues and congruent policies ~~regarding~~**related** to pandemic influenza preparedness and response~~;~~**.** [CMA] When feasible, ~~NMAs should~~ coordinate with other healthcare professionals' organizations as well as other NMAs to identify common issues and congruent policies regarding to pandemic influenza preparedness and response [NMA] … regarding ~~to~~ pandemic influenza preparedness and response~~;~~**.** [RDMA, SAMA] ~~When feasible, NMAs should~~ **C**oordinate with other healthcare professionals' organizations … [AMA]	
e	When available, NMAs should consider the implementation of support strategies for members involved in the response including mental health services, facilitation of health emergency response teams, and locum relief among others;	~~When available, NMAs should~~ **C**onsider ~~the~~ implementation of support strategies for members involved in ~~the~~ **pandemic influenza** response**,** including mental health services, facilitation of health emergency response teams, and ~~locum~~ **local** relief ~~among others~~. [SwMA] When available, ~~NMAs should~~ consider the implementation of support strategies for members involved in the response including mental health services, facilitation of health emergency response teams, and locum relief among others~~;~~**.** [CMA] When available, ~~NMAs should~~ consider the	~~should~~ **C**onsider **implementing** ~~the implementation of~~ support strategies for members involved in the response including mental health services, facilitation of health emergency response teams, and locum relief.

		implementation of support strategies for members involved in the response including mental health services, facilitation of health emergency response teams, and locum relief among others. [NMA] ~~When available, NMAs should~~ **C**onsider **implementing** ~~the implementation of~~ support strategies for members involved in the response including mental health services, facilitation of health emergency response teams, and locum relief ~~among others.~~ [AMA]	
f	NMAs should be prepared to advocate on behalf of members who, during a pandemic, will have rapidly emerging professional needs that must be met and on behalf of patients and the public who will be affected by the unfolding events.	~~NMAs should be prepared to~~ **A**dvocate**,** ~~on behalf of members who,~~ **before and** during a pandemic, **for allocation of adequate resources to meet foreseeable and emerging needs of healthcare, patients and the general public.** ~~will have rapidly emerging professional needs that must be met and on behalf of patients and the public who will be affected by the unfolding events~~ [SwMA] ~~NMAs should be prepared to a~~**A**dvocate on behalf of members who, during a pandemic, will have rapidly emerging professional needs that must be met and on behalf of patients and the public who will be affected by the unfolding events. [CMA] ~~NMAs should~~ be prepared to advocate on behalf of members who, during a pandemic, will have rapidly emerging professional needs that must be met and on behalf of patients and the public who will be affected by the unfolding events [NMA] NMAs should be prepared to advocate on behalf of members who, during a pandemic, will have rapidly	**A**dvocate**,** ~~on behalf of members who,~~ **before and** during a pandemic, **for allocation of adequate resources to meet foreseeable and emerging needs of healthcare, patients and the general public.** *(Response from the rapporteur to the question by the RDMA: During pandemics and outbreaks, and given the significant stress placed on healthcare professionals and facilities, needs will arise that are usually not accounted for by authorities, such as staff shortages, education and training, personal protective equipment,*

		emerging professional needs that must be met ~~and~~ on behalf of patients and the public who will be affected by the unfolding events. [RDMA] *[RDMA does not understand what is meant by this sentence. Please clarify.]* NMAs should be prepared to advocate on behalf of members who, during a pandemic, will have rapidly emerging professional needs **- education, supplies, and manpower -** that must be met and on behalf of patients and the public who will be affected by the unfolding events. [AM] … on behalf of patients and the public who will be affected by the unfolding events**.** [SAMA] ~~NMAs should be prepared to~~ **A**dvocate on behalf of members who, during a pandemic, will have rapidly emerging professional needs that must be met and on behalf of patients and the public who will **also** be affected ~~by the unfolding events~~ [AMA]	*vaccine doses, antiviral supplies, burnout etc. NMAs should be prepared to advocate on behalf of their members to ensure that the essential needs are met, but also on behalf of patients and the public which are also affected by shortages, inadequate supplies, specific care needs, etc.)*
		[Added paragraph:] **g. Encourage health personnel to protect themselves by vaccination** [NMA] *[It should not be necessary to repeat NMAs in the sub items, confer the headline. Not only physicians should be vaccinated (item 9b), but all health care personnel.]* [NMA]	**g. Encourage health personnel to protect themselves by vaccination**
		[Added paragraph:] **g. Develop their own organization-specific business contingency plans to ensure continued support of their members.** [AMA]	**h. Develop their own organization-specific business contingency plans to ensure continued support of their members.**
9.	Physicians:		Physicians:

a	Physicians must be sufficiently knowledgeable about pandemic influenza and transmission risks, including local and international epidemiology;	Physicians must **receive sufficient education so as to** be ~~sufficiently~~ knowledgeable about pandemic influenza and transmission risks, including local and international epidemiology. [SwMA] Physicians must be sufficiently knowledgeable about pandemic influenza and transmission risks, including local**, national** and international epidemiology. [CMA]	a. Physicians must be sufficiently knowledgeable about pandemic influenza and transmission risks, including local**, national** and international epidemiology
b	Physicians should implement infection control practices and vaccination if available, to protect themselves as well as other staff members during both seasonal and pandemic influenza;	Physicians should implement infection control practices and vaccination ~~if available~~, to protect themselves as well as other staff members during both seasonal and pandemic influenza. [SwMA] Physicians should implement infection control practices and vaccination ~~if available~~, to protect themselves as well as other staff members during both seasonal and pandemic influenza. [AM] Physicians should implement infection control practices and ~~vaccination if available~~ **be vaccinated in order** to protect themselves as well as other staff members during **outbreaks of** both seasonal and pandemic influenza. [AMA]	b. Physicians should implement infection control practices and vaccination ~~if available~~, to protect themselves as well as other staff members during seasonal and pandemic influenza **outbreaks**.
c	Physicians must participate in local/regional pandemic influenza preparedness planning.	Physicians ~~must~~ **should, to the extent possible,** participate in local/regional pandemic influenza preparedness planning [SwMA] Physicians must participate in local/regional pandemic influenza preparedness planning **and training**. [AM] Physicians must participate **and remain involved** in local/regional pandemic influenza preparedness planning [AMA]	c. Physicians must participate in local/regional pandemic influenza preparedness planning **and training.**

		[Added paragraph:] **d. In case of epidemic, physicians for ethical and professional reasons, will not abandon any patient who needs their care, unless forced to do so by the competent authority or there is an imminent and unavoidable vital risk to their persons**. [CGCM]	*(Response from the rapporteur to the addition by CGCM: I would leave the decision to NMAs whether to include this in the policy, however from the scientific perspective, there are categories of physicians and healthcare professionals who may have certain health conditions that would put them at a very high risk should they become infected with influenza such as pregnant women, transplant or HIV infected healthcare workers, so careful consideration should be placed with a generalized statement.)*
		[Added paragraph:] **d. Develop contingency plans to deal with possible disruptions in essential services and personnel shortages.** [AMA]	**d. Develop contingency plans to deal with possible disruptions in essential services and personnel shortages.**

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21.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**SMAC 209/Nuclear Weapons/Apr2018** **Proposed revision of the WMA Statement on Nuclear Weapons**	Original: English
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note	The WMA Statement on nuclear weapons was adopted in 1998 and amended in 2008 and 2015. The proposed revision from the Japan Medical Association has been prepared in consultation with the International Physicians for the Prohibition of Nuclear Weapons (IPPNW) in the context of the recent adoption of the UN Treaty on the prohibition of nuclear weapons. Amendments are highlighted in **bold**, underlined or ~~strikethrough~~.	

PREAMBLE

The WMA Declarations of Geneva, of Helsinki and of Tokyo make clear the duties and responsibilities of the medical profession to preserve and safeguard the health of the patient and to consecrate itself to the service of humanity. **Therefore, and in light of the catastrophic humanitarian consequences that any use of nuclear weapons would have, and the impossibility of a meaningful health and humanitarian response**, the WMA considers that it has a duty to work for the elimination of nuclear weapons.

RECOMMENDATIONS

Therefore, the WMA:

1. Condemns the development, testing, production, stockpiling, transfer, deployment, threat and use of nuclear weapons;

2. Requests all governments to refrain from the development, testing, production, stockpiling, transfer, deployment, threat and use of nuclear weapons and to work in good faith towards the elimination of nuclear weapons;
3. Advises all governments that even a limited nuclear war would bring about immense human suffering and substantial death toll together with catastrophic effects on the earth's ecosystem, which could subsequently decrease the worlds food supply and would put a significant portion of the world's population at risk of famine;

4. **Is deeply concerned by plans to retain indefinitely and modernize nuclear arsenals; the absence of progress in nuclear disarmament by nuclear-armed states; and the growing dangers of nuclear war, whether by intent, including cyberattack, inadvertence or accident;**

5. **Welcomes the Treaty on the Prohibition of Nuclear Weapons, and joins with others in the international community, including the Red Cross and Red Crescent movement, International Physicians for the Prevention of Nuclear War, the International Campaign to Abolish Nuclear Weapons, and a large majority of UN member states, in calling, as a mission of physicians, on all states to promptly sign, ratify or accede to, and faithfully implement the Treaty on the Prohibition of Nuclear Weapons;** and

6. Requests that all National Medical Associations join the WMA in supporting this Declaration, use available educational resources to educate the general public and to urge their respective governments to work towards the elimination of nuclear weapons.

7. Requests all National Medical Associations to join the WMA in supporting this Declaration and to urge their respective governments to work **urgently** to **prohibit** and eliminate nuclear weapons, **by joining and implementing the UN Treaty on the Prohibition of Nuclear Weapons**.

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12.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no: **Title:**	**SMAC 209/Maternal and Child Health Handbook /Apr2018** **Proposed WMA Statement on the Development and Promotion of a Maternal and Child Health Handbook**	Original: English
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note	This is a proposal from the Japan Medical Association.	
Related WMA policies	▪ WMA Declaration of Ottawa on Child Health ▪ WMA Statement on Supporting Health Support to Street Children ▪ WMA Statement on Obesity in Children	
Keywords:	Maternal and Child Health, Handbook, Mother, Child, Continuum of Care	

PREAMBLE

1. The WMA believes that both a continuum of care and family empowerment is necessary to improve the health and wellbeing of the mother and child. The reduction of maternal mortality rate and infant deaths has been an important objective of the MDGs. The reductions of the maternal mortality ratio, neonatal mortality rate and the under-five mortality rate have been also important targets to be achieved under the Sustainable Development Goals (SDGs).

2. In 1948, Japan became the first country in the world to create and distribute the maternal and child health (MCH) handbook, in order to protect the health of the mother and child. This MCH handbook included information on pregnancy, the child's neonatal and pediatric periods, records of personal growth and vaccination as well as health education, all in one book, to be kept at home.

3. There are now approximately 40-country versions of the MCH handbook, all adapted to the local culture and socio-economic context. The use of MCH handbooks, in particular in low- and medium-income countries, has helped improve the knowledge of mothers on maternal and child health issues, and has contributed in changing behaviors during pregnancy or delivery.

4. The MCH handbook can promote the health of pregnant women, neonates and children by using it as a tool for strengthening continuum of care. Physicians can make better care decisions, by referring to the patient's history and health-check data recorded in the MCH handbook. Such benefit of the handbook should be shared in more number of countries.

5. In Japan, a digital handbook is spreading progressively. It is also expected to utilize the digital handbook in consideration of confidentiality of health information of the individual patient.

RECOMMENDATIONS

1. The WMA recommends that the constituent member associations encourage their health authorities and health institutions to recognize that the MCH handbook is an important tool to help health promotion of mothers, neonates and children.

2. The WMA recommends that the constituent member associations and medical professionals to promote the utilization of MCH handbook for realizing leaving no one behind in SDGs, such as non-literate people, migrant families, refugees, minorities, mothers, neonates and children in remote areas.

3. In using a MCH handbook, digital or in print form, the confidentiality of health information of the individual and privacy of mothers and children should be strictly protected.

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20.03.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**SMAC 209/Pseudoscience/Apr2018**	Original: English
Title:	**Proposed WMA Declaration on Pseudoscience, Pseudotherapies, intrusion and sects in the field of health**	
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For consideration**
Note	This is a proposal from the Spanish Medical Association submitted within the deadline required for new item submission. The Review Committee considered the proposal and asked to the Spanish Medical Association to work further on the document (inclusion / clarification of terms).	
Keywords:	Pseudoscience, Pseudotherapies, Intrusion	

Summary

Thanks to scientific advances, the developed/developing societies in which we live have made significant progress in treating and relieving numerous illnesses affecting human health.

Health systems and social healthcare systems are based on conventional science. Within the healthcare field, it is very important to preserve our different legislation and national systems, since these are among our most prized assets. There is no doubt about as to the affinity felt by the public toward its systems and traditions.

Given the scarcity of medicines in certain developing countries, the use of medicinal plants can be justified when there is supporting evidence of their efficacy and harmlessness. Of course, so too can its use in traditional and indigenous medicine in communities and countries that lack other resources or healthcare systems. In this sense, so-called traditional/complimentary medicine should also be based on scientific proof, in order to be considered as an integral part of healthcare services (*WHO Traditional Medicine Strategy 2014-2023- World Health Organization*).

The concept of **pseudoscience (false science)** covers beliefs and practices that are falsely presented as science, as they do not follow a valid and recognised scientific method. The main characteristic of pseudoscientific practices or beliefs is that they cannot be asserted as true, as what they claim

or imply cannot be demonstrated using reliable and valid scientific methods.

Pseudoscience is a collection of knowledge, methods, beliefs or practices mistakenly regarded as being based on scientific method, and which cannot be corroborated by the scientific community. (Definition based on the Oxford American Dictionary).

According to Karl Popper, Austrian philosopher and the father of critical rationalism, the boundary between science and non-science lies in the fact that scientific theories make verifiable, and therefore falsifiable, claims and predictions, which can therefore be discarded or refuted when they do not stand up to scrutiny. **Characterisation as pseudoscience is not determined by the subject itself, but rather by the claims on which its study is built.**

Pseudotherapies are broadly defined as approaches to curing illnesses, relieving symptoms or improving health that use procedures, techniques, products or substances based on criteria not backed up by available scientific evidence demonstrating their effectiveness (simulated treatments with supposed medicines, techniques based on fantasy, absurd logic, falsification, mind or emotional manipulation techniques, the use of banned or toxic products, etc.)

Pseudotherapies, provided by healthcare professionals or others, constitute therapeutic offerings that lack the necessary scientific basis to evaluate either their validity or effectiveness. Fortunately, their actual impact on society is small. Nonetheless, this should be understood and analysed to prevent its spread. **No healthcare professional should offer pseudotherapies in their clinical practice.**

Professional inclusion is defined as the performance of medical procedures by unskilled and unqualified persons.

In relation to the medical profession, note that, strictly speaking, a medical procedure consists of the prevention, diagnosis or treatment of diseases using scientific-experimental methods of the official medical art taught in Faculties of Medicine.

There is a worrying increase in the entry of unqualified people into the medical profession, which is based on the use of new technologies and bolstered by insufficient regulation and restriction of these practices.

The entry of unqualified people into the medical profession has special implications, as it poses a public health risk which directly affects citizens. It is the responsibility of the health authorities and of regulated and collegiate professional organisations to protect the health of citizens, and therefore to combat the intrusion of unqualified people into the medical profession.

Introduction

1. In general, pseudoscience and pseudotherapies are either not recognised by the health authorities of the majority of countries or are given lower status and frequently surrounded by stigma and major controversy regarding the scientific rationale on which they are based.

2. Most countries have no regulatory framework, which has allowed pseudotherapies/pseudoscience to proliferate. We used to regard pseudotherapies as inoffensive due to their lack of side effects, but there is growing evidence to suggest that they should not be seen as such and are in fact problematic. New legislation is required to put a stop to the proliferation of pseudotherapies.

3. Pseudotherapies use a variety of mechanisms to appear effective: the natural evolution of the condition, regression towards the mean, the inducement of mechanisms pertaining to the placebo effect, among others. They cause some patients to perceive a cause-and-effect relationship between pseudotherapies and the perception of improvement.

4. These pseudotherapies are based on "false science" and represent a significant danger for various reasons:

   4.1 The risk that patients abandon effective medical treatments in favour of practices that have not demonstrated or lack therapeutic value, which can lead to serious health problems and even death.
   4.2 The common likelihood of dangerous delays and "loss of opportunity" in the application of medicines, procedures and techniques that are recognised and endorsed by the scientific community.
   4.3 Apart from causing medical treatment to be abandoned, some pseudotherapies have negative effects on health.
   4.4 They cause patients to suffer financial and moral damages.
   4.5 The rising costs of procedures, which are given on multiple occasions.
   4.6 Intrusion into in the medical profession, worryingly on the rise due to internet use, can only be curtailed using legal measures. Government policy must not tolerate these practices, and a serious commitment is required on the part of the authorities.
   4.7 Cults are frequently involved in the practice of pseudoscience and pseudotherapies.

5. A current, broader definition of "Safety" in patient care includes: increasing the patient's opportunities to receive appropriate, evidence-based care. Impeding access to this type of care in any way can be considered to be a loss of opportunity and, as such, a possible failure of the healthcare system, which must be addressed and resolved. It is the responsibility of national governments, but also of professional organisations, scientific societies and patients' associations to fulfil this commitment.

Recommendations

6. Considering that the WMA, NMAs and the medical profession in general need to be aware of the problem and of its medical and social repercussions, given its proliferation and consequences.

7. Considering the commitment of the WMA, NMAs and the medical profession, and their responsibility to health and to the protection of individual and collective health, the following recommendations apply:

8. Doctors must continue to practice medicine as a service based on the application of critical scientific knowledge, skills within their specialist field and ethical attitudes and behaviour. As individuals, they must maintain and keep this up to date, and all organisations and authorities involved in the governance and regulation of the medical profession must commit to it as well.

9. The risk of assuming that pseudoscience and pseudotherapies have a role to play in appropriately treating human suffering goes hand in hand with the ethical debate on the role of the placebo in treatment. Ethical reasoning must play a part in scientific reasoning, since the first cannot be formed without the second.

10. WMA and the NMAs must recommend that national authorities not finance this type of supposed treatment, since healthcare systems should not reimburse the costs derived from these pseudotherapies, except where they are shown to be efficient, effective, supported by evidence through rigorous testing, and safe.

11. In line with the CPME position paper on complementary and alternative treatments (CPME/AD/Board/26052015/130_Final/EN), the safety and efficacy of all existing treatments should be constantly reassessed. All new diagnostic and therapeutic methods should be tested in accordance with scientific methods and ethical principles (as recommended in the WMA Declaration of Helsinki: Ethical principles for medical research in humans—64th WMA General Assembly, Fortaleza, Brazil, October 2013). An exhaustive study is required into the safety, efficacy, efficiency, scope of application and the supposedly alternative and/or complementary character of all of these non-conventional therapies and techniques.

12. Traditional and indigenous medicine in communities that lack other means or healthcare systems must also be based on scientific tests if they are to be considered an integral part of healthcare services. That is why support is needed for research and development in this field, as set out in the "*WHO Strategy on Traditional Medicine 2014-2023"*.

13. A doctor's duty is to provide humane and scientific medical care to all patients and similarly, they should offer the best possible treatment based on scientific evidence. In this regard, the WMA Declaration of Geneva and the International Code of Medical Ethics should be references in high quality and ethical medical care, and for the safety of patients.

14. For the patient's safety and quality of care, the doctor must have the freedom to prescribe, while respecting scientific evidence and the authorised instructions. In every process, the patient must be kept duly informed and be able to participate in the best therapeutic decision-making.

15. The medical profession needs to delve into aspects such as the doctor-patient relationship, personal and social communication, mutual trust, and humanising person-centred healthcare in terms of the patient's decisions and autonomy in order to steer them away from pseudoscience and pseudotherapies by explaining the risks and hazards they pose to their health and their lives.

16. Physicians need to know that some patient groups, such as patients with cancer, psychiatric illnesses or serious chronic diseases, as well as children, are particularly vulnerable to the

risks associated with alternative and/or complementary practices that have not been assessed using evidence-based methods based on conventional science.

17. The doctor's preference must be to perform procedures and prescribe medicines that have been scientifically proven to be effective. It is unethical for practices to be inspired by quackery, to lack scientific basis, to promise cures to sick people, to present illusory or insufficiently tested procedures as being effective, to simulate medical treatments or surgical procedures or to use products of unknown composition.

18. It is the physician's duty to tell patients that traditional non-conventional, alternative and/or complementary practices are not regarded as scientific medical specialities, which means that training certifications in these fields do not constitute specialist qualifications that are recognised by the scientific community, and they are not legally recognised in most countries; nor are they part, in the strict sense, of the contents of the Medical Act.

19. In relation to so-called "Pseudoscience/Pseudotherapies", it is important to remember that:

    a. All medical acts are subject to *Lex Artis ad hoc.*
    b. All medical acts require the doctor to be "adequately trained".
    c. A medical act requires a relationship of trust and good practice between the doctor and his/her patients.
    d. Doctors who perform and apply techniques and therapies that are not endorsed by the scientific community must appropriately inform their patients and assume all the legal, professional and ethical obligations implied by medical activity under *lex artis ad hoc*.
    e. To raise the need to establish a clearer definition of these types of pseudotherapies/pseudosciences and to tighten up lax, permissive or non-existent legislation.
    f. Intrusion into in the medical profession, worryingly on the rise due to internet use, can only be curtailed using legal measures. Government policy must not tolerate these practices, and a serious commitment is required on the part of the authorities.

20. A current and broader definition of "Safety in patient care" includes increasing the patient's chances of receiving adequate and evidence-based care. Any obstacle to their access to this type of care (such as pseudotherapies and pseudoscience without scientific evidence) may be considered a loss of opportunity and, as such, as a possible failure of the healthcare system, which must be addressed and corrected. Fulfilling this commitment is the responsibility of national governments, but also of professional organisations, scientific societies and patients' associations. We recommend:

    a. To report all acts of professional intrusion and all pseudoscience and pseudotherapy activities that put public health at risk, as well as bad practice, misleading advertising and unaccredited websites that offer services and/or products that put the health of patients at risk and/or could be considered fraudulent.

    b. NMAs and the ANM must address pseudotherapies and emotional/mental manipulation techniques with a significant cult element (Germanic New Medicine – GNM – Hamer Method and its variants of BioNeuroEmotion and Biodecoding, emotional theory of disease), as well as those that may contain misleading advertising on curing cancer through the use of unauthorised products (MMS, Miracle Mineral Solution –28% sodium chlorite). All of these must be expressly excluded from all healthcare systems and considered to be an assault on public health and the safety of patients.

21. Governments should establish stricter provisions protecting patients treated with traditional non-conventional, complementary and/or alternative medicines. When such a practice is found to be harmful, there should be a system in place to either stop or substantially restrict any given treatment classified as complementary and/or alternative in order to protect public health.

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09.04.2018

THE WORLD MEDICAL ASSOCIATION, INC.

Document no:	**SMAC 209/Policy Review 2008/Apr2018**	Original: English
Title:	**Annual Policy Review 2008: Recommendations received on SMAC documents**	
Destination:	Socio-Medical Affairs Committee 209th Council Session Radisson Blu Latvija Hotel Riga, Latvia 26-28 April 2018	Action(s) required: **For Consideration**

The ongoing policy review process adopted by the WMA requires a review of every policy for which it had been ten years since adoption or last revision.

The first step in the review process is to survey Constituent Members for their advice on whether a policy requires (a) reaffirmation, (b) minor or editorial changes before reaffirmation (c) a major revision, or (d) rescinding and archiving. On 6 February 2018, a memo was sent to Constituent Members asking them to recommend the classifications of the 2008 policies. The result of this consultation is as follows:

1) List of Respondents (26):

Australian Medical Association (AuMA)	Norway Medical Association (NMA)
Bangladesh Medical Association (BaMA)	Netherlands medical Association(RDMA)
Canadian Medical Association (CMA)	Consejo General de Colegios Medicos de España (CGCM)
Conseil National de l´Ordre des Médecins France (CNOM)	Swedish Medical Association (SwMA)
Danish Medical Association (DMA)	Taiwan Medical Association (TMA)
Israeli Medical Association (IsMA)	Medical Association of Thailand (MAT)
Japan Medical Association (JMA)	Turkish Medical Association (TuMA)
Korean Medical Association (KMA)	British Medical Association (BMA)
Kuwait Medical Association (KuMA)	Vatican Medical Association (AMV)
German Medical Associaiton (GMA)	Pakistan Medical Association (PkMA)
Austrian Medical Chamber (AMC)	Finnish Medical Associaiton (FMA)
Rwanda Medical Association (RMA)	American Medical Associaiton (AMA)
Colegio Medico de Mexico (CMM)	The South African Medical Association (SAMA)

2) Policies' abbreviations :

Access of Women : Resolution on Access of Women and Children to Health Care and the Role of Women in the Medical Profession

Veterinary: Resolution on Collaboration Between Human and Veterinary Medicine

Poppies:	Resolution on Poppies for Medicine Project for Afghanistan
Economic crisis:	Resolution on the Economic Crisis: Implications for Health
Mines:	Resolution Supporting the Ottawa Convention on the Prohibition of the Use, Stockpiling, Production, and Transfer of Anti-Personnel Mines and on Their Destruction
Sodium:	Statement on Reducing Dietary Sodium Intake
Mercury:	Statement on Reducing the Global Burden of Mercury
AM Drugs:	Statement on Resistance to Antimicrobial Drugs
Violence:	Statement on Violence and Health

3) Specific comments from NMAs:

Access of Women

(JMA) JMA believes that "Resolutions" should not undergo a major revision because they are supposed to have been adopted reflecting the times when they were adopted. This resolution should be also reaffirmed without changes, then we can focus on the discussion of the newly proposed Statement on Women in Medicine

(KMA) Due to religious and cultural background, women and children in many countries still face discrimination. However, access to employment, education and health care services are basic human rights that apply to all people, which is why it
is desirable that the WMA makes concerted efforts to promote women's and children's
human rights

(KuMA) The resolution doesn't contradict the proposed statement by IsMA and the Resolution looks fine as it is as women participation and leadership in medicine should be mentioned in both documents.

(BMA) Need to contextualize the statement and make it relevant for the issues and challenges that doctors, in particularly women doctors face. The barriers lie more around women's progression to senior posts, the effect of taking time out to care for children/relatives, impact of part time working due to caring responsibilities. In terms of women's access to healthcare services, although there are specific examples of lack of access -eg abortion services in Northern Ireland, it is not correct to say this is 'all' healthcare. The wording on discrimination also needs updating and clarity around discrimination against doctors and patients/public

(RDMA) We agree with the staff that the subjects of access to health care for children and women on the one hand, and women working in medicine on the other hand should be handled separately. Therefore, we agree to reaffirm with major revision the resolution on access to health care.

Veterinary

(AuMA) No view expressed.

(DMA) The DMA recommends *major revision* instead of *minor revision*. The description of the *One-Health* initiative should be updated and we suggest that the recommendations include a statement on the importance of resistance to antimicrobial drugs.

(JMA) Same (as comments above) applies to this Resolution.

(KMA) The collaboration between human and veterinary medicine should take place in the medical (veterinary medicine) education, clinical research, public health and research and development. In case of the occurrence of an infectious disease, countermeasures need to be developed to take action through a close cooperation among human and veterinary medicine specialty organisations.

(RDMA) We agree with minor revision, although we do not quite understand what the staff proposes exactly with regard to the preamble and infectious disease. We notice that the resolution already states: "The majority of the emerging infectious diseases, including the bioterrorist agents, are zoonoses."

Economic crisis

(CMA) Agree with new comprehensive policy on this issue.

(BMA) Out of date. Important sentiment.

Sodium

(JMA) As the WMA Secretariat says, the data quickly get outdated, so we should avoid including specific data in the Statement. However, it is meaningless to remove the data because they were useful at least when the statement was adopted. To update the issue of sodium intake, it would be better to draft a new statement.

(CNOM) The CNOM suggests Dr Elena to be rapporteur for the revision of this policy.
Le CNOM propose deux rapporteurs les Drs Ahr et Ellena sur les dossiers respectivement la résistance aux antibiotiques et sur la consommation alimentaire de sel ;

(KuMA)To update background information and recommendations based on up to date literature.

(SwMA) We agree with the Secretariat that information that will get outdated quickly should be removed from the policy.

(RDMA) We think it is very important to substantiate the additions with proper scientific evidence. If this cannot be found, to leave out that particular addition.

Mercury

(JMA) Japan already implements the UN Minamata Convention on Mercury (2013), and JMA agrees to refer to this convention in the Statement. However, it is unnecessary to refer to the WMA Statement on Environmental Degradation and Sound Management of Chemicals.

(KMA) In Korea, we advise not to use mercury containing devices and products, including blood pressure meter, thermometer, battery and experimental equipment. It is necessary for the WMA to maintain its policy on prohibiting the use of mercury containing devices and products to women in their childbearing years and child patients

AM Drugs

(BMA) Needs to be updated with latest progress made at international level

(JMA) It is fine to refer to the WHO Report on Surveillance (2014). The Statement should also mention "one health" concept. In Japan, national intersectoral plan to address the issue of microbial resistance is already implemented.

(CNOM) The CNOM suggests Dr Ahr to be rapporteur for the revision of this policy.

(KuMA)To update background information and recommendations based on up to date literature.

(RDMA) We only think that the mentioning of the package size of this medicine would be too much a detail for a WMA-Statement. Furthermore, this seems to be up to the prescribing physician.

Violence

(JMA) This Statement deals with the issue of violence and health in general while the other violence-related documents deal with the particulars. JMA reiterates its belief that listing the related documents in the Preamble will lead to an endless, unnecessary work. The data in the Preamble will change quickly and should be deleted. Each document can exist independently and there is no need to compile them.

(RDMA) We propose to not specifically include the violence against health care workers, since this cannot be said to be worse to other kinds of violence. Furthermore, we hesitate if emphasis on the economic consequences is appropriate, since this is not the most serious result of violence. We think it is important that the WMA stresses that violence why whoever against whoever is intrinsically wrong and harmful to all people.

4) Constituent Members' classification

Name of Policy / Constituent Members	Access of Women	Veteri-nary	Poppies	Econo-mic crisis	Mines	Sodium	Mercury	AM Drugs	Violence
AMA	C	B	D	D	A	C	B	C	C
AMC	C	B	D	D	A	C	B		
AuMA	C		D	D	A	C	B	C	C
BaMA	A	A	A	A	A	A	A	A	A
BMA	C	B	D	D	A	B	B	C	C
CGCM	C	B	D	D	A	C	B	C	
CMA	C	B	D	D	A	C	B	C	C
CMM	C	B	D	D	A		B	A	A
CNOM	C	A	D	D	A	C	B	C	C
DMA	C	C	D	D	A	C	B	C	C
GMA	C	B	D	D	A	C	B	C	C
FMA	C	B	D	D	A	C	B	C	C
IsMA		B	D	D	A	C	B	C	C
JMA	A	A	D	D	A	A	B	C	C
KMA	C	B	D	D	A	C	B	C	C
KuMA	A	B	D	D	A	C	A	C	C
NMA	C	B	D	D	A	A			

PkMA	C	B	D	D	A	C	B	C	C
RDMA	C	B	D	D	A	C	B	C	C
RMA	C	B	D	D	A	C	B	C	C
SAMA	C	B	B+D	D	A			C	C
SwMA	C	B	D	D	A	C	B	C	C
TMA	C	B	D	C+D	A	C	B	C	C
MAT	A	A	A	A	A	A	A	A	A
TuMA	C	B	D		A	B	B	C	B
VMA	C	B	D	D	A	C	B	C	C
TOTAL	**25**	**25**	**26**	**25**	**26**	**24**	**24**	**24**	**23**

5) Summary of classification

Name of Policy / Classification	Access of Women	Veterinary	Poppies	Economic crisis	Mines	Sodium	Mercury	AM Drugs	Violence
Reaffirm (a)	4	4	2	2	26	4	3	3	3
Reaffirm with minor revision (b)		20	1			2	21		1
Major revision (c)	21	1		1		18		22	19
Rescind and archive (d)			24	23					
Proposed classification based on members' recommendations	**C**	**B**	**D**	**D**	**A**	**C**	**B**	**C**	**C**

In the light of these responses, the Committee is asked to recommend to Council a classification for these policies in SMAC.

The Secretariat can take care of a policy requiring minor revision, which will be circulated to the member associations for comment and considered at the October 2018 Committee and Council meetings. Constituent Members are invited to volunteer, either individually or in workgroups, to undertake any major policy revision. Recommendations for rescinding and archiving will go to the Assembly in October 2018 for final decision.

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