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## Editorial

Dear colleagues!

How I am missing you!

The meetings of the WMA – the Assembly General and the Council Session – are like gulps of fresh water allowing to be refreshed and setting new dimensions. Meetings with colleagues from other countries, particularly – the leaders of National Medical Associations, make it possible not only to learn and obtain new information, but also to look at things from a different perspective. The WMA is an organisation that combines the ordinary with the different – our likeness as professionals and differences as representatives of our cultural environment. The WMA Assembly General in Cordoba was successful; there was versatility of opinion and drawing up of serious documents. And yet – this meeting lacked human contact that allows you to shake hands and look into the eyes of the other person, get a colleague's smile and return it.

I believe that colleagues all over the world are on the verge of a new challenge. Vaccines against Covid-19 have been produced and vaccination has started in different countries. Still, we all have our doubts: whether there has been sufficient vaccine research, whether it will be safe, whether it will provide sufficient immunity, or whether we will manage to stop the pandemic with this vaccine.

Herd immunity will require 60–80% of the world population to be vaccinated against Covid-19. Vaccination is treated differently in different countries. There are quite a large number of people who are against the new vaccine as well as those who have not decided whether to vaccinate or not.

At least in 2021, there will not be enough vaccines for everyone. It should be quite strongly noted that the people to receive vaccination first are those who are most vulnerable to the disease – the elderly, with a number of cardiovascular, endocrinological or oncological diseases, people with reduced immunity, very slow-moving and adipose patients, patients with lung diseases, etc. And there would be no grounds for initially vaccinating those who have already had the disease with or without symptoms or already had antibodies for Covid-19. And it should be remembered that there are also among doctors elderly people with reduced immunity, with multiple illnesses, and they would deserve to be vaccinated first.

The other thing we all need to agree in principle is: a vaccine is a biological drug, and medication is prescribed by doctors, not officials nor politicians. Today, politicians from many countries want to be doctors and rescuers of humanity.

Moreover, we live like in war-time conditions. There are more or less stringent restrictions in all countries of the world. There are different business closures and there are considerably fewer opportunities to travel as well as to meet doctors from other countries. However, there is a book written a century ago and it describes the current feelings incredibly well. And from this book I would like to send you the message: "Meet me at 6 o'clock after the war." It is a quote from one of the greatest books provoked by World War I – it is *The Fate of the Good Soldier Švejk* which is an unfinished satirical dark comedy novel by the Czech writer Jaroslav Hašek, published in 1921–1923, about a good-humoured, simple-minded middle-aged man who is enthusiastic to serve Austria-Hungary in World War I.

*Dr. med. h. c. Peteris Apinis,  
Editor-in-Chief of the World Medical Journal*

## Valedictory Speech by the WMA President, Dr. Miguel Jorge. WMA General Assembly Cordoba (Virtual), October, 2020



*Miguel R. Jorge*

Dear Colleagues and Friends, Ladies and Gentlemen,

Our tradition requests that the World Medical Association (WMA) outgoing President, deliver a so-called Valedictory Speech at this Ceremonial Session of our General Assembly. Accordingly to different dictionaries, valedictory is related to “say goodbye” or “a statement of farewell”. As a psychiatrist, I am very much prone to always try to be in contact with feelings and emotions, mine and from those people to whom I am in relationship. Therefore, I hope to not just shortly report what I have done during my Presidential year but also how I felt others and myself during the period ending today. I can guarantee to you all, that it was quite different from any other Presidential term.

I started my Presidential term just after our General Assembly in Tbilisi, Georgia, going from there directly to Tokyo, Japan, for the Commemorative Ceremony of the 72<sup>nd</sup> Anniversary of the Japan Medical Association (JMA) on the 1<sup>st</sup> of November 2019. JMA

has carried out during its existence not just many important activities on behalf of the Japanese people but was and continue to be an outstanding member of the WMA.

In the beginning of December 2019, Taiwan Medical Association, one another important member of the WMA, has organized an International Symposium on Primary Health Care, in Taipei, where I had the opportunity to speak about the theme I choose to highlight during my Presidential term – the importance of the doctor-patient relationship – which is even more important in the context of primary health care.

From Taipei, I went directly to Muscat, in the Emirate of Oman, for the World Health Organization (WHO) Global Meeting on Non Communicable Diseases (NCDs) and Mental Health. I have spoken in two different panels, emphasizing the contributions WMA and some of its National Medical Associations (NMAs) have been developing, sometimes in collaboration with other health professional organizations, to better prepare those responsible for assisting patients with NCDs and their mental health.

Not exactly from my role as WMA President but as a member of the WMA Workgroup which is revising the International Code of Medical Ethics (ICoME), I have organized in early March of the current year, in São Paulo, a regional conference to discuss different medical ethics issues of interest to Latin America countries and also to Portugal and Spain, our “country brothers” from Europe. There were 50 people from nine different countries discussing different themes of interest to the revision of the ICoME.

Well ... then ... the coronavirus pandemic impacted us. All meetings that WMA and its NMAs were planning and/or were invit-

ed to participate, were cancelled, postponed or changed to occur through Internet ways of communication. Many countries, all over the world, started to face lockdowns in different regions and cities, and a vast majority of international flights was cancelled. As we say ... the world was placed upside down! Moreover, we have to experience months of quarantine at home.

With such a change in the way we live and work, we were pushed to be more resilient and creative. I was confined in my apartment and did not see even my daughter and grandsons for weeks in a row. Initially, I was thinking that it would be a time to do all those things we never have time to do before but ... I have never worked so tireless. My duties as President of the World Medical Association, Chair of the Research Ethics Committee of my University, and Director of the Brazilian Medical Association, left me not much time to relax.

You can have an idea of my doings just reading my Presidential report to the WMA Council, encompassing at least 24 activities during the pandemic: live, recorded or written interviews, and presentations. I spoke about many topics related to the pandemic such as the role of the WMA and other medical organizations, physicians and patients’ safety, ethics, climate change, solidarity, and different issues on mental health – of common people and of physicians and other health personnel at the frontline care.

I am sure it was difficult times to all, much more to some than to others. At the beginning, we had very little knowledge about the virus characteristics and particularly about the COVID19 disease: no vaccine and no specific treatment available; high transmission and a considerable lethality; great concern of a collapse of health services.

Therefore, most people were experiencing anxiety and fears, including physicians who – at many and different places – where also experiencing a work overload and a lack of enough and adequate personal protective equipment. And, in times of many discrediting science and spreading fake news, with a major contribution even from people in position of command – like the President of my country and of the country of our next WMA President – I believe that much more people were inadequately exposed to the virus, were infected and many died. At the time when I am writing this speech – the middle of October – WHO is counting more than 38 million of cases and more than one million of deaths. Those numbers are considered very much under what happened in reality and the pandemic is still going on everywhere.

During the pandemic, I have listened that we all were at the same ship. It could be true but lets remember that many ships have passengers in the first, second and third classes. Our world is an unequal world and for many people the recommendation to stay at home and keep physical distance one

from another sounds as a joke. I am not just referring to people who lives in slums or as homeless in my country, Brazil, but also to – accordingly to the World Bank data – almost half of the world's population who still struggles to meet basic needs or to almost 10% of the world's population who lives in extreme poverty.

COVID19 has directly affected physical and mental health of millions, and indirectly affected socially and economically billions of people. Poverty and inequality are growing and people will continue, for many years, to suffer from fears, grief, anxiety, depression, loneliness, uncertainties, economic loss, and social disruption. Now, more than ever, universal health coverage – including mental health care – would be the best way to provide health for all.

It is time to start thinking about the future, at short, medium and long-term. It was clear that the WHO and governments were not well prepared to deal with emergencies such as those related to pandemics caused by infectious diseases or natural disasters. Health does not have enough priority for

many of those who lead our countries and usually is insufficiently funded. In many countries, corruption also contributes to divert part of the budget allocated to health. It was possible to see politicians trying to save their mandates and not human lives, and even the WHO was accused to not act as required in the beginning of the pandemic because of political influences. It was also possible to observe in some regions, a lack of health services, hospital infrastructure and health personnel. The supply chain of medical equipment relies very much in few or sometimes just one source. All these factors will need to be realistic faced and fixed, and they will not be unless the health stakeholders take initiatives to raise awareness and mobilize our communities to push their governments in the desired and needed way.

The diagnosis exists. It needs to be completed and then to adopt a treatment plan to what were harmed and preventive measures to not have further damages.

I am deeply grateful for your continuous support and hope to see you all soon again. Thank you!

## Presidential Inaugural address by David O. Barbe, MD MHA President. WMA General Assembly Cordoba (Virtual), October, 2020

Thank you, Dr. Jorge for your excellent service as our president this past year. Thank you to this Assembly for the confidence you have placed in me. It is an honor and very humbling to serve as your president for the coming year. I look forward to leading the largest and most influential international physician organization on your behalf.

Before I begin my formal remarks, I must express my gratitude to the AMA Board of Trustees and the AMA delegation to the WMA for the confidence they showed by supporting my candidacy for WMA presi-

dent. Thank you. Also, a special thank you to Dr. Ardis D Hoven who was Chair of Council during my time as a delegate to the WMA and a wonderful mentor for me as I became familiar with the policies and processes at the WMA. Thank you, Ardis. I would not be in this position today if it were not for my good friend, former AMA President and delegate to the WMA, Dr. Andrew Gurman. From the very beginning Andy encouraged, supported, and mentored me as a WMA delegate and then as a candidate for WMA president. Andy, I cannot thank you enough for your friendship and your encouragement.

And last, but certainly not least, my wife, Debbie. Without her love and support and the sacrifices she has made, I would not have been able to serve our profession at state, national and now international levels. I could not have asked for a better wife, partner, and friend. Thank you, Debbie! Colleagues – friends – we find ourselves in an unusually complex and difficult health care environment. Just look at our agenda at this meeting. Ethical challenges, clinical challenges, protecting our profession, and assuring quality care for patients. If this were not enough, it is even more difficult due to the coronavirus pandemic.





*David O. Barbe*

It is in times like these that our fellow physicians and our patients need our leadership more than ever. We need strong physician organizations at every level: the WMA, our NMAs and state and local medical societies. It takes collaboration and cooperation between our organizations and our encouragement of one another to address these challenges. We must function as a virtual team comprised of our professional organizations and our physician members.

In one of my speeches to the AMA House of Delegates, I emphasized the importance of “teamwork”. Let me quote from that speech:

“Winning teams recognize that the greatest success comes not from the effort of one or more individuals but from a team effort. One of the greatest individual talents in American baseball, “Babe” Ruth put it this way, “The way a team plays as a whole determines its success. You may have the greatest bunch of individual stars in the world, but if they don’t play together, the (team) won’t be worth a dime.””

Each of you in this virtual meeting today is a strong individual leader. And we need strong individual leaders. But more

than that, we must each be committed to the team. Committed to the WMA’s mission “to serve humanity by endeavoring to achieve the highest international standards in Medical Education, Medical Science, Medical Art and Medical Ethics, and Health Care for all people in the world.” This is an ambitious goal, but we can make significant advances in these important areas if we work together as a WMA team.

Let me briefly touch on a few issues that I believe are most important for the WMA.

I will start with COVID-19. Who could have imagined a pandemic of this magnitude that would not only threaten the health of our patients but place our physicians and nurses in danger and cripple our economies? However, that is what we are facing, and that is what we must address. We must continue to advocate for adequate personal protective equipment, appropriate facilities and medical equipment, and adequate support staff. We must work with public health officials to pursue policies that reduce the frequency and severity of disease while at the same time allow for an orderly and safe conduct of business and education. We must continue to let the science lead us and be vocal advocates for evidence-based treatment and safe and effective vaccines.

A second area that is critically important is the WMA’s unwavering advocacy in medical ethics. It was a key reason for the founding of the WMA in 1947 and it remains as important and relevant now as it was then. The multiple WMA declarations and statements that address medical ethics must be living, evolving documents that meet the changing needs of patients, physicians and society while at the same time preserving the essence of who we are as physicians and affirming our responsibilities to patients and society. This may be one of our most difficult challenges because medical ethics rests squarely on our shoulders. We cannot delegate it or relegate it to others. Although we must facilitate discussions among a

broad group of stakeholders, the ultimate decision on what our profession stands for is ours alone to make. Closely related to our position on ethical issues is our dedication to professionalism. As physicians, we must hold ourselves to the highest standards. We must stay committed to the core principles of the patient-physician relationship. We must speak out and seek remedies to address violence against patients and physicians. We must point out the inhumanity of societal or governmental actions that target ethnic or religious groups or that use chemical, biological or nuclear weapons against others. I am proud of our WMA declarations and statements on these topics, and I am encouraged that we are refining these policies as we identify unethical and inhumane practices around the world.

One final area that needs our continued attention is our primary role as physicians in delivering high-quality, medical care for all. We must continue to address the inequities in health and healthcare in our populations. At the same time, we are still battling a rise in chronic disease worldwide. In fact, the COVID-19 pandemic has made the intersection of health inequities and chronic disease even more apparent. Those already experiencing health inequity are often those with chronic diseases who are also at increased risk for COVID-19. Chronic diseases such as cardiovascular disease, diabetes, and hypertension occur with greater incidence in populations of color, Asians and those in lower socio-economic sectors. We can address both health inequities and chronic disease at this meeting. We can improve our policies on health inequities by adopting the major revisions to the Declaration of Oslo, and we can expand our policies on chronic disease by adopting the WMA statement on hypertension and cardiovascular disease. These are just a few examples of where the WMA and our NMAs must lead the national and international discussions on issues that will benefit our patients, our physicians and society. I look forward to working on your behalf during my term as president to

promote the new policies from this meeting and our extensive existing policy.

I started with a quote by Babe Ruth on the importance of working together as a team. He made another observation that I think is equally important.

He said, "It's hard to beat a person who never gives up." Your WMA leadership will never give up in our efforts to advance our policies and achieve our common goals. However, we are depending on each of you as part of the WMA team to use what we do here at the WMA to advocate on behalf

of patients and physicians to "achieve the highest international standards" in medicine "and Health Care for all people in the world."

Thank you.

## WMA 2020 General Assembly Report

Cordoba (Virtual), October 26–30, 2020



Nigel Duncan

The WMA's 71<sup>st</sup> annual General Assembly was due to be held in Cordoba, Spain to mark the 100<sup>th</sup> anniversary of the Spanish Medical Association. But regrettably, because of Covid-19, the Assembly had to be held online. From October 26 to 30, the WMA organised a five-day virtual conference, with more than 100 delegates from almost 60 national medical associations registering for the committee meetings, and the Council and Assembly sessions.

### Monday October 26

#### Council

The Secretary General, Dr. Otmar Kloiber, welcomed participants to the meeting.

The Chair of Council, Dr. Frank Ulrich Montgomery, said it had been decided to postpone until 2021 the scientific session due to be held in Cordoba.

#### *Vice Chair of Council*

Dr. Kenji Matsubara (Japan), a Council member for the past six years, was elected unopposed as Vice Chair of Council.

#### *President's Report*

The President, Dr. Miguel Jorge (Brazil), reported on his activities since his inauguration a year ago. He reminded the meeting that his theme had been the importance of the physician-patient relationship. Among the meetings he had attended were the 72<sup>nd</sup> Anniversary of the Japan Medical Association, the 7<sup>th</sup> International Congress of Person Centered Medicine and the International Symposium on Primary Health Care. He said it had been a very busy, if unusual year, with the outbreak of the pandemic. He was now looking forward to his term as Immediate Past President.

#### *Secretary General's Report*

Dr. Kloiber referred the meeting to the lengthy written report to Council about the work of the secretariat. He said that there might be a need to discuss Covid-19 in more depth than was possible at this meeting, and it had been suggested that a separate conference might be held next year.

The Chinese Medical Association proposed an amendment to the report, deleting the section relating to the WMA press release denouncing a reported breakdown of medical care and

humanitarian assistance for protesters in Hong Kong. The Chinese delegate said these reports of physicians and other medical staff being arrested, and injured students and protesters being denied medical assistance, were not true.

But in the absence of a seconder, the amendment fell.

#### *Chair's Report*

Dr. Montgomery, in his written report, referred to his visits to Hong Kong, Taipei and Kolkata in India. Then SARS-CoV2 engulfed the world. Countries and continents followed different strategies to fight the pandemic virus, ranging from efforts to attain 'herd immunity' quickly by allowing people to maintain contacts and exposure to the virus, to total shut-down scenarios. He said the outcome of these various strategies was going to be the subject of scientific scrutiny for a long time to come.

#### *Emergency Resolutions*

Four emergency motions were submitted to the Council for consideration.

#### *Medical Profession and Covid*

The Spanish Medical Association, supported by the medical associations of France, Uruguay, Brazil, South Africa, South Korea and Australia, introduced an emergency resolution entitled 'The Medical Profession and COVID-19'. The purpose of the resolution was to address the problems facing

physicians, thousands of whom were losing their lives practicing their profession and fulfilling their ethical duties. The resolution called for sufficient provision of equipment and personal protection material, and urged governments to adopt a multilateral and co-ordinated approach on a global scale of the crisis to promote equality in interventions, access to health services, treatments and future vaccines. It demanded the strengthening of health care systems and for SARS CoV-2 infection to be recognized as an occupational disease with the medical profession declared a 'profession at risk'. Finally, it called for zero tolerance towards violence in healthcare settings, following reports of violence against physicians.

The Council agreed that the resolution be forwarded to the Assembly for adoption.

### *International Day of the Medical Profession*

The Spanish delegate presented a second resolution proposing an International Day of the Medical Profession on October 30 as a tribute to the commitment of physicians during the pandemic. Such a day would recognise those physicians who had lost their lives during Covid-19 and those who continued to combat the pandemic. A suggestion that health care workers should be included was not supported.

The resolution was approved for forwarding to the Assembly for adoption.

### *Turkish Medical Association*

The third resolution was proposed by the Turkish Medical Association, Resolution in support to the Turkish Medical Association. This expressed deep concern at the recent Turkish Government announcement to dismantle the Turkish Medical Association as a national professional organization, allegedly to 'protect patients and the profession from terrorists'. The delegate from Turkey said the reference to the physician members of the Turkish Medical Association as terrorists constituted a grave defamation and an insult to the entire profession. He called for the protection of the Turkish Medical Association as a national independent asso-

ciation and main representative of all physicians in the country.

After several speakers voiced their support for the resolution, the Council agreed that it should be forwarded to the Assembly for adoption.

### *Equitable Vaccines*

A fourth emergency resolution on equitable global distribution of COVID-19 vaccine was proposed by the German Medical Association. This stated that given the limits on vaccine production capacity, it was essential to advocate for equitable worldwide procurement and distribution. The resolution also declared that all clinical trials, including those on accelerated schedules, must adhere to the ethical principles outlined in the Declaration of Helsinki. Finally, it stressed the need to build public trust in the face of disinformation.

The resolution was approved for forwarding to the Assembly for adoption.

## **Finance and Planning Committee**

Dr. Jung Yul Park (Korea) took the chair and called the committee to order.

### *Financial Statement*

The committee considered the Audited Financial Statement for 2019. The Treasurer, Dr Ravindra Sitaram Wankhedkar (India), said that the Statement reflected the WMA's sound financial situation with a surplus.

The committee recommended that the Statement be approved by the Council and forwarded to the General Assembly for adoption.

### *WMA Budget*

The committee considered the proposed Budget for 2021 vs. Actual 2019 Expenditures.

The Financial Advisor reported that the budget was calculated on the basis of expenses in a normal financial year and had not yet taken into account any potential implications of the Covid-19 pandemic, including a potential reduction in expenses if one or both meetings needed to be held

on a virtual basis. The budget would be adjusted in March 2021 and a report would be made at the next Finance Committee in April 2021.

The committee recommended that the Budget be approved by the Council and forwarded to the General Assembly for adoption.

### *Membership Dues Payments and Arrears*

A report on Membership Dues Payments for 2020 was introduced. The meeting heard from the Financial Adviser on the situation relating to membership arrears and it was agreed that the document would be forwarded to the General Assembly for information. The committee considered a proposal to postpone a 2.5 per cent increase in membership dues scheduled for 2021.

It was agreed to recommend that the Council approve the postponement until the increase became necessary and forward this to the General Assembly for approval.

### *WMA Strategic Plan*

The committee received a report on the WMA Strategic Plan. The Secretary General said that the four strategic areas of the Plan, medical ethics, Universal Health Coverage, human rights and health and operational capacity had all been deeply affected by the Covid-19 pandemic. Working procedures, cooperation, advocacy and outreach had changed considerably, with workgroups and other discussions having to be held online. He said the pandemic had once more underlined the need for Universal Health Coverage, especially well functioning primary care structures. In many parts of the globe, there had been a substantial lack of pandemic preparedness in both resource-rich and resource-poor countries. This had demonstrated once more that emergency preparedness must be a vital part of Universal Health Coverage. Dr Kloiber said the Plan was still valid and no change was needed.

The report was received.

### *WMA Statutory Meetings*

The committee considered dates for meetings in 2024, two invitations for hosting



meetings in 2024, 2025 and 2026, and the theme of Scientific Session at the General Assembly in 2021.

The Secretary General reported that invitations had been received from the Finnish Medical Association to host the 2024 General Assembly in Helsinki to mark the 60<sup>th</sup> anniversary of the Declaration of Helsinki, and from the Pakistan Medical Association to hold meetings in Karachi.

The committee agreed that a decision on Karachi should be postponed until further information on security and travel was available.

The meeting agreed to recommend to the Assembly that the 226<sup>th</sup> Council session be held from 18-20 April 2024 at a venue to be decided and that the 75<sup>th</sup> General Assembly be held in Helsinki from 2-5 October 2024. The Chair, on behalf of the Korean Medical Association as host of the next Council Session in April 2021, reported that the KMA would communicate with the WMA Secretariat in early January 2021 to determine whether the situation would allow an in-person meeting in Seoul in April.

### *Scientific Session 2021*

It was proposed that the theme for the Scientific Session at the 2021 General Assembly in London be the global response to antimicrobial resistance in the context of COVID-19.

The British Medical Association said that the effort to prevent the development and spread of AMR was reaching a critical point, and that the global response to the Covid-19 pandemic had important implications for tackling antimicrobial resistance. AMR infections were estimated to cause 700,000 deaths each year globally and were predicted to rise to 10 million by 2050 if no action was taken. The rise of AMR would also lead to people suffering for longer, as infections became more difficult to treat. Challenges in addressing AMR, such as lack of access to clean water and sanitation, poor infection and disease prevention and control in health care facilities, farms and communities and poor access to medicines

and vaccines, had been exposed during the pandemic.

Covid-19 provided an opportunity to reinforce key actions which addressed the rise of AMR. As the world saw the consequences of not having treatments for infectious disease, a renewed focus on optimising the use of antibiotics was vital. The pandemic response had shown the importance of infection control and prevention, and the need to develop accurate diagnostics. It had also confirmed that the environment, in which humans and animals interacted, had an impact on health outcomes, illustrating the need to take global action through a One-Health approach. The handling of future pandemics would need all actions aimed at slowing down the development of AMR to be firmly in place. The committee approved the theme for the Scientific Session.

### *Membership*

Two applications for constituent membership were received from the *Círculo Paraguayo de Médicos*, Paraguay and for the return of The Royal Dutch Medical Association.

The committee recommended that the applications be sent to Council for adoption by the Assembly.

### *Associate Members*

Dr. Joe Heyman, Chair of the Associate Members, tabled a written report, detailing the webinars organised and planned by the group. The report referred to the work of three groups within the Associate Membership, the Junior Doctors Network, the Past Presidents and Chairs Network, and the direct members. Consideration had been given to the idea of a survey to find out what associate members wanted out of the WMA and ways to improve networking among the three parts of the group. A steering committee had been established and had already met.

The Finance Committee received this report, as well as reports from the Junior Doctors Network and the Past Presidents and Chairs of Council Network.

### *Bylaws*

Proposed amendments to the WMA Bylaws were considered. The first related to voting in the General Assembly, adding the paragraph: 'The votes scored by each candidate in the election shall be made known to delegates at the General Assembly, immediately after conclusion of counting of votes'.

The committee recommended that the proposed amendment be circulated to the constituent members for comments.

A second amendment was proposed to ensure better representation and enhanced participation from underrepresented regions by increasing the number of Council seats. After a lengthy debate on the allocation of seats, the committee again recommended that the proposed amendment be circulated to the constituent members for comments.

### *World Medical Journal*

The editor reported that the Journal had reported from countries around the world on how they were dealing with Covid-19. Three editions of the Journal had been produced this year with a fourth imminent. He thanked all authors and said they were the strength and brains of the Journal.

### *Public Relations*

The Committee received a report on the extensive publicity that the WMA had received during the Covid-19 pandemic. A number of press releases had been issued on support for front line health personnel, insufficient personal protection, condemnation of assaults on physicians and continuing support for funding the WHO. Numerous interviews had been given by the Chair of Council and other WMA leaders, resulting in the WMA achieving an extremely high global profile for much of the year.

## Tuesday October 27

### **Socio-Medical Affairs Committee**

Dr. Osahon Enabulele (Nigeria) took the chair and called the committee to order.

## Health and Environment

The committee heard a report about the most recent meeting of the Environment Caucus. Among the issues discussed were the [#HealthyRecovery](#) initiative launched by the [WHO-Civil Society Working Group to Advance Action on Climate Change and Health](#), and the global survey on climate change launched by the Global Climate and Health Alliance and George Mason University's Center for Climate Change Communication, in collaboration with the WHO.

A draft proposal on greening WMA meetings was also considered. This was expected to be finalized soon for submission to the next Council session in April 2021.

The committee received the report.

## Network on Disaster Medicine

The Japan Medical Association reported on the Network on Disaster Medicine, reminding the meeting that the JMA had proposed the idea of a Network in which the United Nations, governments, the WMA, NGOs/NPOs, academia, and public interest organizations, and Entities collaborated. They were convinced that the combination of these seven parties would dramatically improve the disaster medical response capabilities of the WMA. It was necessary to accumulate the improvement of large and small-scale disaster medical response capabilities in each country for building the seven-party collaboration.

In collaboration with the JMA and CMAAO, AMDA, a Japan-based disaster medicine specialist group, had already signed agreements with several governments and related organizations. Among them, Indonesia, the Philippines, Bangladesh, Myanmar, Nepal, and Pakistan had agreements with their respective medical associations.

On May 29, this year, the Inaugural Conference of the Asia-Pacific version of the World Platform for Disaster Medicine was scheduled to be held, but it was postponed by one year due to Covid-19. Depending on the situation of the pandemic, the Japan Medical Association was planning to hold this international conference in 2021.

## Human Rights Violations against Uighur people in China

The emergency resolution on human rights violations against the Uighur people in China was presented by the British Medical Association.

The Chinese Medical Association immediately submitted an amendment to withdraw the resolution, arguing that it was an interference in China's internal affairs and based on false reports. During the fight against Covid-19 in Xinjiang Autonomous Region in 2020, China had always put the life and health of people in Xinjiang Autonomous Region first.

In the absence of a seconder, the amendment fell.

The British Medical Association said the resolution was motivated by recent numerous reports about the Uighur people, a Muslim ethnic minority, being detained in Chinese detention centres and being forced to make personal protection equipment for exportation. Serious ongoing abuses of health-related human rights were taking place, including torture and the systematic sterilisation of Uighur women. The use of Uighur labour to make PPE warranted an emergency motion. The global health care community should not condone and encourage modern slavery. With continuing reports of physical abuse and forced sterilisation, it was imperative that pressure was put on China to allow UN investigators into the area.

By 14 votes to two, the committee agreed that the emergency resolution be forwarded to the Council for adoption by the Assembly.

The following policy documents were approved by the committee for sending to the Council:

- Statement on Hypertension and Cardiovascular Disease
- Resolution on Protecting the Future Generation's Right to Live in a Healthy Environment
- Major revision of WMA [Resolution on the Access to Adequate Pain Treatment](#)
- Major revision of the [Resolution on Violence against Women and Girls](#)

- Minor revision of the Statement on the Relationship between Physicians and Pharmacists in Medicinal Therapy
- Minor revision of the Resolution on Drug Prescription
- Minor revision of the [Resolution on the Prohibition of Chemical Weapons](#)
- Minor revision of the [Resolution on the Healthcare Situation in Syria](#)

## Pseudoscience and Pseudotherapies

The Spanish Medical Association presented a proposed Declaration on Pseudoscience and Pseudotherapies in the Field of Health that it said was an attempt to warn people about pseudoscience. During the Covid pandemic, those spreading false rumours and pseudotherapies had proliferated in many countries, in particular in South America. The WMA must act against this, as these pseudoscience ideas undermined the values and safety of patients.

In the debate that followed, the meeting accepted two friendly amendments. The American Medical Association proposed moving to the end of the document the first sentence that stated: 'The aim of this Declaration is not the traditional ancestral medicines nor the so-called indigenous medicines, firmly rooted in peoples and nations, forming an intrinsic part of their culture, rites, traditions and history'. It was argued that the intent of the sentence was unclear, and beginning a policy with a negative statement weakened the subsequent text. As explanatory material, the sentence was best included as a footnote.

The AMA moved a further amendment to delete the sentence that read: 'The physician who practices and applies techniques or therapies not endorsed by the scientific community, has the duty to adequately inform its patients and assume all legal, professional, ethical and deontological obligations and consequences that may arise.' It was argued that no physician should practice or apply techniques or therapies not endorsed by the scientific community. This was agreed.

There was also a proposal to delete the word 'knowledge' in the opening definition sentence that read "Pseudoscience" (false science) refers to the set of statements, knowledge, methods, beliefs or practices that, without following a valid and recognized scientific method, are falsely presented as scientific or evidence-based'. But after a brief debate, the amendment was defeated by eight votes to seven.

The committee recommended that the Declaration, as amended, be sent to the Council for adoption by the Assembly.

### *Medical Liability*

The Israeli Medical Association welcomed comments that had been received to the proposed revision of the Statement on Medical Liability, which calls for an end to frivolous medical liability claims. In view of the comments, it was proposed that the document be recirculated.

It was suggested that it would be helpful to include organizational liability in reconsidering the document, as it was not just individuals who were involved on this issue. Systemic factors were often involved.

The committee recommended that the document should be recirculated to members.

### *Child Health*

The South African Medical Association proposed a major revision of the WMA Declaration of Ottawa on Child Health, updating policy to ensure the health and wellbeing of children.

The German Medical Association proposed an additional paragraph inserting the words 'respect for the sexual and gender identity of the child. Harmful practices like genital mutilation or so-called conversion therapies must be forbidden'. It was argued that these issues were too important not to be mentioned in a declaration on child health. These practices had such an impact on the future life of a child that they needed to be mentioned. The amendment was accepted. The committee agreed that the Declaration, as amended, be forwarded to the Council for adoption by the Assembly.

### *Inequalities in Health*

A proposed revision of the Declaration of Oslo on social determinants of health was tabled. It was reported that the WMA Statement on inequalities in health was adopted in 2009 and had not been revised since then. As part of the annual 10-year policy review the secretariat recommended a major revision of the statement by integrating the relevant parts of the statement in the Declaration of Oslo. This new consolidated policy on SDH should refer to Universal Health Coverage and the Sustainable Development Goals, specifically SDG3 and SDG10. The Statement on inequalities in health would then be rescinded.

The committee recommended that, as amended, the Declaration should be sent to the Council and forwarded to the General Assembly for adoption.

### *Use of Telehealth for the Provision of Health Care*

The committee considered a proposed revision of the Statement on Guiding Principles for the Use of Telehealth for the Provision of Health Care.

A suggestion was made to set up a workgroup. The meeting was told that with Covid-19, the world was using much more telehealth and a workgroup would be very timely. It was important that any reconsideration should include the role of telehealth in pandemics.

The committee recommended that the idea of a workgroup should be supported.

### *Access to surgery and anaesthesia care*

A proposed statement was tabled by the Junior Doctors Network on access to surgery and anaesthesia care. The committee recommended that the document be circulated to members.

### *Relationship between Physicians and Commercial Enterprises*

A proposed revision of the Statement Concerning the Relationship between Physicians and Commercial was considered. The Statement, warning about the conflict of

interest that can occur between physicians and commercial enterprise, needed updating under the 10-year revision process.

After a brief debate, the committee recommended that the document be approved by the Council and forwarded to the General Assembly for adoption.

### *Items Deferred*

In view of time constraint, the committee agreed to defer consideration of the following items:

- Observer status for Taiwan to WHO and inclusion as participating party to the International Health Regulations
- Proposed WMA Statement on Photoprotection
- Proposed WMA Statement in support of Ensuring the Availability, Quality and Safety of All Medicines Worldwide
- Medical Technology workgroup
- Revision of WMA policies related to disaster/pandemic preparedness and ethics
- Proposed major revision of Council Resolution on Trade Agreements and Public Health
- Proposed major revision of WMA [Statement on Family Violence](#)
- Proposed major revision and consolidation of WMA policies on migration
- Proposed minor revision of WMA [Resolution on Plain Packaging of Cigarettes](#)

## Wednesday October 28

### **Medical Ethics Committee**

*Dr. Andreas Rudkjoebing (Denmark) took the chair and called the committee to order.*

### *Reproductive Technologies*

An oral report was given by the Chair of the Reproductive Technologies workgroup from South Africa. She reminded the meeting that the workgroup was established with the mandate to work further on the proposed revision of the Statement on Reproductive Technologies in coordination with the workgroup on Genetics and Medicine, given

the number of cross-cutting issues. A list of existing and new reproductive technologies had been collated, and SAMA had reviewed the potential to revise the existing statement on reproductive technologies as a single document, or split it into two, given the complexities of new technologies that might be included. In discussion with the secretariat, SAMA had agreed to wait until after the 2020 online sessions to pick up and progress the work on reproductive health issues. The report was received.

### *International Code of Medical Ethics*

The committee received an oral report from the Chair of the workgroup tasked with revising the International Code of Medical Ethics. He presented an update on the workgroup's progress and a timeline of the revision process for the coming months. The work was on track. Two successful regional conferences had been held, and based on the feedback from these, and a webinar, a revised draft was available for information. Next year an in-person meeting was planned, along with a public consultation. There was still ample time and opportunity to propose amendments to the content and language in the months ahead.

The committee recommended that the current policy draft of the ICoME be approved for the workgroup's ongoing consideration. The committee also supported the proposal for the WMA to host a dedicated conference focused on conscientious objection.

### *Documentation of Torture*

The meeting heard an update from the workgroup set up to revise the proposed Resolution on the Responsibility of Physicians in the Documentation and Denouncing Acts of Torture and Ill-treatment. The Chair of the workgroup spoke about the dilemma facing physicians and the ethical tension between the need for fully respecting the confidentiality of the patient, while at the same time fighting the horrors of torture and documenting systematic torture. After a brief debate, the committee recommended that the revised resolution be ap-

proved by the Council for forwarding to the General Assembly for adoption.

### *Physicians Treating Relatives and Friends*

The committee considered the proposed Statement on Physicians Treating Relatives and Friends submitted by the South African Medical Association.

Delegates were told that the document reminded physicians of their obligations. A debate took place on whether friends should be included in the statement, and the Chair agreed that friends should be omitted. Several delegates said the wording of the statement was too strong and accusatory, particularly when bearing in mind that in some regions a physician family member might be the only option for obtaining healthcare. Concern was also expressed about the reaction of physicians to the proposals. A motion was made to recirculate the document to members and this was agreed.

### *Physician-Patient Relationship*

The Spanish Medical Association presented the proposed Statement on Physician-Patient Relationship, warning that the age-old relationship was under threat. The document had two main aims, to protect the relationship which was both cultural and health-related and to protect the values based on the humane nature of the relationship. But this relationship was being threatened by barriers between the two. The Covid-19 pandemic had showed how important this issue was.

The American Medical Association proposed that the title of the document should be changed to Patient-Physician Relationship, putting the patient first. It was incredibly important to put the patient and patient centred care at the beginning. The Spanish agreed that the patient should be put above any other interest. But in Spanish they talked about the Physician-Patient relationship. Putting physician first demonstrated commitment on behalf of the medical profession to provide quality care. This was a document directed to physicians around the world. If it was

called the Patient-Physician Relationship, it would be thought it was coming from a patients' association.

In a vote, it was agreed by eight votes to five to change the title to Patient-Physician Relationship.

The committee agreed to recommend that the document be called The Declaration of Cordoba.

The committee recommended that the Declaration, as amended, be forwarded to the Council for adoption by the Assembly.

### *Embryonic Stem Cell Research*

The American Medical Association presented a proposed revision of the Statement on Embryonic Stem Cell Research. This stated that public concern about the abuse of stem cell research could be alleviated if laws were adopted in line with established ethical principles.

After a brief debate, the statement was approved for forwarding to the Council for adoption by the Assembly.

### *Gene-Editing*

A proposed Statement on Gene-Editing was submitted by the South African Medical Association. This warned physicians to avoid getting involved in unethical or unapproved human gene-editing research, and listed recommendations for national medical associations following what it called 'alarming reports on abuse' of the emerging technology. The British Medical Association proposed two amendments. The first suggested adding to the sentence 'There are also concerns that germline modifications could create classes of individuals defined by the quality of their engineered genome, possibly enabling eugenics', the additional words 'which could exacerbate social inequalities or be used coercively'. This was agreed.

The second was to add a new paragraph reading: 'The effect of epigenomic changes are unpredictable, and there is disquiet as to how this will affect the existing healthy biological systems, including interactions with other genetic variants, and societal norms. Once introduced into the human popula-



tion, genetic alterations would be difficult to remove and would not remain within any single community or country. The effects could remain uncertain for many subsequent generations, during which time deleterious modifications could be dispersed throughout the population'. This was also agreed. The committee recommended that the statement, as amended, be approved by the Council and forwarded to the General Assembly for adoption.

### *Physicians' Responsibilities in Preventing and Combating Transplant-related Crimes*

The Spanish Medical Association submitted a proposed Statement on Physicians' Responsibilities in Preventing and Combating Transplant-related Crimes. This called for the strengthening of legislation to prohibit and criminalize human organ trafficking. It was argued that transplants had been a major progress in modern medicine for health and humanitarian reasons. But this had led to organ trafficking and had affected human rights, with risks for individuals and for public health. It meant exploitation for the most vulnerable and it required the participation of health care professionals, particularly doctors. It was argued that doctors should be helping to combat these crimes. This Statement was aimed at eradicating the trafficking of human organs. The WMA needed to provide guidance to doctors on how to react when they found themselves in different situations. They needed to inform patients of the consequences of trafficking. When doctors dealt with patients who had obtained organs illegally, they needed to notify the authorities.

The American Medical Association proposed an amendment stating that Governments should 'vigorously enforce' legislative frameworks to prohibit and criminalize trafficking, arguing that laws were powerless if not enforced. The amendment was accepted. A second amendment from the AMA called for national medical associations to develop 'mandatory frameworks' for health professionals to report any confirmed or suspected case of trafficking and that reports on an anonymous basis should be permitted.

This led to a debate in which some speakers opposed the word 'mandatory', while others questioned what was meant by 'anonymous'. The Spanish opposed recirculation. The committee eventually decided to approve the document for forwarding to Council, while discussions continued to find a compromise on the wording of 'mandatory' and 'anonymous'.

### *Declaration of Venice*

The committee was told that following last year's WMA policy decision on euthanasia and physician assisted suicide, a major revision of the Declaration of Venice on Terminal Illness was needed. The American Medical Association volunteered to act as rapporteur for a major revision.

### *Women's right to Health Care and How that Relates to the Prevention of Mother-to-Child HIV Infection*

The South African Medical Association proposed a major revision of the WMA Resolution on Women's right to Health Care and How that Relates to the Prevention of Mother-to-Child HIV Infection.

The committee decided that the proposed resolution should be circulated to constituent members for comment.

### *Declaration on Principles of Health Care for Sports Medicine*

The committee considered the first draft of a proposed major revision of the Declaration on Principles of Health Care for Sports Medicine submitted by the American Medical Association. This reiterated the WMA's opposition to World Athletics' rules requiring female athletes with differences in sex development to take drugs to reduce and maintain their natural level of blood testosterone in order to compete.

The committee recommended that the document be circulated for comment.

### *Declaration of Geneva*

A proposal to amend the French version of the Declaration of Geneva was put forward

to bring it into line with other WMA documents. The English version 'I will maintain the utmost respect for human life' should read in French 'Je veillerai au plus grand respect de la vie humaine' not 'Je veillerai au respect absolu de la vie humaine'.

The committee recommended that the proposed revision be forwarded to the General Assembly for adoption.

### *WMA Council Resolution on Organ Donation in China*

The Chinese Medical Association submitted a proposal to revoke the WMA Council Resolution on Organ Donation in China. It argued that the resolution from 2006 was now outdated and not consistent with today's situation. The meeting was told that after years of reforms starting in 2015, China had stopped transplanting organs from executed prisoners. As a result, the situation in China was as transparent as in other member states in the WHO.

However, the American Medical Association opposed revocation, saying that official information was not yet available. The German Medical Association proposed to invite the Chinese to officially condemn any practice in violation of ethical principles and basic human rights and to assure people that Chinese doctors were not involved in the removal or transplantation of organs from executed Chinese prisoners.

The Chinese said they understood the request and said that in 2015 the Chinese Medical Journal had published a very clear statement that organs should not be transplanted from executed prisoners. The data was public. They argued that the WMA Resolution of 2006 was sending the wrong message to the public.

The committee recommended that the Chinese proposal to revoke the resolution be sent to the Council for adoption by the General Assembly. Meanwhile, the proposal by the German Medical Association for China to officially condemn the practice should be considered by the Council together with the initial proposal



## Thursday October 29

### Resumed Council

The Chair of Council, Dr. Montgomery, welcomed two new members of Council, Dr. Camilla Rathcke, Chair of the Danish Medical Association, replacing Dr. Andreas Rudkjoebing, and Dr. Omar Khorshid from the Australian Medical Association.

### Hong Kong

The Chinese Medical Association proposed a motion to amend the section on Hong Kong in the Council report relating to the WMA press release denouncing a reported breakdown of medical care and humanitarian assistance for protesters in Hong Kong. The Chinese argued that there was not a breakdown of medical care in Hong Kong as stated in the report. But in the absence of a seconder, the motion was not pursued.

The Council then considered reports from the three committees

### Medical Ethics Committee

The Council accepted the following items from the committee for forwarding to the Assembly for adoption:

- International Code of Medical Ethics
- Reproductive Technologies
- Patient-Physician Relationship
- Documentation of Torture
- Physicians Treating Relatives
- Declaration of Venice
- Resolution on the Women's right to Health Care and How that Relates to the Prevention of Mother-to-Child HIV Infection
- Declaration on Principles of Health Care for Sports Medicine
- Declaration of Geneva – French version

### Stem Cell Research

The Statement on Embryonic Stem Cell Research was considered. The British Medical Association referred to the sentence that read 'Investigational stem cell products also may pose unique risks, including unknown long-term health effects such as mutations

and possible cancers'. They wanted a clear definition of the words 'Investigational stem cell products', clarifying whether this referred to pluripotential stem cells or to something else.

They also proposed an amendment to delete the reference to cancer. The beginning of the sentence stated that the risks were unknown. So if they were truly unknown, they should be cautious in suggesting a link to cancer.

The proposal to delete the word cancer was accepted and the meeting agreed to recommend that the document, as amended, be forwarded to the Assembly for adoption.

### Gene Editing

The Council considered the Statement on Gene Editing as amended in the committee following suggestions by the British Medical Association.

The Council recommended that the document, as amended, be forwarded to the Assembly for adoption.

### Transplant Related Crimes

The proposed Statement on Physicians' Responsibilities in Preventing and Combating Transplant-related Crimes was considered. The British Medical Association said it was not happy with the proposal for national medical associations to develop 'mandatory frameworks' for health professionals to report any confirmed or suspected case of trafficking. The BMA wanted to see doctors left with professional discretion. It was proposed that the document should be amended to read 'National medical associations should advocate for the ability of health professionals to report suspected trafficking of individual persons, on an anonymous basis if necessary, to protect the safety of the reporter. Where applicable, the reporting of trafficking cases should be a permitted exception to the physician's obligation to maintain patient confidentiality'.

The amendment was approved and the Council recommended that the statement, as amended, be forwarded to the Assembly for adoption.

### Organ Donation in China

Further debate took place on the Chinese Medical Association proposal to revoke the 2006 WMA Resolution on organ donation in China on the grounds that it was out of date. The Council considered a three-part amendment from the German Medical Association inviting the Chinese Medical Association to condemn the removal of organs from executed prisoners, to ensure that Chinese doctors were not involved in the removal or transplantation of organs from executed prisoners and that no more organs from executed prisoners would be used for transplantation or even accepted as donations in China.

The Chinese responded by arguing again that the original resolution was outdated and contradicted WHO and international experts. The resolution sent the wrong message to the public. The Chinese Medical Association said it would have no trouble in agreeing to the German amendment, but suggested they needed more time for further discussions with the German Medical Association.

The Chair of Council proposed that the German amendment be postponed for discussions to take place. This was agreed.

Further debate then took place on the original Chinese motion to revoke the 2006 Resolution. The Chinese delegate again outlined the progress that had been made in his country on this issue, but other delegates argued that it would be premature for the WMA to withdraw its resolution.

In a vote on the Chinese motion to revoke the 2006 Resolution, the Council decided by eighteen votes to two with three abstentions not to revoke the resolution.

### Finance Committee report

The Council accepted the report of the Finance and Planning Committee without debate.

### Social Medical Affairs Committee

*Human Rights Violations against Uighur people in China*

The Council considered the emergency resolution on human rights violations against

the Uighur people in China presented by the British Medical Association.

The BMA emphasised again the importance of this resolution to bring pressure to bear on China. A strong motion from the WMA would help to take this matter forward.

In a lengthy response, the Chinese Medical Association again opposed the resolution, arguing that the allegations were based entirely on a few very flawed and discredited reports by non-governmental organisations, which were contrary to the scientific spirit and ethics expected of medical organisations. The CMA said the WMA General Assembly should not be used as a place for individual members to engage in political manipulation. There had never been such a thing as re-education camps in Xinjiang. The vocational education and vocational training centres in Xinjiang as well as other counter-terrorism and de-radicalization measures taken there had led to positive outcomes, making important contributions to the global fight against terrorism and radicalization. The rights and interests of workers from Xinjiang were protected by China's Labor Law and Labor Contract Law. In the face of false reports, the Chinese Medical Association resolutely opposed the resolution and demanded that it be rejected. On a vote, the Council accepted the resolution by 19 votes to two.

### *Pseudoscience*

The Council considered the proposed Declaration on Pseudoscience and Pseudotherapies in the Field of Health.

The Chinese Medical Association proposed an amendment to the definition at the start of the document so that it should read "Pseudoscience" (false science) refers to the set of statements, assumptions, methods, inserting the word 'assumptions' instead of 'knowledge'. This was agreed.

The Spanish Medical Association proposed a further amendment to the line in the definition which read "Pseudotherapies" (false therapies) are those unproven alternative therapies intended for curing diseases, alleviating symptoms or improving health with

procedures'. The amendment was to replace the words 'unproven alternative therapies' with the word 'practices'. On a vote, the amendment was agreed by 14 votes to six, with one abstention.

The Council recommended that the Declaration, as amended should be forwarded to the Assembly for adoption.

### *Policies for Major Revision*

The Council agreed that three policy documents should be circulated for comment in preparation for major revision:

- Trade Agreements and Public Health
- Family Violence
- Migration and Health

### *World Health Organisation*

The Secretary General reported on the 2020 World Health Assembly which had to be changed to a shorter meeting because of the pandemic.

He said there had been harsh criticism of the WHO by the American President, Donald Trump, for being under too strong an influence from China, having reported too late and taken decisions too late on the spread of Covid-19. Mr Trump had terminated his country's membership of WHO and this had raised a lot of criticism from both sides. As a result, the process of reforming the WHO had come to an abrupt stop, as the US was the biggest payer to the WHO.

Dr. Kloiber said that most member states now used other channels to pay for global health. These were now the big players who received money from donors and states, and not the WHO. The budget of the WHO was probably the same size as the budget of a big hospital in the US. To expect too much from the WHO was not realistic. He said the WMA had made its position clear in a press release that it did not think the USA was correct in withdrawing from the WHO. The WHO was now proceeding with its review and he hoped nations would stay on board to support reform. The WMA was looking forward to co-operating.

The American Medical Association said it had gone on record saying it did not believe

that the US should withdraw funding from the WHO, particularly during a pandemic. The Chinese Medical Association refuted claims that China had delayed sharing information about the outbreak of Covid-19 in the early part of this year. There had been open transparency and China had shared the available information as quickly as they could.

### **Socio-Medical Affairs Committee**

The Council was told that items not discussed at this week's meeting would be deferred until a resumed SMAC meeting, later fixed for 12 January 2021. The British Medical Association suggested that it would be far more useful, if they were going to meet in December, that they continue discussing Covid-19 at a special meeting next month.

The Chair of Council said this idea would be followed up. He agreed they should have a day to discuss Covid-19 and learn about experiences worldwide.

### **Any Other Business**

#### *President of Brazilian Medical Association*

The President of the Brazilian Medical Association said a few words before finishing his term of office. This was his last meeting at the WMA and he offered his thanks to the WMA.

#### *International Symposium on Vaccination*

The Council was told that the International Symposium on Vaccination, originally scheduled for May this year, had now been rescheduled for July 1 and 2 2021.

#### *Nuclear War*

Bjoern Oscar Hoftvedt, Chair of the Board of The International Physicians for the Prevention of Nuclear War, informed the Council of the good news that the UN Treaty on the Prohibition of Nuclear Weapons was adopted by the 50<sup>th</sup> state last Saturday. He said he was very grateful for all the support for the Treaty that had come from the WMA. With this ratification, the Treaty would come into force on January 22.

## Friday October 30

### General Assembly Ceremonial Session

The session was called to order by the Chair of Council, Dr. Frank Montgomery. He said it was sad they were having to meet online, but the pandemic had a hard grip on them. A formal roll call was taken.

#### *President of Spanish Medical Association*

Dr. Serafin Romero, President of the Spanish Medical Association, welcomed delegates to the Cordoba Assembly. He paid tribute to those physicians who had tragically lost their lives during the pandemic and to those physicians who were fighting complications linked to the infection. He said the Spanish Medical Association had always been a member of the WMA, always committed to promoting the medical profession and its ethical principles. The Spanish Medical Association was celebrating its 100<sup>th</sup> anniversary with the motto 'Committed to society, Committed to doctors', and they wanted to underscore the values of professionalism, which was very much to do with putting patients first. He emphasised how important it had been for Cordoba to host this Assembly so that the Spanish Medical Association could demonstrate its active role in the WMA. They also wanted the Assembly to be a gesture of solidarity with Latin America. He said the Assembly needed to send out a message of support to doctors with discussions on many important issues. They needed to strengthen the doctor patient relationship and he hoped the Assembly would pay tribute to this relationship and approve the Declaration of Cordoba.

#### *Prime Minister of Spain*

The Prime Minister of Spain, Mr Pedro Sanchez, then addressed the Assembly. He said it had given him great pride for Spain to host such an important Assembly on the 100<sup>th</sup> anniversary of the Spanish Medical Association. This was particularly so in the middle of a pandemic, a crisis that was affecting all of them the world over. No country had been spared by the pandemic. It had been a hum-

bling experience for all the world's governments, forcing them to rethink how they operated on a daily basis. It made them realise that without science, without the medical profession they could not achieve anything at all. Physicians had been at the forefront of efforts to combat the pandemic, working tirelessly, giving their all, sometimes giving their own lives, often working in inhumane conditions enduring unbearable pressure in hospitals. They had had to put up with misinformation, unscientific lies and negativism. Physicians were a human shield against the pandemic. But he asked who took care of the physicians. He reassured physicians that they were not alone. It was very clear to public institutions that without the medical profession's dedication and devotion there was no future possible. The pandemic had taught them an important lesson. Governments and societies must invest in public health and must strengthen health systems whose weaknesses had come to light during this crisis. They had to do this with great resolve and without hesitation, making the necessary investment and the honouring a profession that was perhaps the worthiest of all, that of saving lives and caring for lives. This lesson was abundantly clear to the WHO and to the European Union. And it was a priority for the Government of Spain to contain this second wave of the pandemic as quickly as possible.

Mr Sanchez concluded with a simple message to the millions of physicians who were working all over the planet – 'Thank you'.

Dr. Miguel Jorge, the outgoing President of the WMA, invited the Secretary General to read out the Declaration of Geneva for delegates to recite online.

Dr. Jorge then led the meeting in paying tribute to the world medical community on the front line fighting the pandemic, especially to those physicians who had lost their lives in the fight. During one minute of silence, the names of deceased physicians were pictured on the screen.

The Chair of Council, Dr. Montgomery, paid tribute to the outgoing President,

Dr. Jorge. He said there had never been a President whose term of office coincided so dramatically with a global pandemic. None of them expected things to develop as they did when things changed. When they did, Dr Jorge had fought for nurses, physicians and health care workers. This had become the overarching subject of his Presidency, for which Dr. Montgomery thanked him on behalf of the whole Association.

#### *Valedictory Address (see p. 2)*

Dr. Miguel Roberto Jorge then delivered his Valedictory Address.

#### *Installation of New President*

Dr. David Barbe, from the American Medical Association, was installed as President for 2020-21 by the Chair of Council.

#### *Inaugural Address (see p. 3)*

Dr. Barbe delivered his Inaugural Address.

### General Assembly Plenary Session

#### *Election of President*

Dr. Heidi Stensmyren, President of the Swedish Medical Association, was elected unopposed as President for 2021-2022. She said she was honoured to be elected. They were living in challenging times and this would not be over this year. But they were developing strategies and developing treatments as physicians had done for centuries. She said they must continue to contribute their expertise and she hoped the WMA would extend its collaboration with the WHO and other organisations concerning issues such as adequate and safe vaccine programmes and access to health care. The WMA had an important role in stressing equality of access to vaccines, in sharing knowledge and expertise and in fostering access to testing, medication and vaccines.

#### *Report of Council*

The following policies were adopted by the Assembly:

- Resolution regarding the Medical Profession and COVID-19 ([see p. 31](#))

- Resolution in support of an International Day of the Medical Profession, October 30 ([see p. 22](#))
- Resolution on equitable global distribution of COVID-19 vaccine ([see p. 24](#))
- Resolution in support to the Turkish Medical Association ([see p. 23](#))
- Resolution on the responsibility of physicians in the documentation and denouncing acts of torture and ill-treatment treatment ([see p. 28](#))
- Statement on Gene-Editing ([see p. 33](#))
- Statement on Physicians' Responsibilities in Preventing and Combating Transplant-related Crimes ([see p. 36](#))
- Revision of the French version of the WMA Declaration of Geneva

## *Patient-Physician Relationship*

The Assembly considered the proposed Statement on Patient-Physician Relationship. Dr. Serafin Romero (Spain) told the Assembly that in committee the title of the document had been changed from Physician-Patient Relationship to Patient-Physician Relationship. He said he would like the Assembly to take the decision about which title to use. The reason the document was originally called the Physician-Patient Relationship was because this term was more widely understood in Spain and in Portugal and France. He understood that the American Medical Association wanted the title to be Patient-Physician Relationship. But the WHO in its publications used the expression Physician-Patient and on Google there were three million hits for Physician-Patient and only 200,000 hits for Patient-Physician. He said it was important for Spain that the title was Physician-Patient Relationship. He asked who was bringing this document forward – the medical profession. And who was it particularly aimed at – physicians and medical students. He proposed that the title of the document be changed to Physician-Patient Relationship. Dr. Montgomery suggested a compromise under which the title was translated differently in different parts of the world. Dr. Romero accepted that as a friendly amendment and a solution.

The Assembly adopted the document as the Declaration of Cordoba, on the understanding that it be titled Patient-Physician Relationship in the English version and Physician-Patient Relationship in the French and Spanish versions.

## *Embryonic Stem Cell Research*

The Assembly considered the proposed revised Statement on Embryonic Stem Cell Research. Prof. Pablo Requena (Vatican Medical Association) said he would vote against the document. He said he agreed with clinical research to try to find therapies, provided that this respected all human life. The Declaration of Geneva, which they had all just recited, said that they would maintain the utmost respect for human life. He believed this document ran counter to this Declaration and therefore he would be voting against.

On a vote, the Statement was adopted by 88 votes to four with eight abstentions.

The Assembly received for information the following policies:

- Revised Statement on the Relationship between Physicians and Pharmacists in Medicinal Therapy
- Revised Resolution on Drug Prescription.
- [Revised Resolution on the Healthcare Situation in Syria](#)
- [Revised Resolution on the Prohibition of Chemical Weapons](#)

The following policies were adopted:

- Statement on Hypertension and Cardiovascular Disease ([see p. 34](#))
- Resolution on Protecting the Future Generation's Right to Live in a Healthy Environment ([see p. 26](#))
- [Revised resolution on the Access to Adequate Pain Treatment](#) ([see p. 27](#))
- [Revised resolution on Violence against Women and Girls](#) ([see p. 39](#))
- Declaration on Pseudoscience and Pseudotherapies in the Field of Health ([see p. 21](#))
- Revised Declaration of Ottawa on Child Health ([see p. 19](#))
- Revised Declaration of Oslo on Social Determinants of Health ([see p. 18](#))

- Revised Statement Concerning the Relationship between Physicians and Commercial Enterprises ([see p. 31](#))
- Resolution on Threats to Professional Autonomy in Turkey
- Resolution in Support of Dr Serdar Küni ([see p. 23](#))

## *Human Rights Violations against Uighur people in China*

The Assembly considered the Resolution on Human Rights Violations against Uighur people in China proposed by the British Medical Association. This formally condemned the treatment of the Uighurs in China's Xinjiang region

Dr. Shuyang Zhang (China) opposed the resolution. He said it ignored facts and evidence and completely violated scientific evidence, citing false information. These were reports from non-governmental associations full of holes. He said the WMA should not be used for political manipulation. It was not fair to adopt this resolution and would cause great damage to the WMA's reputation. This issue was a highly political one and should not be considered at this Assembly.

Dr. John Chisholm (British Medical Association) strongly refuted the claim that this was a motion intended to achieve political manipulation. It was an approach that was determined to respect human rights and particularly the health-related human rights for the Uighur people. It was also alleged it was factually incorrect and that the motion was based on false reports. There were numerous organisations that had reported the abuses, including Amnesty International, Human Rights Watch, the US Council on Foreign Relations and the British Government. He said he would like to highlight the significance and importance of the resolution regarding the human rights violations. As doctors of the world, they should not condone unethical trade practices that were detrimental to the health of populations globally and they should not be encouraging modern slavery. The continuing reports of political indoctrination, torture, forced sterilizations, forced abortions of minorities



generated serious concern about widespread state-sponsored violations in China. It was imperative that awareness of this situation continued to grow and further pressure was put on the Chinese Government to allow an independent United Nations investigation into what was happening. He hoped that this resolution would be adopted to show that the WMA stood out against health-related human rights abuses.

The Chinese delegate responded again, saying that since 2018 nearly a thousand visitors from more than 90 countries had visited Xinjiang, seeing for themselves the social stability. He said that forced labour by means of violence, threat, or beating, was strictly prohibited. China protected their human rights in Xinjiang. He asked if anyone at the meeting had been to the area. He had been working there. He had many friends and relatives living there and in China they knew the truth of the human rights situation there. Dr. Chisholm replied that while they had not witnessed the abuses personally that was not a suitable criterion on which to judge human rights abuses. But he must point out that eyewitness evidence did exist. The resolution called for independent investigators to be allowed access to the Xinjiang region. He understood the Chinese had not agreed to this request. On a vote, the resolution was adopted by 85 votes to eight with seven abstentions.

### *Declaration of Oslo on Social Determinants of Health*

Tomas Hedmark (Sweden) proposed that the Assembly not only adopt the revised Declaration of Oslo but also rescinded the WMA Statement on Inequalities in Health. One of the purposes of the Declaration was to incorporate relevant parts from the Statement on Inequalities. The proposal was approved.

### *Finances*

The Treasurer, Dr Ravindra Sitaram Wankhedkar, presented his report on the finances of the Association. He spoke about the Financial Statement for 2019 and the budget for 2021, giving an

outline of the Association's assets, income and expenditure. He said the Association's finances were very solid.

The Assembly approved the Financial Statement for 2019 and the Budget for 2021.

The Assembly received the following documents for information:

- Report on Membership Dues Payments for 2020
- WMA Dues Categories 2021
- The date for the 226<sup>th</sup> Council Session in 2024 to be 18-20 April 2024

The meeting also agreed the following:

- That the dues increase of 2.5% for dues categories C and D be postponed until the increase becomes necessary
- That the 75<sup>th</sup> General Assembly be held from 2-5 October 2024
- The invitation from the Finnish Medical Association in Helsinki to host the 75<sup>th</sup> General Assembly in 2024
- That "Global response to antimicrobial resistance, in the context of COVID-19" be the theme for the Scientific Session of the General Assembly, in London 2021

### *Membership*

The Assembly agreed that the application for constituent membership of *Círculo Paraguayo de Médicos* be approved and that the application to rejoin constituent membership from the Royal Dutch Medical Association also be approved.

### *Associate Members*

Dr. Ankush Bansal reported on the recent virtual meeting of the Associate Members and the re-election of the Chair, Dr. Joseph Heyman for 2020-23.

He proposed a Resolution on LGBTQ Equity in Venues Hosting WMA Meetings and Functions. This recommended that it should be WMA practice to consider the safety of its delegates and guests when choosing a host nation for WMA meetings and events. This should include discrimination against or criminalizing members of the LGBTQ community.

The Assembly agreed to circulate the document.

### *Any Other Business*

Dr. Montgomery said the WMA was celebrating the 10<sup>th</sup> anniversary of the Junior Doctors Network. Dr. Yassen Tcholakov, Chair of the JDN, said the Network was hoping to increase its work supporting the WMA and planned a special edition of the JDN newsletter.

### *72<sup>nd</sup> General Assembly*

Dr. Chaand Nagpaul (British Medical Association) showed a video of London, the venue for the 72<sup>nd</sup> Assembly in October 2021. He said that in 2021 the spotlight would be on the UK as the country took centre stage with the climate talks. It was also the year when the UK took the helm of the G7.

### *Vaccination Symposium*

It was reported that the Vaccination Symposium, co-organised by the WMA, the German Medical Association, the Pontifical Academy for Life and the Pontifical Academy of Sciences, originally scheduled for May this year at the Vatican, had now been rescheduled for July 1 and 2 in 2021. They were working on an updated programme to take account of Covid-19. The Assembly was told that the symposium was more relevant than ever.

### *Human Rights Violations against Uighur people in China*

Dr. Zhang Shuyang (China) again expressed his strong indignation and regret about the resolution adopted on the Uighur people. The Chinese Medical Association would never accept the resolution.

### *2021 Council*

Dr. Jung Yul Park (Korea) said it seemed that the Council meeting due to be held in Seoul in April 2021 might not be able to be held as an in-person meeting. But at least they would be able to have an online meeting.

The Assembly ended with thanks from Dr. Kloiber to all those who had helped organise the virtual meeting.



## WMA Declaration of Cordoba on Patient-Physician Relationship

*Adopted by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

The patient-physician relationship is part of a human relationship model that dates back to the origins of medicine. It represents a privileged bond between a patient and a physician based on trust. It is a space of creativity where information, feelings, visions, help and support are exchanged.

The patient-physician relationship is a moral activity that arises from the obligation of the physician to alleviate suffering and respect the patient's beliefs and autonomy. It is usually initiated by mutual consent – expressed or implied – to provide quality medical care.

The patient-physician relationship is the fundamental core of medical practice. It has a universal scope and aims at improving a person's health and wellbeing. This is made possible by knowledge sharing, common decision making, patient and physician autonomy, help, comfort and companionship in an atmosphere of trust. Trust is an inherent component of the relationship that can be therapeutic in and of itself.

The patient-physician relationship is essential to patient-centred care. It requires both the physician and the patient to be active participants in the healing process. While the relationship encourages and supports collaboration in medical care, competent patients make decisions that direct their care. The relationship may be terminated by either party. The physician must then assist the patient in securing transfer of care and refer the patient to another physician with the necessary ability to continue the care.

The patient-physician relationship is a complex issue subject to myriad cultural, technological, political, social, economic or professional influences. It has evolved throughout history, according to culture and civilisation, in the pursuit of what is most appropriate based on scientific evidence for patients by improving their mental and physical health and well-being and alleviating pain. The relationship underwent deep changes as a result of momentous milestones such as the Universal Declaration of Human Rights (1948), the WMA declarations of [Geneva](#) (1948), [Helsinki](#) (1964), and the [Lisbon](#) (1981). The relationship has slowly progressed towards the empowerment of the patient.

Today, the patient-physician relationship is frequently under threat from influences both within and outside health care systems. In some countries and health care systems, these influences risk alienating physicians from their patients and potentially harming patients. Amongst those challenges likely to undermine the therapeutic efficacy of the relationship, we note a growing trend to:

- A technologization of medicine, sometimes leading to a mechanistic view of health care, neglecting human considerations;
- The dilution of trustworthy relationships between people in our societies, which negatively influences healthcare relationships;
- A primary focus on economic aspects of medical care to the detriment of other factors, posing sometimes difficulties to establish genuine relationships of trust between the physician and the patient.

It is of the utmost importance that the patient-physician relationship addresses these factors of influence in such a way that the relationship is enriched, and that its specificity is warranted. The relationship should never be subject to undue administrative, economic, or political interferences.

### Recommendations

Reiterating its [Declaration of Geneva](#), the [International Code of Medical Ethics](#) and its [Lisbon Declaration on Patient Rights](#) and given the vital importance of the relationship between physician and patient in history and in the current and future context of medicine, the WMA and its Constituent Members:

1. Reaffirm that professional autonomy and clinical independence are essential components of high-quality medical care and medical professionalism, protecting the right of the patients to receive the health care they need.
2. Urge all actors involved in the regulation of the patient-physician relationship (governments and health authorities, medical associations, physicians, and patients) to defend, protect and strengthen the patient-physician relationship, based on high-quality care, as a scientific, health, cultural and social heritage.
3. Call on Constituent Members and individual physicians to preserve this relationship as the fundamental core of any medical action centred on a person, to defend the medical profession and its ethical values, including compassion, competence, mutual respect, and professional autonomy, and to support patient-centred care.
4. Reaffirm its opposition to interference from governments, other agents and institutional administrations in the practice of medicine and in the Patient-physician
5. Reaffirm its dedication to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.

6. Commit to address emerging factors which could pose a threat to the patient-physician relationship and to take action to mitigate against those factors.

## WMA Declaration of Oslo on Social Determinants of Health

*Adopted by the 62<sup>nd</sup> WMA General Assembly, Montevideo, Uruguay, October 2011, the title (Statement to Declaration) changed by the 66<sup>th</sup> WMA General Assembly, Moscow, Russia, October 2015, Amended by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

The social determinants of health are the conditions in which people are born, grow, are educated, live, work and age; and the societal influences on these conditions. The social determinants of health are major influences on both quality of life, including good health, and length of disability-free life expectancy. Social determinants of health also include the impact of racism and discrimination, not just from an individualized or interpersonal perspective, but from structural and institutional perspectives.

While health care aims to cure and restore health, it is these social, cultural, environmental, economic and other factors that are the major causes of rates of illness and, in particular, the magnitude of health inequities.

Achieving health equity for all requires strong commitment from governments, the health care sector, health professionals and the international community among others. The UN Sustainable Development Goals (SDG)\* specifically aims to ensure healthy lives and promote well-being for all at all ages (goal 3), to ensure inclusive and equitable education and promote lifelong learning opportunities for all (goal 4) and to reduce inequality within and among countries (goal 10). In the *WMA Statement on Access to Health Care*, the WMA stresses the importance of health care access for all and suggests ways to act on inadequate access and health inequalities. The WMA further supports and promotes the introduction of adequate Universal Health Coverage in all countries. Universal Health Coverage will improve access to appropriate health care for all and thus promote awareness of and action on the social determinants of health.

\* <https://www.un.org/sustainabledevelopment/sustainable-development-goals/>

Historically, the primary role of physicians and other health care professionals has been to treat the sick – a vital and much cherished role in all societies. To a lesser extent, health care professionals have dealt with individual exposures to the causes of disease – smoking, obesity, and alcohol in chronic disease, for example. These familiar aspects of lifestyle can be thought of as ‘proximate’ causes of disease.

The work on social determinants goes far beyond this focus on proximate causes and considers the “causes of the causes”. For example, smoking, obesity, alcohol, sedentary lifestyle are all causes of illness. A social determinants approach addresses the causes of these causes; and in particular how they contribute to social inequities in health. This approach focuses not only on individual behaviors but seeks to address the social and economic circumstances that give rise to premature poor health, throughout the life course. The voice of the medical profession has been and continues to be important in tackling these causes of the causes.

In many societies, unhealthy behaviors follow the social gradient: the lower in the socioeconomic hierarchy, the higher the rate of smoking, the worse the diet, and the less the physical activity. Central to the issue of addressing social determinants of health is the close interrelation between poverty and illness. A major, but not the only, cause of the social distribution of these causes is level of education. Structural inequity can also make access to healthy food difficult.

Specific examples of addressing the causes of the causes are: regulating the price and availability of alcohol, which are key drivers of alcohol consumption; and promoting tobacco taxation, package labeling, bans on advertising and smoking in public places, all of which have had demonstrable effects on tobacco consumption.

There is a growing movement globally that seeks to address gross inequities in health and length of life through action on the social determinants of health. This movement has involved the World Health Organization, several national governments, civil society organizations, and academics. Solutions are being sought and knowledge shared. Physicians need to be well informed about the implications of perpetuating inequalities and be willing to participate in this debate. They can be advocates for action on social conditions that have important effects on health and for strengthening of primary care and public health institutions. The medical profession can contribute significantly to public health, including through working with other sectors to find innovative solutions.

### Recommendations

1. The WMA and National Medical Associations should take an active role in combating social and health inequities and barriers to obtaining health care, striving to enable physicians to provide

equal, high quality health care to all. Adequate Universal Health Coverage in all countries should be a core objective as it will help reduce health inequity.

2. The WMA can add significant value to the global efforts to address the social determinants of health by helping physicians, other health professionals and National Medical Associations to understand what the emerging evidence shows and what works in different circumstances. WMA can call on physicians to lobby more effectively within their countries and across international borders and ensure that medical knowledge and skills are shared.
3. The WMA should help to gather data on successful initiatives and help to engage physicians and other health professionals in sharing experiences and implementing new and innovative solutions.
4. The WMA should work with National Medical Associations to promote education to medical students and physicians on health inequity and the social determinants of health, and to put pressure on national governments and international bodies to take the appropriate steps to minimise health inequity and these root causes of premature poor health.
5. The WMA and National Medical Associations should encourage governments and international bodies to take action on and implement specific policies and tools addressing health inequity and the social determinants of health. Some governments have taken initial steps to reduce health inequity by taking action on the social determinants of health; local areas have drawn up plans of action; there are good examples of general practice that work across sectors improving the quality of people's lives and hence reduce health inequity. The WMA should gather examples of good practice from its members and promote further work in this area.

## WMA Declaration of Ottawa on Child Health

*Adopted by the 50<sup>th</sup> World Medical Assembly, Ottawa, Canada, October 1998, Amended by the 60<sup>th</sup> WMA General Assembly, New Delhi, India, October 2009 And by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

Science has now proven that to reach their potential, children need to grow up in an environment where they can thrive – spiritually, emotionally, mentally, physically and intellectually. That place must be characterized by four fundamental elements:

- A healthy, safe and sustainable physical and emotional environment.
- the opportunity for optimal growth and development;
- adequate health services for healthy child development; and
- monitoring and research for evidence-based continual improvement into the future

Physicians know that the future of our world depends on our children. Early childhood experiences strongly influence future development, including basic learning, school success, economic participation, social citizenry, and health. In most situations, parents and caregivers are only able to provide nurturing environments with help from local, regional, national and international organizations.

The principles of this Declaration apply to all children in the world from birth to 18 years of age, regardless of race, age, ethnicity, nationality, political affiliation, creed, language, gender, sex, disease or disability, physical ability, mental ability, sexual orientation, cultural history, life experience or the socioeconomic status of the child or her/his parents or legal guardian. In all countries of the world, regardless of resources, meeting these principles should be a priority for parents, communities and governments. The United Nations Convention on the Rights of Children (1989) and National Children's rights Charters, set out the broader rights of all children and young people, but those rights cannot exist without health. Furthermore, the United Nations Sustainable and Development Goals, especially SDG3, SDG4, SDG5, and SDG6, apply directly to the health of children and the social determinants of health. Responsibility for giving effect to the principles herein lies with the government of the region where the child is primarily domiciled.

All children should be treated with dignity, tolerance and respect and be taught the same.

All children have the right to the highest attainable standard of physical and mental health and wellbeing.

Addressing the social determinants of health is essential to achieving equity in health and healthcare in children.

While children are generally regarded as the vulnerable groups, the most vulnerable groups of children include children with special needs, orphans, the homeless, refugees and asylum seekers, disabled, children from low-income homes and conflict zones. These groups require special consideration in all areas.

### 1. A healthy, safe and sustainable physical and emotional environment comprises the following elements:

- A safe and sustainable physical environment with minimum climate change, optimum ecosystem free from water, air and soil pollution and degradation;

- Urgent implementation of climate change adaptation and mitigation strategies, and age-appropriate education on climate change to achieve a better and more sustainable environment for all children;
- A safe home, a family setting, available parental care and a community that cares;
- Healthy, safe and stable families, homes, schools and communities;
- Protection from bullying and an environment that promotes positive mental health;
- Protection from discrimination based on age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor;
- Access to a safe infrastructure, including safe sanitation, transportation, and places to play;
- Protection from natural and man-made disasters;
- Protection from physical, sexual, emotional and verbal abuse and neglect;
- Prevention of exploitation in the form of child labour;
- Protection from harmful traditional practices;
- Freedom from witnessing and participating in violence and armed conflict including forced recruitment as child soldiers or into gangs;
- Protection from the harms associated with alcohol, tobacco and substance abuse, including the right to age-appropriate information.

All infants should be officially registered within one month of birth or as soon as possible to enable them to have an official identity, access to health care, social security and any other resources where identification is mandatory.

Asylum seeking children, whether accompanied or unaccompanied, should not be detained, separated from the parents and families sent back to a place where they are at risk of human rights violations.

## 2. The opportunity for optimal growth and development entails:

- Access to adequate healthy and nutritious food to promote long-term health development. This includes the promotion of exclusive breastfeeding, where possible, for the first six months of life as long as the mother and baby are comfortable, access to adequate safe food that satisfies dietary diversity, and protection from obesogenic environments through regulation of unhealthy and processed food and beverages;
- Promotion and encouragement of nutritional literacy, physical activity and physical education from an early age;
- Access to education from early childhood through secondary education with provisions for those without access;
- Access to age-appropriate information as it pertains to health, including the provision of evidence-based comprehensive sexuality education;
- Access to social assistance.

## 3. Access to the full range or appropriate and high-quality healthcare services for all stages of childhood development entails:

The best interests of the child shall be the primary consideration in the provision of health care. The following principles of child health care must be ensured:

- Appropriate preventive, curative, rehabilitative and emergency care for mother and child;
- Prenatal and maternal care for the best possible health at birth and good postnatal care to ensure the best possible outcomes for mother and child;
- Respect for the privacy of children;
- Medical care for all children of asylum seekers and refugees;
- Specialized training necessary to enable caregivers to respond appropriately to the specific medical, physical, emotional and developmental needs of children & their families;
- Basic health care including developmental assessment, health promotion, recommended immunization, early detection of disease, access to medicines, oral and eye-health;
- Multidisciplinary (i.e. consisting of physicians, social workers, psychologists, therapists, occupational therapists, education specialists and others) and community-based mental health prevention, care and prompt referral for intervention when problems are identified;
- Priority access to emergency medical care for life-threatening conditions;
- Hospitalization when appropriate. Hospitals should provide access to parental facilities and policies for continuous parental care;
- Specialist diagnosis, care and treatment when needed;
- Rehabilitation services and supports within the community;
- Pain management and care and prevention (or minimization) of suffering;
- End of life care/Palliative care;
- Informed consent is necessary before initiating any diagnostic, therapeutic, rehabilitative, or research procedure on a child. In the majority of cases, the consent shall be obtained from the parent(s) or legal guardian, or, in some cases, by extended family, although the wishes of a competent child should be taken into account before consent is given. Where a child lacks competence and is able to express a view, his/her wishes should still be taken into account before consent is given. Where appropriate (e.g. reproductive health services), competent children should be allowed to consent to treatment without parental consent. In case of a life-threatening, and when competent children cannot give consent and parents/caregivers are not accessible, for treatment, consent should be presumed for life-saving treatment;
- The full range of sexual and reproductive health services for adolescents including access to abortion according to national legislation;

- Respect for the sexual and gender identity of the child. Harmful practices like genital mutilation or so-called conversion therapies must be forbidden;
- Social assistance and mechanisms to provide for universal access to health care are ensured for all particularly vulnerable children;
- The homeless, orphaned, asylum seeker, refugees and children from conflict zones should be provided with essential and emergency medical care without discrimination.

#### 4. Monitoring & and research for evidence-based continual improvement into the future includes:

- The principles of the Declaration of Helsinki must be observed in any research study involving children as research subjects.

## WMA Declaration on Pseudoscience and Pseudotherapies in the Field of Health

*Adopted by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Definitions

- “Pseudoscience” (false science) refers to the set of statements, assumptions, methods, beliefs or practices that, without following a valid and recognised scientific method, are falsely presented as scientific or evidence-based.
- “Pseudotherapies” (false therapies) are those practices intended for curing diseases, alleviating symptoms or improving health with procedures, techniques, products or substances based on criteria without the support of available up-to-date scientific evidence; and which may have significant potential risks and harms.

### Preamble

Medical practice must be based on the best available up-to-date scientifically proven evidence. The differences between conventional medicine and other practices that are not supported by scientific evidence make up the complex universe of pseudosciences and pseudotherapies.

Pseudosciences and pseudotherapies represent a complex system of theories, assumptions, assertions and methods erroneously re-

garded as scientific, they may cause some patients to perceive a cause-and-effect relationship between pseudotherapies and the perception of improvement, hence they may be very dangerous and are unethical.

There are therapies and techniques accepted by the scientific community that, used in a complementary manner (such as nutritional, comfort or wellness, environmental and relaxation therapies, psychotherapeutic support or reinforcement, affectivity and the use of placebos), provide benefits to the validated main and effective medical therapy.

Many countries lack the regulatory framework to address these pseudotherapies, which has allowed their proliferation. In the past, the medical profession considered them to be harmless due to their perceived lack of side effects, but nowadays there is enough evidence to suggest that they can pose a risk to patient safety.

Pseudoscience and Pseudotherapies may have significant potential risks and harms for various reasons:

- There is a risk that patients abandon effective proved-to-be effective medical treatments or prevention measures in favour of practices that have not demonstrated therapeutic value, sometimes leading to treatment failure for critical conditions that may even lead to death.
- There are frequent likelihood of dangerous delays and loss of opportunity in the application of medicines, procedures and techniques recognised and endorsed by the scientific medical community as evidence-based effective interventions.
- They may cause patients to suffer financial damages psychological-physical traumas, and go against the dignity of people, threatening their moral integrity.
- Unproven therapies may contribute to the rising costs of health-care procedures.

All new diagnostic, preventive and therapeutic methods should be tested in accordance with scientific methods and ethical principles in order to assess their safety, efficiency, efficacy and scope of application.

A physician's duty is to provide quality medical care to all patients based on best available scientific evidence, as referred in the [WMA Declaration of Geneva](#) and the [International Code of Medical Ethics](#) commending the highest ethical norms and quality care for the safety of the patient. The interest of the patient must be placed before any other interest, including the physician's own.

The WMA reaffirms its [Lisbon Declaration on Patient Rights](#) and recalls that Patient Safety requires addressing all opportunities for the patient to receive appropriate, evidence-based care.



## Recommendations

Thus, the WMA makes the following recommendations:

### *National Health Authorities*

1. Appropriate and rigorous regulation commensurate with best practices is necessary to address the risks and reduce the potential harms arising from pseudotherapies and pseudoscience.
2. National authorities and healthcare systems should decline approval of and reimbursement of costs providing pseudotherapies.
3. In collaboration with professional medical organisations, scientific societies and patients' associations, national authorities should develop public campaign raising awareness on the risk of pseudotherapies and pseudosciences.

### *WMA Constituent members and the medical profession*

4. WMA constituent members and the medical profession must recognize and be aware of the risks of pseudotherapies and pseudosciences.
5. Pseudotherapies and pseudosciences should not be regarded as medical specialties recognized by the scientific community and legally endorsed as a specialist or sub-specialist pseudoscience.
6. All acts of professional intrusion, pseudoscience and pseudotherapy activities that put public health at risk must be reported to the competent authorities, including misleading advertising and unaccredited healthcare websites that offer services and/or products and that put the health of patients at risk, yet patient confidentiality has to be respected. The role of the general and specialized media for transparency and truthfulness in increasing critical public scientific awareness is essential.
7. Constituent members should work with governments to establish the highest level of protection for patients treated with pseudotherapies/pseudosciences. When such a practice is found to be harmful or unethical to apply, there should be a system in place to either immediately stop or substantially restrict any given treatment classified as complementary and/or alternative in order to protect public health.

### *Physicians*

8. With the support of the relevant organisations and authorities involved in the governance and regulation of the medical profession, physicians must continue to practice medicine as a service based on the application of critical scientific current knowledge, specialist skills and ethical behaviour and to maintain their skills up to date on developments in their professional field.
9. For the patient's safety and quality of care, the physician must have the freedom to prescribe, while respecting scientific evidence and the standard of care.

10. The patient must be kept duly informed about the available therapy options, their effectiveness and risks, and be able to participate in the best therapeutic decision-making. Good communication, mutual trust and person-centered healthcare are cornerstones of the physician-patient relationship. Patients and physicians should and must be able to discuss the risks of pseudoscience and pseudotherapies. Health education is fundamental.
11. Physicians should be educated to identify pseudoscience/pseudotherapies, logical fallacies, and cognitive biases and counsel their patients accordingly. They should be aware 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 using pseudotherapies.
12. When obtaining the patient's history (anamnesis), the physician should inquire about all therapeutic measures (proven or otherwise) the patient has been exposed or is still exposed to. If necessary, the physician should inform the patient on potential harms associated with the previous use of Pseudotherapies and pseudosciences.
13. The physician must inform the patient that complementary treatment is not a therapeutic alternative or substitute for a validated main medical treatment.

*Note: The aim of this declaration is not the traditional ancestral medicines nor the so-called indigenous medicines, firmly rooted in peoples and nations, forming an intrinsic part of their culture, rites, traditions and history.*

## WMA Resolution in Support of an International Day of the Medical Profession, October 30

*Adopted by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

On the eve of the WMA General Assembly, Córdoba 2020, we are facing an escalation of the COVID-19 pandemic around the world and an alarming exponential pressure on healthcare professionals.

The WMA and its members request that October 30 be recognised as the International Day of the Medical Profession as a tribute to the commitment of physicians to the service of humankind, to the health and well-being of their patients, in the respect the ethical values of the profession.

## WMA Resolution in Support of Dr. Serdar Küni

*Adopted by the 206<sup>th</sup> WMA Council Session, Livingstone, April 2017 and reaffirmed as a Resolution by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

The World Medical Association notes with serious concerns that Dr Serdar Küni, the Human Rights Foundation of Turkey's representative in Cizre and former president of the Şırnak medical chamber, is still imprisoned after 6 months of detention, on charges that he provided medical treatment to alleged members of Kurdish armed groups.

The case of Dr. Küni is one example amongst many of ongoing arrests, detentions, and dismissals of physicians and other health professionals in Turkey since July 2015, when unrest broke out in the southeast.

The WMA condemns such practices that threaten gravely the safety of physicians and the provision of health-care services. The protection of health professionals is fundamental, so that they can fulfil their duties to provide care for those in need, without regard to any element of identity, affiliation, or political opinion.

The WMA recalls the standards of international human rights law, specifically the Universal Declaration of Human Rights (1948) and the International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights (1966) ratified by Turkey. The Covenant on Economic, Social and Cultural Rights guarantees in its article 12 "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". This implies ensuring access to high quality healthcare, supported by a functioning healthcare system and safe conditions for the health workforce.

The WMA recalls as well the standards of international humanitarian law as well as the [UN Security Council Resolution S/RES/2286 on Health Care in Armed Conflict](#) that mandates that states should not punish medical personnel for carrying out medical activities compatible with medical ethics, or compel them to undertake actions that contravene these standards.

Furthermore, the WMA reaffirms the principles of medical ethics, including the [WMA Regulations in Times of Armed Conflict and Other Situations of Violence](#) as well as the [Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies](#) endorsed by the ICRC, civilian and military health-care organisations.

The WMA considers that punishing a physician for providing care to a patient constitutes a flagrant breach of international humanitarian and human rights standards as well as medical ethics. Ultimately it contravenes to the principle of humanity that includes the imperative to preserve human dignity.

Thus, in view of the next hearing on 24 April regarding Dr. Küni case at the Şırnak 2<sup>nd</sup> Heavy Penal Court, the WMA urges national medical associations and the international health community to mobilise in support of the immediate release of Dr. Serdar Küni and the charges based on his medical practice be dropped immediately and unconditionally.

The WMA calls as well national medical associations and the international health community to advocate for:

- The full respect of Turkey's humanitarian and human rights obligations, including the right to health, freedom of association and expression as well as the access to a fair trial;
- The provision of effective remedy and reparation to victims of arbitrary arrests and detentions.

## WMA Resolution in Support to the Turkish Medical Association

*Adopted by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

The WMA and its members are deeply concerned by the recent Turkish governmental announcement to dismantle the Turkish Medical Association as a national professional organisation, allegedly to "protect patients and the profession from terrorists".

The Turkish Medical Association is a dedicated member of the WMA, recognised for its commitment to serve public health interests, to protect patients and physicians with respect of the ethical values of the profession.

The WMA considers that qualifying the thousand physicians' members of the Turkish Medical Association as terrorists constitutes a grave defamation and an insult to the entire profession.

Recalling its [Resolution on the Independence of National Medical Associations](#), the WMA opposes such governmental interference with the independent functioning of a national medical association and

urges the government of Turkey and the members of the parliament to:

1. Protect the establishment of the Turkish Medical Association as a national independent association and main representative of all physicians in the country, and prevent any legal regulation that will harm its professional autonomy;
2. Respect the universal professional values of medicine, which were built upon thousands of years of experience and aim to prioritise patient and public health;
3. Comply fully with international human rights instruments that Turkey is a State Party to.

## WMA Resolution on Equitable Global Distribution of Covid-19 Vaccine

*Adopted by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

The SARS-CoV-2 pandemic has a tight grip on the world. Over a million people have died worldwide and millions more are still suffering the effects of this virus and the disease it causes.

A vaccine is widely seen as the best way to stop the spread of the virus, gain control of the pandemic and save human lives.

WMA policy clearly states that “vaccination and immunisation have been acknowledged as an effective and safe preventive strategy for several communicable diseases. And vaccine development and administration have been the most significant intervention to eradicate infectious diseases and influence global health in modern times”.

While there are currently no approved vaccines for COVID-19, an unprecedented global effort is underway, both in terms of scale and speed, to develop a safe and effective vaccine and to optimise procurement and distribution to ensure that all regions of the world stand to benefit as quickly as possible. Some current predictions anticipate an initial COVID-19 vaccine rollout in the first half of 2021. Due to intensive efforts to produce effective vaccines and fast track them for market authorisation, many clinical trials have been placed on extremely accelerated schedules. Processes usually requiring years are being condensed into months, which could potentially

pose a threat to the ethical principles outlined in the WMA Declaration of Helsinki.

Questions arose quite early in the pandemic about how to distribute a potential new vaccine quickly and equitably. Many higher-income countries have already signed bilateral agreements with pharmaceutical companies to supply or distribute COVID-19 vaccine candidates, which, given the limitations on production capacity, could leave developing countries at a disadvantage as they strive to protect their populations.

It is a fact that a pandemic cannot be contained by one country alone; it requires a collaborative, global effort, as the WMA has outlined in its Statement on Epidemics and Pandemics and the Statement on Avian and Pandemic Influenza.

In the same spirit, GAVI, the Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations (CEPI) and the World Health Organization (WHO) have initiated the COVAX platform in order to guarantee that all participating countries, regardless of their income, have equal access to new COVID-19 vaccines once they are developed.

### Recommendations

The World Medical Association

1. welcomes multilateral solutions in the global battle against COVID-19, in particular the COVAX platform, for ensuring equitable, global distribution of a safe and effective COVID-19 vaccine;
2. emphasises that no country should be left behind in the race to vaccinate its population against this global threat;
3. stresses the need to balance between the desire of each country to protect its citizens and the need for the vaccine to be distributed worldwide;
4. reiterates that all clinical trials must follow the ethical principles for medical research involving human subjects as set forth in the WMA Declaration of Helsinki;
5. states that longer-term, formal safety monitoring is necessary in cases where clinical trials have been accelerated to fast track vaccines for market authorisation;
6. calls attention to the heightened risk faced by health workers and vulnerable populations in a pandemic situation and therefore urges that these individuals be among the first to receive a safe and effective vaccine;
7. renews its call to all constituent members to increase awareness of immunisation schedules and calls upon individual physicians to pay special attention to addressing the concerns of vaccine-hesitant patients;

8. reaffirms its warning on vaccine hesitancy (April 2019) and reiterates the importance of maintaining other important routine vaccinations, e.g. against polio, measles and influenza;
9. calls for coordinated efforts to increase public trust in vaccination in the face of disinformation campaigns and anti-vaccine movements which undermine the health of both children and adults.

## WMA Resolution on Human Rights Violations Against Uighur People in China

*Adopted by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

It is incumbent upon health professionals to consider the health and human rights of people globally and denounce instances where these rights are being abused. The treatment of the Uighur people in the Xinjiang region of China is one such case.

Documented reports of physical and sexual abuse of Uighur people in China reveal unequivocal human rights violations. Reports note numerous violations of the Universal Declaration of Human Rights. The transgressions include, but are not limited to:

- Article 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
- Article 9: No one shall be subjected to arbitrary arrest, detention or exile.
- Article 25 (i): Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.\*

Human rights organisations and sovereign states are increasingly drawing attention to the situation in Xinjiang, with over 20 United Nations ambassadors taking the rare step of issuing a [joint letter](#) to the UN Human Rights Council in 2019 expressing concerns about the treatment of the Uighurs in China and demanding that international independent observers be allowed into the region.

\* <https://www.un.org/en/universal-declaration-human-rights/>

### Recommendations

In the light of information and reports of systematic and repeated human rights violations against Uighur people in China, and its impact on the health of the Uighur people and health care supplies throughout the world, the WMA calls on its constituent members, physicians and the international health community to:

1. formally condemn the treatment of the Uighurs in China's Xinjiang region and call upon physicians to uphold the guidelines set out in the [WMA Declaration of Tokyo](#) and [the WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment](#);
2. support the requests made in the July 2019 letter to the UN Human Rights Council High Commissioner calling for international independent observers to be allowed into the Xinjiang region of China.
3. Reaffirm its [Statement on Forced and Coerced Sterilisation](#), asserting that no person, regardless of gender, ethnicity, socio-economic status, medical condition or disability, should be subjected to forced or coerced permanent sterilisation, and call on its members medical associations to advocate against forced and coerced sterilisation in their own countries and globally; and
4. Reiterate support of its [Declaration on Fair Trade in Medical Products and Devices](#) and urge its medical association members to promote fair and ethical trade in the health sector, and insist that the goods they use are not produced at the expense of the health of workers in the global community. To do this, physicians should;
  - raise awareness of the issue of ethical trade and promote the development of fair and ethically produced medical goods amongst colleagues and those working within health systems.
  - play a leadership role in integrating considerations of labour standards into purchasing decisions within healthcare organisations.

## WMA Resolution on Protecting the Future Generation's Right to Live in a Healthy Environment

*Adopted by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

Exponential increase in the number of climate change related fires, hurricanes, ice meltdowns, heat waves and deforestation, especially of the rainforests, show that there is no time to waste. There is an urgent need to accelerate the efforts that will trigger the changes to be implemented by international and national policy and decision makers in order to stop as well as to adapt to the climate crisis.

Climate change and air pollution are closely connected, both have huge impacts on human health and result from anthropogenic emissions due to the combustion of fossil fuels. As it is mentioned by international bodies such as Clean Air Initiative founded by the UN, the World Health Organization (WHO), the UN Environment Programme (UNEP) and the Climate and Clean Air Coalition (CCAC); all governments, researchers and non-governmental organisations should urgently start to tackle the air pollution and climate crisis together.

Considering the urgency and complexity of climate change, it is needed to create a global change to stop the causes of this crisis. Therefore, WMA calls on international, national, regional or provincial decision makers such as politicians, policy makers and judges to recognize the urgency, complexity, and interconnectedness of the essence of the climate crisis action and to take immediate action in order to protect the rights of future generations for the sake of climate justice.

Climate crisis causes a serious loss, damage or destruction of ecosystems and cultural damage, which has severe impacts on all inhabitants of the world. In order to ensure the right to live for the future generations, there is an imminent need for binding legal measures to be adopted and implemented at the national and international arena against the polluters causing emissions that cause especially climate crisis as well as air, water and soil pollution.

Health professionals have a duty to care, respect and protect the human life, as well as the right to live for future generations and all forms of the natural living world. WMA believes that all people,

including future generations, have the right to the environmental, economic and social resources needed for healthy and productive lives; such as clean air, soil, water and food security. Therefore; WMA has a historical responsibility of acting proactively in order to initiate the necessary changes and solutions to struggle with the climate crisis.

### Recommendations

WMA proposes the following recommendations to its members and other related organizations:

1. Urge to ask its members to collaborate with relevant bodies in their countries in order to raise awareness about the necessity for legally binding sanctions and policies at the national and international level for the polluters that threaten the right to live for the future generations by emitting gases which are proven to cause climate crisis and air, soil and water pollution.
2. Urge all national governments, policy makers, researchers and health professionals to mobilize in order to develop and implement comprehensive policies to struggle with the problems due to the use of fossil fuels by industry as well as the individuals that lead to problems such as climate crisis air, water and soil pollution.
3. Urge all medical professionals, media, governmental and non – governmental institutions to refer climate change as 'climate crisis' and calls the leaders of national, state or provincial, regional, city, and local governments to declare a climate emergency in order to initiate a society-wide action. Moreover, encourage the media to promote the concept and meaning of the right to live for future generations.
4. Update the curriculum at medical schools and add compulsory sections on environmental health in order to educate health professionals that are able to think critically about the health impacts of the environmental problems, are aware of the reasons, impacts/dimensions of the climate crisis and able to offer solutions designed to protect the rights and health of future generations.
5. Advocate and organize interdisciplinary campaigns in order to stop the new permissions from being given to the industrial facilities using fossil fuels that cause climate crisis and pollution.
6. Urge national governments and international bodies such as WHO to adopt stricter regulations on environmental protection and evaluation, permission, monitoring and control procedures of new industrial facilities to limit the health impact resulting from their emissions.
7. Advocate actively for policies that will maximize health benefits by reducing air pollutants (such as ground ozone and particulate matter etc.) and carbon emissions, increase walking, cycling, and use of public transport, and consumption of nutritious, plant-rich diets to ensure climate justice. Urge international, national,



state or provincial, regional, city, and local governments to adopt and implement air quality and climate change policies that will achieve the WHO Ambient Air Quality Guideline values.

8. Urge national, state or provincial, regional, city, and local governments through public campaigns and advocacy to cut subsidies given to fossil fuel industries and to direct these subsidies to support just transition, energy efficiency measures, green energy resources and public welfare.
9. Urge governments and private sector to invest in policies that support a just transition for workers and communities adversely impacted by the move to a low-carbon economy and to build social protection through investment in and transition to green jobs.
10. Urge national, state or provincial, regional, city, and local governments to act on other causes of climate crisis such as industrial agriculture, animal husbandry and deforestation, to promote legal trade and financing policies that prioritize and enable sustainable agro-ecological practices, end deforestation for the expansion of industrial agriculture and to reduce reliance on industrial animal-based agriculture and environmentally damaging agricultural and fisheries practices.
11. Urge national, state or provincial, regional, city, and local governments to invest in human capacity and knowledge infrastructure to spread regenerative agriculture solutions that can produce the change needed while providing myriad co-benefits to farmers and consumers, providing a global support network – on the ground – for farmers and capturing carbon in the soil. Emphasize building resilient and regenerative local food systems that can reduce carbon emissions, support the livelihoods of agricultural communities and provide food security for future generations.
12. Urge national governments, together with the involvement of health sector, to develop national adaptation plans and to conduct national assessments of climate crisis impacts, vulnerability, and adaptation for health.

## WMA Resolution on the Access to Adequate Pain Treatment

*Adopted by the 62<sup>nd</sup> WMA General Assembly, Montevideo, Uruguay, October 2011 And amended by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

Around the world, tens of millions of people with cancer and other diseases and conditions experience moderate to severe pain

without access to adequate treatment. These people face severe suffering, often for months on end, and many eventually die in pain. Those who may not be able to adequately express their pain – such as children, people with intellectual disabilities and those with altered consciousness– and individuals and populations that have historically been undertreated for pain and pain management due to bias, are especially at risk of receiving inadequate pain treatment.

Inadequate pain treatment contributes to individual suffering physically and emotionally, but also causes huge care burdens and negative economic impact on a national level.

However, most of the suffering is unnecessary and is almost always preventable and treatable.

In most cases, pain can be stopped or relieved with inexpensive and relatively simple treatment interventions, which can dramatically improve the quality of life for patients. Sometimes, especially in severe chronic pain, psycho-emotional factors are even more significant than physiologic factors.

Pain treatment in these cases may require a multi-faceted approach to care by multidisciplinary teams.

Over the years, the use of opioids has seen significant growth in some countries. In many other areas around the world, however, access to essential pain treatment remains limited for patients in pain. Even in countries with a high volume of use, it can be difficult for specific populations to receive adequate treatment for their pain. Incomplete pain assessment or improper use of pain medication can bring about adverse drug reactions. All of these are very important and urgent issues need to be addressed.

Governments should adopt effective measures, wherever possible, for adequate pain treatment. For this goal, governments shall ensure that healthcare professionals across fields are entitled to educational training on pain evaluation and management; that the right of all patients in pain to pain treatment is not compromised due to unnecessary regulations; and that policies on the management of controlled drugs help with effective monitoring of and prevention against risks associated with controlled drugs.

### Recommendations

1. Access to adequate pain treatment is a human right. Physicians, medical professionals and health care workers must offer pain assessment and pain treatment to patients with pain. Governments must provide sufficient resources and proper pain treatment regulations.

2. Pain is a complex perception consisting of physical, psychological, social, cultural and spiritual sufferings. Physicians, medical professionals and health care workers must offer holistic pain assessment and appropriate pain treatment, such as pharmacological and/or non-pharmacological interventions to patients with pain. All healthcare professionals should seek to fulfill the goal of effectively evaluating the pain of all patients, including pain suffered by children, cognitively impaired patients and those unable to properly express themselves. Healthcare professionals should also seek to effectively evaluate and treat pain in patients and populations who have historically been undertreated for pain due to implicit and explicit biases.
3. Pain treatment and control education shall be provided to healthcare professionals including physicians, other medical professionals, and other health care workers.

Education should include pain assessment, evidence-based pain control, and the efficacy and risks of painkillers. Education should include pain medicine, including the action of opioids, preventing adverse reactions, and the adjustment and conversion of the dosage of opioids. Patient-centered care should be taught to fulfill the goal of adequately stopping pain and reducing the incidence of adverse reactions. The curriculum shall be highly competence-based in design enhancing the knowledge, the attitude, and the skills of healthcare professionals while treating pain.

Education should support the development of pain and palliative specialists, in order for them to effectively support first-line physicians and other medical professionals.

Pain treatment education for medical professionals shall include the non-medicinal treatment options. Education should equip medical professionals with proper interpersonal communication skills, cultural sensitivity, and the ability to evaluate the overall pain suffered by patients at the physiological, psychological, and spiritual levels and to empower them in inter-professional practice so that professionals can work together to alleviate the pain felt by patients with and without medication.

4. Governments, regulators and healthcare administrators must acknowledge the consequences of pain in terms of health, productivity, and economic burden. Governments should provide ample resources and have suitable regulations governing controlled drugs.

For policies on the control of drugs, governments shall periodically review and adequately revise them to ensure the availability and accessibility of controlled drugs such as opioids. In addition, abuse and illicit use must be prevented.

- Patients in pain shall be given access to effective pain medication, including opioids. Depriving them of such right is a violation of their right to health and is medically unethical.

- Governments must ensure that controlled drugs, including opioids, are made available and accessible to help relieve the suffering. Relief of suffering and prevention against abuse shall be balanced in the management of controlled drugs.

Government shall provide abundant resources and create a national pain management research institute to explore issues in pain treatment and to come up with solutions, in particular:

- Explore issues that become barriers to pain treatment, such as financial condition, socioeconomic status, patient race and ethnicity, urban and rural differences, logistics, insufficient training, and culture (the misunderstanding that people have about opioids, for example)
- Promote the use of validated pain assessment tools.
- Conduct studies of emerging therapies or non-medicinal therapies.
- Establish a system and a standard procedure to record and collect pain-related data for correct statistics and monitoring. Pain-related data includes the incidence and prevalence of pain, cause of pain, burden of pain, pain treatment status, reason for pain not properly treated, and number of people with drug abuse, etc.
- 5. Governments shall prepare a national pain treatment plan to be followed in pain prevention, pain treatment, pain education, and policies on the management of controlled drugs.
  - The national pain treatment plan shall be evidence-based.
  - Governments must take into consideration opinions of policymakers, medical professionals, and the general public in order to prepare a national pain treatment plan that is extensive, practical, and forward-looking, contributing to enhanced nationwide pain treatment efficacy.

## WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment

*Adopted by the 54<sup>th</sup> WMA General Assembly, Helsinki, Finland, September 2003, revised by the 58<sup>th</sup> WMA General Assembly, Copenhagen, Denmark, October 2007 and by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

## Preamble

The dignity and value of every human being are acknowledged globally and expressed in numerous distinguished ethical codes and codifications of human rights, including the Universal Declaration of Human Rights. Any act of torture or cruel, inhuman or degrading treatment constitutes a violation of these codes and is irreconcilable with the ethical principles that lie at their core. These codes are listed at the end of this Statement (1).

However, in the medical professional codes and legal texts, there is no consistent and explicit reference to an obligation upon physicians to document cases and denounce acts of torture or cruel, inhuman or degrading treatment of which they become aware or witness.

The careful and consistent documentation and denunciation of torture or cruel, inhuman or degrading treatment by physicians contributes to the human rights of the victims and to the protection of their physical and mental integrity. The absence of documentation and denunciation of these acts may be considered as a form of tolerance thereof.

Because of the psychological sequelae from which they suffer, or the pressures brought upon them, victims are often unable or unwilling to formulate by themselves complaints against those responsible for the torture or cruel, inhuman and degrading treatment and punishments they have undergone.

By ascertaining the sequelae and treating the victims of torture, either early or late after the event, physicians witness the effects of these violations of human rights.

The WMA recognizes that in some circumstances, documenting and denouncing acts of torture may put the physician, and those close to him or her, at great risk. Consequently, doing so may have excessive personal consequences.

This statement relates to torture and other cruel, inhuman and degrading treatment and punishments as referred by the United Nations Convention against torture, excluding purposely the role of physicians in detention appraisal addressed in particular by the [UN Standard Minimum Rules for the Treatment of Prisoners](#) (Mandela rules).

## Recommendations

The WMA recommends that its constituent members:

1. Promote awareness among physicians of The Istanbul Protocol, including its Principles on the Effective Investigation and Doc-

umentation of Torture and Other Cruel, Inhuman or Degrading Treatment. This should be done at the national level.

2. Promote training of physicians on the identification of different methods of torture and cruel, inhuman and degrading treatment and punishments, to enable them to provide high quality medical documentation that can be used as evidence in legal or administrative proceedings.
3. Encourage professional training to ensure that physicians include assessment and documentation of signs and symptoms of torture or cruel, inhuman and degrading treatment and punishments in the medical records, including the correlation between the allegations given and the clinical findings.
4. Work to ensure that physicians carefully balance potential conflicts between their ethical obligation to document and denounce acts of torture or cruel, inhuman and degrading treatment and punishments and a patient's right to informed consent before documenting torture cases.
5. Work to ensure that physicians avoid putting individuals in danger while assessing, documenting or reporting signs of torture and cruel, inhuman and degrading treatment and punishments.
6. Promote access to immediate and independent health care for victims of torture or cruel, inhuman and degrading treatment and punishments.
7. Support the adoption of ethical rules and legislative provisions:
  - Aimed at affirming the ethical obligation on physicians to report and denounce acts of torture or cruel, inhuman and degrading treatment and punishments of which they become aware; depending on the circumstances, the report or denunciation should be addressed to the competent national or international authorities for further investigation.
  - Addressing that a physician's obligation to document and denounce instances of torture and cruel, inhuman and degrading treatment and punishments may conflict with their obligations to respect patient confidentiality and autonomy.
  - Physicians should use their discretion in this matter, bearing in mind paragraph 69 of the Istanbul Protocol (2).
  - cautioning physicians to avoid putting in danger victims who are deprived of freedom, subjected to constraint or threat or in a compromised psychological situation when disclosing information that can identify them.
  - Work to ensure protection of physicians, who risk reprisals or sanctions of any kind due to the compliance with these guidelines.
  - Provide physicians with all relevant information on procedures and requirements for reporting torture or cruel, inhuman and degrading treatment and punishments, particularly to national authorities, non-governmental organizations and the International Criminal Court.

8. The WMA recommends that the constituent members' codes of ethics include the physician's obligations concerning documentation and denunciation of acts of torture and cruel, inhuman and degrading treatment and punishments as they are stated in this document.

## (1) Codes and codifications:

1. The Preamble to the United Nations Charter of 26 June 1945 solemnly proclaiming the faith of the people of the United Nations in the fundamental human rights, the dignity and value of the human person.
2. The Preamble to the Universal Declaration of Human Rights of 10 December 1948 which states that disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind.
3. Article 5 of the Universal Declaration of Human Rights which proclaims that no one shall be subjected to torture or cruel, inhuman or degrading treatment.
4. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977, revised and adopted by the General Assembly on 17 December 2015.
5. The American Convention on Human Rights, which was adopted by the Organization of American States on 22 November 1969 and entered into force on 18 July 1978, and the Inter-American Convention to Prevent and Punish Torture, which entered into force on 28 February 1987.
6. The Declaration of Tokyo, Adopted by the 29<sup>th</sup> World Medical Assembly, Tokyo, Japan, October 1975 Editorially revised by the 170<sup>th</sup> WMA Council Session, Divonne-les-Bains, France, May 2005 and the 173<sup>rd</sup> WMA Council Session, Divonne-les-Bains, France, May 2006. Revised by the 67<sup>th</sup> WMA General Assembly, Taipei, Taiwan, October 2017.
7. The Declaration of Hawaii, adopted by the World Psychiatric Association in 1977.
8. The Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the United Nations General Assembly on 18 December 1982, and particularly Principle 2, which states: "It is a gross contravention of medical ethics... for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment..."
9. The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which was adopted by the United Nations General Assembly on December 1984 and entered into force on 26 June, 1987.
10. The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which was adopted by the Council of Europe on 26 June 1987 and entered into force on 1 February 1989.
11. The WMA Declaration of Hamburg, adopted by the World Medical Association in November 1997 during the 49<sup>th</sup> General Assembly, and reaffirmed with minor revision by the 207<sup>th</sup> WMA Council session, Chicago, United States, October 2017 calling on physicians to protest individually against ill-treatment and on national and international medical organizations to support physicians in such actions.
12. The Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), adopted by the United Nations General Assembly on 4 December 2000.
13. The Convention on the Rights of the Child, which was adopted by the United Nations on 20 November 1989 and entered into force on 2 September 1990.
14. The World Medical Association Declaration of Malta on Hunger Strikers, adopted by the 43<sup>rd</sup> World Medical Assembly Malta, November 1991 and amended by the WMA General Assembly, Pilanesberg, South Africa, October 2006, and revised by the 68<sup>th</sup> WMA General Assembly, Chicago, United States, October 2017.

## (2) Istanbul Protocol, paragraph 69.

"In some cases, two ethical obligations are in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may refuse to give consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities: to the patient and to society at large, which has an interest in ensuring that justice is done and perpetrators of abuse are brought to justice. The fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions that promote justice without breaking the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases, this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters."



## WMA Resolution Regarding the Medical Profession and Covid-19

*Adopted by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

The current COVID-19 pandemic is causing one of the greatest challenges that healthcare professionals have ever faced in recent decades. According to the World Health Organization (WHO), COVID-19 has exposed healthcare professionals and their social and family environment to unprecedented levels of risk. Although not representative, data from many countries across all regions indicate that the number of SARS CoV-2 virus infections among healthcare professionals has reached alarming numbers for any healthcare system.

The constant risk of infection and, in many cases, the lack of adequate material and human resources, the high number of infected, the physicians' morbidity and mortality and the lack of human resources policies is causing a physical and emotional exhaustion among health professionals. Moreover, thousands of physicians are losing their lives practicing their profession and fulfilling their ethical duties, a number that is increasing as the pandemic advances in most countries.

As a result of this global situation, the WMA offered its support to the [World Health Professions Alliance open letter which calls on immediate G20 action to secure personal protective equipment for health personnel](#) dated April 9, 2020, and denounced it through its [Urgent Call for governments to support healthcare staff in the battle against Covid-19](#) on April 2, 2020.

The derived consequences that the pandemic will cause in the political, economic and social spheres in all countries should be added to this situation. All of this will worsen the global population's health and will require an effort and commitment from the medical profession, its National Medical Associations and the WMA.

### Recommendations

The WMA wants to recognise the fight of the medical profession against the pandemic through this Urgent Resolution and advocates to:

1. Sufficient provision of equipment and personal protection material (PPE) for health professionals, which allows healthcare and guarantees the availability of this material in a situation of possible outbreaks.
2. Urge governments to adopt a multilateral and coordinated approach on a global scale of the crisis to promote equality in interventions, access to health services, treatments and future vaccines.
3. Provide enough financing to healthcare systems so that they can face the costs of the pandemic and guarantee accessible and quality healthcare.
4. The National Medical Associations and the WMA encourage an active participation in the planning and management of all stages of the response to the epidemic.
5. Recognise that SARS CoV-2 infection be recognised as an occupational disease and that the medical profession be declared a "profession at risk". Likewise, we request that taking care of healthcare professionals be a priority, especially in the field of mental health.
6. Fight against violence towards doctors and against any sign of their stigmatisation by promoting zero tolerance of violence in healthcare settings.
7. Support the medical profession that continues to honour its commitment to science and patients. Because current medical professionalism is one of the few and last defence that the seriously ill, excluded and helpless patients have to maintain a minimum of health, quality of life and human dignity.
8. Urge governments to include health system strengthening and resilience as part of national COVID recovery plans.

## WMA Statement Concerning the Relationship Between Physicians and Commercial Enterprises

*Adopted by the 55<sup>th</sup> WMA General Assembly, Tokyo, Japan, October 2004, amended by the 60<sup>th</sup> WMA General Assembly, New Delhi, India, October 2009; And by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

In the treatment of their patients, physicians use medicines, instruments, diagnostic tools, equipment and materials developed and

produced by commercial enterprises. Industry possesses resources to finance expensive research and development programmes, for which the knowledge and experience of physicians are essential. Moreover, industry support enables the progress of medical research, scientific conferences and continuing medical education that can be of benefit to patients and the entire health care system. The combination of financial resources and product knowledge contributed by industry and the medical knowledge possessed by physicians enables the development of new diagnostic procedures, drugs, therapies, and treatments and can lead to great advances in medicine.

However, conflicts of interest between commercial enterprises and physicians occur and can affect the care of patients as well as the reputation of the medical profession. The duty of the physician is to objectively evaluate what is best for the patient and to promote the patient-physician relationship, while commercial enterprises are expected to bring profit to owners by selling their own products and competing for customers. Commercial considerations can affect the physician's objectivity, especially if the physician is in any way dependent on the enterprise.

Rather than forbidding any relationships between physicians and industry, it is preferable to establish guidelines for such relationships. These guidelines must incorporate the key principles of disclosure, transparency, avoidance of conflicts of interest and promoting the physician's ability to act in the best interests of patients.

The guidelines regulating the Physician-Commercial Enterprise relationship should be understood in the light of WMA core ethical values, as stated in particular in the [Declaration of Geneva](#), the [International Code of Medical Ethics](#), the [Statement on Conflict of Interest](#), and the [Declaration of Seoul on Professional Autonomy and Clinical Independence](#).

The autonomy and clinical independence of physicians should be foremost in all physician decisions for patients, regardless of practice setting, whether government-sponsored, private, for profit or not for profit, investor funded, insurance company employers or otherwise.

Curricula of medical schools and residency programs should include educational courses on the relation between enterprises and the medical profession in the light of ethical principles and values of the profession.

## Recommendations

### Medical conferences

1. These guidelines related to medical conferences apply, where pertinent, to corporation events, such as educational events,

and promotional activities including for items of medical utility, sponsored by a commercial enterprise.

2. Physicians may attend medical conferences, sponsored in whole or in part by a commercial entity if these conform to the following principles:
  - The main purpose of the conference is the exchange of professional or scientific information for the benefit of patient care.
  - Hospitality during the conference is secondary to the professional exchange of information and does not exceed what is locally customary and generally acceptable.
  - Physicians do not receive payment directly from a commercial entity to cover travelling expenses, room and board at the conference for themselves or an accompanying person or compensation for their time unless provided for by law and/or the policy of their National Medical Association, or unless it is a reasonable honorarium for speaking at the conference.
  - The name of a commercial entity providing financial support is publicly disclosed in order to allow the medical community and the public to fairly evaluate the information presented. In addition, conference organizers and lecturers are transparent and disclose any financial affiliations that could potentially influence educational activities or any other substantial outcome that may result from the conference.
  - In accordance with the WMA Guidelines on Promotional Mass Media Appearances by Physicians, presentation of material by a physician should be scientifically accurate, give a balanced review of possible treatment options, and not be influenced by the sponsoring organization.
3. In addition, a conference can be recognized for purposes of continuing medical education/continuing professional development (CME/CPD) only if it conforms to the following principles:
  - The commercial entities acting as sponsors, such as pharmaceutical companies or enterprises in the medical devices sector, have no influence on the content, presentation, choice of lecturers, or publication of results.
  - Funding for the conference is accepted only as a contribution to the general costs of the meeting.
  - The independence of the contents of the conference is guaranteed.

### Gifts

4. To preserve the trust between patients and physicians, physicians should decline:
  - cash, cash equivalents and other gifts for personal benefit from a commercial entity
  - gifts designed to influence clinical practice, including direct prescription incentives.
5. Physicians may accept:

- Promotional aids provided that the gift is of minimal value and is not connected to any stipulation that the physician uses certain instruments, medications or materials or refers patients to a certain facility.
- Cultural courtesy gifts on an infrequent basis according to local standards if the gift is of minimal value and not related to the practice of medicine.

## Research

6. A physician may carry out research funded by a commercial entity, whether individually or in an institutional setting, if it conforms to the following principles:
  - The physician is subject only to the law, the ethical principles and guidelines of the Declaration of Helsinki, and clinical judgment when undertaking research and should guard against external pressure regarding the research results or its publications.
  - If possible, a physician or institution wishing to undertake research approaches more than one commercial source for research funds.
  - Identifiable personal information about research patients or voluntary participants is not passed to the sponsoring company without the consent of the individuals concerned.
  - A physician's compensation for research is based on his or her time and effort and such compensation must not be connected to the results of the research.
  - The results of research are made public with the name of the sponsoring entity disclosed, along with a statement disclosing who requested the research. This applies whether the sponsorship is direct or indirect, full or partial.
  - Commercial entities allow unrestricted publication of research results.
  - Where possible, research financed by commercial enterprises should be managed by interposed, non-profit entities, such as institutes or foundations.

## Affiliations with Commercial Entities

7. A physician may not enter into an affiliation with a commercial entity, such as consulting or membership on an advisory board unless the affiliation conforms to the following principles:
  - The affiliation does not compromise the physician's integrity.
  - The affiliation does not conflict with the physician's obligations to his or her patients.
  - The affiliation or other relationship with a commercial entity is fully disclosed in all relevant situations, such as lectures, personal appearances, articles, reports and influential contributions to the mission of medical associations or other non-profit health entities.

## WMA Statement on Human Genome Editing

*Adopted by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

Genome editing, enabled by recent scientific advances, can generate targeted insertions and deletions in DNA and may even offer enough precision to modify a single base pair within the genome of an organism. Basic science research with genome editing is now underway in laboratories globally.

Human genome editing is also advancing rapidly, with clinical trials now in progress for prevention and treatment of various human diseases. These trials, which are currently in early stages, involve somatic (non-reproductive) cells, and thus are not anticipated to introduce genetic changes that will be passed on to offspring or the germline (reproductive) cells.

While genome editing holds great potential to help improve human lives, the technology raises profound safety, ethical, legal, and social concerns. These concerns are compounded by the fact that regulatory and ethical guidance often lag rapid technological developments.

Safety concerns for genome editing include the risk of unintended or unforeseen pleiotropic effects off-target effects (edits in the wrong place) unwanted on-target modifications (imprecise edits), and mosaicism (when only some cells carry the edit), and abnormal immunological responses.

Ethical issues regarding genome editing include concerns that editing may be used for non-therapeutic and enhancement purposes rather than for therapeutic purposes, i.e. improving health or curing disease. There are also concerns that germline modifications could create classes of individuals defined by the quality of their engineered genome, possibly enabling eugenics, which could exacerbate social inequalities or be used coercively.

The effect of epigenomic changes are unpredictable, and there is disquiet as to how this will affect the existing healthy biological systems, including interactions with other genetic variants, and societal norms. Once introduced into the human population, genetic alterations would be difficult to remove and would not remain within any single community or country. The effects could remain uncertain for many subsequent generations, during which time deleterious modifications could be dispersed throughout the population.

Legal issues include providing clarity for risk management and assignment of duties and liabilities, particularly when modifications can be passed to subsequent generations. There are also risks, both legal and ethical, involved in the proliferation of unvalidated direct-to-consumer CRISPR (clustered regularly interspaced short palindromic repeats) kits that allow individuals to undertake gene editing independently in a home setting.

At a social level, debates revolve around the concerns that access to beneficial genome editing will be inequitable (e.g., only the wealthy will have access) and will increase existing disparities in health and medical care.

The WMA reaffirms principles in the [Declaration of Reykjavik on the ethical considerations regarding the use of genetics in health care](#), the Declaration of Taipei on Ethical Considerations regarding Health Databases and Biobanks and the Declaration of Helsinki and makes the following recommendations:

## Recommendations

1. Human genome-editing, like any other medical intervention, should be implemented according to appropriate evidence that is collected via well-conducted and ethically approved research studies.
2. When contemplating use of germline cells for research purposes, germline editing should be permitted only within a separate ethical and legal framework, distinct from an ethical and legal framework applied to somatic genome editing.
3. Governments should:
  - Develop robust and enforceable regulatory frameworks for genome editing in their own countries.
  - Urge continued development of an international consensus, grounded in science and ethics, to determine permissible therapeutic applications of germline genome editing.
4. WMA constituent members should:
  - Be cognisant of the advances in research in genomic medicine and inform their members on scientific advances in genome
  - Advocate for research to understand (i) the benefits and risks of human genome editing, (ii) the socio-political, ethical, and legal aspects of editing the human germline and (iii) the necessity of physician involvement in therapeutic genome editing.
  - Develop and promote ethical guidelines for genome editing for their members, taking into consideration societal perspectives, professional consensus, national laws and regulations, and international standards.
  - Advocate for the development of appropriate laws and regulations for genome editing in accordance with both international and national norms and standards.
  - Where human genome editing is safe and effective, advocate for equal patient access to the technology.

5. Physicians should:

- Educate themselves on the technical, ethical, social, and legal aspects of genome editing.
- Familiarise themselves with the international and local ethical frameworks regulating genome
- Follow all ethical standards for approved research in these areas, including appropriate informed consent.

## WMA Statement on Hypertension and Cardiovascular Disease

*Adopted by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

Hypertension is the single most important risk factor for cardiovascular death globally. It accounts for more deaths from cardiovascular disease than any other modifiable risk factor. More than half of people who die from coronary heart disease and stroke had hypertension. “As populations age, adopt more sedentary lifestyles, and increase their body weight, the prevalence of hypertension worldwide will continue to rise.

Uncontrolled hypertension is a major cause of stroke and other comorbid, chronic conditions, such as heart failure, kidney disease, vision loss, or mild cognitive impairment. Because hypertension can be asymptomatic, it may often go undiagnosed.

In 2010, hypertension emerged as the leading risk factor for disease burden in every region of the world. Moreover, elevated systolic blood pressure (SBP) is a leading global health risk. The WHO Global Plan of Action for the prevention of non-communicable diseases calls for a 25% reduction in the prevalence of elevated blood pressure by 2025.

### Prevalence

Worldwide prevalence of hypertension has grown significantly over the past four decades, and most with hypertension are not achieving optimal control.

Of concern is an increasing disparity in hypertension prevalence between high-income and low/middle-income countries. Almost three



times as many people with hypertension live in low/middle-income countries than in high-income countries. Low-income countries in south Asia, sub-Saharan Africa, and central and eastern Europe, are particularly impacted. Moreover, the prevalence of elevated blood pressure was highest in certain regions of Africa in both sexes.

## Risk Factors

Hypertension risk factors are attributes that increase the likelihood of developing the disease. Risk factors include the following:

- **Lifestyle/Diet:** Unavailability of healthy food choices, lack of access to safe neighborhoods for exercising, and unhealthy lifestyle habits can raise the risk of hypertension. Unhealthy lifestyle habits include unhealthy eating patterns such as eating too much sodium and highly processed food, drinking too much alcohol, smoking, and being physically inactive.
- **Age:** Blood pressure (BP) tends to increase with age. However, the risk of hypertension is increasing for children and teens, possibly due to the rise in the number of children and teens who are overweight or obese.
- **Socioeconomic Status:** In high-income countries, the greatest absolute burden of hypertension disease is in age groups 60 years and older, whereas in low/middle-income countries, the greatest absolute burden is in the middle-aged groups, such as 40 to 59 years. The age-standardized prevalence of hypertension is higher in low/middle-income countries than in high-income countries.
- **Sex:** Before age 55, men are more likely than women to develop hypertension. After age 55, women are more likely than men to develop it.
- **Genetics/Family History:** Research has identified many gene variations associated with small increases in the risk of developing hypertension. Some people are genetically predisposed to dietary sodium sensitivity.

## Accurate blood pressure measurement

The accurate measurement of BP – both within the clinical setting and at home – is essential for the diagnosis and management of hypertension. In many countries, national clinical guidelines recommend how to achieve an accurate BP measurement and offer best practice recommendations.

## Policy implications

Policies and actions at the global, national, and local levels are necessary to recognize and combat hypertension. Much effort is

needed worldwide to improve awareness, treatment, and control for all populations. Current guidelines to diagnose and treat hypertension, and evidence-based guidance on the importance of proper BP measurement, offer anchors for national policies on BP measurement and control. Implementation can make significant progress towards lowering global hypertension prevalence and improving patient outcomes. To address the risk factors for hypertension, policies should also focus on addressing socioeconomic, lifestyle and dietary factors which contribute to the development of the disease.

## Recommendations

1. The World Medical Association recommends that national governments:
  - Recognize hypertension as the single most important risk factor for cardiovascular disease and death.
  - Declare hypertension control a national health priority.
  - Support campaigns to raise public awareness of hypertension, including recognition of its widespread and asymptomatic nature, and its risk of contributing to development of other serious diseases.
  - Deploy adequate resources to improve hypertension awareness, diagnosis, measurement, and management.
  - Develop country-specific strategies which address the risk factors for hypertension and advocate for improvements in awareness, diagnosis, measurement and management.
  - Promote the recommendations adopted by the WMA as stated in the Statement on Reducing Dietary Sodium Intake.
2. The World Medical Association recommends that its constituent members:
  - Advocate at the international, national, and local levels to promote hypertension awareness, healthy lifestyles, and patient access to hypertension diagnosis and treatment including medications. This includes supporting the concept that social determinants of health are part of hypertension disease prevention.
  - Recognize and support national guidelines and strategies for measuring BP accurately.
  - Support the exchange of hypertension research, information, tools, and other resources amongst healthcare teams and patients.
  - Support the development of medical curricula that respond to societal hypertension needs with a focus on community-based primary care training and BP measurement and management skills.
  - Promote research on the causes, mechanisms and effective treatments of hypertension.
  - Advocate for sustained availability antihypertensive medications.

3. The World Medical Association recommends that physicians:
  - Emphasize the risk factors for hypertension and ways to mitigate them, paying special attention to prevention and treatment in high-risk populations.
  - Emphasize team-based care to help prevent and, where it has been diagnosed by a physician, to treat hypertension.
  - Implement BP measurement best practices and techniques, including training and retraining of all healthcare team members.
  - Promote patient hypertension treatment adherence by facilitating ongoing patient BP self-management and involvement in the patient's own care.

## WMA Statement on Measures for the Prevention and Fight Against Transplant-Related Crimes

*Adopted by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

In 2017, almost 140,000 solid organ transplants were performed worldwide. Although impressive, this activity provided for only 10% of the global need for transplanted organs. The disparity between supply and demand of organs has led to the emergence of transplant-related crimes, including trafficking in persons for the purpose of the removal of organs and trafficking in human organs.

These crimes violate fundamental human rights and pose serious risks to both individual and public health. The true extent of transplant-related crimes remains unknown, but it is estimated that 5% to 10% of transplants globally take place in the context of the international organ trade, often involving transplant tourism to destinations where laws against the sale and purchase of human organs are nonexistent or poorly enforced. Trafficking in persons for the purpose of the removal of organs and trafficking in human organs can also take place within the boundaries of a given jurisdiction, not involving travel for transplantation. In all cases, the most vulnerable parts of the population often become victims of exploitation and coercion.

Concerned by the increasing demand for organs and by emerging unethical practices in the field, the World Health Organization has called on governments and health professionals to pursue self-sufficiency in transplantation, through strategies targeted at decreasing the burden of diseases treatable with transplantation and increasing the availability of organs, maximising donation from the deceased and ensuring the overall protection of the living donor. Progress towards self-sufficiency in transplantation is consistent with the establishment of official cooperation agreements between countries to share organs or to facilitate patients' access to transplant programs that have not been developed in their countries of origin. Agreements between countries should be based on the principles of justice, solidarity and reciprocity.

Progress towards self-sufficiency in transplantation is the best long-term strategy to prevent transplant-related crimes.

The distinctive feature of transplant-related crimes is the necessary involvement of health professionals. It is precisely this feature that provides a unique opportunity to prevent and combat these crimes. Health professionals are key in evaluating prospective living donor and recipient pairs. They also care for desperate patients who are vulnerable and at risk of engaging in illicit transplant activities. In addition, since patients who receive a transplant require long-term specialised care, physicians must deal with the many challenges of providing care to patients who have received an organ through illicit means, while unveiling trafficking rings.

International organisations, including the Council of Europe, the European Union and the United Nations, as well as international professional platforms, have developed treaties, resolutions and recommendations for a concerted fight against transplant-related crimes.

The WMA emphasises the responsibility of physicians in preventing and combatting trafficking in persons for the purpose of the removal of organs and trafficking in human organs, as well as the important role of physicians and other health-care professionals in assisting international organisations, medical associations and policy makers in the fight against these criminal activities.

In the fight against transplant-related crimes it is of utmost importance that the principles of transparency of practice, traceability of organs and continuity of care are guaranteed for every transplant procedure performed nationally or abroad.

The WMA reaffirms its [Statement on organ and tissue donation](#) and its [Declaration of Sydney on the determination of death and the recovery of organs](#). Condemning all forms of trafficking in persons for the purpose of the removal of organs and trafficking in human organs,

the WMA calls for the implementation of the following recommendations.

## Recommendations

### Policy makers and health actors:

1. Governments should develop, implement and vigorously enforce legislative frameworks that prohibit and criminalise trafficking in persons for the purpose of the removal of organs and trafficking in human organs, these should include provisions to prevent these crimes and protect their victims.
2. Governments should consider ratifying or acceding to the United Nations Convention against Transnational Organised Crime and the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organised Crime, as well as the Council of Europe Convention against Trafficking in Human Organs. They should also consider co-operating with existing international organisations for a more effective fight against transplant-related crimes. The WMA should play a leading role in influencing ethical practices in donation and transplantation.
3. Health authorities should develop and maintain registries to record information regarding each organ recovery and transplantation procedure, as well as information on the outcomes of living donors and organ recipients, to ensure the traceability of organs, with due regard to professional confidentiality and personal data protection. Registries should be designed to record information on procedures that take place within a country and on transplant and living donation procedures on residents of that country carried out in other destinations.
4. Countries are encouraged to periodically contribute this information to the Global Observatory on Donation and Transplantation developed in collaboration with the World Health Organization.
5. Health authorities and medical associations should ensure that all health professionals are trained in the nature, extent and consequences of transplant-related crimes, as well as in their responsibilities and duties in preventing and fighting these criminal activities and in the means to do so.
6. As self-sufficiency is the best long-term strategy to prevent transplant-related crimes, health authorities and policy makers should develop preventive strategies to decrease the burden of diseases treatable with transplantation and increase the availability of organs.
7. Increasing organ availability should be based on the development and optimisation of ethically sound deceased donation programs following the determination of death by neurological and by circulatory criteria. Of note is that donation after

the determination of death by circulatory criteria is accepted in a limited number of countries. Governments should explore whether donation after the circulatory determination of death is a practice acceptable within their community and, should this be the case, consider introducing it within their jurisdiction.

8. In addition, governments should develop and optimise living donation programs based on recognised ethical and professional standards and ensure due protection and follow-up of living donors.
9. Health authorities and/or insurance providers should not reimburse the costs of transplant procedures that have occurred in the context of transplant-related crimes. However, the costs of medications and post-transplant care should be covered, as for any other transplant patient.
10. Authorities should also ensure that medical and psychosocial care is provided to victims of trafficking in persons for the purpose of organ removal and of trafficking in human organs. Consideration should be given to effective compensation of these persons for the damage suffered.
11. National Medical Associations should advocate for and cooperate with authorities in developing frameworks for health professionals to report any confirmed or suspected case of trafficking of persons for the purpose of the removal of organs and of trafficking in human organs to the relevant authorities. National Medical Associations should advocate for the ability of health professionals to report suspected trafficking of individual persons, on an anonymous basis if necessary, to protect the safety of the reporter. Where applicable, the reporting of trafficking cases should be a permitted exception to the physician's obligation to maintain patient confidentiality.

### Physicians and other health professionals:

12. Physicians should never perform a transplant using an organ that has been illicitly obtained. If there are reasonable concerns about the origin of an organ, the organ must not be used. If a physician or a surgeon is asked to perform a transplant with an organ that has been obtained through a financial transaction, without the valid consent of the donor or without the authorisation required in a given jurisdiction, they must refrain from performing the transplant and should explain the reasons to the potential recipient.
13. Physicians who participate in the preoperative evaluation of potential living donors should not only assess the medical suitability of the individual, but also attempt to ensure that the person has not been subject to coercion of any kind or is participating in the procedure for financial gain or any other comparable advantage. The legitimacy of the donor-recipient relationship and the altruistic motivations for donation should be scrutinised. Physicians should be particularly vigilant of "red flags" suggestive of a transplant-related crime. Non-resident living donors may

be particularly vulnerable and should be given special consideration. For linguistic, cultural and other reasons, assessing the validity of their consent to donation can be especially challenging, as can ensuring that appropriate follow-up is offered to them. A referring physician should be identified in the country of origin of the living donor – and in that of their intended recipient, where appropriate.

14. Physicians should never promote or facilitate the engagement of patients in transplant-related crimes. Moreover, they should inform patients of the risks these activities pose for their own health, that of their loved ones and, more generally, for public health. Patients should also understand that these activities entail an exploitation of vulnerable individuals who may themselves suffer from severe medical and psychosocial complications. By counselling patients, professionals may dissuade them from engaging in illicit transplant activities.
15. Physicians have a duty to care for transplant patients, even if their organ was illicitly obtained. Should a physician have ethical or moral objections about caring for a patient who has received an illicit organ, they should make the necessary arrangements to transfer the care of the patient to another physician.
16. Physicians should contribute to guaranteeing transparency of practices and traceability of organs. When patients who have undergone a donation or a transplantation procedure abroad seek follow-up care in their country of residence, all relevant information should be recorded in national transplant-registries and reported to health authorities, as should happen for all donation and transplantation procedures performed within the national transplant system.
17. Physicians have a responsibility to increase the deceased donor pool in order to satisfy the transplantation needs of patients. Physicians also have a duty towards possible organ donors in considering and facilitating organ donation if this is consistent with patients' values and principles. Donation should be routinely offered as an option at the end of life, always in a respectful manner, taking into account the culture and religion of the potential donor and their surrogates. Conversations about donation opportunities should be led by experienced and trained professionals.
18. Physicians should promote research in the field of donation and transplantation, in particular research targeted at increasing the availability of organs for transplantation, improving the outcomes of transplanted organs, and identifying alternative organ replacement strategies, as in the case of bioartificial organs.

## WMA Statement on Stem Cell Research

*Adopted by the 60<sup>th</sup> WMA General Assembly, New Delhi, India, October 2009 and revised by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

The fields of stem cell research and therapy are among the fastest growing areas of biotechnology.

Stem cells can be harvested from established tissue (adult stem cells) or from the blood of the placenta via the umbilical cord. These sources may create no specific ethical dilemmas.

Stem cells can also be obtained from an embryo (embryonic stem cells). Obtaining and using these stem cells raises specific ethical questions and may be problematic for some people. Another source of stem cells valuable for research is induced pluripotent stem cells, which can be generated from adult tissues, and may in some cases be functionally equivalent to embryonic stem cells, although they are not derived from embryos.

Some jurisdictions have prohibited using embryonic stem cells. Others have allowed using so-called "spare or excess embryos" from assisted reproduction procedures for research purposes, but the production of embryos solely for research purposes may be prohibited. Other jurisdictions have no specific laws or regulations with respect to embryonic stem cells.

Human embryos are considered by some people to have a specific and special ethical status. This has generated debate amongst ethicists, philosophers, theologians, clinicians, scientists, health workers, the public and legislators.

In vitro fertilisation involves the production of embryos outside of the human body. In many cases, some of the embryos are not used to achieve pregnancies. Those not used may be donated for the treatment of others, or for research, or stored for some time and then destroyed.

Stem cells can be used to conduct research into basic developmental biology, human physiology and disease pathogenesis. There are many current research programs investigating the use of stem cells to treat human disease. Adult stem cell therapies, including using bone marrow, cord blood or blood-derived stem cells for transplan-



tation, include several important and well-validated clinical advances. In contrast, clinical studies have not yet validated the use of embryonic stem cells in therapy.

Embryonic stem cells may at times be superior to induced pluripotent stem cells for certain applications, and research with embryonic stem cells may continue to be needed. Some experts anticipate future use of a variety of therapies based on stem cells, including transplants of genetically matched tissue. It is too early to assess the likelihood of success of any specific therapy based on stem cells.

Public views of stem cell research are as varied as those of doctors and scientists. Much public debate centers on concerns of abuse of the technology and the potential for harm in recipients, and specific concerns continue to be raised about the use of embryos. Investigational stem cell products also may pose unique risks, including unknown long-term health effects such as mutations.

Adoption of laws in accordance with established ethical principles\* is likely to alleviate concerns for many members of the public, especially if such laws are carefully and credibly monitored and enforced.

## Recommendations

1. Whenever possible, research should be carried out using stem cells that are not of embryonic origin. Research with stem cells from unused embryos after in vitro fertilization techniques should only be carried out if obtaining the potential results could not also be addressed with the use of other types of stem cells, including induced pluripotent stem cells. Research and other uses should be in accordance with the WMA Resolution on the Non-Commercialisation of Human Reproductive Material.
2. All research on stem cells, regardless of stem cell type, must be carried out according to established ethical principles and with appropriate informed consent. Both established and proposed laws must conform to these principles to avoid confusion or conflicts between law and ethics.
3. The ethical principles should, where possible, follow international agreements. Recognising that different groups have widely varying views on the use of specific stem cell types, these principles should be drafted with enough flexibility to allow different jurisdictions to appropriately regulate levels of research.

## WMA Statement on Violence Against Women

*Adopted by the 61<sup>st</sup> WMA General Assembly, Vancouver, Canada, October 2010 And amended by the 71<sup>st</sup> WMA General Assembly (online), Cordoba, Spain, October 2020*

### Preamble

Violence against women is a worldwide phenomenon and includes violence within the family, within the community and violence perpetrated by or condoned by the state. Many excuses are given for violence generally and specifically; in cultural and societal terms, these include tradition, beliefs, customs, values and religion. Intimate partner violence, rape, sexual abuse and harassment, intimidation at work or in education, modern slavery, trafficking and forced prostitution, are all forms of violence condoned by some societies. One extreme form of such violence is sexual violence used as a weapon of war (United Nations Security Council Resolution 1820). Specific cultural practices that harm women, including female genital mutilation, forced marriages, dowry attacks and so-called “honour” killings are all practices that may occur within the family setting.

All human beings enjoy fundamental human rights. The examples listed above involve denial of many of those rights, and each abuse can be examined against the [Universal Declaration of Human Rights](#), as well as the [Convention on the Elimination of All Forms of Discrimination against Women](#) and the [Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children](#), supplementing the United Nations Convention against Transnational Organized Crime (2000).

The denial of rights and the violence itself have health consequences to women. In addition to the specific and direct physical and health consequences, the general way in which women are treated can lead to an excess of mental health problems and increase of suicidal behavior. The short and long-term mental health consequences of violence may severely influence later wellbeing, enjoyment of life, function in society and the ability to provide appropriate care for dependents. Lack of good nutritional opportunities can lead to generations of women with poorer health, poorer growth and development. Denial of educational opportunities leads to poorer health for all the family members since good education of women is a major factor in the wellbeing of the family.

In addition to being unacceptable in and of itself, violence against women is also socially and economically damaging to the family and

to society. There are direct and indirect economic consequences to violence against women that are far greater than the direct health sector costs. Lack of economic independence, and of basic education, also mean that women who survive abuse are more likely to be or to become dependent upon the state or society and less able to support themselves and contribute to that society.

Physicians have a unique insight into the combined effects of violence against women. The holistic view from physicians can be used to influence society and politicians. Gaining societal support for improving the rights, freedom and status of women is essential.

This Statement alongside with other WMA key related policies, including the statements on [Female Genital Mutilation](#), [Sex Selection and Female Foeticide](#), [Medically-indicated Termination of Pregnancy](#), [Family Violence](#), [Violence and Health](#), [Child Abuse and Neglect](#) and on [the Right of Rehabilitation of Victims of Torture](#), provide guidance to WMA Constituent Members and physicians on ways to support women who are victims of violence, and strive for eradicating violence against women.

## Recommendations

The WMA:

1. Calls for zero tolerance for all forms of violence against women.
2. Asserts that violence against women is not only about physical, psychological and sexual violence but includes neglect and abuses such as harmful cultural and traditional practices and is a major public health issue as well as a social determinant of health.
3. Recognizes the linkage between better education, other women's rights and societal health and wellbeing, and emphasizes that equality in civil liberties and human rights are health-related issue.
4. Calls on WHO, other United Nations agencies and relevant actors at national and international levels to accelerate actions towards ending discrimination and violence against women.
5. Urges the governments to implement WHO's [Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in particular Against Women and Girls, and Against Children](#).
6. Encourages the development of free educational materials online to provide guidance to front line health care personnel on abuse and its effects, and on prevention strategies.

National Medical Associations are urged to:

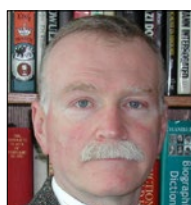
7. Use and promote the available educational materials on preventing and treating the consequences of violence against women and act as advocates within their own country.

8. Seek to ensure that physicians and other health care personnel are alerted on the phenomenon of violence, its consequences, and the evidence on preventative strategies that work, and place appropriate emphasis on this in undergraduate, graduate and continuing education.
9. Recognise the importance of more complete reporting of violence and encourage the development of education emphasising violence awareness and prevention.
10. Advocate for legislation against specific harmful practices including female feticide, female genital mutilation, forced marriage, and corporal punishment.
11. Advocate for the criminalization of intimate partner violence as well as rape in all circumstances including within marriage.
12. Advocate for the development of research data on the impact of violence and neglect upon primary and secondary victims and upon society, and for increased funding for such research.
13. Encourage medical journals to publish more of the research on the complex interactions in this area, thus keeping it in the professions' awareness and contributing to the development of a solid research base and ongoing documentation of types and incidence of violence.
14. Advocate for the national implementation of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

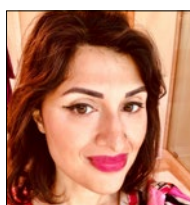
Physicians are encouraged to:

15. Use the material developed for their education to better inform themselves about the effects of violence and the successful strategies for prevention.
16. Treat and reverse, where possible, the complications and adverse effects of female genital mutilation and refer the patient to social support services.
17. Oppose the publication or broadcast of victims' names or addresses without the explicit permission of the victim.
18. Assess risk of family violence in the context of taking a routine social history of a patient.
19. Be alert to the association between alcohol or drug dependence among women and a history of abuse.
20. Where appropriate, report suspected violence or ill-treatment against women to relevant protection services and take the necessary measures to ensure that victims of violence are not at risk.
21. Support global and local action to better understand the health consequences both of violence and of the denial of rights, and advocate for increased services for victims.

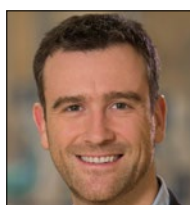
## The Declaration of Geneva: Conscience, Dignity and Good Medical Practice



Sean Murphy



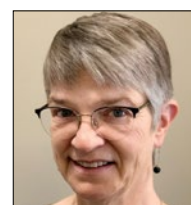
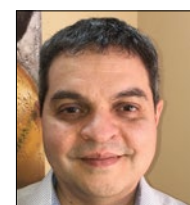
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Since 1948 the *Declaration of Geneva* (the *Declaration*) has insisted that physicians must practise medicine “with conscience and dignity.” In 2017 this provision was modified by adding, “and in accordance with good medical practice” [1].

Good medical practice in Canada is said to include providing euthanasia and assisted suicide or arranging for someone else to do so. From this perspective, physicians who cannot in conscience kill their patients or collaborate in killing are not acting “in accordance with good medical practice,” and – some might say – the revised *Declaration*.

However, this merely literal application of the text cannot be correct, since the WMA later reaffirmed its support for physicians who refuse to provide or refer for euthanasia and assisted suicide even where they are considered good medical practice [2]. A reading informed by the history of the document is necessary and consistent with the care taken in its revision [1]. This yields a rational and coherent account of the relationship of conscience and dignity to medical practice.

### The Declaration of Geneva and the Ethic of Medicine

The possibility that conscience and dignity could conflict with good medical practice did not occur to the authors of the original *Declaration*. On the contrary: they believed

conscience and human dignity were inextricably embedded in good medical practice because they understood the practice of medicine to be a moral enterprise. They believed that practising “with conscience” meant conforming to “eternal moral values” discernable in the spirit of the Hippocratic Oath, including respect for “the value and sanctity of every individual human being” [3].

Jewish WMA delegates identified “the eternal base of the medical moral [i.e., ethic]” as “man thou art my brother” [4]. This succinct statement reflected Judeo-Christian traditions, but it is consonant with a rational, cogent and trans-cultural medical ethic compatible with religious and non-religious belief. It sums up an “other-self” ethic: the conviction that physicians’ ethical obligations flow directly from recognition of the patient as another self.

Thus, to practise “with conscience” is to treat the other as oneself: to impartially care for patients to the best of one’s ability, applying “scientific methods allied with the spirit of charity and service”: to provide for their bodily needs, relieve suffering, prolong human life and prevent disease: to defend fundamental human rights and respect patients’ human dignity and “moral freedom” [3, 5, 6]. Further, recognition of a patient as another self obliges physicians to prevent and resist harm to patients, and makes deliberately harming them an especially egregious offence [4, 5, 7].

The WMA founders denounced physicians involved in crimes against humanity for having treated human beings as things to be exploited, and for acting or allowing themselves to be used as mere technicians or tools of the state, conduct they characterized literally as prostitution [3, 6]. For physicians in a world staggering back from the edge of an abyss, to practise medicine “with dignity” meant that physicians must act as moral agents, not puppets, and patients must be respected, protected and cared for, not used as objects for manipulation, scientific study or personal gratification [8].

### The Declaration of Geneva and the UDHR

This account accords remarkably with the contemporaneous development of Article 1 of the *Universal Declaration of Human Rights* (UDHR), which asserts that all human beings are endowed with conscience and equal in dignity. Unsurprisingly, the authors of the UDHR also held that human dignity forbids the use of human beings as means to ends chosen by others [9].

Of particular interest, “conscience” was added to Article 1 because it was thought to combine the Confucian concept of *jen* (pronounced “ren”) with the western idea of a unique human attribute that grounds moral obligations [9, 10]. When translated literally as “two-man-mindedness” – consciousness of fellow human beings – *jen*

corresponds to the medical ethic expressed by the aphorism, “man thou art my brother.” Indeed, *jen* – “Confucius’ version of the golden rule” – is a foundational principle in traditional Chinese medical ethics [11, 12].

The symmetry of UDHR Article 1 and the *Declaration* and congruence with religious and non-religious belief in their approach to conscience and human dignity seem particularly fitting in documents addressed to the global community. Here we develop some key elements relevant to medical practice.

## To practise “With Conscience and Dignity”

We reaffirm the foundational insight of the authors of the *Declaration* that the practice of medicine is an inescapably moral enterprise. Physicians first consider the good of patients [13], always seeking to do them some kind of good and protect them from evils [14, 15]. Hence, moral or ethical views are intrinsic to the practice of medicine, and every decision concerning treatment is a moral decision, whether or not physicians consciously advert to it. To demand that physicians must not act upon moral beliefs is to demand the impossible, since one cannot practise medicine without reference to moral beliefs.

The practice of medicine is a moral enterprise, and the practice of morality is a human enterprise. None can avoid the classic ethical question, “How ought I to live?” Answers reflect two fundamental moral norms; do good, avoid evil. These basics have traditionally been undisputed; disputes begin with beliefs about good and evil and what constitutes “doing” and “avoiding.” Such issues are the province of philosophy, ethics, theology and religion – not science.

Further, since morality is a human enterprise, moral judgement is an essential activity of every human person. Beliefs are always “personal” in the sense that one is personally

committed to them. Religious and non-religious people “personally” adhere to beliefs about human dignity and justice. In neither case does “personal” commitment imply that their beliefs are merely idiosyncratic preferences that can be dismissed.

Maintaining one’s personal moral integrity is the aspiration of all who wish to live rightly. The physician who makes claims of conscience is a unique *someone* with a single identity, served by a single conscience governing all conduct in private and professional life [16]. The moral integrity or moral unity of the human person was highly prized by Martin Luther King Jr., who described it as essential for “a complete life” [17, 18].

Finally, with the authors of the *Declaration*, we affirm that moral agency is central to medical practice. Treating physicians as tools in the hands of the state, health systems or other masters – as means to ends rather than moral agents responsible for their actions – violates human dignity and is incompatible with human equality and freedom.

## Freedom of Conscience

Agreement on foundational principles does not eliminate disagreements, since people hold differing reasonable comprehensive world views leading to different ethical theories, like deontology, consequentialism, principlism and virtue ethics [19]. Recognition of rational moral pluralism [20] enables people to live peacefully and productively with these differences, and this is best ensured by robust protection of freedom of thought, of conscience and of religion, all recognized in Article 18 of the UDHR. The focus here, as in the *Declaration*, is on conscience.

## Reason and Conscience

According to UDHR Article 1, “all human beings are endowed with reason and con-

science and should act toward one another in a spirit of brotherhood.” This implies that reason and conscience are compatible and should lead to a common understanding of fundamental moral obligations even among people having different reasonable comprehensive views [9].

Indeed, “reasonable persons will think it unreasonable,” said John Rawls, “to suppress comprehensive views that are not unreasonable, though different from their own” [21] – including comprehensive views informed by religious belief. He used the parable of the Good Samaritan to demonstrate how religiously informed views can be incorporated into public discourse. It is noteworthy that Leo Alexander, writing fifty years earlier, had used the parable to explain the basis of medical ethics [7]. Crucially, claims of conscience cannot be dismissed as entirely disconnected from reason; they are the consequence and expression of rational moral deliberation about the good.

## Conscience in Action

The *Declaration’s* authors understood that the exercise of conscience involves doing what one believes to be right (identified here as *perfective* freedom) and refusing to do what one believes to be wrong (here *preservative* freedom). Doing what one believes to be right we call “perfective” because individual and collective human flourishing or perfection can be advanced by the pursuit of apparent goods. Refusing to do what one believes to be wrong we call “preservative” because individual and collective moral integrity and other goods are preserved by refusing to participate in apparent evils.

This distinction is independent of particular beliefs about right, wrong, human flourishing or perfection [22]. It enables a principled approach to defending physicians’ ability to practise “with conscience and dignity” based upon the nature of the freedom itself.



## Perfective Freedom of Conscience

Since one can always find more good to be done, the exercise of perfective freedom of conscience is self-driven, proactive, and expansive. Moreover, pursuing social goods often requires resources and the cooperation and assistance of others and can conflict with others who are pursuing different goals. Hence, the exercise of perfective freedom of conscience is likely to have a greater impact on the fundamental freedoms of others than simply refusing to do what one believes to be wrong.

International instruments and national constitutions already protect perfective freedom of conscience as an aspect of freedom of conscience generally. Physicians motivated by conscience to care for their patients are usually supported by societies and governments. Restrictions or limitations usually result from lack of resources or other practical impediments that can often be mitigated or overcome in time.

One must not minimize the distress felt by physicians struggling against difficult odds to do the good they want to do for their patients [23]. Physicians express frustration and alarm when government policies keep them from providing medical services to vulnerable populations [24]. They are outraged when warring factions attack medical personnel and make it almost impossible to treat people desperately in need [25].

But it is crucial to recognize that physicians in these situations are not responsible or culpable for injustices they have been unable to prevent or correct. They may experience disappointment, frustration, a sense of failure and even anger, but moral culpability lies on other shoulders. Their moral integrity is unaffected. The solution to such problems is to provide adequate resources, change government policies, and halt attacks on medical personnel in war zones. Additional protection for perfective freedom will not

help to address these problems. Indeed, it can introduce other difficulties.

For example, managing the scope of even specific policy positions grounded on perfective freedom of conscience is especially challenging. In 2014 the Canadian Medical Association (CMA) resolved to support all physicians who “follow their conscience in deciding whether to provide medical aid in dying” [26]: both those who provide and refuse to provide the services (exercising perfective and preservative freedom of conscience respectively). This commits the CMA to support EAS for *any* reason for *any* person and under *any* circumstances as long as it is legal. The commitment is not conditional upon competence, consent, age or even medical diagnosis.

Further, physicians are capable of causing grievous and widespread harm *especially* when pursuing ostensibly therapeutic goals. This was demonstrated at a Canadian psychiatric institution, where, for 15 years, physicians openly employed “patient on patient therapy” [27] designed to undermine patients’ personal dignity and sense of self-worth, described by a court as an “invasive and brutal” experimental methodology [28]. It would be imprudent and even dangerous to increase this risk. And it is unnecessary, because there is no need to augment protection for perfective freedom of conscience to enable or encourage the provision of medical treatment, which ought to be justifiable on empirical and ethical grounds alone.

## Preservative Freedom of Conscience

The justification for protecting freedom of conscience is the need to preserve personal integrity and human dignity. Applied to physicians, this protects patients by ensuring that others cannot force physicians to act unethically [29]. Augmenting protection for perfective freedom of conscience is

not required to achieve this end, but there are a number of reasons to enact protections specific to preservative freedom of conscience.

Preservative freedom of conscience is reactive, typically exercised only in response to external pressures. Beyond alternative arrangements customary for accommodating conflicting rights claims, preservative freedom of conscience makes no special demands on social resources, does not require others to assist or cooperate and is less likely than perfective freedom of conscience to infringe others’ fundamental freedoms.

Refusing to act wrongfully is foundational for the individual and society, contributes substantially to social stability and is the necessary but not sufficient condition for perfective freedom of conscience. It is essential for ethical medical practice because it protects personal and professional integrity and can be the ultimate safeguard for patients.

Moreover, coerced participation in perceived wrongdoing does not merely restrict preservative freedom of conscience but suppresses it entirely by forcing a physician to assume moral responsibility and culpability for what follows. In contrast, physicians prevented from providing treatment are relieved of moral responsibility and culpability.

General guarantees of freedom of conscience in international instruments and national constitutions apply to preservative freedom of conscience, but, unlike perfective freedom of conscience, they are frequently ignored or interpreted so as to suppress it [30, 31]. Preservative freedom of conscience among health care professionals has been attacked around the world with increasing intensity for at least 20 years [32, 33, 34, 35]. In some parts of Canada, the medico-legal establishment now demands that unwilling physicians become parties

to killing their patients; [36] pressures to conform to this expectation are considerable [37] and sometimes vicious [38].

Suppression of preservative freedom of conscience directly attacks personal integrity because one cannot act unless one chooses to act. By yielding to coercion one consciously commits oneself to a perceived evil (killing one's patient) as better than the consequences of refusal (losing one's job), contrary to one's actual beliefs. By virtue of the moral unity of the person, one cannot separate oneself from one's choices and acts even if they have been coerced. One knows forever after that one could have acted differently, and this awareness is manifested in profound guilt [39].

For example, a palliative care physician, succumbing to fear of professional discipline, referred a patient for euthanasia. She described the experience as "destructive to my very core." Haunted for months by the memory, she doubted she could continue in palliative care [40].

There is a further point. When the state forces physicians to do what they believe to be wrong it demands the submission of intellect, will, and conscience to serve ends they find morally abhorrent. They are treated as cogs in the state machine, or, to use the words of Martin Luther King Jr., they are "thingified" [41]. Immanuel Kant's insistence that a human person must never be treated as a means to an end [42] – what we call the principle against servitude – forbids the imposition or acceptance of this kind of treatment, which is fundamentally incompatible with human dignity, freedom and equality and contributes to deeply felt and lasting shame.

## Rational Distinctions, Limits and Priorities

The distinction between perfective and preservative freedom of conscience is rationally

derived from the exercise of conscience, without reference to particular ethical systems or morally contested procedures, while the principle against servitude recognized by the authors of the *Declaration* and the UDHR is widely accepted [12, 43, 44, 45, 46, 47, 48]. Granted that we cannot address all issues related to conscience, dignity and good medical practice within the scope of this paper, the distinction and principle indicate how different reasonable comprehensive views can be accommodated within free and democratic societies.

First, setting aside the case of objective error established on the basis of the facts of a particular case, while one can affirm an ethical obligation to do what one believes to be right, it would be incoherent to posit an ethical obligation to do what one believes to be wrong.

Second, preservative freedom of conscience requires less of society than perfective freedom, and the effects of its suppression more serious. Thus, much more substantial grounds are required to justify its suppression, and in the event of conflict, preservative freedom of conscience must take precedence.

Third, suppression of preservative freedom of conscience that also violates the principle against servitude is unacceptable.

## A WMA Protection of Conscience Policy

There is clearly a need for a WMA preservative freedom of conscience policy consistent with physicians' traditional and undisputed obligations to their patients, including duties of respect, care and non-abandonment. The goal is to protect physician integrity in relation to the moral and medical character of their actions, not the character or characteristics of patients. This will help to ensure that patients will be cared for by physicians whom they know are "free to make clinical

and ethical judgements without any outside interference" [49].

Preservative freedom of conscience should be protected in relation to all procedures, services and acts contested on the basis of reasonable comprehensive views, even views supported by the state or the medico-legal establishment. A procedure-specific policy is unsatisfactory in principle and not realistic in view of ethical challenges continually arising from rapid biotechnological developments, some bordering on science fiction [50, 51]. Existing WMA policies demonstrate that it will never be possible to develop a complete and universally acceptable list of morally contested procedures and services [52, 53, 54, 55, 56].

A succinct and general statement in the *International Code of Medical Ethics* should reinforce the principle that physicians have a duty to resist and refuse to participate in acts that can reasonably be construed as harmful to patients, a principle already reflected in WMA policy [57, 58]. Former WMA Director of Ethics Dr. John R. Williams has suggested, "A physician should resist all attempts by governments, regulators and patients to force him/her to perform or facilitate actions to which he/she has a well-founded and defensible conscientious objection" [59]. To this we would add, "while continuing to provide necessary treatment and care unrelated to the morally contested action. To ensure the health of the patient is not endangered".

A general ICME statement should be supplemented by guidance to help physicians defend their personal and professional integrity while providing medical services within the context of patient-centred practice. Guidance should support physicians resisting not only direct personal provision of morally contested services or procedures, but also other forms of involvement acknowledged by the WMA to be morally relevant: referral [2], countenancing, condoning, facilitating or aiding [59, 60], pro-

viding skills, premises, supplies, substances or knowledge, including individual health information [60], planning, instruction or training [61], preparation of reports [62] and retrospectively affirming or supporting unethical practices [55, 63].

An ICME statement and guidance of this kind would be fully consistent with the origins and purpose of the *Declaration of Geneva*. The authors of the *Declaration* understood that human dignity is safeguarded when physicians resist attempts to compel them to do what they believe to be wrong. They would never have set conscience in opposition to good medical practice. Neither should we.

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## The World Health Organization Fifty-fifth Expert Committee on Specifications for Pharmaceutical Preparations Special Session with non-State Actors. Virtual, 6 October 2020



Rui Nakamura

The World Health Organization (WHO) Fifty-fifth Expert Committee on Specifications for Pharmaceutical Preparations (EC-SPP) Special Session with non-State actors, coordinated from WHO headquarters, was held virtually on October 6, 2020. According to the invitation from Dr. Mariângela Simão, Assistant Director General of the WHO, Access to Medicines, Vaccines and Pharmaceuticals, on behalf of Dr. Tedros Adhanom Ghebreyesus, Director General of the WHO, many representatives nominated by their organizations attended from all over the world. Thanks to the nomination by the World Medical Association (WMA), I participated in this great session.

Dr. Sabine Kopp, Team Lead of Norms and Standards for Pharmaceuticals, Health Products Policy and Standards Department of the WHO, who chaired the session, introduced current activities associated with the ECSPP covering norms and standards for pharmaceuticals, including medicines

quality assurance, regulatory guidance, good practices, WHO model schemes and quality control specifications.

The ECSPP, an expert committee of the WHO, covers Norms and Standards for Pharmaceuticals: development, production, quality control, regulatory standards, inspection, distribution and supply. The EC-SPP offers about 170 current official WHO guidance texts and guidelines for medicines quality assurance and regulatory standards. Those guidance texts and guidelines were developed in response to recommendations and requests by WHO Governing Bodies, WHO Programmes or in response to major public health needs, following strict rules and procedures. Reviewed by expert groups and discussed in annual Expert Committee meetings, those texts would be adopted by the ECSPP, and recommended to Member States.

In my opinion, the process of developing guidance texts and guidelines by the EC-SPP is similar to that of developing policies, aiming 'to serve humanity by endeavoring to achieve the highest international standards in Medical Education, Medical Science, Medical Art and Medical Ethics, and Health Care for all people in the world' [1], by the WMA as the global representative voice of physicians. As the representative to the General Assembly of the WMA, I strongly feel the importance of experts' discussions and communications, including us, healthcare professionals. Besides, I'd like to refer to the fantastic messages from Dr. Jacques de Haller, Former President of the Standing Committee of European Doctors (CPME) and the Swiss Medical Association (FMH): 'I think it is most effective when groups are challenged by their own members. I mean, if

doctors speak to patients or if they speak to students, they can be felt as paternalistic. If students speak to patients, they are not experienced. So, if patients' organisations speak to patients and if doctors speak to their colleagues knowing what they feel, think and how they reflect about it, the communication can be more efficient' [2].

A wonderful presentation regarding COVID-19 related activities by the ECSPP was given as a technical agenda of the Fifty-fifth ECSPP. Many topics were raised, including specifications of oxygen, dexamethasone, dexamethasone phosphate injection, dexamethasone tablets, and remdesivir. As the matters of guidelines and guidance texts, compilation of relevant WHO guidance for SARS-CoV2 COVID-19 treatment, review and revision of existing WHO guidelines and guidance texts including WHO Good Manufacturing Practice for investigational pharmaceutical products for clinical trials in humans, WHO guidelines on transfer of technology in pharmaceutical manufacturing, and GMP guideline on the required practices during research and development of medical products were pointed out. In addition, the issues about 'biowaiver' studies were discussed.

I supposed that the main effect of COVID-19 pandemic would be the escalation of inequities and injustice that exist due to the pandemic, but then I was told that I was nominated for the COVID-19 Educational Award, Harvard University. It would be the time to make full use of the principles prepared before the pandemic, for example, the WMA Declaration of Helsinki (DOH) as an ethical guide for research involving human participants in clinical trials. It would be great if the DOH were



spoken about more. We can refer to the excellent article [3] describing the process of the DOH revision in 2013 by Dr. Cecil B. Wilson, Past President of the WMA and the American Medical Association (AMA). I think it is essential 'to involve in discussions those physicians not familiar with the work of WMA and thereby increase the visibility of the association' [4] commented by Dr. Jon Snaedal, Past President of the WMA and the Icelandic Medical Association. As Dr. Joe Heyman, Chair of Associate Membership of the WMA, Former Chair of the AMA Board of Trustees, and Former President of the Massachusetts Medical Society, kindly mentioned in his outstanding article, the Japan Medical Association published part of the WMA Journal in its own journal and spread it among all Japanese medical students and physicians along with an appeal for associate membership of the WMA [5].

When I wrote the first chapter of a textbook, published in 2018 by Oxford University Press, regarding clinical research and medical ethics, I quoted the golden and everlasting saying of Stephen W. Hawking, an English theoretical physicist, written in his best-seller *A Brief History of Time* as the epigraph: "The whole history of science has been the gradual realization that events do not happen in an arbitrary manner, but that they reflect a certain underlying order, which may or may not be divinely inspired."

I hope and am sure the discussion regarding COVID-19 pandemic in that session contributes to the history of science, clinical trials and medical ethics. Moreover, I'd like to remind of the critical message, 'In reality, the practical issues tend to override patient rights. This needs to be kept in mind' [6] said by Dr. Jon Snaedal in his outstanding lecture in Japan several years ago.

As another technical agenda, international pharmacopoeia including the monograph development process was introduced. The main features of the monograph development process are: designed to ensure wide consultation and transparency; governed by publicly available rules and procedures, for example, 'schedule for the adoption process' outlining the development history is included in each working document; foreseeing continuous revision of methods and specifications to reflect advances in analytical science and regulatory requirements; allowing participation of all interested parties; applying conflict of interest and confidentiality rules. We would learn a lot from the chapter [7] regarding confidentiality written by Dr. Raanan Gillon, Immediate Past President of the British Medical Association, and Dr. Daniel K. Sokol.

After closing the successful session, I felt the importance of the perspectives of physicians/clinicians in every aspect dealt with there. I believe the more we participate, the

more we contribute to the WMA's sublime mission.

Lastly, I am grateful to Ms. Claire Vogel, NSP at the WHO, Ms. Anne-Marie Delage, Secretary of the WMA, and Dr. Otmar Kloiber, Secretary General of the WMA, for their generous support.

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# Official Letter to the World Medical Journal

We regrettably received the political hostile comment of two Canadian politicians on the development of organ transplantation and national policies in China. This comment is in the same form of the conspiracy theory that the authors propagandized during last decade, in the attempt to disguise as academic paper, but filled with non-scientific misconduct (self-citation, confusing circular logic, invalid reference, personal attack). The two David ignored the basic facts of the development of organ transplantation in China and insisted on smearing and slandering the development of China with unconfirmed evidence. In fact, as described in the article *The Reform Process of Organ Donation and Transplantation in China*, the Chinese government has repeatedly discussed the history and development of organ transplantation in China since 2005 [1, 2]. In response to international doubts about organ donation and transplantation in China, the Washington Post made a detailed introduction to the development and history of organ transplantation in China by citing authoritative evidence in 2017[1]. The content is informative and credible, and it is also for most rational readers. In recent years, the development of organ transplantation in China has been officially recognized by international transplant scientific community, such as the World Health Organization (WHO), The Transplant Society (TTS), Pontifical Academy of Science [2, 3, 4]. The two David attempted to extend the political attack and discredit on China to the academic field. To this end, we resolutely oppose politicizing academic issues and publishing letters of fabrication from two Canadian politicians in the World Medical Journal.

Regarding the part of the letter concerning Professor Shi Bingyi's personal remarks, we have thoroughly verified with Professor Shi Bingyi. Professor Shi Bingyi's statement is as follows: "As the two David said in their letters, I have responded many times through various channels (8,9 Phoenix TV and JAMA). I personally did not mentioned the number of organ transplants in China on any occasion. In view of the fact that the two David didn't put forward any new evidence, and all the evidence was in 2007, I won't make any new response. The figures of organ transplantation in China before 2007 that David paid attention to can refer to Professor Huang Jiefu's report published in Lancet magazine [2] and Washington Post's report on the development of organ transplantation in China [1].

We have always maintained an open attitude and responded positively to the challenges and criticisms from the international community, especially from the international transplant community, regarding organ transplantation in China. Professor Huang Jiefu has published a series of articles, comments, etc., introducing the reform and current situation in the field of organ transplantation in China. As we pointed out in the article, the reform and development of organ transplantation in China cannot be separated from international wisdom, and we have always welcomed the help of international transplant experts in organ

transplantation reform in China. In recent years, the reform in the field of organ transplantation in China has been recognized by leading members of international transplant and scientific communities. Many experts who are skeptical about China have also personally visited China and witnessed the process of organ donation and transplantation in China, thus changing their negative attitude towards China. The two Canadian politicians have never conducted any field investigation on organ donation and transplantation in China. Although they are extremely concerned about China's negative information, the information they have received is hearsay information or even deliberately fabricated lies.

The direct evidence from many international experts of WHO, TTS and PAS, who visited China and witnessed the reform and development of organ transplantation in China, has been deliberately and selectively ignored by the group headed by the two Canadian politicians.

In summary, we oppose the letter of political comments from two Canadian politicians with vinous of scientific misconducts to be published in any academic journal. Professor Shi Bingyi has repeatedly responded the unfounded accusation from 13 years ago in various forms and on various occasions. China will strengthen and enlarge the exchanges & cooperation with the international transplant communities, continue to strive to build an ethical organ transplantation system in line with WHO guiding principles and contribute "Chinese Wisdom" to the progress of organ transplantation in the world.

Sincerely,  
Rao Keqin

*Vice President and Secretary General of Chinese Medical Association*

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