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# JUNIOR DOCTORS NETWORK

*empowering young physicians to work together towards a healthier world through advocacy, education, and international collaboration*

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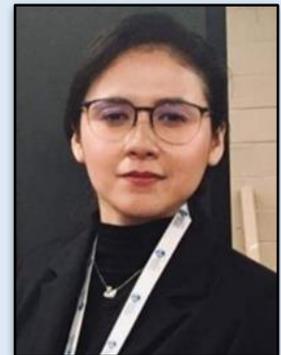
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## Words from the Chairperson

[Yassen Tcholakov](#), MD MScPH MIH  
Chairperson (2020–2021)  
Junior Doctors Network  
World Medical Association



Dear colleagues,

It is my pleasure to introduce this special edition of the *Junior Doctors Network (JDN) Newsletter*. Congratulations are in order for the Medical Ethics Working Group, with a dynamic team that has supported JDN contributions on this important theme for the second year in a row! Also, we recognize the hard-working and always reliable Publications Team that has guided the editorial process and worked closely with JDN members!

Ethics is a core tenet of the medical profession, which is why doctors are among the most trusted individuals in many societies. Nevertheless, this past year has proven fraught with ethical dilemmas, from prioritising resources during the worst times of this pandemic, to adapting new ways of practicing medicine while trying to preserve quality of care, confidentiality, and patient trust. This year was also marked by a series of disruptions in training programs by re-deployments, where junior doctors were sometimes asked to perform care in less than optimally supervised settings outside their field of expertise.

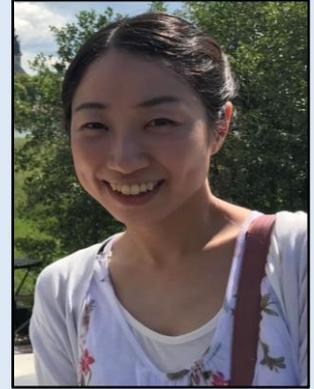
Finally, the topic of racism, gender inequity, and other injustices are of foremost concern, with respect to how we treat patients and how we manage collegial interactions within our profession. While we try to hold ourselves to high standards of civility and respect, there is evidence of sexism and discrimination within our own profession. Women and other marginalized groups are often underrepresented in medical leadership, despite representing a major portion of the global health workforce. As the next generation of medical professionals, we must promote improved working conditions and encourage inclusive workplace environments for all health professionals.

Enjoy the read!

Sincerely,  
Yassen Tcholakov

## Words from the Communications Director

[Maki Okamoto](#), MD  
Communications Director (2020–2021)  
Junior Doctors Network  
World Medical Association



Dear colleagues,

It is my pleasure to welcome you to the Medical Ethics Special Edition of the *Junior Doctors Network (JDN) Newsletter*.

In their daily clinical practice, junior doctors encounter workplace situations that require the application of medical ethics principles for difficult decisions. The decision-making process in medical ethics is complex and challenging as there are no absolute answers. It is further compounded by a lack of comprehensive or clear guidelines which cover the unique situations that junior doctors encounter each day in their workplace.

Under these circumstances, it is important to promote positive communication with patients and their families, where junior doctors actively listen to patients, provide adequate information, and support their decisions. As JDN members, we play a significant role in direct patient care during our training. Our empathetic listening and understanding is essential, especially during difficult life decisions such as the management of severe coronavirus disease 2019 (COVID-19) infections and end-of-life care.

Please enjoy reading this Special Edition and be inspired by your JDN colleagues who share their various experiences and perspectives on medical ethics topics. We hope that this resource offers valuable ideas that can guide you during your training.

Sending love from Berlin,  
Maki Okamoto

## Words from the Medical Ethics Working Group Chair

[Lwando Maki](#), MD  
Medical Ethics Officer (2020–2021)  
Medical Ethics Working Group Chair (2020–2021)  
Junior Doctors Network  
World Medical Association



Dear Junior Doctors, Members of the WMA, and Colleagues in health,

On behalf of the Medical Ethics Alive Team (2020–2021) of the Junior Doctors Network (JDN) Medical Ethics Working Group, it is with great pleasure that I introduce the 2<sup>nd</sup> annual Medical Ethics Special Edition of the *JDN Newsletter*.

In the World Medical Association (WMA)'s [Medical Ethics Manual](#) (2015), medical ethics is recognised as the branch of ethics that examines moral issues in medical practice, with strong connections to biomedical ethics. It clarifies that medical ethics primarily addresses issues that originate in medical practice, whilst biomedical ethics focuses on moral issues that arise from the biological sciences. Medical ethics forms the foundation of the medical profession and comprises an integral part of global health.

Over the past decades, medical ethics has been brought into the limelight, as a result of the active participation of health professionals in national and international discussions on clinical competencies and responsibilities, human and animal research, patient confidentiality and autonomy, and end-of-life care. The current coronavirus disease 2019 (COVID-19) pandemic has highlighted the importance of medical ethics as well as the urgent need for medical curricula reform. As such, it behooves junior doctors to take the lead in championing efforts to increase awareness about medical ethics topics in clinical practice amongst the global health workforce.

This 2<sup>nd</sup> annual Medical Ethics Special Edition of the *JDN Newsletter* marks the first anniversary of the historic milestone recognized as the first JDN officer collaboration. This collaboration between the JDN Publications Team and the JDN Medical Ethics Working Group is a symbol of the leadership, synergy, and enthusiasm of junior doctors who share their experiences and expertise on topics that affect junior doctors in the clinical and community workplace.



The Medical Ethics Working Group will continue to work towards empowering young physicians with the knowledge and understanding of medical ethics as they continue to work towards a healthier world through advocacy, education, and international collaboration.

Stay connected, and let your voice reach the world!

Sincerely  
Lwando Maki

## Words from the Medical Ethics Working Group Project Co-Lead

[Aashish Kumar Singh](#), MBBS  
Medical Ethics Working Group Project Co-Lead (2020–2021)  
Junior Doctors Network  
World Medical Association



Dear colleagues,

In this era of globalisation and capitalism, where the world is mostly driven by financial gain, ethics is often overlooked. We observe this scenario within the medical community, where hospitals often disregard the rights of health care workers and exploit them to the point of burnout. Similarly, medical students are not universally taught about ethical principles and challenging clinical scenarios, which can impact their clinical training and doctor-patient rapport and communication.

As Junior Doctors Network (JDN) members, we must collaborate on initiatives that promote the understanding of ethical principles in the health professions. By better understanding the role of medical ethics in clinical and community health practice, we will be prepared to highlight unethical practices, advocate for improved workplace conditions, and contribute significantly to global health discussions on best approaches for the future of health care service delivery.

It has been an honor to serve as project co-lead on the innovative development of this second Medical Ethics Special Edition with my colleagues, Dr Uchit Thapa (Project Co-Lead, Medical Ethics Working Group) and Dr Lwando Maki (Chair, Medical Ethics Working Group). Likewise, I appreciate the leadership of Dr Helena Chapman (Director, Publications Team), who has led the editorial process with utmost sincerity and dedication for this unique collaboration. I also recognize the editorial expertise of the JDN Publications Team, who has supported this collaboration and editorial tasks to completion. Finally, I thank all JDN member authors who provided their scientific perspectives and reports on relevant medical ethics topics for this issue.

Stay connected, and let your word reach the world!

Sincerely,  
Aashish Kumar Singh

## Words from the Medical Ethics Working Group Project Co-Lead

[Uchit Thapa](#), MBBS

Medical Ethics Working Group Project Co-Lead (2020–2021)  
Junior Doctors Network  
World Medical Association



Dear respected junior doctors,

Medical ethics defines us as physicians, guides us towards perfecting our medical practice, and helps us find the correct path in times of dilemma. During our medical training, although we are trained to solve medical mysteries, little emphasis is placed on understanding our patients as individuals and family members. We also learn the essential skills of empathetic listening and communication throughout our clinical rotations.

The Medical Ethics Working Group of the Junior Doctors Network (JDN) aims to highlight the importance of medical ethics through our clinical activities. We guide individuals in different phases of medical practice, identify challenges facing young physicians, answer questions through our collective experiences, and make our voices heard on an international platform. The JDN has played a crucial role in promoting the value of junior doctors, including advocating for pressing ethical issues such as gender equity in medical leadership and the impacts of climate change. Over the years, these achievements have been successful in bridging the gap between young doctors and audiences worldwide.

The *JDN Newsletter* has served as a perfect platform where young physicians can raise their voices about health challenges, advocate for vulnerable populations, and present solutions to authorities. This resource has always provided young doctors with a voice without discrimination and highlighted issues of utmost importance on the international stage. I believe that this Special Edition will continue to provide valuable information to young doctors around the world.

I would also like to take this opportunity to applaud Dr Lwando Maki for the highly recommendable work put forth in the field of medical ethics, leading the JDN Medical Ethics Working Group to new heights, and bestowing confidence in myself as the Project Co-lead. Also, I offer my utmost respect to Dr Helena Chapman and the JDN Publications Team for their relentless efforts and time invested for years devoted to JDN activities. Lastly, I would like to thank all authors who have contributed to the *JDN Newsletter* and all readers who will gain insight from included scientific perspectives and clinical experiences.

Sincerely, Uchit Thapa

## Words from the Publications Director

[Helena Chapman](#), MD MPH PhD  
Publications Director (2020–2021)  
Junior Doctors Network  
World Medical Association



Dear JDN colleagues,

On behalf of the Publications Team (2020-2021) of the Junior Doctors Network (JDN), we are excited to share the Medical Ethics Special Edition of the *JDN Newsletter* with junior doctors across the world.

This 23<sup>rd</sup> issue of the *JDN Newsletter* marks the second collaborative effort between the JDN Publications Team and the JDN Medical Ethics Working Group to develop a joint Special Edition issue. This collaboration exemplifies the enthusiasm, passion, and leadership of junior doctors who share key clinical and community health experiences and perspectives on topics related to medical ethics.

The *JDN Newsletter* offers a global stage for junior doctors across the globe to contribute and disseminate updates on JDN activities, critical analyses on emerging health issues, and reflections on clinical and community experiences. Their inspirational activities can empower other junior doctors to seek opportunities to share their expertise and experiences, engage in valuable collaborations, and strengthen communication between JDN members and the World Medical Association (WMA).

We recognize the dedicated efforts of all leaders of the Medical Ethics Working Group and editors of the JDN Publications Team 2020-2021, as we finalized this 23<sup>rd</sup> issue. We greatly appreciate the continued support of the JDN Management Team and WMA leadership as our team refined the content of this high-quality resource for junior doctors. We appreciate the support of our JDN family and hope that you enjoy reading about junior doctors' experiences in this 23<sup>rd</sup> issue!

Together in health,  
Helena Chapman

## Reflections on Promoting Medical Ethics by the JDN Publications Team (2020–2021)

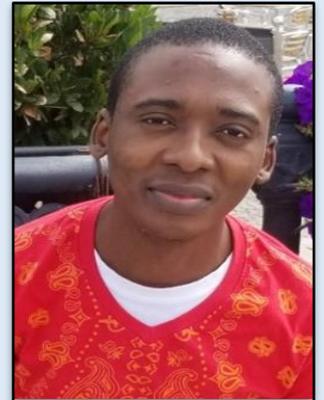
### Dr Helena Chapman (Dominican Republic)

As junior doctors, we must promote high-quality principles of medical ethics in our daily clinical and community practice. By reviewing the principles of medical ethics through case studies, we can enhance our analytical skills and be prepared on how to best manage and communicate ethical challenges with our colleagues as well as patients and families. Together, we can advocate for best clinical practices that prioritize medical ethics across our health systems.



### Dr Victor Animasahun (Nigeria)

Medical ethics is the standard code of conduct that guides our daily clinical practice. It is the unbiased framework for making fair and safe clinical decisions and forms the blueprint for navigating ethical dilemmas.



### Dr Nishwa Azeem (Pakistan)

I believe that the basis of medical ethics in practise is respect. We must view our patients as enabled and equal individuals, who we seek to serve as a part of our duty.



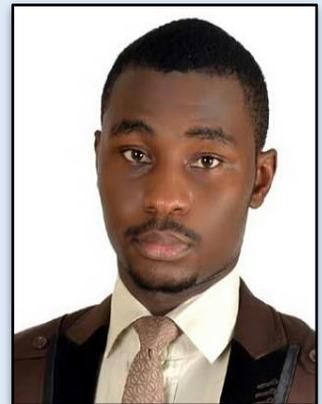
### **Dr Ricardo Correa (Panama/United States).**

Medical ethics offers a framework for the best practice of medicine in a humane and empathetic manner. The principles of medical ethics should govern our clinical practice, and we should advocate that ethical practices should be widely applied across health systems.



### **Dr Suleiman Ahmad Idris (Nigeria)**

As a thin line exists between 'Medical Doctor' and 'Doctor Frankenstein', medical ethics ensures that we do not cross this line while delivering our services to humanity. We should create time to learn the ethics of medical practice and advocate for its consistent application in our daily clinical responsibilities.



### **Dr Giacomo Crotti (Italy)**

The COVID-19 pandemic and resulting public health measures – social distancing and vaccination efforts – have uncovered a defining dilemma of public health ethics: the complex balance between individual rights and public interest. In light of the pandemic response efforts, the need to alternatively compress autonomy over utility forces us to reflect: Can increased community awareness of this dilemma improve adherence and participation? As doctors, we can advocate for in-depth discussions that lead to community action.



### **Dr Mashkur Abdulhamid Isa (Nigeria/United Kingdom)**

To me, Medical Ethics refers to the moral codes and values that guide the practice and conduct of medical professionals, based on the principles of autonomy, beneficence, non-maleficence, and justice. In a rapidly changing world, ethics is invaluable to ensure that medical professionals are able to fulfill their obligations in patient care.



### **Dr Jooyoung Moon (Republic of Korea)**

As physicians, we often have to make difficult health care decisions for our patients. While everyone may have a different set of moral values, we cannot make such decisions based on our emotions or personal preferences. It would help to remember that, in any case, we must always act in the best interests of our patients.



### **Dr Mellany Murgor (Kenya)**

Medical ethics guides the practice of medicine and offers a platform for the continued discussion of evolving topics in clinical practice. It is shaped by various internal and external determinants in health, with various perspectives that should be understood. As junior doctors, we have the opportunity to advocate for high ethical standards that shape the future of medical practice. We must continue to share our experiences, learn from past mistakes, and prioritize ethical principles throughout our training.



## **Dr Vandrome Nakundi Kakonga (Democratic Republic of the Congo)**

Many ethical questions are raised by health systems in low-income countries, including challenges faced by patients who cannot afford medical care for their families. Doctors, who accept their professional devotion to patient care, may face significant limitations when providing clinical care. Universal health coverage is a global priority, as doctors are trained to care for all individuals, not only those who are financially secure to afford care.



## Reflections on Promoting Medical Ethics by JDN Members

### **Dr Dabota Yvonne Buowari (Nigeria)**

The practice of medicine is guided by the application of the principles of medical ethics. In our clinical practice, we can promote high-quality ethical practices that can prevent misunderstanding and potential litigation, enhance patient-doctor rapport, and manage ethical dilemmas.



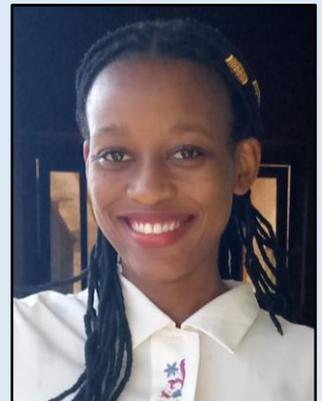
### **Dr Shiv Joshi (India)**

As doctors, our actions and approaches in medicine reflect our identity, priorities, and underlying values. We must continue to promote the practise of ethically competent medicine in our daily clinical practice.



### **Dr Kelechukwu Oranu (Nigeria)**

Medical ethics offers a check in medical practice for health professionals. It ensures that patients' decisions for management plans are respected and that treatment protocols result in maximum benefit with minimal harm.



### **Dr Jasmine Shrestha (Nepal)**

When the difference between right and wrong becomes blurred or complicated, our application of medical ethics based on moral principles and values can guide our clinical decisions.



### **Dr Mary Adaeze Ugah (Nigeria)**

Medical ethics is a career-long process of understanding, analysing and properly managing a plethora of distinct clinical scenarios that usually occur. As doctors, we must use the basic tenets of ethics – autonomy, do good, do no harm, and be just – while seeking clarification or assistance during challenging scenarios in clinical practice.

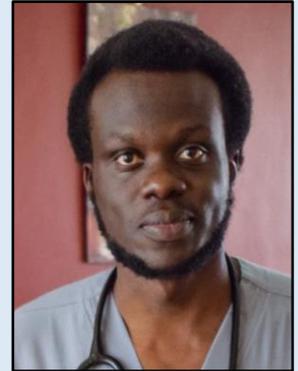


## Ethical Dilemmas during the COVID-19 Pandemic: Reflections from the Frontline

[Mellany Murgor](#), MD  
Medical Officer  
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Medical Officer  
Nairobi, Kenya

[Robert Okinyi](#), MBCh.B  
Medical Officer  
Nairobi, Kenya



In medical practice, it is a general rule that the first few years after medical school graduation are usually the most challenging time for junior doctors. As they are supervised in their clinical training, their senior colleagues, supervisors, and teachers provide essential guidance and recommendations. However, during the coronavirus disease 2019 (COVID-19) pandemic, junior and senior doctors have navigated uncharted waters, pushed to the limits with minimal time and flexibility as they deliver medical care.

**This article recounts two reflections from our clinical experiences, as we worked tirelessly on the frontline during the ongoing COVID-19 pandemic in Kenya.**

### **First, Do No Harm: The System Fails the Hippocratic Oath**

Patient A, a 65-year-old man, experienced chest pain and immediately scampered to the nearest hospital. As a spirited fight against his diabetes and hypertension, aided by a cocktail of medication, he knew that his ailments were well controlled. Still, he knew that he had a heightened cardiovascular disease risk, and this chest pain did not bode well with him. On initial assessment, we evaluated the chest pain by conducting a complete blood

count and electrocardiogram (EKG). We noted that his oxygen saturation was teetering between 85-90% on room air, causing slight breathlessness. His radiographic imaging resulted in a diagnosis of atypical pneumonia. As the COVID-19 inpatient isolation unit was almost full, he secured the last bed in the unit.

Patient B, a 38-year-old female with no known chronic illnesses, experienced rapid breathing and traveled to the hospital. A rapid medical evaluation concluded that her oxygen saturation was 60% on room air. Her radiographic images concluded pneumonia, most likely due to COVID-19, and with this COVID-19 wave, facilities lacked space for hospital admissions.

Since Patient A had registered before Patient B, Patient A was prioritized for the COVID-19 inpatient isolation unit ward bed, although Patient B had a more clinical severe COVID-19 presentation. However, Patient A had multiple risk factors that could not be ignored, including his advanced age and other co-morbidities.

### **Notably, this clinical scenario of two sick patients presented an ethical dilemma: Who should be hospitalized?**

#### **Physician, Heal Thyself**

As we completed our duties during the peak periods of the pandemic in Kenya, we recall when we were overwhelmed by COVID-19 cases for three weeks. Our clinical schedules started at 7AM, and we would still be conducting ward rounds at 5PM. During our night shifts, we would have to be alert all night, vigilantly caring for our COVID-19 patients. It was often impossible to take any breaks, since we were fully donned in personal protective equipment (PPE), which we would only remove when exiting the isolation unit. Other less urgent albeit important tasks – such as updating patients' next of kin – were often delayed due to the demanding workload and worsened by visiting restrictions to maintain infection control measures.

This scenario offers junior doctors several important reflections: Was there ever a time, in the middle of our busy clinical shifts, when we should have prioritized our well-being over our patients' care? Even if we should prioritize our well-being, how could we apply this step in practice? With rising COVID-19 cases and few medical staff, should we have bypassed some of our institutional processes to recruit new staff and risk inadequately inducted frontline workers on the medical team? How much harm occurred when we had barred interactions between patients and families or delayed our clinical updates to families?

### **We Strive to do Better**

Many global healthcare workers have provided clinical and community care, as they continue to advance their knowledge about this novel coronavirus. Bedside clinicians have had to engage in difficult decision-making, where each decision has benefits and risks. Often, some decisions have already been made, due to health system inadequacies. The price paid in these less-than-perfect circumstances include undermining patients' care, harming the physical and psychological well-being of healthcare workers, patients, and families, loss of family income, risking inadequate vaccine coverage in lieu of individual autonomy, deploying ill-trained and ill-equipped caregivers, and contributing to adverse outcomes of patients or caregivers.

In anticipation of future pandemics and for the benefit of expanding the knowledge base of medical ethics, it is important that junior doctors share the ethical issues that they have faced during the COVID-19 pandemic.

**These collective experiences can help future doctors and decision-makers in their clinical and community practice, as we shape future response efforts to pandemics and other emerging health threats.**

## COVID-19 Protocol in Implementation: 'The Insignificant Contacts'

[Habeeb Ogundipe](#), MBBS

Junior Resident, Department of Surgery  
University College Hospital  
Ibadan, Oyo State, Nigeria



The coronavirus disease 2019 (COVID-19) pandemic has continued to evolve since its onset in December 2019, and signs of a third wave have already been observed (1). Several countries and agencies have developed protocols for infection control, including early case identification, isolation, treatment, contact identification, and quarantine. These policies have helped control the spread of this virus, whose replication rate is higher than previous coronaviruses of epidemiological importance, such as the severe acute respiratory syndrome coronavirus (SARS-CoV) and Middle East respiratory syndrome coronavirus (MERS-CoV) (2). As of July 23, 2021, 192,284,207 confirmed cases and 4,136,518 deaths due to COVID-19 have been reported (1).

Following emergency approval of several vaccines against SARS-CoV-2, many countries are implementing vaccination programs that prioritize healthcare workers and vulnerable populations. As of July 25, 2021, 3,646,968,156 vaccine doses have been administered worldwide (1). This leaves a significant proportion of the population, especially in low- and middle-income countries, largely undervaccinated.

### Defining and Managing COVID-19 Contacts

*Case definition.* According to the World Health Organization (WHO), a COVID-19 contact is defined as: 1) a person who has had direct physical contact or exposure within 1 meter and for at least 15 minutes with a probable or confirmed case of COVID-19; or 2) a person who has been involved in the direct care for a patient with probable or confirmed COVID-19 disease without the use of recommended personal protective equipment (PPE), with exposure occurring between two days before and 10 days after the onset of symptoms (3).

*Isolation.* The WHO recommends that all contacts of confirmed or probable COVID-19 cases should be quarantined in a designated facility or at home for 14 days from their last exposure (4). The Centers for Disease Control and Prevention (CDC), however, excludes individuals who have recently been diagnosed with COVID-19 (preceding three months) and persons fully vaccinated against COVID-19 (5).

## The Challenge

One significant challenge in the control of this infection is the failure to follow established protocols for COVID-19 prevention and management. The following case scenario describes the situation of a patient with symptoms suggestive of COVID-19 in a typical public hospital in a low-income country (**Box 1**).

In some settings, a hospitalized patient with symptoms suggestive of COVID-19 is assigned to a bed in an open general ward with other patients. In the **best-case scenario**, the patient is immediately moved to a designated COVID-19 isolation ward, and nasal swab testing is conducted. In the **worst-case scenario**, nasal swab testing is conducted, and the patient remains in the open general ward until the result is available. If the result is positive, then the patient would be relocated to a designated COVID-19 isolation ward.

**Box 1.** Case scenario.

This case scenario marks the potential exposure risk of three categories of individuals:

- Hospital staff:* Doctors and nurses provide direct clinical care to patients.
- Relatives:* Family members help their sick loved ones by buying medications and food, spending time to comfort them during visiting hours, and offering additional errands.
- Surrounding patients and families on hospital ward:* Although there is minimal direct contact with non-relative patients, other individuals on the hospital ward may be in contact.

If this case scenario occurs in resource-constrained settings, diagnostic testing or isolation may not be available for close contacts of the index case, as they continue their regular daily activities. As these COVID-19 contacts are erroneously treated as 'insignificant contacts', there is an increased risk of SARS-CoV-2 transmission, especially by asymptomatic carriers.

**Ongoing research studies have demonstrated that infection control measures are key to mitigate exposure risk to susceptible individuals.**

## Clinical Evidence

One study noted that persons who directly care for individuals with the viral infection have an increased risk of COVID-19 disease and hospitalization (6). This suggests that healthcare workers and relatives of newly diagnosed COVID-19 cases are at the highest risk of infection. Another study concluded that COVID-19 contact tracing is fundamental to

treat contacts and reduce community transmission (7). Additional infection prevention and control measures include extensive screening for SARS-CoV-2, quarantining patients on affected hospital wards, and use of PPE during all patient contacts. However, compliance may be limited in certain settings, due to the health worker shortage, limited capacity on hospital wards and quarantine facilities, and constant need of relative support to offer support and accompaniment.

However, these considerations have been counteracted by other scientists. Another study reported that the logistic and economic impact of implementing the protocols for COVID-19 contacts should be prioritized (8). Authors highlighted that of the 376 health workers in this study, 94 symptomatic COVID-19 cases and 81 asymptomatic contacts of COVID-19 cases were quarantined for 10 to 14 days, and 201 health workers remained to provide medical care. The implementation of these quarantine measures led to a depleted health workforce for direct medical care and economic loss to the hospital (8). However, authors failed to consider the possible role of asymptomatic individuals on COVID-19 transmission (8). Furthermore, the CDC has provided interim guidance for individuals with high-risk exposure in non-U.S. healthcare settings, where the decision for quarantine measures should be balanced against several factors, including the ability to maintain staffing levels to provide adequate care to all patients (9). This guidance, however, has led health workers to fear for their safety as well as the safety of other health workers, patients, and families.

**Irrespective of our challenges to implement standard quarantine protocols for COVID-19 contacts, there is a clear need to protect patients, contacts, and society from continued disease transmission.**

Although vaccination programs are ongoing and expanding to cover the entire population, vaccination does not guarantee full immunological protection, especially with the evolving SARS-CoV-2 strains. Thus, continued virus transmission and increased COVID-19-related mortality may persist even when persons are fully vaccinated, suggesting the need for additional protection, irrespective of vaccination status. All COVID-19 contacts are at risk of viral infection, constitute a significant vehicle for disease transmission, and should be protected irrespective of logistical constraints.

The continued enforcement of non-pharmacologic preventive measures – such as the use of facemasks and handwashing hygiene – should always be emphasized. Augmenting these measures with safe and effective chemoprophylaxis will go a long way in helping all COVID-19 contacts. There is a need to evaluate available data on COVID-19 chemoprophylaxis and consider emergency authorization for the most promising and safe candidates.

### Conclusion

COVID-19 is still around, and no one should be considered an insignificant COVID-19 contact, irrespective of management challenges as a key factor in disease control. While countries aim to adhere to existing hospital protocols and guidelines, there is a need to strengthen immunological protection against COVID-19 beyond vaccination and non-pharmacologic preventive measures. A viable and safe option remains chemoprophylaxis against SARS-CoV-2 in both vaccinated and unvaccinated groups.

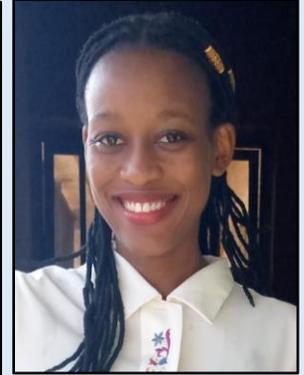
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## Confidentiality: Until Death Do Us Part?

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Confidentiality begets trust. As an underlying principle of medical ethics, it behooves every medical practitioner to ensure that trust is never tampered with or disregarded (1,2). Although it is a non-negotiable tenet of medical practice, there are exceptional situations where patient information may be disclosed. For instance, the law may require the release of patient information when preparing a coronary report or death certificate for the Ministry of Health records. It also may occur when meeting a statutory duty of candour, described when there is imminence of harm to identifiable individuals or public health (e.g. disease outbreak) or when there is potential benefit to at-risk individuals or public health (e.g. genetic disease) (2,3). However, some patient deaths can lead to a multiplex state, where healthcare providers must decide whether and which information to share with family members and health authorities.

**The question remains: Can confidentiality be respected when patients die? Let's take a closer look at two real-life ethical scenarios that occurred in Nigeria in May 2021.**

### Clinical Scenario 1

An Instagram video surfaced of the family member of a deceased patient (Patient A) who was treated in a public hospital prior to his death. The hospital management were implicated for the death of Patient A by the relatives. They claimed that they were unaware of the kind of care given to Patient A, who was frequently left unattended. As the social media video went viral, people expressed shock at the alleged hospital negligence. In response to these allegations, the hospital's next action was intriguing: The hospital directors revealed classified medical records of the Patient A, noting that these records had already been publicized by the relatives (4).



By analyzing these two clinical scenarios, we emphasize that confidentiality, as a fundamental requirement of medical practice, should be protected at all times. Healthcare providers should prioritize effective communication skills with patients and family members about medical management at every step of clinical care. There are situations, however, where doctors may be swayed by public sentiments to disclose patient information, especially in the advent of death, as noted in these described scenarios. These actions can be averted by applying the basic principles of ethics, respecting the rule of law, and seeking counsel.

**As junior doctors, we can advocate for confidentiality and the use of ethical principles as we care for and communicate with our patients and their family members.**

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## Signing against Medical Advice in the Emergency Room: An Ethical Dilemma

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Signing against medical advice (SAMA) is also known as leaving against medical advice (LAMA), discharge against medical advice (DAMA), or leaving before the visit or admission is complete (LBVC). SAMA occurs when hospitalized patients who are mentally and psychologically stable decide to discharge themselves and discontinue treatment. They sign a formal document that confirms that they have been counselled by healthcare professionals about their illness and willingly decide to forego further treatment and accept any consequence of their actions. Hence, healthcare professionals would no longer be held responsible for any future health complication.

Globally, DAMA patients may decide to leave the hospital prior to admission or while being managed as in-patients, accounting for 1% of the total number of in-patients (1,2). Adequate definitive care and treatment is the principle behind hospitalization, in order to reduce risk of life-threatening consequences (2). If DAMA patients seek medical care after discharge, it may impose additional stress, health risks, and financial costs to patients and health facilities (2,3).

**This is a significant burden in low- and middle-income countries, where citizens have limited access to health insurance and most patients have to pay out-of-pocket expenses.**

In the emergency department, SAMA patients represent a high-risk population, irrespective of their illness. Patients decide to leave the hospital for various reasons, affected by cultural or religious beliefs, traditions, and disagreement with hospital regulations (4). Hospitals have established several measures to document the request by SAMA patients, and attending physicians counsel patients about their health conditions and must attest that patients are mentally and psychologically stable (5).

### **Ethical Implications of Signing against Medical Advice**

Since doctors must respect the autonomous decisions of SAMA patients, there are potential ethical implications that expose physicians to litigations of SAMA (5). For example, if patients' health deteriorates after leaving the hospital, they may sue physicians for authorizing their discharge home or disagree with the DAMA signed by relatives or caregivers (6,7). This can subsequently cause a disruption in patient-doctor relationships, affecting the ethical principles of autonomy and beneficence (6,7). Due to communal living in low- and middle-income countries, the decision-making process is often made by other family members, rather than individual patients – whether the head of the family, oldest male family member, husband or father-in-law, financially responsible family member or religious leader.

### **Conclusion**

Patients who seek medical care in the emergency room may decide to discharge themselves against medical advice, which can lead to ethical dilemmas and exposure of physicians to litigation.

**To minimize potential risks, physicians should take measures to document their clinical management as well as counselling efforts with patients in their clinical notes, especially for SAMA, DAMA, and LBVC patients.**

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## A cursory Look at the Ethical Challenges of Surgical Residency and Fellowship Training

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Surgical education is complex and requires the theoretical application of clinical knowledge for patient management. Hands-on skills are obtained and refined through years of training in surgical residency and fellowship programs.

**This training comes with unique ethical considerations, especially with patient consultations for surgical procedures and the application of surgical simulations and new technologies.**

### **Patient Consultations for Surgical Procedures**

As trainees prepare for surgical procedures, especially trainees in the early curve of their learning, peri-operative safety and surgical outcomes are of significant concern. As such, training centers have a structured system to supervise procedures. For example, trainees are initially introduced to simple and isolated tasks during the surgical procedure before they are certified to be competent to handle more technically challenging and complete procedures. Notwithstanding, conflict can ensue between teams' internal control to maintain beneficence and non-maleficence in a training setting and ensure social justice. Future surgeons are trained to provide in-depth descriptions of the surgical intervention, including the composition of the surgical team, and encourage patients' autonomy as they make decisions for their care. They must gain rapport with patients, in efforts to eliminate any erroneous perception of being experimented upon and any concerns about the level of patient-centered care (1).

### **Application of Surgical Simulations and New Technologies**

This ethical dilemma to maintain professional education has indeed led to the increased adoption of simulation for surgical training. As practice is said to lead to improvement and subsequent perfection, it cannot be overemphasized in surgical training. This innovative technology has been used to enhance technical skills education through augmented perception of the sense organs via haptic feedback, mastery of hand-eye coordination, and

the perfection of surgical skills with optimal speed and minimal errors. Today, its application ranges from use in simple procedures, such as bowel anastomosis and excision of soft tissue swelling, to more complex surgeries, like hepatic resection and laparoscopic operations (2).

*Animal and Computer-based Models.* Live animals have been used in wet laboratories as models for simulation training. Ethical concerns have been centered on the potential benefits and risks of these invasive procedures conducted on animals during the simulation training. With technological advances leading to the emerging use of virtual and augmented reality for training purposes, some issues associated with animal rights have been obviated. Others have argued, however, that this new training method may have challenges related to integrating non-technical skills, which are germane to the value-based system of ethics (3). Furthermore, the predictive validity of this tool in real practice and its capability to completely assess competence need further research.

*Artificial Intelligence.* The emerging trend of the use of artificial intelligence in surgery may simplify decision making in patient management. Implications, however, may include a deficit in the comprehension of core pathophysiological principles by trainees. Another critique of this pathway is the notion that this technology does not incorporate the factor of empathy in the provision of care (4).

**In addition to traditional hospital-based records, the internet has provided tremendous opportunities to advance surgical training.**

*Virtual Technology.* First, many health institutions have integrated online data systems to manage medical records. Although privacy rules on the handling of medical information exist, any data breach can result in significant consequences for patient care and the healthcare system. Second, video-based teaching has the potential to expand instructional content as well as create a community of practice. However, strict rules must caution trainees about the legal implications of posting uncensored information without patient consent.

### **Additional Ethical Considerations**

A few other ethical issues remain in relation to the use of surgical simulations. First, conflicting interests of surgical innovators with dual affiliations to industries and healthcare institutions could affect robust validation before its incorporation into training. Second, the costs of surgical education tools and the overall benefits to trainees and patients may be unknown and contentious (5). Third, there are disproportionate levels of access to high fidelity simulation systems between low-, middle-, and high-income countries, which stresses the need to promote global surgery education, research, and training.

**To address these challenges, the *winning model* – or partnerships among academic institutions in low- and middle-income countries and high-income countries – has been employed as a means to expose surgeons to surgical procedures.**

Some activities are limited, however, by the ethical requirements of medical licensing for practice within specific countries (6).

To conclude, surgical training in residency and fellowship programs is complex and is supported by various educational aids and faculty supervision. As junior doctors, we should recognize the ethical considerations that impact surgical training as well as patient management. After all, it is important to consider the thin line between clinical training and breaching one of the basic tenets of clinical practice, *primum non nocere* (first, do no harm).

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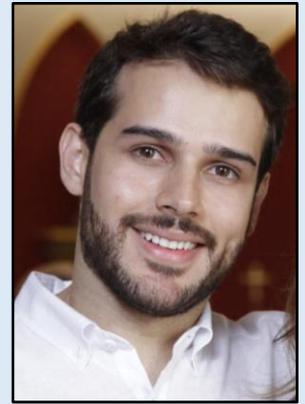
## COVID-19 and Bioethical Challenges: The Limits of Professional Autonomy

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The World Medical Association (WMA) recognizes professional autonomy and clinical independence as “*essential elements in providing quality health care to all patients and populations*” (1). Professional autonomy, which is defined as the state of being independent and self-directing in making decisions, secures the freedom to exercise professional judgement. When applied to medical practice, it defines conduct regarding the care and treatment of patients “*without undue or inappropriate influence by outside parties or individuals*” (1).

During the coronavirus disease 2019 (COVID-19) pandemic, health professionals faced numerous challenges in daily clinical practice, including limitations in adequate health infrastructure (e.g. personal protective equipment, excess work load and schedules), bad remuneration, and lack of continuing medical education platforms. These experiences emphasize the presence of bioethical conflicts in light of rapid transmission of a novel pathogen.

### **In Brazil, health professionals across the country were dedicated to providing medical care as they aimed to combat COVID-19.**

In April 2020, the Brazilian Federal Council of Medicine (CFM, in Portuguese) published the Technical Report that allowed the use of chloroquine and hydroxychloroquine, under exceptional conditions, for the treatment of COVID-19 (2). As this report was disseminated, physicians across Brazil adopted the “off-label use” of diverse drug therapies to manage COVID-19 cases. Now, in 2021, this report remains valid, although new high-impact research and consensus studies by national and international agencies and medical associations have concluded the ineffective use of chloroquine and hydroxychloroquine for COVID-19 treatment. On this basis, Brazilian medical doctors can administer their therapy

of choice to COVID-19 patients, regardless of the new scientific evidence. Although these actions prioritize medical autonomy in a clear bioethical conflict, they juxtapose the principles of non-maleficence and patient autonomy. For example, some doctors have administered nebulizer treatments with crushed hydroxychloroquine pills, without support from clinical guidelines or ethical research protocols. This scenario highlights the existing technical and political challenges to adopt therapies – with unproven clinical benefit – as public health policies.

Taking a closer look at the WMA declarations, the WMA Declaration of Geneva requires doctors to maintain the utmost respect for human life (3). The WMA Declaration of Helsinki defines that the medical intervention involving human subjects “*must be evaluated continually through research for their safety, effectiveness, efficiency, accessibility and quality*” and that “*physicians should consider the ethical, legal and regulatory norms and standards for research involving human subjects in their own countries as well as applicable international norms and standards*” (4).

Despite ensuring medical autonomy as a fundamental principle, the Brazilian Code of Medical Ethics states that “*medicine will be exercised using the technical and scientific means available aimed at achieving the best results*” (5). It also limits the process of professional decision-making to informed consent and patients’ autonomy on choosing diagnostic and therapeutic procedures, as long as they are appropriate and scientifically recognized. For this reason, we should be aware of three ethical considerations related to understanding medical autonomy for our clinical practice.

First, we should recognize that medical autonomy does not conflict with other bioethical principles, such as nonmaleficence, beneficence, and justice (**Table 1**) (6).

Ethical Principle	Definition
Nonmaleficence	Ensures that doctors should not intentionally bring harm upon patients
Beneficence	Defines the obligation to seek out and provide benefits to others, recognized as a duty towards caring
Justice	Refers to the fair and equitable distribution of benefits, which follows reasonable parameters when related to public health policies

**Table 1.** Definitions of three ethical principles (6).

Second, medical autonomy is not a “free-pass” for human experiments, as the conditions for medical research are well established by international standards. The WMA Declaration of Helsinki clearly stated that medical research involving human subjects must follow accepted scientific principles and be conducted only by individuals with the appropriate scientific training and qualifications (4). Even in exceptional circumstances, such as the COVID-19 pandemic, informed consent must be obtained, and strict ethical protocols must be followed.

Third, the conflict between “science” and “non-science” should be examined on the global platform. The current models of health professions education can be revised and adapted to incorporate the importance of the scientific method and evidence-based medicine across curricula. Likewise, scientific results should be disseminated in a clear manner to the general public. These actions can directly impact society by increasing access to scientific findings, enhancing understanding, and dispelling myths.

In conclusion, medical autonomy is an important principle that can benefit patients’ care. As junior doctors, we can promote medical autonomy in our clinical practice and mitigate potential bioethical conflicts during clinical treatment.

**We should seek up-to-date scientific findings to guide our clinical training and prioritize our application of evidence-based medicine across our clinical and surgical disciplines.**

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## Ethics in Public Health: Commentary from a Junior Doctor

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**Public health is “*the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals.*”**

**– CEA Winslow (1)**

The current coronavirus disease 2019 (COVID-19) pandemic has emphasized the role of public health as a scientific discipline connected with administrative and policy decision-making. While the promotion of population health has been the classic goal of public health practice and policy, new objectives connecting autonomy and equality have been introduced in recent decades (2). As public health considers the health and well-being of communities and populations collectively, the principles of medical ethics should be incorporated into decision-making activities, especially since ethical dilemmas can arise from intersectoral collaborations and stakeholder engagement.

By definition, we can observe that ethical principles focus on theoretical reflections, and health policies direct concrete courses of action. However, ethics can lose its purpose if it does not guide specific, practical policies (3). Public health ethics highlights the moral implications that drive these policies and influence a wide range of interventions aimed at maintaining and improving population health (4). As such, the adoption of community measures and strategies – such as the allocation of medical-surgical supplies, workforce staff, and economic support – must be efficient and comprehensive, while benefiting the maximum portion of the population. The equitable distribution and allotment of these resources determine the outcomes of a particular public health measure, success or failure, and the extent.

During the COVID-19 pandemic, public health ethical frameworks have been designed and implemented in public health practice, yielding substantial reflections for discourse. First, rapid decisions and emergency authorisation procedures have rested on the support of ethical frameworks that guide health policies within the national and international context. Second, the global debate of public interests and individual liberty, autonomy and priority setting, and allocation of scarce resources, has raised key questions related to ethical implications (4).

**This observation highlighted that pandemic planning must be squarely situated in the larger realm of public health, and an ethical framework for public health should recognize vulnerable populations in society (5).**

### Conclusion

As the evolution of public health ethical frameworks signifies the need to focus on collective values, greater discussion should incorporate a variety of ethical concepts. These concepts include utility, evidence-based effectiveness, distributive justice and fairness, solidarity and social responsibility, community empowerment and participation, transparency, accountability, and trust (4). Recognizing public health ethics as an opportunity – not an obstacle – is therefore fundamental for public health policy because the implementation of effective “policy analysis lies squarely (if uncomfortably) between science and ethics” (6).

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## The Blame Game: Providers under Pressure

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In this article, I present a hypothetical scenario faced by healthcare providers and my analysis based on my clinical experiences during my training in Nepal (**Photo 1**).

### Clinical Scenario

One early morning (6AM), a 57-year-old man complained of chest pain to his wife. He expressed a distressing pain, where he was unable to breathe but did not want to seek medical care. He waited a few hours for the symptoms to resolve, but there was no improvement. Then, by mid-morning (10AM), he called the ambulance, but due to traffic, the ambulance reached his home one hour later (11AM) and then the hospital (12PM).

That day, the emergency room had reached full capacity, and there was a sudden staff shortage with many providers calling in sick. Within the next 30 minutes, the patient was assigned a bed and evaluated by the physician, who quickly realized the possibility of a myocardial infarction and ordered an electrocardiogram (EKG) and troponin tests. Although the EKG did not reveal any acute ST-T wave changes, he awaited the laboratory test before he could confirm or exclude the diagnosis of myocardial infarction.

The laboratory tests were delayed by one hour, due to technical difficulties in the medical equipment. In the meantime, the patient had suffered a sudden cardiac arrest, and despite the best efforts from the medical team, he was unable to be resuscitated. In response, the patient's family was furious, physically assaulted the medical staff, and destroyed hospital property.



**Photo 1.** Dr. Uchit Thapa on his clinical rotation at the hospital.  
Credit: Dr. Uchit Thapa.

## Analysis

This unfortunate reality across some Asian countries highlights multiple faults in the health system, although ultimately an individual is blamed (1). In this case scenario, the question remains: Who is to blame? Is it the patient who delayed seeking medical care, the ambulance driver stuck in traffic, nursing staff for bed management, laboratory staff for delayed laboratory results, hospital administration for staffing issues or the physician who waited for laboratory results to avoid misdiagnosis? The “blame game” begins, and physicians are frequently the scapegoat for any unexpected event or complication.

In previous decades, this “blame game” was observed in the U.S. health system. In this case, health leaders realized that blaming the medical staff neither improved the quality of medical care nor decreased the risk of adverse events. As they realized that medical staff made errors due to the intrinsic weaknesses of the health system, they identified and subsequently reduced systemic errors, leading to declining rates of medical errors (2,3).

As a call to action, It is time that physicians accept that our health system in Asia is broken and needs repair. Physical assault and property damage are barbaric approaches to display dissatisfaction and frustration with medical care. These hideous acts lead to increased fear and uncertainty among physicians to take risks, save lives, and serve the sick. Health leaders should together work to strengthen the health system infrastructure, invest in the health system, and avoid the “blame game” against the medical team (4).

**Moving forward, global health leaders should actively identify systemic errors in health care infrastructure and seek to improve health care service delivery for all patients.**

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## A Pandemic and Fractured Mental Health

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In June 2020, I was on call for my first duty in the intensive care unit (ICU) for patients with coronavirus disease 2019 (COVID-19). That morning, I received a call that a 40-year-old male patient was admitted to the COVID-19 ICU with dyspnoea and hypoxia, with blood oxygen saturation of 40%. As I donned my personal protective equipment (PPE), I observed the patient with severe respiratory distress, including unstable vital signs and blood oxygen saturation of 20%. Immediately, I called for assistance to implement the clinical protocol to intubate the patient. I noted that clinical staff were reluctant to assist, as they passed instruments from afar. Although the intubation was successful, his health declined, and he suffered fatal consequences the following day due to acute respiratory distress syndrome. To address the observed challenges, I requested a meeting with clinical staff to discuss their reluctant behavior. Their collective response was related to their fears of developing COVID-19.

Since March 2020, the COVID-19 pandemic has affected all populations, but notably placing health professionals at high risk on the frontline. With a substantial number of medical colleagues who have lost their lives in the line of duty, their mental health has been significantly impacted, including new fears of becoming infected and losing one's life or the lives of loved ones (1).

### **Their dedicated efforts in providing clinical care to COVID-19 patients has taken a heavy toll on their physical and mental well-being (1).**

One recent systemic review conducted during the peak of the pandemic showed high prevalence of depression, anxiety, and insomnia among healthcare workers involved in COVID-19 duties (2). These mental health issues can be attributed to long working hours without breaks, post-exposure isolation and quarantines, and ineffective communication with patients due to PPE. Social stigma was also observed regarding those who were infected or recovered from COVID-19 as well as the inability to meet with family and friends due to social distancing restrictions (2,3).

## However, one question remains: What are we doing to tackle mental health challenges due to COVID-19 in the clinical workplace?

Sadly, when I look around my workplace, I observe limited actions by hospital management to develop plans that address the mental health impacts of COVID-19. As we seek guidance from the evidence-based literature, there are numerous activities that can benefit the mental health of healthcare workers (4,5). Some of these approaches include: 1) early assessments of medical staff for mental health and timely psychiatric interventions; 2) counselling services by multidisciplinary mental health teams; 3) continued education on mental health and stress management; and 4) standardised work hours with appropriate breaks.

Since junior doctors are the backbone of any health delivery system, it is our responsibility to look for signs of depression and anxiety among our fellow colleagues and encourage them to seek help. Although the described recommended actions are not a comprehensive list, they can relieve stress, improve overall functioning, and ultimately lead to enhanced delivery of high-quality patient care. Moving forward, the medical community must first openly accept that mental health woes among healthcare workers – including burnout – are common challenges. Together, we must work towards creating an environment where healthcare workers are comfortable to share their mental health issues without fear of judgment.

**This pandemic will pass, but its effect on mental health will haunt us for years to come, unless we embrace the issue and act now.**

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## Involving Medical Students as COVID Warriors: An Ethical Critique

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The decision to include medical students in the fight against the coronavirus disease 2019 (COVID-19) is thought to have a utilitarian ethical justification, with the public health manager using the utilitarian approach to maximize the benefit to the greatest number of people possible (1). However, because of the uncertainties and lack of evidence, countries are free to respond in their own way. Due to the inherent urgency of the situation, this may facilitate the approval of public measures without adequate ethical analysis.

**This article will examine the inclusion of medical students in COVID-19 response efforts from an ethical viewpoint.**

### **The Risk-benefit Debate**

Before finalizing any decisions, it is necessary to assess the risks inherent in the proposed measures to maximize their beneficial effects as well as identify and minimize any harmful exposures of medical students, as stated in Articles 4 and 20 of the Universal Declaration of Bioethics and Human Rights (UDBHR) (2) (**Table 1**). This increased risk of contamination is inherent when working on the frontlines, as observed and supported by the evidence from the current COVID-19 pandemic (3). As such, the inclusion of medical students may increase the work capacity of health systems and offer students with unique opportunities for clinical learning.

**The current pandemic, however, has not provided the same medical education and training as it once did, as a result of overworked health workers and the suspension of outpatient services (4).**

According to the public health acts and legislatures of each country, the provision of medical services has become mandatory (*obligation*) for the majority of these students (5). As such, any attempt to undermine individual liberties and autonomy is unethical and violates Articles 3 and 5 of the UDBHR, which describe human dignity and individual responsibilities (2) (**Table 1**). Also, the dedicated hours of these medical services represent a substitute for the required coursework of medical curricula (6). While the exemption from mandatory coursework may seem like a “fair” reward for students who volunteered to help with the pandemic, there is evidence that socio-demographic factors may influence medical student engagement and volunteerism during a public health crisis (7). This infringes upon the equal treatment and participation of rights, reinforced by Article 10 of the UDBHR (2) (**Table 1**). The long-term implications of such substitution measures necessitate an in-depth discussion among experts.

### **The Ethical Approach**

Considering the logic of applying utilitarian ethics (1), all consequences of these actions must be evaluated before implementation. After a detailed analysis of the risk-benefit ratio, a series of risk mitigation measures should be confirmed after deliberations. This would ensure the personal integrity of medical students involved and encourage the prudent use of their intellectual capacity with adequate compensation, as supported by Articles 8 and 18 of the UDBHR (2) (**Table 1**). Therefore, alternatives to direct assistance to patients suspected of COVID-19 infection should be evaluated. Some activities – such as the creation of digital content aimed at educating the medical community and the general public – can be conducted remotely. Additional tasks can include the development of platforms with up-to-date scientific evidence and social networks for disseminating accurate health information, dispelling myths through fake news (*infodemic*), and resolving local and national community concerns. Medical student volunteers could also collaborate with management and regulatory teams to develop safety protocols and train professionals in the proper use of personal protective equipment.

### **Conclusion**

For an effective response to the COVID-19 pandemic, the adopted measures must be collectively structured, taking advantage of students’ existing capabilities and respecting their limitations, vulnerabilities, and freedoms.

**Ethical decisions made in the context of medicine and future generations of health professionals can have far-reaching implications for these individuals, their patients, and communities.**

Article	Resolution
Article 3: Human dignity and human rights	1) Human dignity, human rights and fundamental freedoms are to be fully respected. 2) The interests and welfare of the individual should have priority over the sole interest of science or society.
Article 4: Benefit and harm	In applying and advancing scientific knowledge, medical practice and associated technologies, direct and indirect benefits to patients, research participants and other affected individuals should be maximized and any possible harm to such individuals should be minimized.
Article 5: Autonomy and individual responsibility	The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests.
Article 8: Respect for human vulnerability and personal integrity	In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected.
Article 10: Equality, justice and equity	The fundamental equality of all human beings in dignity and rights is to be respected so that they are treated justly and equitably.
Article 18: Decision-making and addressing bioethical issues	1) Professionalism, honesty, integrity and transparency in decision-making should be promoted, in particular declarations of all conflicts of interest and appropriate sharing of knowledge. Every endeavour should be made to use the best available scientific knowledge and methodology in addressing and periodically reviewing bioethical issues. 2) Persons and professionals concerned and society as a whole should be engaged in dialogue on a regular basis. 3) Opportunities for informed pluralistic public debate, seeking the expression of all relevant opinions, should be promoted.
Article 20: Risk assessment and management	Appropriate assessment and adequate management of risk related to medicine, life sciences and associated technologies should be promoted.

**Table 1.** Relevant articles from the [Universal Declaration of Bioethics and Human Rights](#) (2).

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## Ethical Issues on Task Shifting in the Healthcare System: Observed Practices in the Republic of Korea

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In 2000, the United Nations (UN) Millennium Declaration was formally signed by global leaders, recognizing the seven Millennium Development Goals (MDG) to improve diverse aspects of population health. Notably, one MDG included targets to combat human immunodeficiency virus / acquired immunodeficiency syndrome (HIV/AIDS), malaria, and tuberculosis. However, the world, especially in low- and middle-income countries, was facing a chronic shortage of health workers. To address this global health worker crisis, the UN held a special session on HIV/AIDS and the World Health Organization (WHO) launched the Treat, Train, Retain (TTR) plan.

**The WHO later held the first global conference on ‘task shifting’ and published global recommendations and guidelines for task shifting to tackle the health worker shortage (1).**

The basic goal of task shifting is the rational re-distribution of tasks (1). In fact, most of the task shifting is traditionally unidirectional, from health professionals with higher levels of training to those with lower levels of training. Task shifting is considered a necessary ethical alternative to mitigate the health worker shortage, although accountability may be questioned when physicians’ duties are placed upon the non-physician workforce. However, task shifting can occur due to other factors in areas without any health worker shortage (2). In these cases, the ethical aspect of task shifting should be managed since it may jeopardize the quality of healthcare.

The role of physician assistants (PA), who are allowed to practice medicine under a physician's supervision, serves as a key example of task shifting. Established during the mid-1960s in the United States, this medical occupation was created to broaden the delivery of general medical services to the public (3). Numerous countries adopted the occupation and assigned various jurisdiction and practical roles in efforts to improve national health systems and expand coverage to citizens (4).

In the Republic of Korea, PAs, like nurse practitioners, represent a legitimate profession, which was stated in Article 78 of the Medical Service Act and amended in February 2008. However, there are discrepancies observed in practice. For example, the Medical Service Act does not state the specific duties or range of duties that lead the judicial precedent to conclude that medical practice beyond the regular nursing purview is illegitimate (5). Nevertheless, PAs have worked anonymously in diverse medical fields. One Parliamentary document (2014) reported that more than 500 PAs were working in national hospitals in 2014, doubling the number from 2010 (6). Another estimate has indicated that 10,000 PAs are currently working throughout the Republic of Korea (7).

**Since there is no special education or training program for PAs in the Republic of Korea, currently employed PAs are recognized as long-serving nurses.**

These PAs fill the physician shortage by conducting duties that are beyond their authority, such as prescribing medications, writing medical records or handling surgical procedures (6,7). Inappropriate medical practice conducted by unlicensed assistants as well as issues of task shifting with PAs have been perpetually disclosed to the national platform.

In 2019, the Ministry of Health and Welfare (Republic of Korea) composed a consultant group – with the Korean Medical Association and the Korean Intern Medical Association – to specify the duties of each health occupation (8). Unfortunately, uncompromising conflict of interests among stakeholders had deferred the initial meeting for several weeks, and the consultant group subsequently produced a mere agreement without debate on the role of PAs. Although under these indeterminable disputes, in May 2021, the Seoul National University Hospital, one of the largest and most renowned hospitals in the country, arbitrarily announced to officially approve the role of clinical practice nurses as PAs. This alarming news has reawakened an embedded conflict among numerous stakeholders on task shifting in the health system in the Republic of Korea.

Sadly, it appears that there are few ethical concerns regarding these countless arguments. In the Republic of Korea, PAs are alleviating the physician shortage, which was commonly placed on other health professionals with less training. Thus, the physician shortage is a matter of balance, rather than an absolute number. The imbalance of specialties results from the lack of compensation, including insufficient medical reimbursement rates, lack of legal safeguards on unpreventable outcomes, and more arduous medical training. It is by no means considered ethical to exploit medical professionals with less training to simply fill the deficiency caused by complex factors. The truly ethical discussion for improving the health system under the condition of sufficient capacity and resources is the integral redistribution of health resources and tasks.

According to the *WMA Resolution on Task Shifting from the Medical Profession* (2019), the effect of task shifting on the overall functioning of health systems remains unclear (2). In spite of this uncertainty, task shifting in the health system will be inevitable as the world faces diverse challenges beyond the health workforce shortage. This is a call to action where the physician's role should be revised, and duties should be reallocated to manage emerging issues like new medical technologies, physician-patient rapport, and elevating expectations of health care services.

**Considering the direct impact on quality of care, task shifting should always be incorporated into ethical debates, recognizing patient safety as a top priority.**

### **Conclusion**

Task shifting in the healthcare system continues to be a complicated and debated topic across national health systems. Since physicians are recognized as highly trained health professionals, they should lead local and national discussions and ultimately judge if patient safety is threatened by task shifting. To date, the concept of task shifting has not been widely discussed across global medical societies, albeit significant health challenges including the coronavirus disease 2019 (COVID-19) pandemic. However, the WMA has recently confirmed its interest to revise the *WMA Resolution on Task Shifting from the Medical Profession* (2019) and establish a framework that can offer medical societies appropriate guidelines to implement task shifting within their health systems.

**As junior doctors, we can advocate for and participate in this global dialogue, where we can continue to emphasize the delivery of high-quality medical care, patient safety in clinical and surgical procedures, and optimal work-life balance for all health workers.**

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## Myanmar Junior Doctors Uphold the Physician Pledge while Defying the Coup

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More than six months has passed since the Myanmar military, known as the Tatmadaw, staged a coup to depose the country's democratically-elected government authorities. This coup was in response to a democratic administration that was elected in 2015, after a history of military dictatorship since 1962. Despite the continual threat of incarceration, the majority of Myanmar junior doctors have joined the Civil Disobedient Movement (CDM) until democracy is restored. Myanmar's CDM protest is distinct from other nations' strikes, which are intended to improve doctors' working conditions. In Myanmar, physicians, nurses, other health professionals, and government employees are collectively participating in CDM protests to enhance the national health system, which has been recognized with the poorest health indicators across the world. Notably, under the democratic government led by State Counsellor Daw Aung San Suu Kyi (2015–2021), Myanmar's health system had improved national health indicators at an exponential rate.

**As junior doctors, we adhere to rigorous ethical norms and prioritize the health and well-being of our patients as first priority, as stated in the WMA Declaration of Geneva (1).**

Resisting the coup, CDM doctors guarantee that critical and emergency health services as well as continuity of treatment are delivered. They constantly offer continuous and up-to-date information to their patients and the general public about the demands to remove dictatorships and the measures that are being implemented. Myanmar citizens have supported physicians' decisions to leave state-run hospitals. Since the coup, however, soldiers have been stationed across health facilities, discouraging Myanmar citizens from seeking medical attention. In response, the general population has refused to seek medical care or COVID-19 vaccinations at military-controlled facilities (2).

The Myanmar military junta has ordered the suspension of medical clinics, which are depriving thousands of patients from receiving ongoing diagnosis and treatment for human immunodeficiency virus / acquired immunodeficiency syndrome (HIV/AIDS) and tuberculosis (3). As doctors treated patients at private hospitals or charity clinics for free, their clinics were invaded, and they were kidnapped (4). Doctors who have participated in strikes were considered 'criminals', and their photographs were widely disseminated across state-run media like "Wanted" posters. As such, the military and police have declared war on doctors of the health system, who were among the first and most vociferous opponents of the coup in February 2021. Security forces are detaining, assaulting, and murdering medical personnel, branding them as state enemies.

### **Junior doctors continue to be in grave trouble as they provide essential medical care to the Myanmar people.**

Currently, with doctors forced underground in the midst of a worldwide epidemic, the country's already precarious health system is collapsing (5). Nowadays, Myanmar junior doctors treat patients in secret, risking their own lives while upholding their ethical obligation to patients.

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## COVID-19 and Mental Health

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Although the scientific literature recognizes the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) epidemic as a pandemic, this virus co-exists with other public health challenges such as infectious (e.g. malaria, tuberculosis) and chronic diseases (e.g. diabetes, obesity, hypertension). Like other countries, Italy has emerged with new public health concerns that have challenged the health system over the past two years. Few researchers, however, have correctly used the term *syndemia* in their reports. This article aims to discuss four major ethical issues that can serve as a starting point in a discussion that will hopefully lead to global debate and solutions.

**These public health challenges with major ethical issues include public misinformation, vaccine delivery, hospitalizations, and mortality.**

### **Ethics and Public Misinformation**

Some Italian media outlets exaggerated the severity of the adverse effects of the coronavirus disease 2019 (COVID-19) vaccines in efforts to entice readers to buy their articles (“clickbait”) (1,2). However, readers who purchased these *click bait* papers followed a sequence of reactions – frightened, acceptance, and suspicious – to official sources of information. Notably, this trend of public misinformation was observed across other countries (3).

### **Ethics and Vaccine Delivery**

The introduction of vaccines during the COVID-19 pandemic has triggered several questions: Is it right to subject all citizens to mandatory vaccination or is individual self-determination more important? Should vaccines be prioritized for the most vulnerable persons (e.g. elderly) or for the general workforce which can restart the economy? Do healthcare personnel have an additional *moral obligation* toward vaccine acceptance than the general population?

**These questions are complex and have more than one right answer.**

### **Ethics and Hospitalizations**

The COVID-19 pandemic has been used as an excuse to justify the slow actions within the political administration and healthcare system. With reduced funding and shortage of health workers, access to local health facilities was reduced, leading to suspended health screenings for the prevention or management of chronic diseases. Consequently, health complications from poor pharmacological management of chronic diseases led to a surge in capacity in emergency rooms that were already facing limitations before the pandemic.

On March 6, 2020, the Italian Society of Anesthesia, Analgesia Resuscitation, and Intensive Care (SIAARTI, in Italian), published the consensus paper entitled, "*Recommendations of Clinical Ethics for Admission to Intensive Treatments and their Suspension*" (4). On November 24, 2020, the National Institute of Health and the National Federation of Physicians and Dentists (highest body of all Italian doctors) published the paper entitled, "*Decisions for Intensive Care in the Event of Disproportion between Care Needs and Resources Available during the COVID-19 Pandemic*" (5). These two publications aimed to use evidence-based criteria and create a hierarchy for patient care when facing limited resources during the pandemic. This ranking system resulted in the observed sacrifice of vulnerable patients, such as the elderly and patients with co-morbidities. These clinical experiences make us reflect on history – back to the Napoleonic wars – as triage ("triere" in French) referred to those patients who could be selected or saved.

## Ethics and Mortality

As Italy was one of the first countries to implement lockdown measures during the COVID-19 pandemic, leaders aimed to reduce incidence and mortality rates. The ethical questions behind the placement of lockdown measures are complex and multifactorial.

After a few months, the social pressures from the business and commerce world became publicly evident. The Italian Government acknowledged the community need to balance economic sustainability with an “acceptable” daily mortality rate. However, is there really an “acceptable” daily mortality rate? What moral or ethical mechanism allows us to understand and quantify the “acceptable” mortality rate? Unfortunately, there are no straightforward answers to these questions.

**Clearly, it is not a simple task to balance autonomy (individual) with the greater good of the community (public health).**

In summary, the COVID-19 pandemic has triggered a series of questions among all health care workers – including junior doctors – which can facilitate shared experiences, inputs, and thoughts. Moving forward, we hope that this global dialogue will help shape the response in the ongoing pandemic and as we prepare for any future response.

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## Racism: The Insidious Social Determinant of Health

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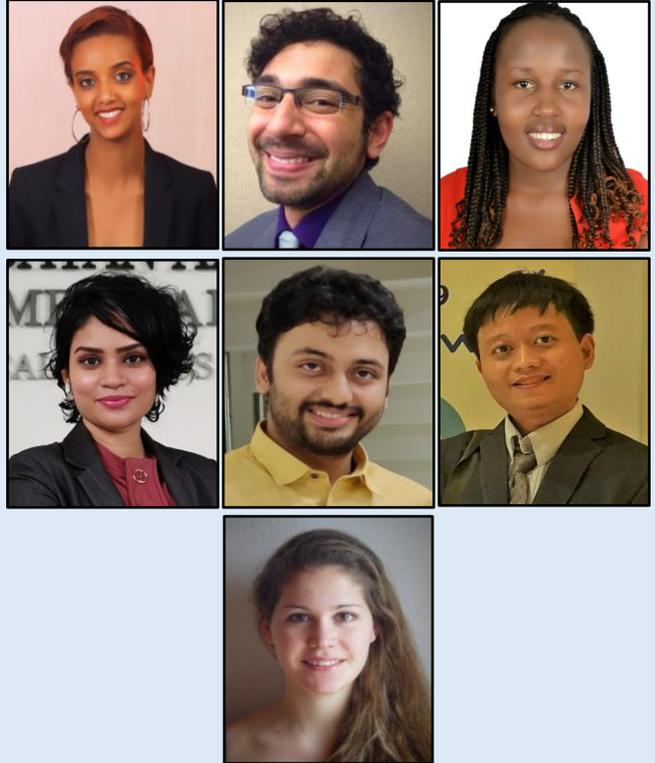
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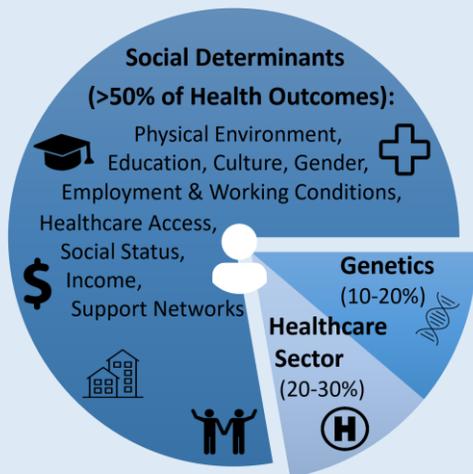
### Health is Largely Determined by Factors Outside our Current Healthcare Systems

*“Water-borne diseases are not caused by lack of antibiotics but by dirty water and the political, social and economic forces that fail to make clean water available to all; heart disease not by a lack of coronary care units but by the lives people lead shaped by the environments in which they live; obesity not caused by moral failure of individuals but by the excess availability of poor foods...”*

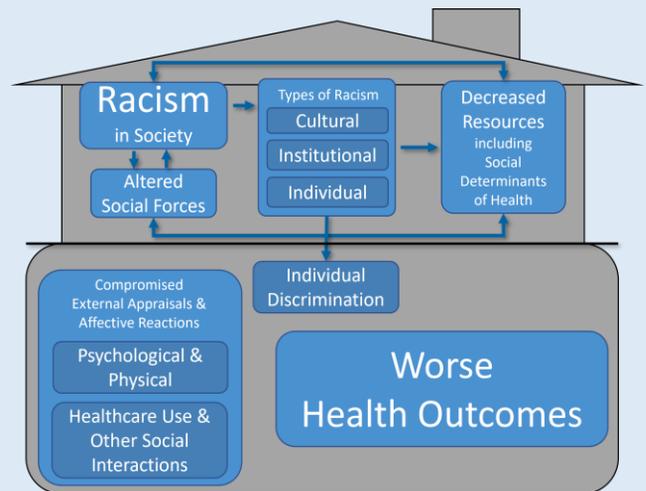
–WHO Commission on Social Determinants of Health (2008)

Social Determinants of Health (SDH) drive over 30-50% of health outcomes. They dwarf the healthcare sector, which accounts for under 25% of outcomes, despite consuming a majority of health expenditures in most high-income countries (1). SDHs are non-medical factors – social systems, economic policies, and political agendas – that influence health, and they are exacerbated by economic crises, political unrest, and other social stressors (**Figure 1**). Until recently, racism and other forms of discrimination have been largely excluded from discussions (2).

Discrimination is defined as differential treatment based on actual or perceived characteristics, such as race and ethnicity. One form is racism, described as a system of practices at the individual, institutional, and structural levels to devalue, disempower, and decrease opportunities to groups regarded as inferior, often according to skin color (e.g. people of color) or numerical representation in a community (e.g. minorities) (**Figure 2**). This inequity is deeply embedded in society historically and continually through its interaction with social forces and their determinants of health. This threatens the health of physicians, patients, and our healthcare systems.



**Figure 1.** Contributions to health outcomes.  
 Sources: Standing Committee on Social Affairs, Canada, 2009; Noun Project.



**Figure 2.** The house that racism built  
 Source: Adapted from Williams, 2019 (3).

### Impact of Discrimination including Racism on Health

*“Structural racism in health care and our society exists and it is incumbent on all of us to fix it”*

– Dr. James L. Madara, CEO of the American Medical Association (2021)

### For Physicians

Reports of physician rudeness, emotional abuse, anger, toxicity, and physical harm are rising (4). Often unreported, over 30-60% of young physicians face at least one episode of violence in their careers, with increased prevalence in minority groups (5). The cost of such incivility is high, including burnout and suicidal thoughts (6). This leads to unequal training opportunities, research contributions, and career progression, including remuneration and reputation that self-selects a health workforce vulnerable to perpetuating this trauma.

**Overcoming racism is needed to provide high-quality patient care, engage in constructive learning, and uphold our pledge for humanity in medicine.**

**For Patients**

Discrimination threatens patient safety via several pathways, including emotional and psychological distress, access to health education and care, participation in healthy behaviors, and physical injury including racially-motivated attacks. Racism is consistently linked to poor mental and physical outcomes (7). Drug development often sidelines minorities for convenience, especially since some are not always informed of the true nature of experiments (e.g. Tuskegee Study). While research policy such as the Declaration of Helsinki helps prevent exploitation, vulnerable populations are routinely excluded from clinical trials and the full benefit of discoveries. When the Sustainable Development Goals counted metrics like maternal care, they highlighted inequities. For example, black women across the United States and United Kingdom are 3-4 times more likely to die from pregnancy-related complications than white women (8), with similar trends for infant mortality, heart disease, stroke, cancer, and diabetes. Racism is the risk factor for poor health outcomes that needs to be addressed, not race.

**Racism, which is historically engraved through systemic racial profiling and discriminatory segregation, continues to persist through self-perpetuating algorithms into the digital age.**

**For Effective Health Systems**

Discrimination erodes health systems and the economies supporting them. Members of the healthcare workforce facing discrimination have worse productivity, capacity, and turnover. Lack of diversity further compromises innovation and the quality of care. Disadvantaged populations have worse health outcomes with increased costs of care. In the United States, one study estimated that over 30% of direct medical costs faced by African Americans, Hispanics, and Asian Americans were due to health inequities totaling over US\$230 billion over four years. By adding indirect costs, including lost productivity, wages, absenteeism, family leave, and premature death, this total rose to US\$1.24 trillion (9). High value care requires controlling the costs of discrimination.

## Why?

Discrimination, including racism, is not just one of the SDHs, but it also is the fundamental determinant affecting all others. Structural racism is etched in historic and ongoing legislative policies, hiring practices, resource distribution or other inequitable practices that restrict access to education, job opportunities, safe housing and neighborhoods. It can also hinder opportunities for some groups through their institutions, interpersonal relationships, or ethnicity or race. Discrimination drives health inequities and is a barrier for a better future of work, living and learning, and universal healthcare coverage.

## What Can We Do?

The Primary Health Care (PHC) approach is recognized internationally as a powerful tool to reduce health inequities (10). It includes integrated health services (including primary care and essential public health), multisectoral policy, and empowerment of people and communities towards comprehensive care – a promising approach to address discrimination and SDHs.

Some targets include:

- ❑ *Data-Driven Truths*: Governments and health organizations must measure and report on the impact of discrimination as a structural, institutional, and individual overarching SDH.
- ❑ *Recognition and Justice*: Country leaders, health ministries, and other stakeholders must recognize discrimination in all health practices and develop stronger mechanisms to ensure physical and psychological safety for disadvantaged groups.
- ❑ *Peace through Health*: Countries must deploy strong affirmative action to actively increase inclusion of previously neglected groups and prevent the health consequences of discrimination.

## Role as Junior Doctors

As a networked and informed generation, we are positioned to break the cycle of discrimination. We can improve the effectiveness of our healthcare systems, care of our patients, and our own lived experiences by understanding, recognizing, and taking steps to prevent discrimination. This means highlighting discrimination as an overarching SDH by including it in all policy design, implementation, and evaluation for accountability “upstream”. We must prevent it from negatively affecting how we care for each other and our patients “downstream” as well as increase awareness of its direct and indirect health consequences throughout. This will not be an easy task, but treading together safely we can resonate.

**“Of all the forms of inequality, injustice in health is the most shocking and the most inhuman.”**

**–Martin Luther King, Jr.**

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## WMA Declaration of Geneva



### WMA DECLARATION OF GENEVA

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*Adopted by the 2<sup>nd</sup> General Assembly of the World Medical Association, Geneva, Switzerland, September 1948  
and amended by the 22<sup>nd</sup> World Medical Assembly, Sydney, Australia, August 1968  
and the 35<sup>th</sup> World Medical Assembly, Venice, Italy, October 1983  
and the 46<sup>th</sup> WMA General Assembly, Stockholm, Sweden, September 1994  
and 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  
and amended by the 68<sup>th</sup> WMA General Assembly, Chicago, United States, October 2017*

#### **The Physician's Pledge**

AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour.

# WMA International Code of Medical Ethics



## WMA INTERNATIONAL CODE OF MEDICAL ETHICS

*Adopted by the 3<sup>rd</sup> General Assembly of the World Medical Association, London, England, October 1949  
and amended by the 22<sup>nd</sup> World Medical Assembly, Sydney, Australia, August 1968  
and the 35<sup>th</sup> World Medical Assembly, Venice, Italy, October 1983  
and the 57<sup>th</sup> WMA General Assembly, Pilanesberg, South Africa, October 2006*

### DUTIES OF PHYSICIANS IN GENERAL

A PHYSICIAN SHALL	always exercise his/her independent professional judgment and maintain the highest standards of professional conduct.
A PHYSICIAN SHALL	respect a competent patient's right to accept or refuse treatment.
A PHYSICIAN SHALL	not allow his/her judgment to be influenced by personal profit or unfair discrimination.
A PHYSICIAN SHALL	be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.
A PHYSICIAN SHALL	deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.
A PHYSICIAN SHALL	not receive any financial benefits or other incentives solely for referring patients or prescribing specific products.
A PHYSICIAN SHALL	respect the rights and preferences of patients, colleagues, and other health professionals.
A PHYSICIAN SHALL	recognize his/her important role in educating the public but should use due caution in divulging discoveries or new techniques or treatment through non-professional channels.
A PHYSICIAN SHALL	certify only that which he/she has personally verified.
A PHYSICIAN SHALL	strive to use health care resources in the best way to benefit patients and their community.
A PHYSICIAN SHALL	seek appropriate care and attention if he/she suffers from mental or physical illness.
A PHYSICIAN SHALL	respect the local and national codes of ethics.

## DUTIES OF PHYSICIANS TO PATIENTS

A PHYSICIAN SHALL	always bear in mind the obligation to respect human life.
A PHYSICIAN SHALL	act in the patient's best interest when providing medical care.
A PHYSICIAN SHALL	owe his/her patients complete loyalty and all the scientific resources available to him/her. Whenever an examination or treatment is beyond the physician's capacity, he/she should consult with or refer to another physician who has the necessary ability.
A PHYSICIAN SHALL	respect a patient's right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.
A PHYSICIAN SHALL	give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care.
A PHYSICIAN SHALL	in situations when he/she is acting for a third party, ensure that the patient has full knowledge of that situation.
A PHYSICIAN SHALL	not enter into a sexual relationship with his/her current patient or into any other abusive or exploitative relationship.

## DUTIES OF PHYSICIANS TO COLLEAGUES

A PHYSICIAN SHALL	behave towards colleagues as he/she would have them behave towards him/her.
A PHYSICIAN SHALL	NOT undermine the patient-physician relationship of colleagues in order to attract patients.
A PHYSICIAN SHALL	when medically necessary, communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information.

# WMA Declaration of Helsinki



## WMA DECLARATION OF HELSINKI – ETHICAL PRINCIPLES FOR MEDICAL RESEARCH INVOLVING HUMAN SUBJECTS

Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964  
and amended by the:

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

### Preamble

1. The World Medical Association (WMA) has developed the Declaration of Helsinki as a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data.

The Declaration is intended to be read as a whole and each of its constituent paragraphs should be applied with consideration of all other relevant paragraphs.

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

### General Principles

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

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

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

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

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

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

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

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

11. Medical research should be conducted in a manner that minimises possible harm to the environment.
12. Medical research involving human subjects must be conducted only by individuals with the appropriate ethics and scientific education, training and qualifications. Research on patients or healthy volunteers requires the supervision of a competent and appropriately qualified physician or other health care professional.
13. Groups that are underrepresented in medical research should be provided appropriate access to participation in research.
14. Physicians who combine medical research with medical care should involve their patients in research only to the extent that this is justified by its potential preventive, diagnostic or therapeutic value and if the physician has good reason to believe that participation in the research study will not adversely affect the health of the patients who serve as research subjects.
15. Appropriate compensation and treatment for subjects who are harmed as a result of participating in research must be ensured.

### **Risks, Burdens and Benefits**

16. In medical practice and in medical research, most interventions involve risks and burdens. Medical research involving human subjects may only be conducted if the importance of the objective outweighs the risks and burdens to the research subjects.
17. All medical research involving human subjects must be preceded by careful assessment of predictable risks and burdens to the individuals and groups involved in the research in comparison with foreseeable benefits to them and to other individuals or groups affected by the condition under investigation. Measures to minimise the risks must be implemented. The risks must be continuously monitored, assessed and documented by the researcher.
18. Physicians may not be involved in a research study involving human subjects unless they are confident that the risks have been adequately assessed and can be satisfactorily managed. When the risks are found to outweigh the potential benefits or when there is conclusive proof of definitive outcomes, physicians must assess whether to continue, modify or immediately stop the study.

### **Vulnerable Groups and Individuals**

19. Some groups and individuals are particularly vulnerable and may have an increased likelihood of being wronged or of incurring additional harm. All vulnerable groups and individuals should receive specifically considered protection.
20. Medical research with a vulnerable group is only justified if the research is responsive to the health needs or priorities of this group and the research cannot be carried out in a non-vulnerable group. In addition, this group should stand to benefit from the knowledge, practices or interventions that result from the research.

### **Scientific Requirements and Research Protocols**

21. Medical research involving human subjects must conform to generally accepted scientific principles, be based on a thorough knowledge of the scientific literature, other relevant sources of information, and adequate laboratory and, as appropriate, animal experimentation. The welfare of animals used for research must be respected.
22. The design and performance of each research study involving human subjects must be clearly described and justified in a research protocol. The protocol should contain a statement of the ethical considerations involved and should indicate how the principles in this Declaration have been addressed. The protocol should include information regarding funding, sponsors, institutional affiliations, potential conflicts of interest, incentives for subjects and information regarding provisions for treating and/or compensating subjects who are harmed as a consequence of participation in the research study. In clinical trials, the protocol must also describe appropriate arrangements for post-trial provisions.

## Research Ethics Committees

23. The research protocol must be submitted for consideration, comment, guidance and approval to the concerned research ethics committee before the study begins. This committee must be transparent in its functioning, must be independent of the researcher, the sponsor and any other undue influence and must be duly qualified. It must take into consideration the laws and regulations of the country or countries in which the research is to be performed as well as applicable international norms and standards but these must not be allowed to reduce or eliminate any of the protections for research subjects set forth in this Declaration.

The committee must have the right to monitor ongoing studies. The researcher must provide monitoring information to the committee, especially information about any serious adverse events. No amendment to the protocol may be made without consideration and approval by the committee. After the end of the study, the researchers must submit a final report to the committee containing a summary of the study's findings and conclusions.

## Privacy and Confidentiality

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

## Informed Consent

25. Participation by individuals capable of giving informed consent as subjects in medical research must be voluntary. Although it may be appropriate to consult family members or community leaders, no individual capable of giving informed consent may be enrolled in a research study unless he or she freely agrees.

26. In medical research involving human subjects capable of giving informed consent, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail, post-study provisions and any other relevant aspects of the study. The potential subject must be informed of the right to refuse to participate in the study or to withdraw consent to participate at any time without reprisal. Special attention should be given to the specific information needs of individual potential subjects as well as to the methods used to deliver the information.

After ensuring that the potential subject has understood the information, the physician or another appropriately qualified individual must then seek the potential subject's freely-given informed consent, preferably in writing. If the consent cannot be expressed in writing, the non-written consent must be formally documented and witnessed.

All medical research subjects should be given the option of being informed about the general outcome and results of the study.

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

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

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

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

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

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

### **Use of Placebo**

33. The benefits, risks, burdens and effectiveness of a new intervention must be tested against those of the best proven intervention(s), except in the following circumstances:

Where no proven intervention exists, the use of placebo, or no intervention, is acceptable; or

Where for compelling and scientifically sound methodological reasons the use of any intervention less effective than the best proven one, the use of placebo, or no intervention is necessary to determine the efficacy or safety of an intervention

and the patients who receive any intervention less effective than the best proven one, placebo, or no intervention will not be subject to additional risks of serious or irreversible harm as a result of not receiving the best proven intervention.

Extreme care must be taken to avoid abuse of this option.

### **Post-Trial Provisions**

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

### **Research Registration and Publication and Dissemination of Results**

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

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

### **Unproven Interventions in Clinical Practice**

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

# WMA Declaration of Cordoba on Patient-Physician Relationship



## 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
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 of 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.