Comment on the draft International Code of Medical Ethics of the World Medical Association

20 May 2021

In the context of the International Code of Medical Ethics' revision, the European Institute of Bioethics (EIB) would like to share some comments with the World Medical Association (WMA) Assembly on **paragraph 27 of the draft**.

Since 2001, the **European Institute of Bioethics** has developed an expertise in healthcare ethics, with a special focus on the right of healthcare practitioners to freedom of conscience in their practice.

We acknowledge that the International Code of Medical Ethics (hereafter: the Code) is not a binding instrument for the WMA member states. However, one cannot deny the considerable influence the Code may have on national codes of deontology and even on national laws. Moreover, physicians and healthcare organizations expect from the WMA to promote the highest quality of healthcare relationship between physicians and patients.

Paragraph 27 of the Code is drafted as follows:
"Physicians have an ethical obligation to minimise disruption to patient care. Conscientious objection must only be considered if the individual patient is not discriminated against or disadvantaged, the patient's health is not endangered, and undelayed continuity of care is ensured through effective and timely referral to another qualified physician. »

In the following note, we discuss one by one the different parts of this paragraph which we consider, written as such, highly problematic for the physicians' rights and the patients' care.

a) *"Physicians have an ethical obligation to minimise disruption to patient care"*

It is indeed of the utmost importance for the patient that a stable therapeutic relation can be established between the physician and himself. If the physician, for a practical or personal reason, is not able to manage/deal with/take care of the patient, he must refer his patient to another physician able to take over the patient's health pathway, provided that the referral does not concern an act to which he objects. It is a matter of health, good communication/transmission of patient's information, but also of confidence and psychological security for the patient.

b) "Conscientious objection must only be considered if the individual patient is not discriminated against or disadvantaged"

According to the second sentence of the paragraph, the exercise of conscientious objection is subject to the fulfilment of three cumulative conditions. The first condition is that the patient must not be "discriminated against or disadvantaged".

Given the very broad possible interpretation of the notion of "discrimination" and "disadvantage", it does not seem appropriate to subordinate the exercise of a fundamental right – the right to freedom of conscience – to such a condition. In particular, the word "disadvantaged" is much too vague and broad to be balanced against the right to conscientious objection.

In the field of medicine, some practices are developed and normalized that may confront the physician to acts which his conscience rejects. This rejection can be easily understood, given the fact that those practices were traditionally forbidden by the medical deontology itself. We think especially of abortion and euthanasia. In countries where these practices are legal, legislators have guaranteed healthcare practitioners the possibility to personally object to an act that he or she deems contrary to his/her convictions or mission.

The European Court of Human Rights recognizes the fundamental right to freedom of conscience, including in the field of medicine. The Court requires that conscientious objections rely on a serious and objective criterium: the objector's convictions may be religious or not but must necessarily constitute "a conviction or belief of sufficient cogency, seriousness, cohesion and importance" to deserve the protection of article 9 of the European Convention of Human Rights (ECHR, *Bayatyan v. Armenia*, nr 23459/03, 7 July 2011, para. 110).

To subordinate the right to conscientious objection – which relies on a serious and objective criterium – to the absence of *disadvantage* for the patient – which can be subjectively interpreted –, would put a fundamental right for the physician into great danger. For instance, the mere fact that a doctor refuses to perform euthanasia on his patient could be considered as a disadvantage by the patient himself since the patient would have to continue to live with his illness or delay the euthanasia.

c) "Conscientious objection must only be considered if (…) the patient's health is not endangered"

The second condition for claiming conscientious objection according to the drafted Code, is that the patient's health is not endangered. If the word "health" is understood according to the definition of the World Health Organization, it then means "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Here again, making the physician's conscientious objection potentially dependent on the "mental and social well-being" of his patient, is considerably weakening the physicians' right to freedom of conscience. The notion of "mental well-being" as well as the terms of

“social well-being”, can be broadly interpreted for they encompass various situations. For instance, a physician’s conscientious objection to an abortion could conflict with the social or psychological well-being of a woman who considers her family is complete and who is not ready to raise an additional child.

d) *“Conscientious objection must only be considered if (…) undelayed continuity of care is ensured through effective and timely referral to another qualified physician“*

As worded in the draft Code, this obligation is in strong opposition to the WMA's recently confirmed position on euthanasia, which states: "*No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end*."(own underlining) How does the WMA intend to justify this contradiction within its own instruments?

More fundamentally, the chosen wording tends to oppose conscientious objection and continuity of care, whereas both conducts are not incompatible, on the contrary. Why would a physician, who conscientiously objects to perform euthanasia, not ensure the continuity of care for his or her patient, besides the very act he opposes to? As a matter of fact, it is highly questionable whether, strictly speaking, healthcare does include practices to which conscientious objection can be made. In any case, there is no doubt that euthanasia is not part of healthcare, because it suppresses the person’s life.

The provision as it stands requires the objecting physician to refer “effectively and timely” to another physician, in order to ensure “continuity of care” of the patient. In other words, it associates conscientious objection with discontinuity or rupture of care. Thus, it encourages the physician to break the therapeutic bond as soon as he uses his right to conscientious objection. Yet, it would be in the patient’s interest to continue to be treated by the doctor who is used to treat him or her, except, of course, for the act to which the objection is made. Moreover, the effective referral obligation forces the objecting doctor to act against his conscience by asking him to indicate his patient a “qualified” physician, i.e. who will be able to carry out the act that he himself objects to. The choice of the word "effective referral", indeed, clearly indicates that the objecting physician must ensure that the patient can achieve the desired result: the performance of the objected-to act, for example, euthanasia.

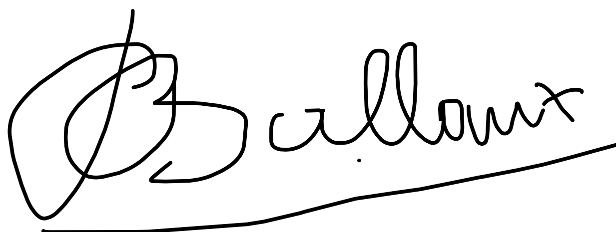
The effective referral obligation described above constitutes a clear and unjustified infringement of the right to freedom of conscience for doctors who conscientiously consider that euthanasia is not a good option for their patient. Such a cooperation is not indispensable for any euthanasia to be performed. However, the referral can facilitate the process, especially when the objecting doctor knows that his or her patient complies with the legal conditions required for euthanasia (see in this sense A. HAMBLER, Religious Expression in the Workplace and the Contested Role of Law, Abingdon, Routledge, 2015, p.100). Even if the referral is not an immediate cooperation to euthanasia, it still consists in providing the patient with the means to eventually obtain the result objected to by the physician. This cooperation has serious consequences for the objecting physician’s conscience since the primary act to which he or she does not wish to cooperate is significant: in case of euthanasia, it involves the provoked death of a human being.

The infringement of the physicians' freedom of conscience is aggravated by the fact that it does not consist in a simple obligation to *refrain* from performing an act or making certain statements, but rather in an obligation to *actively and effectively* refer the patient to another physician, that is to make statements going directly against their conscience. In this respect, the infringement related to the obligation to speak against one's conscience is significantly more serious than an infringement related to an obligation to abstain. (E. Cloots, « Het recht om (andermans) mening niet te hoeven uiten. Over klimaatmarsen, huwelijkstaarten en nieuwkomersverklaringen », *Tijdschrift voor Bestuurswetenschappen en Publiekrecht*, 2019, n° 7, pp. 375-384).

The cited provision would gravely impact the countries that have legalized ethically controversial practices, especially euthanasia. The problem with such an obligation is that it follows the possible extension of the scope of euthanasia and therefore impacts an ever-increasing number of doctors (e.g. Belgian paediatricians, since euthanasia is allowed on children in Belgium since 2014, Dutch and Belgian psychiatrists, since euthanasia is possible in case of psychiatric disease in those countries). For the time being, the number of countries allowing euthanasia remains limited, but if other countries choose to legalize euthanasia, there is a strong possibility that national legislators will take up the WMA's ethical rule regarding the obligation to effective referral in case of conscientious objection. Some of the countries that have legalized euthanasia have already introduced a referral obligation into their legislation (Ontario (Canada), Belgium), and it reveals itself to be very problematic for physicians as well as for patients' care. In Belgium, this obligation is currently being challenged before the Constitutional Court. This very small minority of countries should not be allowed to impose their infringements of freedom of conscience on other countries in the world.

Consequently, the European Institute of Bioethics would like to **suggest the following modification to paragraph 27 of the draft Code**. The wording conforms with the WMA 2019 declaration on euthanasia, as well as the WMA principles of medical ethics:

> *"In the line of the WMA strong commitment to the principles of medical ethics and to the utmost respect for human life, physicians have a right to conscientious objection based on a conviction or belief of sufficient cogency, seriousness, cohesion and importance, even if national law permits the practice in question.*
>
> *No physician should be forced to participate in ending a human life, nor should any physician be obliged to make referral decisions to this end."*



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