Protection of Conscience Project
www.consciencelaws.org

ADVISORY BOARD
Iain Benson, PhD
Professor of Law, University of Notre Dame Australia;
Extraordinary Professor of Law, University of the Free State, Bloemfontein South Africa

J. Budziszewski, PhD
Professor, Departments of Government & Philosophy, University of Texas, (Austin) USA

Shimon Glick, MD
Professor (emeritus, active) Faculty of Health Sciences, Ben Gurion University of the Negev, Beer Sheva, Israel

Mary Neal, PhD
Senior Lecturer in Law, University of Strathclyde, Glasgow, Scotland

David S. Oderberg, PhD,
Dept. of Philosophy, University of Reading, England

Abdulaziz Sachedina,PhD
Dept. of Religious Studies, University of Virginia, Charlottesville, Virginia, USA

Roger Trigg, MA, DPhil
Senior Research Fellow, Ian Ramsey Centre for Science and Religion, University of Oxford, England

PROJECT TEAM
Human Rights Specialist
Rocco Mimmo, LLB, LLM
Ambrose Centre for Religious Liberty, Sydney, Australia

Administrator
Sean Murphy

Revision Date: 2021 May 23

Submission to the World Medical Association
Re: *International Code of Medical Ethics* revision

23 May, 2021

Abstract

This submission responds to the World Medical Association (WMA) request for public feedback about a proposed revision to the *International Code of Medical Ethics* (*ICME*). Amendments to Paragraphs 14 (Patient-centred practice) and 27 ("Conscientious objection") are the principal concern.

Paragraph 14 (Patient-centred practice) expresses the central principle of the *ICME*. Current controversies about freedom of conscience in health care frequently manifest fundamental disagreement about the meaning of terms used here: "care", "health", "well-being" and "best interest." The Project recommends that "care" be replaced with "recommendations and treatment."

What is thought to be in a patient's "best interest" can be disputed for a variety of legitimate reasons. The *ICME* should indicate the role and obligations of physicians by specifying that recommendations and treatments must be only those a physician "believes in good faith" to be in a patient's best interest, "belief" making clear that the judgement is that of the physician, and "good faith" indicating reasonableness, good will and absence of duplicity, prejudice or discrimination.

The proposed text of Paragraph 27 ("Conscientious objection") is anomalous in relation to medical practice because it ignores the role of conscience in medicine and adopts an inadequate and prejudicial analytical framework. It does not attempt or even suggest how to accommodate physician integrity and patient requests when they conflict. It is also anomalous in relation to existing WMA policy and related functionally interdependent paragraphs in the proposed *ICME*.

The Project proposes an amended Paragraph 27 that

- reflects the role of conscience in medical practice;
- identifies conduct morally relevant to participation in contested procedures;
- recognizing the potential for conflict between physicians and state or other authorities, brings other provisions of the ICME into play;
- includes brief guidance about physician obligations to provide information and ensure patient safety and continuity of care.

The Project recommends that the ICME be supplemented by WMA policy on physician freedom of conscience. It strongly urges that a planned WMA conference should focus on conscience in medical practice, not "conscientious objection."

TABLE OF CONTENTS

I. Introduction

I.1 The Protection of Conscience Project is a non-profit, non-denominational initiative with an international scope that has advocated for freedom of conscience in health care since 1999. The Project does not take a position on the morality or acceptability of contested procedures or services.

I.2 This submission responds to the World Medical Association (WMA) request for public feedback about a proposed revision to the *International Code of Medical Ethics* (*ICME*). It expands upon Project recommendations and comments in the WMA public consultation feedback form (Appendix "A").

I.3 The submission is notably informed by the impact of Canada's legalization of assisted suicide and euthanasia (EAS) on practitioners opposed to the procedures, described in the *World Medical Journal* (W*MJ*) by Canadian physicians.[1,2] It also draws on *WMJ* articles (co-authored by the Project Administrator) describing the origins of the *Declaration of Geneva* and the *ICME*[3] and the relationship between the revised *Declaration of Geneva* and good medical practice.[4]

I.4 The following paragraphs from the draft *ICME* are functionally interdependent and relevant to the issue of conscience in medical practice (headings added here for convenience):

2. Primary duty of physicians

3. Personal and professional integrity

6. Primacy of ethical principles

9. Integrity of medical judgement

14. Patient-centred practice*

27. Conscientious objection*

30. Ethical collaboration

39. Resistance to legal subversion of ethics

40. Collegial support and resistance to oppression

I.5 The recommended amendments to Paragraphs 14* and 27* are the principal concern of this submission. Discussion includes consideration of the functionally interdependent provisions.

I.6 Recommended amendments to Paragraphs 2, 5, 13, 16, 21 and 35 are collateral to the Project's interest. Reasons for the revisions are given in the WMA public consultation feedback form and do not require further elaboration.

II. Paragraph 14: Patient-centred practice

II.1 Paragraph 14 expresses the central principle of the ICME and underlies the primary duty of physicians (Paragraph 2). The relevant functionally interdependent provisions — including the provision on conscientious objection — encourage, enable and protect patient-centred practice by supporting personal and professional integrity.

II.2 The Project's first recommendation concerns terminology: that "care" should be replaced with "recommendations and treatment."

II.3 The second recommendation addresses the nature of the physician's obligation to act in a patient's "best interest."

Terminology

II.4 The terms "care", "health", "well-being" and "best interest" used in Paragraph 14 are useful only to the extent that there is agreement about their meaning. Current controversies about freedom of conscience in health care frequently manifest fundamental disagreement about the meaning of these terms that cannot be ignored in policy making.

II.5 For example, euthanasia by lethal injection is accurately described as a service, procedure or treatment. To call it a *health* service, *medical* procedure or *care* gives normative force to disputed "metaphysical, philosophical and moral premises that can be rationally contested but cannot be empirically validated," among them "the dogmatic claim that a human being can be better off dead."

> In a free and democratic society, it ought to be unacceptable to force physicians to profess this article of faith, or to demonstrate practical adherence to it by killing or facilitating the killing of a patient.[5]

II.6 However, unreflective use of terms like "care" or "health" may express or invite uncritical acceptance of such underlying premises and beliefs, thus prejudicing discussion, legal reasoning and policy from the outset; polemical use of the terms certainly does. It is important to recognize that this can incidentally or deliberately effect the kind of subversion of medical ethics that Paragraphs 39 and 40 insist physicians must oppose and resist.

II.7 By replacing "care" with "treatment and recommendations" the *ICME* will recognize the typical and uncontroversial elements of medical practice in a manner less open to polemical misuse in relation to contested services or procedures. The amendment will also make it easier to defend against the kind of ethical, legal and regulatory subversion and oppression contemplated in Paragraphs 39 and 40.

"Best interest"

II.8 Notwithstanding agreement that priority must be given to the patient's "best interest," what is thought to be in a patient's "best interest" can be disputed for a variety of legitimate reasons, quite apart from further interpretive difficulties introduced by contested underlying beliefs (II.4– 6). An increasingly persistent claim is that what is in a patient's best interest should be

determined by the patient — not the physician.

> Physicians may reasonably disagree. If, despite this, physicians are compelled to further a patient's request, the concepts of benefit, harm and best interest become irrelevant. All that remains is the demand of the patient, backed by the power of the state to ensure compliance.
>
> This treats physicians as mere technicians or state functionaries, as cogs in a state machine delivering services upon demand, not as responsible moral agents who, like their patients, must form and act upon judgements about benefits and harms. It imposes a form of servitude that is incompatible with human equality, dignity and personal and professional integrity.[6]

II.9 With respect to professional integrity, grave concern has been expressed that displacing the traditional responsibility of the medical profession to independently "make considered medical determinations based on evidence, unique knowledge and expertise" amounts to "a stunning reversal of the central role of the medical and legal concept of the standard of care."[7]

II.10 What counts as "best interest" must be determined on a case-by-case basis and cannot be defined by the *ICME*. However, the ICME should indicate the role and obligations of physicians in making this determination. Here the law on fiduciary obligation is informative. Physicians must assess what is in a patient's best interest independently and in good faith, using their own judgement, without becoming a "puppet" by taking direction from anyone else, including the patient and state medical regulators. If they thus conclude that doing X is not in a patient's best interest, the law requires them to refuse.[8]

II.11 The concept of fiduciary obligation as developed in common law jurisdictions is not readily transposed to civil law jurisdictions, which variously articulate duties of care, loyalty, fidelity and good faith to achieve similar ends.[9] It is not clear to what extent either common law or civil law traditions inform the current draft of the *ICME*. However, it does seem that the requirements for independence and good faith described in II.10 are common to both. This inference is supported by expectations in the *European Charter of Medical Ethics*[10] and *Principles of European Medical Ethics*.[11] Moreover, requirements for independence and good faith are fully consistent with the *ICME*'s stress on patient priority (Paragraphs 2, 5, 7, 14–19, 21, 28, 31) and professional independence (Paragraphs 3, 6, 9, 25, 27, 39 and 40).

II.12 Hence, in Paragraph 14 the *ICME* should specify that recommendations and treatments must be only those a physician "believes in good faith" to be in a patient's best interest, "belief" making clear that the judgement is that of the physician, and "good faith" indicating reasonableness, good will and absence of duplicity, prejudice or discrimination.

III. Paragraph 27: "Conscientious objection"

III.1 The proposed text of Paragraph 27 is anomalous in relation to medical practice because it ignores the role of conscience in medicine and adopts an inadequate and prejudicial analytical framework limited to "conscientious objection." In so doing it fails to make distinctions that would, if recognized, suggest how both physician integrity and patient access to services can be accommodated. For these reasons it is also anomalous in relation to existing WMA policy and related functionally interdependent paragraphs in the proposed *ICME*.

Conscience in medicine

III.2 The central role of conscience in medical practice was a prominent concern of the organizers of the WMA and the assemblies that first approved the *Declaration of Geneva* and *ICME*.[12,13] In reviewing the origins of these documents, the Project Administrator and co-authors affirmed and applied the insight of the WMA founders:

> [T]he practice of medicine is an inescapably moral enterprise. Physicians first consider the good of patients, always seeking to do them some kind of good and protect them from evils. Hence, moral or ethical views are intrinsic to the practice of medicine, and every decision concerning treatment is a moral decision, whether or not physicians consciously advert to it. To demand that physicians must not act upon moral beliefs is to demand the impossible, since one cannot practise medicine without reference to moral beliefs. (References omitted)[14]

III.3 Relevant here is an observation by Dr. Ewan Goligher, a WMA associate member and co-author of two of the *WMJ* articles cited herein. He notes that objections to conscientious objection in medicine claim that it

a) imposes doctors's values on patients,

b) undermines professional standards, and

c) denies access to care.

Dr. Goligher points out that these claims are themselves "conscience-based ethical objections."

"The real question," he says, "is not whether conscience should be exercised, but rather which kinds of conscientious objections are appropriate and which kind are not."[15]

III.4 For example, no difficulty arises from the perspective of freedom of conscience when the only issue is clinical competence in relation to a service or procedure that the physician believes is in a patient's best interests. Facilitating or arranging for the service to be provided by someone else is then a natural extension of the physician's responsibilities to the patient and is consistent with the physician's professional and personal moral integrity. Effective referral in this situation becomes an obligation, and refusing or failing to make an effective referral can be characterized as abandonment. This is the basis for *ICME* Paragraph 21.

III.5 On the other hand, physicians who refuse to provide or to make effective referrals for a treatment because evidence of efficacy is insufficient are acting in a manner consistent with their ethical obligations. Similarly, physicians who conclude that a treatment is medically contraindicated because it is harmful are ethically obliged to *refuse* to provide or facilitate that treatment. Both kinds of refusals can be properly described as examples of the exercise of conscience (or conscientious objection) based on clinical judgement. Again, Dr. Goligher:

> In all these cases, I have not only a technical reason, but also a moral obligation, not to perform such interventions. As such, these are unavoidably conscience-based refusals; I can't offer this treatment because it would be unethical for me to do so.[16]

Inadequate, prejudicial analytical framework

III.6 Paragraph 27 is irrelevant to conscientious objection in the circumstances described above because it ignores the role of conscience in medicine. For the same reason it does not and cannot provide coherent ethical guidance on conscientious objection by physicians. In that respect it is wholly inadequate.

III.7 Further, Paragraph 27 clearly assumes that what an objecting physician refuses to do is morally/medically acceptable and necessary "care" or medical treatment. It uncritically accepts as a matter of fact the very point that is usually contested in these cases. Beginning with the premise that objecting physicians are wrong to refuse a contested procedure, it concludes that their refusal can only be tolerated in strictly limited circumstances. This is not merely inadequate but a clearly prejudicial framework that lends itself to morally partisan abuse.

III.8 Finally, in demanding effective referral Paragraph 27 requires a form of collaboration that many objecting physicians reasonably consider ethically unacceptable, and that the WMA also considers unacceptable in relation to unethical procedures. Indeed, in relation to unethical activities the WMA identifies a range of morally relevant conduct that physicians should avoid, including referral,[17] countenancing, condoning, facilitating or aiding,[18,19] providing skills, premises, supplies, substances or knowledge, including individual health information,[20] planning, instruction or training, preparation of reports,[21,22] incitement[23] and retrospectively affirming or supporting unethical practices.[24] This demonstrates that Paragraph 27 is anomalous in relation to WMA policy, inadequate and prejudicial.

Critical distinctions not recognized

III.9 Objecting practitioners are typically willing to work cooperatively with patients and others in relation to patient access to services as long as cooperation does not involve collaboration: an act that establishes a causal connection to or de facto support for the services to which they object. They are usually willing to provide patients with information to enable informed decision-making and contact with other health care practitioners.

III.10 The distinctions between cooperation and collaboration and providing information vs.

providing a service enable an approach that accommodates both patients and practitioners. However, these critical distinctions are irrelevant within the analytical framework adopted in Paragraph 27, so they are not recognized. As a result, Paragraph 27 does not attempt or even suggest how to accommodate physician integrity and patient requests when they conflict.

III.11 On the other hand, avoiding, minimizing and satisfactorily managing such conflicts can be challenging, and Paragraph 27 correctly identifies some of the issues that must be addressed, such as patient health and continuity of medical treatment. It does not follow, however, that they can be adequately addressed in a paragraph in the *ICME*. It may be that the shortcomings of Paragraph 27 reflect an attempt to accomplish more than can actually be accomplished within the constraints imposed by the nature of the document.

Conflict with existing WMA policy on euthanasia/assisted suicide

III.12 Euthanasia and/or assisted suicide are considered to be part of medical practice in Belgium, Netherlands, Luxembourg, Switzerland, Canada, Colombia, Australia, New Zealand, parts of the United States and (soon) Spain. Some former and present constituent members of the WMA consider the procedures to be in accord with good medical practice. It seems likely that other countries and national medical associations will follow suit.

III.13 Some physicians in these countries, like the WMA, remain opposed to euthanasia and assisted suicide. Currently, physicians are nowhere required to personally provide euthanasia or assisted suicide, but two medical regulators in Canada demand that objecting physicians collaborate in killing their patients by effective referral. Notwithstanding opposition to effective referral by the Canadian Medical Association,[25] the position of objecting physicians in Canada is difficult and tenuous.[26,27] Physicians in other countries may eventually find themselves in a similar position.

III.14 The WMA clearly asserts that this is unacceptable: "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."[28] In contrast, Paragraph 27 purports to establish an ethical obligation to actively and deliberately collaborate in a procedure a physician believes to be unethical, not excluding planned and deliberate medical homicide and assisted suicide.

III.15 Here it is relevant to recall what motivated physicians to found the WMA:

> National medical association delegates returning [to] London in September, 1946 were uneasy and ambivalent about plans to nationalize health care systems in Britain and the Continent. On the one hand, they welcomed the growing interest in medicine by governments around the world. On the other, they worried about the consequences of (as later expressed) transforming all physicians into "Civil servants controlled by the state." They conceived an international medical association as support for national associations defending practitioners from government demands. (References omitted)[29]

III.16 Current WMA policy on euthanasia and assisted suicide supports objecting physicians in the manner intended by the founders of the Association. Paragraph 27 in its present form not

only abandons them, but can and most certainly will be used against them. To assert that Paragraph 27 cannot be used in this way because the WMA considers euthanasia/assisted suicide unethical would be a parochial and morally partisan response that would make the *ICME* irrelevant in every jurisdiction where the procedures are legal.

Conflict with interdependent ICME provisions

III.17 Paragraph 27 undermines all of the functionally interdependent provisions of the *ICME* associated with practising medicine with conscience. Specifically, if physicians are compelled by Paragraph 27 to collaborate in procedures they reasonably believe to be contrary to good medical practice, harmful to patients, or otherwise unethical, it will be impossible for them

- to "practise with conscience, honesty, and integrity, while always exercising independent professional judgment and maintaining the highest standards of professional conduct;"
  (Paragraph 3: Personal and professional integrity)
- to maintain their "commitment to the ethical principles set forth" in the ICME;
  (Paragraph 6: Primacy of ethical principles)
- to steadfastly maintain "their sound professional medical judgments" against "instructions from non-physicians" — including patients, legislators, regulators, ethicists etc.
  (Paragraph 9: Integrity of medical judgement)
- to "commit to the primacy of patient health and well-being and . . .offer care in the patient's best interest" (when, contrary to their views about health, well-being and best interest, physicians are compelled by Paragraph 27 to collaborate even in killing their patients);
  (Paragraph 14. Patient-centred practice)
- to ensure that "ethical principles are upheld when working in teams";
  (Paragraph 30: Ethical collaboration)
- to "prevent national or international ethical, legal, or regulatory requirements that undermine" ethical obligations (since Paragraph 27 provides a vehicle for national, international, ethical, legal and regulatory authorities to compel physicians to collaborate in procedures they reasonably believe to be contrary to good medical practice, harmful to patients, or otherwise unethical);
  (Paragraph 39: Resistance to legal subversion of ethics)
- "to support fellow members in upholding" ethical responsibilities or "to take measures to protect them from undue influence, from violence and from oppression" (Paragraph 40: Collegial support and resistance to oppression)

Recommended amendments to Paragraph 27

III.18 The amendments to Paragraph 27 proposed by the Project make four changes:

- The analytical framework is expanded so that the amended Paragraph 27 addresses the exercise of freedom of conscience within medical practice in relation to contested procedures or services.
- Consistent with recognized ethical principles and other WMA policies, providing, facilitating, recommending and supporting are identified as morally relevant conduct in relation to contested procedures or services.
- The amendment explicitly recognizes the potential for significant ethical disagreement between physicians and the state or other authorities and gives practical force to the functionally interdependent provisions of the ICME identified in I.4 and III.17.
- The amended Paragraph 27 includes brief guidance about physician obligations to provide information to enable informed medical decision making and ensure patient safety and continuity of care.

III.19 A paragraph in the ICME can make key points but cannot comprehensively address this subject. The Project recommends that the amended Paragraph 27 be supplemented by a stand-alone WMA policy on physician freedom of conscience "to help physicians defend their personal and professional integrity while providing medical services within the context of patient-centred practice."[30]

III.20 It will be possible to discuss a policy of this kind at the conference planned for 2021 or 2022. However, for reasons that should be apparent from this submission, the conference should be dedicated to the subject of conscience in medical practice, not to "conscientious objection."

Appendix "A"

Project responses in consultation feedback form

	Current revised text (as of April 2021) SUBJECT TO CHANGE	Proposed amendments Specific Comments Additions: **bold/underlined** Deletions: ~~lined-out~~ Comments only: *[italic]*	Reasoning/comments
	WMA INTERNATIONAL CODE OF MEDICAL ETHICS		
	Preamble		
1.	The World Medical Association (WMA) has developed the International Code of Medical Ethics as a canon of ethical principles for the members of the medical profession worldwide. In concordance with the Declaration of Geneva and the WMA's entire policy apparatus, it defines and elucidates the professional duties of physicians toward their patients, other physicians and healthcare professionals, themselves, and society as a whole. The International Code of Medical Ethics should be read as a whole and each of its constituent paragraphs should be applied with consideration of all other relevant paragraphs. Consistent with the mandate of the WMA, the Code		

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
	is addressed to physicians. The WMA encourages others who are involved in healthcare to adopt these principles.		
	General principles		
2.	The primary duty of the physician is to promote the health and well-being of individual patients by providing competent, compassionate care in accordance with good medical practice. The physician also has a responsibility to contribute to the health of the populations they serve and society as a whole. In providing medical care, the physician must respect the dignity and rights of the patient.	The primary duty of the physician is to promote the health and well-being of individual patients by providing competent, compassionate **medical treatment and** care in accordance with good medical practice. The physician also has a responsibility to contribute to the health of the populations they serve and society as a whole. ~~In providing medical care, the physician must respect the dignity and rights of the patient.~~ *[Paragraph 2 reflects the unifying ethical principle of the Code expressed in Paragraph 14].*	The primary duty of a physician *qua* physician is to provide medical treatment and ancillary care, not simply care. The revision elucidates this point and is also desirable for the reasons given in relation to recommended revisions to Paragraphs 14 and 21. Paragraphs 13 and 15 set out the obligation to respect the dignity and rights of the patient, so there is no need to refer to the obligation in Paragraph 2. Dropping the final sentence keeps the emphasis in Paragraph 2 on the primary duty of physicians, which appears to be its focus.
3.	The physician must practise with conscience, honesty, and integrity, while	*[Paragraphs 3, 6, 9, 14, 27,30, 39 and 40 are functionally interdependent.]*	

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
	always exercising independent professional judgment and maintaining the highest standards of professional conduct.		
4.	Physicians must not allow their professional judgment to be influenced by the possibility of benefit to themselves or their institution. They must recognise and avoid, whenever possible, or otherwise declare and manage real or potential conflicts of interest.		
5.	The physician must practise medicine fairly and justly and provide care without engaging in discriminatory conduct or bias on the basis of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor. Care should be provided based on the patient's medical needs.	. . . ~~Care~~ **Treatment and recommendations** should be provided based on the patient's medical needs.	The revision is meant to be consistent with recommended revisions to Paragraphs 2, 14 and 21.
6.	The physician is obliged to be aware of applicable national ethical, legal, and	*[Paragraphs 3, 6, 9, 14, 27,30, 39 and 40 are functionally interdependent.]*	

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
	regulatory norms and standards, as well as relevant international norms and standards. Such norms and standards must not reduce or eliminate the physician's commitment to the ethical principles set forth in this document.		
7.	The physician must strive to use health care resources in a way that optimally benefits the patient, in keeping with fair, just, and prudent stewardship of the shared resources with which the physician is entrusted.		
8.	When providing professional certification, physicians must only certify what they have personally verified.		
9.	Physicians must take responsibility for their medical decisions and must not alter their sound professional medical judgments on the basis of instructions from non-physicians. However, physicians should consult with other health care professionals when appropriate.	*[Paragraphs 3, 6, 9, 14, 27,30, 39 and 40 are functionally interdependent.]*	

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
10.	Physicians should offer help in medical emergencies, while considering their own safety and competence, and the availability of other options for care.	*["Care" (rather than "treatment") is appropriate in this context because the help a physician is competent and able to provide may not be a medical treatment or intervention. Cf Paragraphs 2, 5, 14, 21]*	
11.	Physicians must engage in continuous learning throughout their professional lives in order to maintain and develop their professional knowledge and skills.		
12.	Physicians should strive always to practise medicine in ways that are environmentally sustainable with a view to minimising environmental health risks to current and future generations.		
	Duties to the patient		
13.	A physician must always provide medical treatment with the utmost respect for human dignity and life.	A physician must always ~~provide medical treatment with~~ **demonstrate** the utmost respect for human dignity and life **in practising medicine.**	Practising medicine entails interactions with people that involve more than providing medical treatment. The suggested revision counters a reductionist emphasis on technique or function. It directs attention to the need to respect all persons *per se*, distinct but

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
			not derogating from their autonomy and rights (Paragraph 15).
14.	The physician must commit to the primacy of patient health and well-being and must offer care in the patient's best interest.	The physician must commit to the primacy of patient health and well-being and must offer ~~care~~ **only recommendations and treatment the physician believes in good faith to be** in the patient's best interest. *[Note that the terms "health", "well-being" and "best interest" are unhelpful when the meanings of the terms are disputed. See II.4 to II.7 in this submission.]* *[Paragraphs 3, 6, 9, 14, 27,30, 39 and 40 are functionally interdependent.]*	"Care" is an overbroad and loaded term. In Canada and elsewhere it includes euthanasia; physicians who refuse to collaborate are accused of failing to provide "care." The suggested revision is more precise and less open to polemical misuse. Physicians' fiduciary obligations require them to independently and in good faith determine what is in a patient's best interest, even if the patient or others disagree. The suggested revision incorporates these key elements and ensures that an evaluation of "best interest" cannot be forced upon a physician who disagrees. See II.8 to II.12 in this submission.

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
15.	The physician must respect the autonomy and rights of the patient, including the right to accept or refuse treatment in keeping with the patient's values and preferences.		
16.	Physicians must obtain patients' voluntary informed consent prior to treatment, ensuring that patients receive and understand the information they need to make independent, well-informed decisions about their care.	. . . **When presenting an opinion that is contrary to the generally held opinion of the profession, they must so indicate.**	Patients typically assume that a physician's recommendations are consistent with the general view of the profession. They seldom know if they are not. Disclosure ensures patient decision-making is properly informed. The same recommendation is made in relation to Paragraph 35, which addresses public statements by physicians rather than physician-patient consultations. The recommended addition is from the 2004 version of the Canadian Medical Association *Code of Ethics.*
17.	In emergencies, where the patient is not able to participate in decision making, physicians may initiate treatment in the best interests of the patient without prior informed consent.		

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
18.	When a patient has substantially limited, undeveloped, impaired or fluctuating decision-making capacity, the physician must work with the patient's trusted surrogate, if available, to make decisions in keeping with the patient's preferences, when those are known or can reasonably be inferred, or in the patient's best interests, when the individual's preferences cannot be determined, always in keeping with the principles set forth in this Code.		
19.	Physicians should be considerate of and collaborate with others, where available, who are central to the patient's care, including family members, significant others, or other health care professionals in keeping with the patient's preferences and best interest.	*["Care" (rather than "treatment") is appropriate in this context. Cf Paragraphs 2, 5, 14, 21]*	
20.	When medically necessary, the physician must communicate with other physicians and health professionals who are involved in the care of the patient or who are qualified to assess or recommend		

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
	treatment options. This communication must respect patient confidentiality and be confined to necessary information.		
21.	If any aspect of caring for the patient is beyond the capacity of a physician, the physician must consult with or refer the patient to another physician or health professional who has the necessary ability.	If ~~any aspect of caring for~~ **medical treatment needed by** the patient is beyond the ~~capacity~~ **ability** of a physician, the physician must consult with or refer the patient to another physician or health professional who has the necessary ability.	"Caring" is overbroad. In Canada and elsewhere, "care" includes lawful killing of patients by lethal injection. "Capacity" is also overbroad. This paragraph is apparently meant to refer to specific knowledge or technical expertise or skill in relation to medical treatment the physician believes is necessary for the health of the patient. Suggested revisions achieve the purpose of the paragraph with greater precision and less likelihood of misunderstanding or misinterpretation.
22.	The physician must respect a patient's right to confidentiality, even after a patient has died. It may be ethical to disclose confidential information when the patient consents to it or, in exceptional cases, when disclosure is necessary to safeguard a significant and overriding ethical obligation and the		

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
	patient does not or cannot consent to that disclosure. This disclosure must be limited to the minimal necessary information.		
23.	If a physician is acting on behalf of or reporting to any third parties with respect to the care of a patient, the physician must inform the patient accordingly. At the outset of an interaction, the physician must disclose to the patient the nature and extent of those commitments and must obtain prior consent for the interaction with the patient to continue.	*["Care" (rather than "treatment") is appropriate in this context. Cf Paragraphs 2, 5, 14, 21]*	
24.	Physicians must refrain from intrusive advertising and marketing and ensure that all information used by them in advertising and marketing is correct and not misleading. Physicians may not participate in advertising or marketing of products related to their professional activity.		
25.	The physician should not allow commercial, financial, or other		

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
	conflicting interests to take precedence over the physician's professional judgment.		
26.	When providing medical consultation or treatment in the form of telemedicine, the physician must ensure that this form of communication is medically justifiable and that the necessary medical care is guaranteed, particularly through the manner in which diagnostic assessment, medical consultation, treatment and documentation are carried out. The physician is also obligated to inform the patient about the particularities of receiving medical consultation and treatment via communications media. Wherever helpful, physicians must aim to provide medical consultation and treatment to patients through direct, personal contact.		
27.	Physicians have an ethical obligation to minimise disruption to patient care. Conscientious objection must only be considered if the individual patient is not	~~Physicians~~ **Individual** physicians have an ethical obligation to ~~minimise disruption to patient care. Conscientious objection must only be considered if the~~	Paragraphs 3, 6, 9, 14, 27, 30, 39 and 40 are functionally interdependent. See Part III of this submission for

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
	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.* ** This paragraph will be debated in greater detail at the WMA's dedicated conference on the subject of conscientious objection in 2021 or 2022. However, comments on this paragraph are also welcome at this time.*	~~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.~~ **refuse to provide, facilitate recommend or support interventions they reasonably consider inefficacious, harmful, discriminatory or otherwise unethical, notwithstanding contrary ethical, legal or regulatory requirements, norms or standards. They should provide information necessary to enable informed decision-making and continue to provide necessary treatment and care unrelated to a contested intervention to ensure the health of the patient is not endangered.**	detailed discussion of Paragraph 27.
28.	Appropriate professional boundaries must be maintained. Physicians must not engage in a sexual relationship with a current patient and must never engage in abusive or exploitative relationships with a patient.		

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
29.	In order to provide care of the highest standard, physicians must attend to their own health, well-being and abilities. This includes seeking appropriate care to ensure that they are able to practise safely.	*["Care" (rather than "treatment") is appropriate in this context. Cf Paragraphs 2, 5, 14, 21]*	
	Duties to other physicians and health professionals		
30.	The physician must engage with other physicians and health professionals in a respectful and collaborative manner. Physicians must also ensure that ethical principles are upheld when working in teams.	*[Paragraphs 3, 6, 9, 14, 27, 30, 39 and 40 are functionally interdependent.]*	
31.	The physician should respect colleagues' patient-physician relationships and not intervene unless needed to protect the patient from harm. This should not prevent the physician from recommending alternative courses of action considered to be in patients' best interests.		

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
32.	Physicians should report conditions or circumstances which impede them from providing care of the highest standards, including violence against physicians and other health personnel, inappropriate working conditions, and any other unsustainable stress factors.	*["Care" (rather than "treatment") is appropriate in this context. Cf Paragraphs 2, 5, 14, 21]*	
33.	Due respect should be granted to teachers and students of medicine and other health professionals.		
	Duties to society		
34.	Physicians must support fair and equitable provision of health care. This includes addressing inequities in health and care, the determinants of those inequities, as well as violations of the rights of patients and health care professionals.	*["Care" (rather than "treatment") is appropriate in this context. Cf Paragraphs 2, 5, 14, 21]*	
35.	Physicians play an important role in matters relating to the health and safety of the public, health education and health literacy. In fulfilling this responsibility, physicians should be prudent in	. . . to distinguish in their public comments between evidence-based scientific information and their own personal opinions. **When presenting an opinion that is contrary to the**	The same recommendation is made in relation to Paragraph 16, which addresses physician-patient consultations rather public statements by physicians. The recommended addition is from the 2004

	Current revised text (as of April 2021) SUBJECT TO CHANGE	**Proposed amendments** **Specific Comments** **Additions: bold/underlined** **Deletions**: ~~lined-out~~ **Comments only:** *[italic]*	**Reasoning/comments**
	discussing new discoveries, technologies, or treatments in non-professional, public venues and should ensure that their statements are scientifically accurate. Physicians should be especially careful to distinguish in their public comments between evidence-based scientific information and their own personal opinions.	**generally held opinion of the profession, they must so indicate.**	version of the Canadian Medical Association *Code of Ethics*.
36.	Physicians should avoid acting in such a way as to weaken public trust in the medical profession. To maintain that trust, physicians must hold themselves and fellow physicians to the highest standards of professional conduct and be prepared to report unethical or incompetent behaviour.		
37.	Physicians should share their medical knowledge and expertise for the benefit of patients and the advancement of healthcare.		
38.	Physicians have a duty to support the conduct of scientifically sound medical		

	Current revised text (as of April 2021) SUBJECT TO CHANGE	Proposed amendments Specific Comments Additions: **bold/underlined** Deletions: ~~lined-out~~ Comments only: *[italic]*	Reasoning/comments
	research in keeping with the ethical principles of the Declaration of Helsinki.		
	Duties of the physician as members of professional medical organisations		
39.	As members of professional medical organisations, physicians shall follow, protect, and promote the ethical principles of this code. They shall help prevent national or international ethical, legal, or regulatory requirements that undermine any of the duties set forth in this document.	*[Paragraphs 3, 6, 9, 14, 27,30, 39 and 40 are functionally interdependent.]*	
40.	As members of professional medical organisations, it is the task of physicians to support fellow members in upholding the responsibilities set out in this code and to take measures to protect them from undue influence, from violence and from oppression.	*[Paragraphs 3, 6, 9, 14, 27,30, 39 and 40 are functionally interdependent.]*	

Notes

1. Rene Leiva et al, "Euthanasia in Canada: A Cautionary Tale" (2018 Sep) 64:3 World Med J 17, online: <.https://www.wma.net/wp-content/uploads/2018/10/WMJ_3_2018-1.pdf#page=19> [*Leiva et al*].

2. Leonie Herx, Margaret Cottle & John Scott, "The Normalization of Euthanasia in Canada: the Cautionary Tale Continues" (2020 Apr) 66:2 World Med J 28, online:<https://www.wma.net/wp-content/uploads/2020/04/wmj_2_2020_WEB.pdf#page=30> [*Herx et al*].

3. Sean Murphy *et al*, "The WMA and the Foundations of Medical Practice: Declaration of Geneva (1948), International Code of Medical Ethics (1949)" (August, 2020) 66:3 World Med J 2 [*WMJ Foundations*], online: <https://www.wma.net/wp-content/uploads/2020/08/wmj_3_2020_WEB.pdf#page=4>.

4. Sean Murphy *et al*, "The Declaration of Geneva: Conscience, Dignity and Good Medical Practice" (December, 2020) 66:4 World Med J 43, [*WMJ Conscience*] online: <https://www.wma.net/wp-content/uploads/2020/12/wmj_4_2020_WEB.pdf#page=43>.

5. *WMJ Foundations*, *supra* note 3 at p 5–6.

6. *Ibid*.

7. Trudo Lemmens, Mary Shariff, & Leonie Herx, "How Bill C-7 will sacrifice the medical profession's Standard of Care" (11 February, 2021) Policy Options, online: <https://policyoptions.irpp.org/magazines/february-2021/how-bill-c7-will-sacrifice-the-medical-professions-standard-of-care/>.

8. *Canadian Aero Service Ltd. v. O'Malley*, [1974] SCR 592, 1973 CanLII 23 (SCC)at 606; *McInerney v MacDonald*, [1992] 2 SCR 138, 1992 CanLII 57 (SCC) at 139, 149, 152; United Kingdom, Law Commission, Report No. 350 Fiduciary Duties of Investment Intermediaries (Williams Lea Group for HM Stationery Office,2014), Law Commission [UKLCR350] at para 3.53, note 107, citing *Selby v Bowie* (1863) 8 LT 372, *Re Brockbank* [1948] Ch 206.

9. Martin Gelter & Geneviève Helleringer, "Fiduciary Principles in European Civil Law Systems"(2018 March) European Corporate Governance Institute Law Working Paper No. 392/2018, online: <https://ecgi.global/sites/default/files/working_papers/documents/finalgelterhelleringer_0.pdf>.

10. Conseil Européen Ordres Médecins, "European Charter of Medical Ethics" (10 June, 2011) *Conseil Européen Ordres Médecins* (website), at Principles 6, 8, 11, 15, online: <http://www.ceom-ecmo.eu/sites/default/files/documents/en-european_medical_ethics_charter-adopted_in_kos.pdf>.

11. International Conference of Medical Professional Associations and Bodies with Similar Remits, "Principles of European Medical Ethics" (6 January 1987) *Conseil Européen Ordres Médecins* (website), at Articles 2, 5, 24, online: <http://www.ceom-ecmo.eu/sites/default/files/documents/european_medical_ethics_principles-1987-1995_ceom_cio_0.pdf>.

12. *WMJ Conscience*, *supra* note 4 at 41.

13. *WMJ Foundations*, *supra* note 3 at 3.

14. *WMJ Conscience*, *supra* note 4 at 42.

15. CMDA Canada, "Understanding Conscience in Health Care" (21 April, 2021), online:YouTube <https://www.youtube.com/watch?v=KyakqSesnGA> at 00h:04m:01s to 00h:04m:48s [*Goligher*].

16. *Ibid* at 00h:05m:54s to 00h:07m:16s

17. World Medical Association, "WMA Declaration on Euthanasia and Physician-Assisted Suicide" (13 November, 2019), *WMA* (website), online: <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/> [*WMA Euthanasia*].

18. World Medical Association, "WMA Declaration of Hamburg Concerning Support for Medical Doctors Refusing to Participate in or to condone, the use of Torture and other Cruel, Inhuman or Degrading Treatment" (13 July 2020), *WMA* (website), online: <https://www.wma.net/policies-post/wma-declaration-of-hamburg-concerning-support-for-medical-doctors-refusing-to-participate-in-or-to-condone-the-use-of-torture-or-other-forms-of-cruel-inhuman-or-degrading-treatment/> at para 1.

19. World Medical Association, "WMA Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment" (25 May, 2020), *WMA* (website), online: <https://www.wma.net/policies-post/wma-declaration-of-tokyo-guidelines-for-physicians-concerning-torture-and-other-cruel-inhuman-or-degrading-treatment-or-punishment-in-relation-to-detention-and-imprisonment/> at para 1, 5, 9.

20. *Ibid* at para 2, 5

21. World Medical Association, "WMA Resolution on the Prohibition of Physician Participation in Capital Punishment" (6 October, 2018), *WMA* (website), online: <https://www.wma.net/policies-post/wma-resolution-on-prohibition-of-physician-participation-in-capital-punishment/>.

22. World Medical Association, "WMA Resolution on Prohibition of Forced Anal Examination to Substantiate Same-Sex Sexual Activity" (17 October, 2017), *WMA* (website), online: <https://www.wma.net/policies-post/wma-resolution-on-prohibition-of-forced-anal-examinations-to-substantiate-same-sex-sexual-activity/> at para 6.

23. *Ibid* at para 2.

24. World Medical Association, "WMA Statement on Organ and Tissue Donation" (21 August, 2020), *WMA* (website), online: <https://www.wma.net/policies-post/wma-statement-on-organ-and-tissue-donation/> at para 34–36.

25. Canadian Medical Association, "Submission to the College of Physicians and Surgeons of Ontario Consultation on CPSO Interim Guidance on Physician-Assisted Death" (13 January, 2016), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/background/policy/associations-013.aspx>.

26. *Leiva et al*, *supra* note 1.

27. *Herx et al*, *supra* note 2.

28. *WMA Euthanasia*, *supra* note 17.

29. *WMJ Foundations*, *supra* note 3 at 2.

30. *WMJ Conscience*, *supra* note 4 at 44.