COMMITTEE ON ETHICS

The Committee on Ethics shall be concerned with:

(i) the elaboration, interpretation and amendment of the Code of Ethics;

(ii) problems related to ethics to The Canadian Medical Association.

1. The Committee on Ethics held two formal meetings, one on November 12, 1976 and one on March 28, 1977. At the November meeting along with the staff members, Dr. F. Rhodes Chalke, Department of Psychiatry, Royal Ottawa Hospital, and Dr. D. Craigen, Director General of Medical and Health Services, Canadian Penitentiary Services were in attendance. At the March 28, 1977 meeting, Dr. Terry Firth and Mr. Carey Stevens, Department of Psychiatry, Royal Ottawa Hospital and the University of Ottawa, attended.

GUIDELINES RE BIO-MEDICAL RESEARCH

2. The following resolution, passed by the Alberta Medical Association at its annual meeting was forwarded to the committee.

"That the Board of Directors consider suggesting to the Canadian Medical Association that a multi-discipline committee of physicians, lawyers, theologians, social workers and others study the subject of bio-ethics to develop guidelines in this area."

3. In considering the above resolution the committee recognized that at both national and international levels such committees, so constituted, are studying the problems of bio-ethics in their various contexts. It was the opinion of the committee that it would be redundant for the CMA to attempt to set up such a committee at this time. However, there was agreement that it would be valuable to have a committee formed from a smaller geographic area as a pilot project and a request was submitted to the CMA Board of Directors that the Alberta division be asked to undertake such a project.

DECLARATIONS OF HELSINKI AND TOKYO

4. These declarations of the World Medical Association have been under continuous study by the Committee on Ethics and the CMA Board of Directors.

5. As will be noted, the committee reported to General Council that the Declaration of Tokyo (Torture) had been approved at the meeting of the World Medical Association in Tokyo in 1975. The Declaration of Helsinki (Biomedical Research) had been updated.

6. The revised Declaration of Helsinki has sections which have ethical implications of concern to CMA. The committee agreed that these problem areas are adequately dealt with in the section of the present code entitled "Responsibilities to the Patient - Clinical Research". The committee further agreed that this section of the code should remain unchanged.

GUIDELINES FOR THE CARE OF PRISONERS IN CANADIAN PENITENTIARIES

7. Dr. D. Craigen and Dr. Rhodes Chalke were invited to attend the meeting of November 12, 1976 to discuss a series of ethical guidelines which were developed at a national conference held in Kingston, Ontario, November 2-5, 1975. The committee reviewed the guidelines which cover the professional conduct of health professionals in Canadian penitentiaries and suggested some amendments.

8. The Speaker then brought forth the following motion which was

Moved by Dr. J.W. Ibbott
Seconded by Dr. F.N. Rigby

Whereas the Canadian Medical Association does not wish to interfere with the internal policy of the ministry of the Solicitor General's Department

with respect to the organization, structure of its various components and the rules and regulations affecting its employees, it considers relevant to examine the expanding role of the health care division in Canadian penitentiaries in general.

Recognizing the need for improved and appropriate medical care for the inmates and taking note of the policy guidelines and recommendations prepared by the National Health Care Commission and the Psychiatric Board of Consultants.

Emphasizing the need to delineate clearly the responsibilities of the medical professionals involved in providing the appropriate health care in penitentiaries within the accepted code of medical ethics and traditionally recognized medical responsibilities.

Aware of the danger of the use of medical professionals for the purpose of control of inmates in penitentiaries by using medical techniques, psychiatric and others.

Reaffirming the need for appropriate autonomy so that the medical services can be rendered within its limitations and on a par with the same quality of service available outside the penitentiary system.

Be it resolved that

1. All physicians practising medicine in the Canadian penitentiary system must obtain at least temporary license from the respective College of Physicians and Surgeons of the province prior to commencing practice.

2. All medical personnel, primary care physicians, psychiatrists, surgeons, should be professionally accountable to the professional regulatory licensing body and not be considered as subordinate to lay prison administrators.

3. A licensed physician must be allowed to exercise his judgement in discharging his professional responsibilities.

4. The regional psychiatric centres in all provinces must operate as hospitals within the meaning of the Hospital Act of the respective province and the administration of such hospitals must follow the rules and regulations laid down by the Canadian Council on Hospital Accreditation and
(*) therapy must not be influenced by the necessities of custody and control of the inmates.

5. There should be no interference by the penitentiary service in terms of admission, discharge and clinical services.

6. The chief executive of the hospital should report to a board of governors as is customary in all Canadian hospitals.

7. All provincial medical associations should establish a special committee to monitor the medical services delivered in the prisons of the respective provinces.

(*) editorial change

9. Dr. Ibbott gave a brief background for the submission of this recommendation. He said that he was a member of the National Health Services Advisory Committee for Western Canada - a committee that was struck by the Solicitor General's Department some three years ago. This committee brought forth nearly 150 recommendations for improvement of medical and health care services within the Canadian Penitentiary Services. He

He believed that the CMA has, for the last several years, had a deep involvement in the care of prisoners who happen to be also patients within the federal prison service. The matter of concern which gave rise to the seven points in the resolution was the evident concern from individuals associated with psychiatric services within the regional psychiatric centres of the CPS. There is a deep concern that there has been administrative and political constraint interfering with the professional medical services within the system. This represents basically a conflict between thereapy and custody and it is this conflict of the administrative role involving custody of the patient/inmate and treatment of the patient/inmate that has given rise to the seven points.

10. General Council decided that they would deal with parts 1, 2 and 3 together, 4 and 5 together and parts 6 and 7 individually.

11. On a point of information, the mover of the motion said that there was a parliamentary committee struck to look at the federal prisons throughout Canada. This committee tabled its report in the House of Commons within recent weeks and it is expected that the Solicitor General, Mr. Francis Fox, will respond to that report within a short period of time. He added that it was fair to suggest that the spirit of recommendations of the parliamentary committee blended in with the spirit of the recommendations referred to earlier which arose from the National Health Advisory Committee.

12. Parts 1,2 and 3 were not debated by General Council. The question was called on the motion and it was CARRIED.

13. Dr. Ibbott said that part 4 was of great importance. In opening discussion on this section (4 and 5), Dr. R.O. Jones said that he would like to support these two recommendations strongly. He is a member of Dr. Chalke's committee and he is hoping that the Maritime Provinces will have such a centre before too long. He said that there was a basic problem in part 5. The administrator of such has a very different idea of the purpose of these psychiatric centres and his (the administrator) thought is that they should get rid of their difficult people by sending them to the psychiatric centre. The psychiatric decision is that such a centre is a medical institution and patients will be admitted - difficult or not - if it is felt that they are in need of medical help. He commented that this recommendation as submitted by Dr. Ibbott is very similar to a resolution which was moved by Dr. Chalke and seconded by him at a recent meeting of the Canadian Psychiatric Association. Dr. Ibbott agreed that this was so.

14. Dr. E. Baergen was concerned about part 5 because it may create a wrong impression. To him, it suggested that the psychiatrist in charge of inmates may make a decision about discharge from the penitentiary services. He did not think that was the intent. He wondered if it could be clarified.

15. Dr. Ibbott said that there was absolutely no confusion within the minds of the formulators of this section. In other words, the doctors will not determine a change in the sentence of the patient/inmate. Dr. Baergen argued that Dr. Ibbott was saying that there should be no interference by the penitentiary services in terms of admission, discharge and clinical services from what. Dr. Ibbott retorted, "no interference by the penitentiary services in terms of admission, discharge and clinical services from <u>regional psychiatric centres</u>". Dr. Baergen said that the phrase could be included in Section 5. The mover and seconder agreed that this be an editorial change.

16. Dr. R.C.B. Corbet of Alberta questioned Dr. Ibbott on why the recommendation is limited to "regional psychiatric centres", why not regional medical services or a somewhat more embracing term. To this,

Dr. Ibbott said that the thrust of this recommendation has been directed to regional psychiatric centres because they have borne the brunt of the problems within the Canadian Penitentiary Service insofar as the conflict between custody and therapy is concerned, and this was his prelude to the submission of this recommendation (see paras 8 & 9).

17. The Deputy Speaker felt that sufficient discussion had ensued on this section and called the question on parts 4 and 5 which was CARRIED (as changed editorially).

18. Part 6 was dealt with by Dr. Ibbott who affirmed that this is consistent with the recommendations of the Parliamentary Committee to involve lay advisors, boards and so forth, although the parliamentary committee has not dealt specifically with regional psychiatric centres. The model that exists for boards with Government now are as follows - Department of National Defence - the Surgeon General is in fact "the board"; Department of Veterans Affairs - an individual is "the board"; within the Canadian Penitentiary Services, medical and health care branch, the Director-General, Dr. D. Craigen, is in fact "the board". Dr. Ibbott suspected that if the CMA were to recommend a board of governors in the conventional sense of an appointed board, that this would be resisted by the Solicitor General's department.

19. Dr. J.Y. Gosselin, representing the Canadian Psychiatric Association, asked whether the mover of the motion would consider the addition of two words in part 6 so as to facilitate interpretation. The two words were "or equivalent" which would be inserted after the words "Board of Governors". Dr. Ibbott said that that would be very acceptable. Then Dr. W. Tysoe of British Columbia asked whether the word "hospital" could be changed to "regional psychiatric centres" since the recommendation deals mainly with regional psychiatric centres. This was agreed to.

The question was called on part 6 and was CARRIED.

20. Dr. Ibbott, in dealing with part 7, said that the word "monitor" is really the key word in this part. Monitoring, he continued, can be interpreted in a very broad way. In BC, there is a committee that is looking at prisons in general, both provincial and federal prisons and, indeed, what he is trying to suggest in this part of the recommendation is that the individual divisions might have such committees so that the physicians involved in administrative medicine and in organized medicine might have a keener awareness of the nature of penitentiary medicine, both at the psychiatric and general health care level.

21. Dr. J.H. Quigley said that this is a superfluous section, since part 2 which has been passed has already suggested that the licensing bodies should be accountable for these institutions. He did not believe that the medical association should really be the people to monitor the medical services plan and he therefore suggested that part 7 be withdrawn. The speaker entertained this as a motion and thus it was

Moved by Dr. J.H. Quigley
Seconded by Dr. E.H. Baergen

That part 7 be withdrawn.

22. Dr. N. Rigby, seconder of the original motion, did not think this was proper since part 2 referred to the College of Physicians and Surgeons as being the auditing regulating and registering body. Part 7 refers to the provincial divisions of the CMA - which is a "different arm with a different function". It was hoped that the divisions would monitor, look at, audit and make recommendations with regard to the running of these institutions which is of some importance.

The vote was taken on the motion to withdraw which was LOST.

The original part 7 was thus before General Council.

23. Dr. I.A.D. Todd suggested an editorial change which would insert the words "be prepared" after the word "should" thereby deleting the clause "establish a special committee". He felt that any reference to the establishment of a committee would hamper the passage of this section. The mover and seconder agreed with this change.

The question was called on part 7 which was CARRIED.

The motion as amended was CARRIED.

RESOLUTION 14

WHEREAS THE CANADIAN MEDICAL ASSOCIATION DOES NOT WISH TO INTERFERE WITH THE INTERNAL POLICY OF THE MINISTRY OF THE SOLICITOR GENERAL'S DEPARTMENT WITH RESPECT TO THE ORGANIZATION, STRUCTURE OF ITS VARIOUS COMPONENTS AND THE RULES AND REGULATIONS AFFECTING ITS EMPLOYEES, IT CONSIDERS RELEVANT TO EXAMINE THE EXPANDING ROLE OF THE HEALTH CARE DIVISION IN CANADIAN PENITENTIARIES IN GENERAL.

RECOGNIZING THE NEED FOR IMPROVED AND APPROPRIATE MEDICAL CARE FOR THE INMATES AND TAKING NOTE OF THE POLICY GUIDELINES AND RECOMMENDATIONS PREPARED BY THE NATIONAL HEALTH SERVICES ADVISORY COMMITTEE AND THE PSYCHIATRIC BOARD OF CONSULTANTS.

EMPHASIZING THE NEED TO DELINEATE CLEARLY THE RESPONSIBILITIES OF THE MEDICAL PROFESSIONALS INVOLVED IN PROVIDING THE APPROPRIATE HEALTH CARE IN PENITENTIARIES WITHIN THE ACCEPTED CODE OF MEDICAL ETHICS AND TRADITONALLY RECOGNIZED MEDICAL RESPONSIBILITIES.

AWARE OF THE DANGER OF THE USE OF MEDICAL PROFESSIONALS FOR THE PURPOSE OF CONTROL OF INMATES IN PENITENTIARIES BY USING MEDICAL TECHNIQUES, PSYCHIATRIC AND OTHERS.

REAFFIRMING THE NEED FOR APPROPRIATE PROFESSIONAL AUTONOMY SO THAT THE MEDICAL SERVICES CAN BE RENDERED WITHIN ITS LIMITATIONS AND ON A PAR WITH THE SAME QUALITY OF SERVICE AVAILABLE OUTSIDE THE PENITENTIARY SYSTEM.

BE IT RESOLVED THAT

1. ALL PHYSICIANS PRACTISING MEDICINE IN THE CANADIAN PENITENTIARY SYSTEM MUST OBTAIN AT LEAST TEMPORARY LICENSE FROM THE RESPECTIVE COLLEGE OF PHYSICIANS AND SURGEONS OF THE PROVINCE PRIOR TO COMMENCING PRACTICE.

2. ALL MEDICAL PERSONNEL, PRIMARY CARE PHYSICIANS, PSYCHIATRISTS, SURGEONS, SHOULD BE PROFESSIONALLY ACCOUNTABLE TO THE PROFESSIONAL REGULATORY LICENSING BODY AND NOT BE CONSIDERED AS SUBORDINATE TO LAY PRISON ADMINISTRATORS.

3. A LICENSED PHYSICIAN MUST BE ALLOWED TO EXERCISE HIS JUDGEMENT IN DISCHARGING HIS PROFESSIONAL RESPONSIBILITIES.

4. THE REGIONAL PSYCHIATRIC CENTRES IN ALL PROVINCES MUST OPERATE AS HOSPITALS WITHIN THE MEANING OF THE HOSPITAL ACT OF THE RESPECTIVE PROVINCE AND THE ADMINISTRATION OF SUCH HOSPITALS MUST FOLLOW THE RULES AND REGULATIONS LAID DOWN BY THE CANADIAN COUNCIL ON HOSPITAL ACCREDITATION AND THERAPY MUST NOT BE INFLUENCED BY THE NECESSITIES OF CUSTODY AND CONTROL OF THE INMATES.

5. THERE SHOULD BE NO INTERFERENCE WITHIN REGIONAL PSYCHIATRIC CENTRES BY THE PENITENTIARY SERVICE IN TERMS OF ADMISSION, DISCHARGE AND CLINICAL SERVICES.

6. THE CHIEF EXECUTIVE OF THE REGIONAL PSYCHIATRIC CENTRES SHOULD REPORT TO A BOARD OF GOVERNORS OR EQUIVALENT AS IS CUSTOMARY IN

ALL CANADIAN HOSPITALS.

7. ALL PROVINCIAL MEDICAL ASSOCIATIONS SHOULD BE PREPARED TO MONITOR THE MEDICAL SERVICES DELIVERED IN THE PRISONS OF THE RESPECTIVE PROVINCES.

CARRIED.

17.

RESOLUTION 14

ATTENDU QUE L'ASSOCIATION MEDICALE CANADIENNE NE SOUHAITE PAS S'IMMISCER DANS LA REGIE INTERNE DU

18.: MINISTERE DU SOLLICITEUR GENERAL RELATIVEMENT A L'ORGANISATION ET A LA STRUCTURE DE SES DIVERSES COMPOSANTES, PAS PLUS QU'ELLE NE CHERCHE A INTERVENIR AU CHAPITRE DES STATUTS ET REGLEMENTS QUI REGISSENT LES EMPLOYES DU MINISTERE, ELLE CONSIDERE QU'IL EST DE SON RESSORT D'ETUDIER, D'UNE FACON GENERALE, LE ROLE CROISSANT DE LA DIRECTION GENERALE DES SOINS MEDICAUX ET DE SANTE DANS LES PENITENCIERS CANADIENS.

RECONNAISSANT LA NECESSITE D'AMELIORER LES SOINS MEDICAUX PRODIGUES AUX PRISONNIERS ET A LES RENDRE PLUS CONFORMES A LEURS BESOINS, PRENANT CONSCIENCE DES DIRECTIVES ET RECOMMANDATIONS PRESENTEES PAR LE COMITE CONSULTATIF NATIONAL SUR LES SERVICES DE SANTE ET LE CONSEIL D'EXPERTS EN PSYCHIATRIE,

SOULIGNANT LA NECESSITE DE DELIMITER CLAIREMENT LES RESPONSABILITES DU PERSONNEL MEDICAL IMPLIQUE DANS LA DISTRIBUTION DES SOINS MEDICAUX REQUIS DANS LES PENITENCIERS, CONFORMEMENT AU CODE DE DEONTOLOGIE MEDICALE ET COMPTE TENU DES RESPONSABILITES TRADITIONNELLES DE LA PROFESSION,

CONSCIENT DE SES FONCTIONS MEDICALES, PSYCHIATRIQUES ET AUTRES DANS LE BUT DE CONTROLER LES DETENUS DANS LES CENTRES DE DETENTION,

REAFFIRMANT LA NECESSITE D'UNE CERTAINE AUTONOMIE PROFESSIONNELLE DE TELLE SORTE QUE LES SERVICES MEDICAUX PUISSENT ETRE RENDUS, COMPTE TENU DES CONTRAINTES DE LA SITUATION, ET QU'ILS AIENT LA MEME VALEUR QUE LES SERVICES DISPONIBLES EN DEHORS DU SYSTEME PENITENTIAIRE,

QU'IL SOIT RESOLU QUE

1. TOUS LES MEDECINS QUI PRATIQUENT LA MEDECINE DANS LE SYSTEME PENITENTIAIRE CANADIEN DOIVENT OBTENIR AU MOINS UN PERMIS TEMPORAIRE DU COLLEGE DES MEDECI ET CHIRURGIENS DE LA PROVINCE AVANT DE COMMENCER A PRATIQUER.

2. TOUT LE PERSONNEL MEDICAL - LES MEDECINS DE PREMIERE LIGNE, LES PSYCHIATRES, LES CHIRURGIENS - SOIT RESPONSABLE, AU PLAN PROFESSIONNEL, DEVANT L'ORGANISME PROFESSIONNEL QUI REGIT L'EMISSION DES PERMIS ET NE SOIT PAS SUBORDONNE AUX ADMINISTRATEURS CIVILS DES PRISONS.

3. UN MEDECIN LICENCIE PUISSE EXERCER SON JUGEMENT EN TOUTE LIBERTE DANS L'EXERCICE DE SES FONCTIONS PROFESSIONNELLES.

4. LES CENTRES PSYCHIATRIQUES REGIONAUX DANS TOUTES LES PROVINCES MENENT LEURS OPERATIONS COMME DES HOPITAUX SELON L'ESPRIT DE LA LOI SUR LES HOPITAUX DE LA PROVINCE, QUE L'ADMINISTRATION DE TELS HOPITAUX RESPECTE LES STATUTS ET REGLEMENTS ETABLIS PAR LE CONSEIL CANADIEN D'AGREMENT DES HOPITAUX ET QU'ELLE NE SOIT DONC PAS INFLUENCEE PAR LES CONTINGENCES DE LA SURVEILLANCE ET DU CONTROLE DES PRISONNIERS.

5. LE SERVICE PENITENTIAIRE N'INTERVIENNE PAS AUPRES DES CENTRES PSYCHIATRIQUES REGIONAUX AU

ALL CANADIAN HOSPITALS.

7. ALL PROVINCIAL MEDICAL ASSOCIATIONS SHOULD BE PREPARED TO MONITOR THE MEDICAL SERVICES DELIVERED IN THE PRISONS OF THE RESPECTIVE PROVINCES.

CARRIED.

RESOLUTION 14

ATTENDU QUE L'ASSOCIATION MEDICALE CANADIENNE NE SOUHAITE PAS S'IMMISCER DANS LA REGIE INTERNE DU MINISTERE DU SOLLICITEUR GENERAL RELATIVEMENT A L'ORGANISATION ET A LA STRUCTURE DE SES DIVERSES COMPOSANTES, PAS PLUS QU'ELLE NE CHERCHE A INTERVENIR AU CHAPITRE DES STATUTS ET REGLEMENTS QUI REGISSENT LES EMPLOYES DU MINISTERE, ELLE CONSIDERE QU'IL EST DE SON RESSORT D'ETUDIER, D'UNE FACON GENERALE, LE ROLE CROISSANT DE LA DIRECTION GENERALE DES SOINS MEDICAUX ET DE SANTE DANS LES PENITENCIERS CANADIENS.

RECONNAISSANT LA NECESSITE D'AMELIORER LES SOINS MEDICAUX PRODIGUES AUX PRISONNIERS ET A LES RENDRE PLUS CONFORMES A LEURS BESOINS, PRENANT CONSCIENCE DES DIRECTIVES ET RECOMMANDATIONS PRESENTEES PAR LE COMITE CONSULTATIF NATIONAL SUR LES SERVICES DE SANTE ET LE CONSEIL D'EXPERTS EN PSYCHIATRIE,

SOULIGNANT LA NECESSITE DE DELIMITER CLAIREMENT LES RESPONSABILITES DU PERSONNEL MEDICAL IMPLIQUE DANS LA DISTRIBUTION DES SOINS MEDICAUX REQUIS DANS LES PENITENCIERS, CONFORMEMENT AU CODE DE DEONTOLOGIE MEDICALE ET COMPTE TENU DES RESPONSABILITES TRADITIONNELLES DE LA PROFESSION,

CONSCIENT DE SES FONCTIONS MEDICALES, PSYCHIATRIQUES ET AUTRES DANS LE BUT DE CONTROLER LES DETENUS DANS LES CENTRES DE DETENTION,

REAFFIRMANT LA NECESSITE D'UNE CERTAINE AUTONOMIE PROFESSIONNELLE DE TELLE SORTE QUE LES SERVICES MEDICAUX PUISSENT ETRE RENDUS, COMPTE TENU DES CONTRAINTES DE LA SITUATION, ET QU'ILS AIENT LA MEME VALEUR QUE LES SERVICES DISPONIBLES EN DEHORS DU SYSTEME PENITENTIAIRE,

QU'IL SOIT RESOLU QUE

1. TOUS LES MEDECINS QUI PRATIQUENT LA MEDECINE DANS LE SYSTEME PENITENTIAIRE CANADIEN DOIVENT OBTENIR AU MOINS UN PERMIS TEMPORAIRE DU COLLEGE DES MEDECINS ET CHIRURGIENS DE LA PROVINCE AVANT DE COMMENCER A PRATIQUER.

2. TOUT LE PERSONNEL MEDICAL - LES MEDECINS DE PREMIERE LIGNE, LES PSYCHIATRES, LES CHIRURGIENS - SOIT RESPONSABLE, AU PLAN PROFESSIONNEL, DEVANT L'ORGANISME PROFESSIONNEL QUI REGIT L'EMISSION DES PERMIS ET NE SOIT PAS SUBORDONNE AUX ADMINISTRATEURS CIVILS DES PRISONS.

3. UN MEDECIN LICENCIE PUISSE EXERCER SON JUGEMENT EN TOUTE LIBERTE DANS L'EXERCICE DE SES FONCTIONS PROFESSIONNELLES.

4. LES CENTRES PSYCHIATRIQUES REGIONAUX DANS TOUTES LES PROVINCES MENENT LEURS OPERATIONS COMME DES HOPITAUX SELON L'ESPRIT DE LA LOI SUR LES HOPITAUX DE LA PROVINCE, QUE L'ADMINISTRATION DE TELS HOPITAUX RESPECTE LES STATUTS ET REGLEMENTS ETABLIS PAR LE CONSEIL CANADIEN D'AGREMENT DES HOPITAUX ET QU'ELLE NE SOIT DONC PAS INFLUENCEE PAR LES CONTINGENCES DE LA SURVEILLANCE ET DU CONTROLE DES PRISONNIERS.

5. LE SERVICE PENITENTIAIRE N'INTERVIENNE PAS AUPRES DES CENTRES PSYCHIATRIQUES REGIONAUX AU

CHAPITRE DE L'ADMISSION, DES CONGES ET DES SERVICES CLINIQUES.

6. LE DIRECTEUR ADMINISTRATIF DE TOUT CENTRE PSYCHIATRIQUE REGIONAL SOUMETTE UN RAPPORT A UN BUREAU DES GOUVERNEURS OU SON EQUIVALENT COMME C'EST LE CAS DANS TOUS LES HOPITAUX CANADIENS.

7. TOUTES LES ASSOCIATIONS MEDICALES PROVINCIALES SOIENT DISPOSEES A SURVEILLER LES SERVICES MEDICAUX FOURNIS DANS LES PRISONS DES PROVINCES RESPECTIVES.

ADOPTE

CORRESPONDENCE

24. The Committee exchanged views with a number of correspondents on a variety of topics relative to the interpretation of the code of ethics. This correspondence represents interpretation of the code as it applies to specific situations and does not alter the policy or the code proper and is not recorded here. The correspondence is available in CMA House and can be reproduced when necessary.

COMPETITION ACT AND ADVERTISING

25. The committee reviewed the implications of Bill C-2 - an amendment to the Combines Investigation Act, extending the authority of this legislation over all services. In essence, this legislation makes it illegal for professional bodies to prohibit advertising (and the resultant interprofessional competition) via a professional code of ethics.

26. In keeping with the advice received by the Association, the committee recommended to the Board of Directors:

That the Board of Directors and Officers of the Association be commended for action taken to date;

That the CMA Code of Ethics be retained in its current form, in particular the section dealing with physicians' advertising;

That through the provincial divisions, efforts be made to:

(a) ensure that current medical acts specifically designate authority relative to control of advertising to the medical licensing authorities, or

(b) that action be stimulated between the medical licensing authority and provincial governments (via CMA divisions) to grant the medical licensing bodies the authority to prohibit advertising via the medical act.

27. More information on this subject is contained within the Board of Directors report.

THE ASSOCIATION'S CODE OF ETHICS

28. Several divisions have suggested changes to the Code of Ethics and these are recommended to General Council.

It was thus

Moved by Dr. H.A. Arnold
Seconded by Dr. G. Gingras

That section 15 of the Code of Ethics be amended to read:

RECOMMENDATIONS FOR CHANGE

"Responsibilities to the Profession - Consultation"

"An Ethical Physician:

15. will request the opinion of an appropriate confrere acceptable to the patient and physician when diagnosis or treatment is difficult or obscure, or when the patient requests it. Having requested the opinion of a confrere, he will make available all relevant information and indicate clearly whether he wishes his confrere to assume the continuing care of the patient during his illness.

Current wording of code

15. will request the opinion of an appropriate confrere acceptable to the patient when diagnosis or treatment is difficult or obscure, or when the patient requests it. Having requested the opinion of a confrere, he will make available all relevant information and indicate clearly whether he wishes his confrere to assume the continuing care of the patient during his illness.

29. In opening discussion, Dr. E. Moran said that his division looked at this recommendation and were sympathetic to the intent of the amendment to the code but in fact they would suggest that the proposed amendment is at best redundant and probably at worst a bit patronizing. They considered that the word "appropriate" in the 2nd line really carried with it the sense of the concern that was conveyed to the Ethics Committee recognizing that the purpose of the code was to act as a guide. They were not in support of the amendment.

30. Dr. Clark suggested that Recommendations I and II should be looked at together at least in discussing Recommendation I. He added that under section 5 of the Code of Ethics as it relates to the rights of the patient, it states quite clearly "that the patient has the right to accept or reject any physician and any medical care recommended to him". This right appears to be the basis of the patient's rights component of the code. It seemed to him that the fact that the physician must approve of the consultant does in fact undermine the patient's rights to accept or reject any physician and any medical care. If General Council wishes to accept Recommendation I, then he suggested that the first sentence in Recommendation II -

- which is in fact Section 5 of the Patient's Right section of the Code - should be deleted. A physician cannot give the patient the right to reject any physician or any medical care and then continue to qualify that and really say that the patient does not have the complete right as stated in Section 5. There is a conflict between Recommendations I and II. As well, there is a conflict within Section 5. In Section 5 the right of the patient is again qualified which is not appropriate. If General Council feels that the patient should not have the right to accept the physician of his choice, then the code should be amended accordingly. However, if General Council believes that this is right and that the principle should be maintained in the code, then Recommendation I is inappropriate.

31. Dr. R.O. Jones said that there are many patients both in the neurotic and psychotic brackets who still go on requesting one consultation after another. He thought that in the management of those patients, it is very important for the physician to say "no". In this light, he was not quite certain how these recommendations would do that and still allow a physician to be ethical.

32. To this, Dr. Arnold said that his personal answer would be that the physician must be able to, or be prepared to, advise the patient to see someone else on an unreferred basis, either terminating or not terminating the doctor/patient relationship, but he felt that it is a judgement situation according to where one finds one's self after having discharged what is considered to be the physician's responsibility.

33. No further discussion ensued. The vote was taken and the motion was LOST.

34. Subsequently, it was

Moved by Dr. H.A. Arnold
Seconded by Dr. R.C.B. Corbet

That Section 5 of the Code of Ethics be amended to read:

"Responsibilities to the Patient - Patient's Rights"

"An Ethical Physician:

5. will recognize that the patient has the right to accept or reject any physician and any medical care recommended to him. The patient has the right to request opinions from other physicians acceptable to both patient and referring physician.

Current wording of code

5. will recognize that the patient has the right to accept or reject any physician and any medical care recommended to him. The patient having chosen his physician, has the right to request of that physician opinions from other physicians of the patient's choice.

35. Dr. Clark, on a point of clarification, asked whether Recommendation II would be considered inappropriate since Recommendation I was defeated and since both recommendations I and II are related.

36. Dr. Arnold said that the Committee on Ethics would like to see this recommendation considered at this meeting of General Council. The committee did not feel that there was a conflict between the first and second sentences in this recommendation. They felt that even after the application of the suggested principle,as outlined in the second sentence, the first sentence may still apply after the physician and patient have arrived at a decision as to who might be a consultant. They saw no conflict in those two sentences.

37. Dr. Porter disagreed with Dr. Arnold but agreed with Dr. Clark's comments that there is a clear conflict. He believed that it could be stated that the patient has the right to accept any medical care and then in the very next sentence say that a recommended physician must be acceptable to another physician. He felt that the two sentences are in conflict and one or the other will have to be changed. He added that this was debated on the floor of General Council when the first recommendation was put. The two recommendations are interdependent. He urged General Council to reject this motion.

38. The question was called on the motion which was LOST.

39. The third recommendation put forward by the Committee on Ethics was

Moved by Dr. H.A. Arnold
Seconded by Dr. G.R. Zetter

That Section 16 of the Code of Ethics be amended to read:

"Responsibilities to the Patient - Personal Morality"

"An Ethical Physician:

16. when his personal morality prevents him from recommending some form of therapy which might benefit his patient will so acquaint his patient and will advise the patient of his right to seek other opinions.

Current wording of code

16. when his personal morality prevents him from recommending some form of therapy which might benefit his patient will so acquaint the patient.

40. Dr. W. Mason did not agree with the word "benefit" in the third line of the motion and suggested the word "affect" as he believed that it is tied in with the first line on the question of personal morality. He felt that a physician's personal morality may make him feel that a particular mode of therapy may not be of benefit to the patient and therefore there would be no conflict in his mind about this matter.

41. Thus it was

Moved by Dr. W.F. Mason
Seconded by Dr. J.F. Hamm

That Recommendation III be amended by substituting the word "benefit" with the word "affect".

42. At this point, Dr. LeRiche had put forward an amendment to the amendment which he felt would encompass the previous amendment as submitted by Dr. Mason.

43. This was appropriate and hence it was

Moved by Dr. L.H. Leriche
Seconded by Dr. H.W.V. Letts

When his personal morality prevents him from recommending some form of therapy, he will so acquaint his patient and will advise the patient of other sources of assistance.

44. Dr. Leriche, in presenting his motion, said that we must not forget an important fact which distinguishes a profession and that is "ethics". The medical profession must stand by its ethics and in so doing, does have a responsibility to patients who should not be abandoned in any regard.

45. He intimated that the medical profession is based on compassion and help and this is manifest throughout the entire CMA Code of Ethics, the very foundation that makes medicine a profession and not an occupation. He was of the opinion that every physician has a responsibility not merely to abandon a patient once he does not agree with a particular form of therapy. This is a fundamental area that the medical profession must concern itself with if they are to maintain their compassion which is the basis of ethics.

46. The Committee on Ethics, he added, is perhaps one of the most important to this General Council at this time because there are changing principles and philosophies and the profession should adjust itself accordingly. Finally, he said that he wished to correct any misapprehension or misunderstanding that "other sources of assistance" meant that a physician must inevitably refer a patient to somebody who will agree with his (the physician) philosophy.

47. Dr. Mason and his seconder agreed to withdraw their amendment in favour of the one presented by Dr. Leriche.

48. Then, Dr. Gourdeau said that the word "morality" bothered him. "Personal Morality" to him is the way a person behaves himself and it is not the same as personal convictions or personal moral values, and he did not feel that the choice of the word "morality" was very good.

49. Dr. E. Moran from Ontario suggested the word "ethic" which was accepted by Dr. Leriche and Dr. Gourdeau and was treated as an editorial change rather than an amendment.

50. There being no further discussion on the amendment, the question was called and the amendment was CARRIED.

The motion as amended was CARRIED.

RESOLUTION 15

"An ethical physician:

16. WHEN HIS PERSONAL ETHIC PREVENTS HIM FROM RECOMMENDING SOME FORM OF THERAPY, HE WILL SO ACQUAINT HIS PATIENT AND WILL ADVISE THE PATIENT OF OTHER SOURCES OF ASSISTANCE.

CARRIED.

RESOLUTION 15

"le médecin doit:

16. LORSQUE SES CONVICTIONS PERSONNELLES L'EMPECHENT DE PRESCRIRE UNE CERTAINE FORME DE TRAITEMENT, EN FAIRE PART A SON PATIENT ET LUI CONSEILLER D'AUTRES POSSIBILITES D'ASSISTANCE.

ADOPTE.

MODERN MEDICINE UNDER FIRE: A CRITIQUE OF FRAMEWORKS

51. The chairman of the Committee on Ethics attended this seminar at Montreal on October 8, 1976. The symposium marked the inauguration of the "Centre for Bio-ethics" as a department of "The Clinical Research Institute of Montreal". The institute is affiliated with the University of Montreal and is wholly devoted to applied research in the etiology, mechanism and most effective treatment of diseases.

MORAL DILEMMAS IN MEDICAL STUDENTS AND PSYCHIATRIC RESIDENTS

52. As a direct result of an article which appeared in the popular medical press and gave the impression that medical students had rejected the Code of Ethics of the CMA, the committee met with Dr. Terry Firth and Mr. Carey Stevens, both of whom are working with the Department of Psychiatry, Faculty of Medicine, University of Ottawa, Royal Ottawa Hospital, on March 28, 1977. The following quotation by these authors may be of interest and is here quoted in its entirety.

53. "There is increasing interest in ethics in psychiatry and medicine as indicated by the recent proliferation of articles and books in the area. One reason for this may be that at no other point in medical history has the physician been faced with so many moral issues as at the present time. Euthanasia, definition of death, patients' rights, abortion, human experimentation, behaviour control, allocation of scarce resources, genetic engineering are just a few of the major issues currently under close scrutiny. Redlich and Mollica have recently reviewed the ethical issues related to psychiatry. However, it is quite likely that these issues have not been clarified by present research. Most articles have been impressionistic, anecdotal and highly opinionized. The problem with the literature in this area is that it explores and describes ethics and virtues as situational specific attributes and as conformity to a societal standard instead of looking for basic principles such as justice, dignity and the sanctity of life. Further, the previous research has utilized too non-standardized and unsystematic approaches to warrant any definitive statements."

54. In their discussion with the committee, it became apparent that there is a place for educating the medical students and residents in ethics. This education must take the form of discussing specific moral and ethical situations and provide for open discussions in seminars. A knowledge in the field of bio-ethics was again brought to the attention of the committee as a challenge to modern day physicians. The committee has asked Dr. Firth and Mr. Stevens to forward information and suggestions. The committee intends to give this area further study in the ensuing year.

ASSOCIATION WITH ALLIED HEALTH PROFESSIONALS

55. The committee is aware that there are discussions being held in some divisions relative to ethical guidelines regarding physicians' association with other allied health professionals. Any pertinent information when available will be forwarded to all divisions.

RECOMBINANT DNA: GUIDELINES FOR CANADIAN RESEARCH

56. The Report to the Medical Research Council on Guidelines for Handling Recombinant DNA Molecules and Animal Viruses and Cells was studied and the committee feels that it is important that all members of CMA read the article, a summary of which appeared in the CMA Journal on April 9, 1977.

57. The committee thanks Flora M. Dunn for assistance. The Deputy Speaker noted at this point that Dr. Arnold had served as the Chairman of this committee for the past five years and that this was his last presentation to General Council. Dr. Varvis, on behalf of the members of General Council, expressed sincere thanks to Dr. Arnold for the work which he has done so well over this period of time.

Respectfully submitted,

R.G. Wilson, M.D., C.M.
Secretary

H.A. Arnold, M.D.
Chairman

MEMBERS

Dr. Peter Lehmann, Vancouver, B.C.
Dr. A.H. Parsons, Halifax, N.S.