Handbook of WMA Policies

World Medical Association

Version History

Version 2010, Vancouver; Printed in March 2011
Version 2011, Montevideo; Printed in December 2011

- Replacements

Code	Short Title
D-2000-01-2010 by D-2000-01-2011	Prison Conditions on TB (amended in 2011)
S-1988-01-2005 by R-1988-01-2005	Correction of misclassified document type
S-1988-05-2007 by S-1988-05-2011	Tobacco Products Health Hazards (amended in 2011)
S-1996-05-2006	Replacement due to typo in the footer
S-1997-01-2007	Correction (in 2007 it was reaffirmed, not amended)
S-1997-02-2007	Correction of typo in the header

- Additions of the policies newly adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011

D-2011-01-2011	Disaster Preparedness
D-2011-02-2011	End-of-Life Medical Care
D-2011-03-2011	Leprosy Control
S-2011-01-2011	Chronic Disease
S-2011-02-2011	Monitoring Tokyo Declaration
S-2011-03-2011	Protection and Integrity of Medical Personnel
S-2011-04-2011	Social Determinants of Health
S-2011-05-2011	Social Media
R-2011-01-2011	Adequate Pain Treatment
R-2011-02-2011	Bahrain
R-2011-03-2011	Economic Embargoes and Health
R-2011-04-2011	Independence of Medical Associations

Version 2012, Bangkok; Printed in October 2012

- Replacements

D-2002-04-2002 by D-2002-04-2012	Advanced Technology (amended in 2012)
S-1956-01-2006 by S-1956-01-2012	Armed Conflict (amended in 2012)
R-2002-05-2002 by R-2002-05-2012	Abuse of Psychiatry (amended in 2012)

- Removals of the policies rescinded and archived by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012

R-2002-03-2002	Health Care Services in Afghanistan
R-2002-04-2002	Pan American Health Organization

- Additions of the policies newly adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012

S-2012-01-2012	Electronic Cigarettes
S-2012-02-2012	Collective Action by Physicians
S-2012-03-2012	Forced and Coerced Sterilisation
S-2012-04-2012	Organ and Tissue Donation
S-2012-05-2012	Prioritisation of Immunisation
S-2012-06-2012	Violence in the Health Sector
R-2012-01-2012	Minimum Price for Alcohol
R-2012-02-2012	Plain Packaging of Cigarettes
R-2012-03-2012	Capital Punishment
R-2012-04-2012	Professor Cyril Karabus

Version 2013-1, Bali; Printed in April 2013

- Replacements

Code	Short Title
D-1981-02-1999 by D-1981-02-2010	Correction (in 2010 it was reaffirmed, not amended)
S-2003-02-2003 by S-2003-02-2013	Living Wills (reaffirmed in 2013)
R-2002-01-2002 by R-2002-01-2013	Euthanasia (reaffirmed in 2013)
R-2003-01-2003 by R-2003-01-2013	Annual Medical Ethics Day (reaffirmed in 2013)

Version 2013-2, Fortaleza; Printed in February 2014

- Replacements

Code	Short Title
S-2003-01-2003 by S-2003-01-2013	Forensic Investigations of the Missing (amended in 2013)
R-2002-06-2002 by R-2002-06-2013	Women's Right to Health Care (amended in 2013)

- Removals of the policies rescinded and archived by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013

R-2003-04-2003	SARS

- Additions of the policies newly adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013

S-2013-01-2013	Fungal Disease
S-2013-02-2013	Human Papillomavirus Vaccination
S-2013-03-2013	Natural Variations of Human Sexuality
S-2013-04-2013	Victims of Torture
S-2013-05-2013	Death Penalty
R-2013-01-2013	Criminalisation of Medical Practice
R-2013-02-2013	Healthcare Situation in Syria
R-2013-03-2013	Prohibition of Chemical Weapons
R-2013-04-2013	Standardisation in Medical Practice and Patient Safety
R-2013-05-2013	Support of the AMB

Version 2014-1, Tokyo; Printed in June 2014

- Replacements

Code	Short Title
R-2004-01-2004 by R-2004-01-2014	WFME (reaffirmed in 2014)

Version 2014-2, Durban; Printed in January 2015

- Replacements

Code	Short Title
D-2002-01-2003 by D-2002-01-2012	Biological Weapons (reaffirmed in 2012)
D-2002-03-2002 by D-2002-03-2012	Patient Safety (reaffirmed in 2012)
S-2002-01-2002 by S-2002-01-2012	Safe Injections in Health Care (amended in 2012)
S-2002-02-2002 by S-2002-02-2012	Self-Medication (reaffirmed in 2012)
S-2003-03-2003 by S-2003-03-2014	International Migration of Health Workers (amended in 2014)
S-2004-03-2004 by S-2004-03-2014	Water and Health (amended in 2014)
R-2002-02-2002 by R-2002-02-2012	Female Foeticide (reaffirmed in 2012)
R-2003-03-2003 by R-2003-03-2014	Non-Commercialization of Human Reproductive Material (amended in 2014)

- Removals of the policies rescinded and archived by the 65th WMA General Assembly, Durban, South Africa, October 2014

S-2004-01-2004	Health Emergencies Communication & Coordination

- Additions of the policies newly adopted by the 65th WMA General Assembly, Durban, South Africa, October 2014

D-2014-01-2014	Protection of Healthcare Workers
S-2014-01-2014	Aesthetic Treatment
S-2014-02-2014	Air Pollution
S-2014-03-2014	Solitary Confinement
R-2014-01-2014	Ebola Viral Disease
R-2014-02-2014	Migrant Workers' Health and Safety in Qatar

Version 2015-1, Oslo; Printed in June 2015

- Replacements

Code	Short Title
D-1981-01-2005 by D-1981-01-2015	Lisbon (Patient's Rights) (reaffirmed in 2015)
D-1987-01-2005 by D-1987-01-2015	Euthanasia (reaffirmed in 2015)
D-1989-01-2005 by D-1989-01-2015	Hong Kong (Elderly Abuse) (reaffirmed in 2015)
S-2005-02-2005 by S-2005-02-2015	Drug Substitution (reaffirmed in 2015)
S-2005-04-2005 by S-2005-04-2015	Medical Liability Reform (reaffirmed in 2015)
R-1988-01-2005 by R-1988-01-2015	Academic Sanctions or Boycotts (reaffirmed in 2015)

Version 2015-2, Moscow; Printed in June 2016

- Replacements

Code	Short Title
S-2011-04-2011 by D-2011-04-2015	Social Determinants of Health (adopted in 2011 and the title (S to D) changed in 2015)
S-1995-02-2006 by S-1995-02-2015	Patients with Mental Illness (amended in 2015)
S-1985-01-2005 by S-1985-01-2015	Non-Discrimination in Professional Membership and Activities of Physicians (amended in 2015)
S-1998-01-2008 by S-1998-01-2015	Nuclear Weapons (amended in 2015)
R-1999-01-1999 by R-1999-01-2015	Curriculum of Medical Schools World-wide (amended in 2015)

- Additions of the policies newly adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

Code	Short Title
D-2015-01-2015	Alcohol
S-2015-01-2015	Mobile Health
S-2015-02-2015	Physicians Well-Being
S-2015-03-2015	Health Support to Street Children
S-2015-04-2015	Riot Control Agents
S-2015-05-2015	Transgender People
S-2015-06-2015	Vitamin D Insufficiency
S-2015-07-2015	Promotional Mass Media Appearances by Physicians
R-2015-01-2015	Healthcare In Turkey
R-2015-02-2015	Bombing on the Hospital of MSF in Kunduz
R-2015-03-2015	Global Refugee Crisis

Version 2016-1, Buenos Aires; Printed in January 2019

- Replacements

Code	Short Title
S-1988-04-2006 by S-1988-04-2016	Environmental Issues (reaffirmed in 2016)
S-1993-03-2006 by S-1993-03-2016	Patient Advocacy and Confidentiality (reaffirmed in 2016)
S-1989-01-2006 by S-1989-01-2016	Animal Use in Biomedical Research (reaffirmed in 2016)
R-2006-02-2006 by R-2006-02-2016	Child Safety in Airline Travel (reaffirmed in 2016)
R-2006-04-2006 by R-2006-04-2016	North Korean Nuclear Testing (reaffirmed in 2016)

Version 2016-2, Taipei; Printed in January 2019

- Replacements

Code	Short Title
D-1968-01-2006 by D-1968-01-2016	Determination of Death and the Recovery of Organs (amended in 2016)
D-1975-01-2006 by D-1975-01-2016	Medical Doctors concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment (amended in 2016
D-2002-02-2002 by D-2002-02-2016	Ethical Considerations regarding Health Databases and Biobanks (amended in 2016)
S-1984-01-2006 by S-1984-01-2016	Child Abuse and Neglect (amended in 2016)
S-1990-01-2006 by S-1990-01-2016	Injury Control (amended in 2016)
S-1990-04-2006 by S-1990-04-2016	Traffic Injury (amended in 2016)
S-1991-01-2006 by S-1991-01-2016	Adolescent Suicide (amended in 2016)
S-1992-01-2006 by S-1992-01-2016	Alcohol and Road Safety (amended in 2016)
S-1993-01-2005 by S-1993-01-2016	Body Searches of Prisoners (amended in 2016)
S-1993-02-2005 by S-1993-02-2016	Female Genital Mutilation (amended in 2016)
S-1995-04-2006 by S-1995-04-2016	Physicians and Public Health (amended in 2016)
S-1996-05-2006 by S-1996-05-2016	Weapons of Warfare and Their Relation to Life and Health (amended in 2016)
S-2006-05-2006 by S-2006-05-2016	Physician's Role in Obesity (amended in 2016)
S-2006-06-2006 by S-2006-06-2016	Responsibilities of Physicians in Preventing and Treating Opiate and Psychotropic Drug Abuse (amended in 2016)
CR-2005-05-2005 by R-2005-05-2016	Implementation of the WHO Framework Convention on Tobacco Control (amended in 2016)
CR-2016-01-2016 by R-2016-03-2016	Refugees and Migrants (adopted as a Council Resolution in April 2016 and adopted as a Resolution in October 2016)
CR-2016-02-2016 by R-2016-04-2016	Zika Virus Infection (adopted as a Council Resolution in April 2016 and adopted as a Resolution in October 2016)

- Removals of the policies and archived by the 67th WMA General assembly, Taipei, Taiwan, October 2016

Code	Short Title
R-2006-03-2006	Combating HIV/AIDS

- Addition of the resolution newly adopted by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

S-2016-01-2016	Ageing
S-2016-02-2016	Cyber-Attacks on Health and Other Critical Infrastructure
S-2016-03-2016	Divestment from Fossil Fuels
S-2016-04-2016	Ethical Considerations in Global Medical Electives
S-2016-05-2016	Obesity in Children
R-2016-01-2016	Protection of Health Care Facilities and Personnel in Syria
R-2016-02-2016	Occupational and Environmental Health and Safety

Version 2017-1, Livingstone; Printed in January 2019

- Replacements

Code	Short Title
R-2007-01-2007 by R-2007-01-2017	Health and Human Rights Abuses in Zimbabwe (reaffirmed in 2017)

Version 2017-2, Chicago, United States; Printed in January 2019

- Replacements

Code	Short Title
D-1948-01-2006 by D-1948-01-2017	Declaration of Geneva (amended in 2017)
D-1991-01-2006 by D-1991-01-2017	Hunger Strikers (amended in 2017)
D-1997-02-2007 by D-1997-02-2017	Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman, or Degrading Treatment (reaffirmed in 2017)
D-2009-01-2009 by D-2009-01-2017	Health and Climate Change (amended in 2017)
D-2015-01-2015 by D-2015-01-2017	Alcohol (amended in 2017)
S-1983-01-2005 by S-1983-01-2017	Boxing (amended in 2017)
S-1984-01-2016 by S-1984-01-2017	Child Abuse and Neglect (amended in 2017)
S-1988-02-2006 by S-1988-01-2017	Access to Health Care (amended in 2017)
S-1992-05-2007 by S-1992-05-2017	Noise Pollution (reaffirmed in 2017)
S-1994-01-2006 by S-1994-01-2017	Medical Ethics in the Event of Disasters (amended in 2017)
S-1996-04-2007 by S-1996-04-2017	Family Planning and the Right of a Woman to Contraception (reaffirmed in 2017)
S-2004-03-2014 by S-2004-03-2017	Water and Health (amended in 2017)
S-2006-03-2006 by S-2006-03-2017	HIV/AIDS and the Medical Profession (amended in 2017)
S-2006-04-2006 by S-2006-04-2017	Medical Education (amended in 2017)
S-2012-04-2012 by S-2012-04-2017	Organ and Tissue Donation (amended in 2017)
R-1997-02-2007 by R-1997-01-2017	Economic Embargoes and Health (reaffirmed in 2017)
R-2006-01-2006 by R-2006-01-2017	Medical Assistance in Air Travel (amended in 2017
R-2006-05-2006 by R-2006-05-2017	Tuberculosis (amended in 2017)
R-2007-02-2007 by R-2007-02-2017	Support of the Medical Associations in Latin America and the Caribbean (reaffirmed in 2017)

- Removals of the policies rescinded and archived by the 68th WMA General Assembly, Chicago, United States, October 2017

S-1997-01-2007	Unites Nations Rapporteur on the Independence and Integrity of Health Professionals
S-2005-01-2005	Reducing the Global Impact of Alcohol on Health and Society
R-2012-01-2012	Minimum Price for Alcohol

- Additions of the policies newly adopted by the 68th WMA General Assembly, Chicago, United States, October 2017

D-2017-01-2017	Quality Assurance in Basic Medical Education
D-2017-02-2017	Fair Medical Trade
S-2017-01-2017	Bullying and Harassment within the Profession
S-2017-02-2017	Armed Conflicts
S-2017-03-2017	Medical Cannabis
S-2017-05-2017	Epidemics and Pandemics
S-2017-06-2017	Role of Physicians in Preventing Exploitation in Adoption Practices
R-2017-01-2017	Poland
R-2017-02-2017	Prohibition of Forced Anal Examinations to Substantiate Same-Sex Sexual Activity

Version 2018-1, Riga; Printed in January 2019

- Replacements

Code	Short Title
R-1998-05-2008 by R-1998-01-2018	Supporting the Ottawa Convention on the Prohibition of the use, stockpiling, production and transfer of anti-personnel mines and on their destruction (reaffirmed in 2018)

Version 2018-2, Reykjavik, Iceland; Printed in January 2019

- Replacements

Code	Short Title
D-2008-01-2008 by D-2008-01-2018	Professional Autonomy and Clinical Independence (amended in 2018)
D-1970-01-2006 by S-1970-01-2018	Medically-Indicated Termination of Pregnancy (name changed and amended in 2018)
S-1997-02-2007 by S-1997-02-2018	Physicians convicted of Genocide or Crimes (name changed and amended in 2018)
S-1998-01-2015 by S-1998-01-2018	Nuclear Weapons (amended in 2018)
S-2006-02-2006 by S-2006-02-2018	Avian and Pandemic Influenza (amended in 2018)
S-2007-02-2007 by S-2007-01-2018	Ethics of Telemedicine (amended in 2018)
S-2008-02-2008 by S-2008-02-2018	Reducing the Global Burden of Mercury (reaffirmed in 2018)
S-2010-01-2010 by S-2010-01-2018	Environmental Degradation and Sound Management of Chemicals (amended in 2018)
R-2008-03-2008 by R-2008-01-2018	Collaboration Between Human and Veterinary Medicine (reaffirmed in 2018)

- Removals of the policies rescinded and archived by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

Code	Short Title
S-1996-03-2006	Professional Responsibility for Standards of Medical Care
R-1981-01-2008	Physician Participation in Capital Punishment
R-2008-01-2008	The Economic Crisis: Implications for Health
R-2008-02-2008	Poppies for Medicine Project for Afghanistan

- Addition of the resolution newly adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

S-2018-01-2018	Biosimilar Medicinal Products
S-2018-02-2018	Development and Promotion of a Maternal and Child Health Handbook
S-2018-03-2018	Gender Equality in Medicine
S-2018-04-2018	Medical Tourism
S-2018-05-2018	Sustainable Development
R-2018-01-2018	Migration
R-2018-02-2018	Prohibition of Physician Participation in Capital Punishment

Version 2019-1, Santiago, Chile; Printed in May 2019

- Replacements

Code	Short Title
S-1999-01-2009 by S-1999-01-2019	Patenting Medical Procedures (reaffirmed in 2019)
R-2009-03-2009 by R-2009-03-2019	Task Shifting from the Medical Profession (reaffirmed in 2019)

Version 2019-2, Tbilisi, Georgia; Printed in November 2019

- Replacements

Code	Short Title
D-1997-01-2009 by D-1997-01-2019	Continuous Quality Improvement in Health Care (reaffirmed with minor revision in 2019)
D-2009-02-2009 by D-2009-02-2019	Professionally-led Regulation (amended in 2019)
S-1996-01-2008 by S-1996-01-2019	Antimicrobial Resistance (name changed and amended in 2019)
S-2003-04-2008 by S-2003-04-2019	Violence and Health (amended in 2019)
S-2005-03-2009 by D-2005-01-2019	Ethical considerations regarding the use of genetics in health care (name and title changed (S to D) and amended in 2019)
S-2008-01-2008 by S-2008-01-2019	Reducing Dietary Sodium Intake (amended in 2019)
S-2014-03-2014 by S-2014-03-2019	Solitary Confinement (amended in 2019)
R-1997-03-2008 by S-1997-03-2019	Access of Women and Children to Health Care (title changed (R to S) and amended in 2019)
R-2002-02-2012 by S-2002-03-2019	Sex Selection Abortion and Female Foeticide (name and title changed (R to S) and amended in 2019)
R-2009-01-2009 by R-2009-01-2019	Legislation against Abortion in Nicaragua (amended in 2019)
CR-2003-01-2003 by D-2003-01-2019	Relation of Law and Ethics (adopted as a Declaration in 2019)

- Removals of the policies rescinded and archived by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

Code	Short Title
D-1987-01-2015	Euthanasia
S-1992-06-2015	Physician-Assisted Suicide
R-1998-03-2009	Improved Investment in Public Health
R-2002-01-2013	Euthanasia

- Additions of the policies newly adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

D-2019-01-2019	Euthanasia and Physician-Assisted Suicide
S-2019-01-2019	Augmented Intelligence in Medical Care
S-2019-02-2019	Free Sugar Consumption and Sugar-sweetened Beverages
S-2019-03-2019	Healthcare Information for All
S-2019-04-2019	Medical Age Assessment of Unaccompanied Minor Asylum Seekers
R-2019-01-2019	Climate Emergency
R-2019-02-2019	Revocation of WHO Guidelines on Opioid Use

Version 2020, Cordoba (online), Spain; Printed in January 2021

- Replacements

Code	Short Title
D-1998-01-2009 by D-1998-01-2020	Child Health (amended in 2020)
D-2011-04-2015 by D-2011-04-2020	Social Determinants of Health (amended in 2020)
S-1984-02-1984 by S-1984-02-2020	Freedom to Attend Medical Meetings (reaffirmed with minor revision in 2020)
S-1999-02-2010 by S-1999-02-2020	Relationship between Physicians and Pharmacists in Medical Therapy (reaffirmed with minor revision in 2020)
S-2004-02-2009 by S-2004-02-2020	Relationship between Physicians and Commercial Enterprises (amended in 2020)
S-2009-02-2009 by S-2009-02-2020	Stem Cell Research (name changed and amended in 2020)
R-2003-01-2013 by R-2003-01-2020	Designation of an Annual Medical Ethics Day (reaffirmed in 2020)
R-2003-02-2008 by R-2003-02-2020	Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment (amended in 2020)
R-2010-02-2010 by S-2010-02-2020	Violence against women (name and title changed (R to S) and amended in 2020)
R-2010-01-2010 by R-2010-01-2020	Drug Prescription (reaffirmed with minor revision in 2020)
R-2011-01-2011 by R-2011-01-2020	Access to adequate pain treatment (amended in 2020)
R-2013-02-2013 by R-2013-02-2020	Healthcare Situation in Syria (reaffirmed with minor revision in 2020)
R-2013-03-2013 by R-2013-03-2020	Prohibition of Chemical Weapons (reaffirmed with minor revision in 2020)
CR-2017-01-2017 by R-2017-03-2020	Support of Dr Serdar Küni (reaffirmed as Resolution in 2020)

- Removals of the policies rescinded and archived by the 71th WMA General Assembly (online), Cordoba, Spain, October 2020

Code	Short Title
S-2009-03-2009	Inequalities in Health
CR-2012-02-2012	Professional Autonomy in Turkey

- Additions of the policies newly adopted by the 71th WMA General Assembly (online), Cordoba, Spain, October 2020

Code	Short Title
D-2020-01-2020	Patient-Physician Relationship
D-2020-02-2020	Pseudoscience and Pseudotherapies in the field of health
S-2020-01-2020	Human Genome Editing
S-2020-02-2020	Hypertension and Cardiovascular Disease
S-2020-03-2020	Measures for the Prevention and Fight against Transplant-Related Crimes
R-2020-01-2020	International Day of the Medical Profession
R-2020-02-2020	Turkish Medical Association
R-2020-03-2020	Equitable Global Distribution of COVID-19 Vaccine
R-2020-04-2020	Human Rights violations against Uighur people in China
R-2020-05-2020	Protecting the Future Generation's Right to Live in a Healthy Environment
R-2020-06-2020	Medical Profession and COVID-19

Version 2021-1, Seoul (online), South Korea; Printed in May 2021

- Replacements

Code	Short Title
R-1999-01-2015 by R-1999-01-2021	Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-wide (reaffirmed in 2021)
R-2002-05-2012 by R-2002-05-2021	Abuse of Psychiatry (reaffirmed in 2021)
R-2003-03-2014 by R-2003-03-2021	Non-Commercialisation of Human Reproductive Material (reaffirmed in 2021)
R-2004-01-2014 by R-2004-01-2021	WFME Global Standards for Quality Improvement of Medical Education (reaffirmed in 2021)
R-2011-04-2011 by R-2011-04-2021	Independence of Medical Associations (reaffirmed in 2021)
R-2012-02-2012 by R-2012-02-2021	Plain Packaging of Cigarettes (reaffirmed with minor revision in 2021)
R-2013-01-2013 by R-2013-01-2021	Criminalisation of Medical Practice (reaffirmed in 2021)
R-2013-04-2013 by R-2013-04-2021	Standardisation in Medical Practice and Patient Safety (reaffirmed in 2021)
R-2014-02-2014 by R-2014-02-2021	Migrant Workers' Health and Safety in Qatar (reaffirmed in 2021)

Version 2021-2, London (online), United Kingdom; Printed in February 2022

- Replacements

Code	Short Title
D-1981-02-2010 by D-1981-02-2021	Principles of Health Care for Sports Medicine (amended in 2021)
D-2011-03-2011 by D-2011-03-2021	Leprosy Control around the World and Elimination of Discrimination against persons affected by Leprosy (reaffirmed with minor revisions in 2021)
S-1996-02-2010 by S-1996-02-2021	Family Violence (amended in 2021)
S-1997-03-2019 by S-1997-03-2021	Access of Women and Children to Health Care (amended in 2021)
S-1998-02-2010 by S-1998-02-2021	Medical Care for Migrants (name changed and amended in 2021)
S-2005-04-2015 by S-2005-04-2021	Medical Liability (name changed and amended in 2021)
S-2011-02-2011 by S-2011-02-2021	Development of a Monitoring and Reporting Mechanism to permit Audit of Adherence of States to the Declaration of Tokyo (reaffirmed with minor revisions in 2021)
R-2002-06-2013 by S-2002-04-2021	Women's Right to Health Care and How that Relates to the Prevention of Mother-to-Child HIV Infection (title changed R to S and amended in 2021)
R-2005-05-2016 by R-2005-05-2021	Implementation of the WHO Framework Convention on Tobacco Control (reaffirmed with minor revisions in 2021)
R-2006-02-2016 by R-2006-02-2021	Child Safety in Airline Travel (reaffirmed with minor revisions in 2021)
R-2006-04-2016 by R-2006-04-2021	North Korean Nuclear Testing (reaffirmed with minor revisions in 2021)
R-2009-02-2009 by R-2009-02-2021	Rights of Patients and Physicians in the Islamic Republic of Iran (amended in 2021)
R-2016-01-2016 by R-2016-01-2021	Protection of Health Care Facilities and Personnel in Syria (reaffirmed with minor revisions in 2021)
CR-2005-04-2005 by R-2005-04-2021	Taiwan’s participation in all WHO Health Programs and inclusion in the International Health Regulations (IHR) Mechanism (adopted as a Statement and amended in 2021)
CR-2015-01-2015 by S-2015-08-2021	Trade Agreements and Public Health (adopted as a Statement and amended in 2021)
CR-2021-01-2021 by R-2021-01-2021	Countries worst affected by the Covid-19 crisis (adopted as a Resolution in 2021)
CR-2021-02-2021 by R-2021-02-2021	Support of Medical Personnel and Citizens of Myanmar (adopted as a Resolution in 2021)

- Additions of the policies newly adopted by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

Code	Short Title
S-2021-01-2021	Ensuring the Availability, the Quality and the Safety of Medicines Worldwide
S-2021-02-2021	Access to Surgery and Anesthesia Care
S-2021-03-2021	Solar Radiation and Photoprotection
R-2021-03-2021	Covid-19 Vaccines and International Travel Requirements
R-2021-04-2021	Repression of Nicaraguan Doctors

- Removals of the policies rescinded and archived by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

Code	Short Title
R-2015-03-2015	Global Refugee Crisis
R-2016-03-2016	Refugees and Migrants
R-2018-01-2018	Migration

Version 2022-1, Paris (hybrid), France; Printed in May 2022

- Replacements

Code	Short Title
R-1997-01-2017 by R-1997-01-2022	Economic Embargoes and Health (reaffirmed in 2022)

Version 2022-2, Berlin, Germany; Printed in October 2022

- Replacements

Code	Short Title
D-1949-01-2006 by D-1949-01-2022	International Code of Medical Ethics (revised in 2022)
D-1983-01-2006 by D-1983-01-2022	End of Life Medical Care (name changed and revised in 2022)
D-2000-01-2011 by D-2000-01-2022	Prison Conditions and the Spread of Communicable Diseases (name changed and revised in 2022)
D-2002-03-2012 by D-2002-03-2022	Patient Safety (revised in 2022)
S-1988-05-2011 by S-1988-05-2022	Health Hazards of Tobacco Products and Tobacco-Derived Products (revised in 2022)
S-2002-01-2012 by S-2002-01-2022	Safe Injections in Health Care (reaffirmed with minor revisions in 2022)
S-2002-02-2012 by S-2002-02-2022	Self-Medication (reaffirmed with minor revisions in 2022)
S-2006-01-2006 by S-2006-01-2022	Assisted Reproductive Technologies (revised in 2022)
S-2009-04-2009 by S-2009-04-2022	Digital Health (name changed and revised in 2022)
S-2011-01-2011 by S-2011-01-2022	Global Burden of Chronic Non-Communicable Disease (name changed and revised in 2022)
S-2011-03-2011 by S-2011-03-2022	Protection and Integrity of Medical Personnel in Armed Conflicts and Other Situations of Violence (revised in 2022)
S-2011-05-2011 by S-2011-05-2022	Professional and Ethical Use of Social Media (revised in 2022)
S-2012-02-2012 by S-2012-02-2022	Ethical Implications of Collective Action by Physicians (reaffirmed with minor revisions in 2022)
S-2012-06-2012 by S-2012-06-2022	Workplace Violence in the Health Sector (name changed and revised in 2022)
R-2006-01-2017 by S-2006-07-2022	Medical Assistance in Air Travel (title changed (R to S) and reaffirmed with minor revisions in 2022)
R-2006-05-2017 by R-2006-05-2022	Tuberculosis (reaffirmed with minor revisions in 2022)

R-2016-02-2016 by S-2016-06-2022	Occupational and Environmental Health and Safety (title changed (R to S) and revised in 2022)
R-2017-02-2017 by R-2017-02-2022	Prohibition of Forced Anal Examinations to Substantiate Same-Sex Sexual Activity (reaffirmed in 2022)
CR-2022-01-2022 by R-2022-01-2022	Medical Personnel and Citizens of Ukraine in the face of the Russian invasion (adopted as a Resolution in 2022)

- Additions of the policies newly adopted by the 73rd WMA General Assembly, Berlin, Germany, October 2022

Code	Short Title
D-2022-01-2022	Racism in Medicine
D-2022-02-2022	Discrimination against Elderly Individuals within Healthcare Settings
S-2022-01-2022	Physicians Treating Relatives
R-2022-02-2022	Providing Covid-19 Vaccines for All
R-2022-03-2022	Humanitarian and Medical Aid to Ukraine

- Removals of the policies rescinded and archived by the 73rd WMA General Assembly, Berlin, Germany, October 2022

Code	Short Title
D-2011-02-2011	End-of-Life Medical Care
D-2014-01-2014	Protection of Healthcare Workers in Situations of Violence
S-2007-02-2018	Ethics of Telemedicine
S-2015-01-2015	Mobile Health
R-2007-01-2017	Health and Human Rights Abuses in Zimbabwe
R-2017-01-2017	Poland

PREFACE

Before World War II came to an end, a number of medical associations gathered in London to reinvent the approach to international collaboration among the world's physicians. The old model, represented by the pre-war "Association Professionnelle Internationale des Médecins" (APIM), would no longer meet the needs of the post-war medical profession. It was time to create something new.

After only two years of preparation, 27 national medical associations met in Paris on September 18th, 1947 for the inauguration of a new global physicians' association, the World Medical Association (WMA). The lead-up to this first Assembly was paralleled by the Nuremberg trial against Nazi doctors, which was a key driver of the mission focus of the new WMA. This terrible episode in the history of medicine dictated that the organization must seek to become the authoritative voice on global standards for medical ethics and professional conduct, rather than focus solely on protecting the interests of the profession.

Effectively coordinating an international organization was anything but easy in the late 1940s. There was no internet, e-mail, mobile phones, personal computers, fax, or even photocopiers. For many physicians, attending the Assembly required a cross-continental, multi-day journey across a deeply scarred planet, by train and ship and only in exceptional circumstances by plane. Yet the commitment of these founding WMA members to their vision was even greater than the challenges they faced in achieving it. That vision, and the accompanying goals, ideals, and unity of purpose, are as relevant today as they were during those early days. They are now ours to carry on.

The WMA Handbook of Policies is evidence that the engagement of the world medical profession does, in fact, persist. The WMA now is bigger, stronger and more active then ever before, and our Handbook is the product of physicians coming together for more than half a century to provide ethical guidance, moral support and practical advice to help their colleagues serve their patients to the best of their ability. From the Declaration of Geneva, often referred to as the "Modern Hippocratic Oath" to the Declaration of Helsinki advising physicians doing medical research on human subjects, to the Declaration of Tokyo prohibiting physicians from participating in torture and degrading treatment – to mention just a few of WMA's landmark policies – the guidance provided by the WMA is as necessary now as it has ever been.

There are many other policies in this world dealing with physician conduct, many of which try to be "modern", "easily readable" and "politically correct". The WMA has never capitulated against the "Zeitgeist", but has stood firm with its values, the most important of which are caring, ethics and science.

Sir William Osler said: "The most important thing is caring, so do it first, for the caring physicians best inspires hope and trust." Hope and trust are the basis for any treatment. A physician who cannot generate trust will face more challenges than the one who receives the trust of the patients. A patient with hope is far better off than one without.

But caring must go hand-in-hand with medical ethics and proper conduct. Physicians are often confronted with questions of life and death, resource allocations, and dual loyalties when serving a single patient and at the same time respecting the needs of a community or population. The questions are often too difficult and the problems too burdensome for one person alone. We are far away from having answers for all such questions, but for many, the WMA can provide the ethical guidance that protects patients, supports physicians, and duly considers the interests of the communities and populations they both belong to.

Finally, science is what distinguishes medicine from well-intended kindness. In medicine, quality care and ethical conduct cannot be separated from sound science. Still, despite our sincere and continual quest for increased scientific knowledge, understanding and solutions, we will never be protected from all mistakes. Therefore, practicing the science of medicine with faithful adherence to clear ethical guidance is the best we can do.

This new handbook* provides a good part of this guidance. It is proof of our continued engagement with our colleagues in the different parts of this world and our commitment to our patients, wherever and whoever they may be. It is a living document and the WMA will continue to improve and expand it, in service to the profession and the health of those we serve as physicians.

J. Edward Hill
Chairman of Council

Otmar Kloiber
Secretary General

Wonchat Subchaturas
President 2010-2011

* The World Medical Association is most grateful to the Korean Medical Association for seconding Ms. Seongmi LEE to the WMA Office at Ferney-Voltaire, providing valuable help in putting this collection of policies together.

TABLE OF CONTENTS

- Chronological Order -

DECLARATIONS

STATEMENTS

RESOLUTIONS

* **Code explanation (sorting criteria):**

D-1948-01-2006

- Year of last action
- Serial number
- Year of adoption
- Document type

D: Declarations / S: Statements / R: Resolutions

TABLE OF CONTENTS

- Order by Short Title -

[C]

[D]

[E]

[F]

[G]

[H]

[N]

[O]

[P]

[Q]

[R]

[S]

[T]

[U]

[V]

[W]

[Z]

WMA DECLARATION OF GENEVA

Adopted by the 2nd General Assembly of the World Medical Association,
Geneva, Switzerland, September 1948
and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968
and the 35th World Medical Assembly, Venice, Italy, October 1983
and the 46th WMA General Assembly, Stockholm, Sweden, September 1994
and editorially revised by the 170th WMA Council Session,
Divonne-les-Bains, France, May 2005
and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006
and amended by the 68th WMA General Assembly, Chicago, United States, October 2017

The Physician's Pledge

AS A MEMBER OF THE MEDICAL PROFESSION:

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

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

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

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

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

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

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

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

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

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

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

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

WMA INTERNATIONAL CODE OF MEDICAL ETHICS

Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949
revised by the 22nd World Medical Assembly, Sydney, Australia, August 1968
the 35th World Medical Assembly, Venice, Italy, October 1983
the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

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 WMA Declaration of Geneva: The Physician's Pledge and the WMA's entire body of policies, it defines and elucidates the professional duties of physicians towards their patients, other physicians and health professionals, themselves, and society as a whole.

The physician must be aware of applicable national ethical, legal, and regulatory norms and standards, as well as relevant international norms and standards.

Such norms and standards must not reduce the physician's commitment to the ethical principles set forth in this Code.

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 is addressed to physicians. The WMA encourages others who are involved in healthcare to adopt these ethical principles.

GENERAL PRINCIPLES

1. The primary duty of the physician is to promote the health and well-being of individual patients by providing competent, timely, and compassionate care in accordance with good medical practice and professionalism.

   The physician also has a responsibility to contribute to the health and well-being of the populations the physician serves and society as a whole, including future generations.

   The physician must provide care with the utmost respect for human life and dignity, and for the autonomy and rights of the patient.

2. The physician must practise medicine fairly and justly and provide care based on the patient's health needs without bias or engaging in discriminatory conduct on the basis of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, culture, sexual orientation, social standing, or any other factor.

3. 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.

4. The physician must practise with conscience, honesty, integrity, and accountability, while always exercising independent professional judgement and maintaining the highest standards of professional conduct.

5. Physicians must not allow their individual professional judgement to be influenced by the possibility of benefit to themselves or their institution. The physician must recognise and avoid real or potential conflicts of interest. Where such conflicts are unavoidable, they must be declared in advance and properly managed.

6. Physicians must take responsibility for their individual medical decisions and must not alter their sound professional medical judgements on the basis of instructions contrary to medical considerations.

7. When medically appropriate, the physician must collaborate with other physicians and health professionals who are involved in the care of the patient or who are qualified to assess or recommend care options. This communication must respect patient confidentiality and be confined to necessary information.

8. When providing professional certification, the physician must only certify what the physician has personally verified.

9. The physician should provide help in medical emergencies, while considering the physician's own safety and competence, and the availability of other viable options for care.

10. The physician must never participate in or facilitate acts of torture, or other cruel, inhuman, or degrading practices and punishments.

11. The physician must engage in continuous learning throughout professional life in order to maintain and develop professional knowledge and skills.

12. The physician should strive 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. In providing medical care, the physician must respect the dignity, autonomy, and rights of the patient. The physician must respect the patient's right to freely accept or refuse care in keeping with the patient's values and preferences.

14. The physician must commit to the primacy of patient health and well-being and must offer care in the patient's best interests. In doing so, the physician must strive to prevent or minimise harm for the patient and seek a positive balance between the intended benefit to the patient and any potential harm.

15. The physician must respect the patient's right to be informed in every phase of the care process. The physician must obtain the patient's voluntary informed consent prior to any medical care provided, ensuring that the patient receives and understands the information needed to make an independent, informed decision about the proposed care. The physician must respect the patient's decision to withhold or withdraw consent at any time and for any reason.

16. When a patient has substantially limited, underdeveloped, impaired, or fluctuating decision-making capacity, the physician must involve the patient as much as possible in medical decisions. In addition, the physician must work with the patient's trusted representative, if available, to make decisions in keeping with the patient's preferences, when those are known or can reasonably be inferred. When the patient's preferences cannot be determined, the physician must make decisions in the patient's best interests. All decisions must be made in keeping with the principles set forth in this Code.

17. In emergencies, where the patient is not able to participate in decision making and no representative is readily available, the physician may initiate an intervention without prior informed consent in the best interests of the patient and with respect for the patient's preferences, where known.

18. If the patient regains decision-making capacity, the physician must obtain informed consent for further intervention.

19. The physician should be considerate of and communicate with others, where available, who are close to the patient, in keeping with the patient's preferences and best interests and with due regard for patient confidentiality.

20. 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 appropriately qualified physician or health professional who has the necessary capacity.

21. The physician must ensure accurate and timely medical documentation.

22. The physician must respect the patient's privacy and confidentiality, even after the patient has died. A physician may disclose confidential information if the patient provides voluntary informed consent or, in exceptional cases, when disclosure is necessary to safeguard a significant and overriding ethical obligation to which all other possible solutions have been exhausted, even when the patient does not or cannot consent to it. This disclosure must be limited to the minimal necessary information, recipients, and duration.

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 and, where appropriate, during the course of any interactions. The physician must disclose to the patient the nature and extent of those commitments and must obtain consent for the interaction.

24. The physician must refrain from intrusive or otherwise inappropriate advertising and marketing and ensure that all information used by the physician in advertising and marketing is factual and not misleading.

25. The physician must not allow commercial, financial, or other conflicting interests to affect the physician's professional judgement.

26. When providing medical care remotely, the physician must ensure that this form of communication is medically justifiable and that the necessary medical care is provided. The physician must also inform the patient about the benefits and limitations of receiving medical care remotely, obtain the patient's consent, and ensure that patient confidentiality is upheld. Wherever medically appropriate, the physician must aim to provide care to the patient through direct, personal contact.

27. The physician must maintain appropriate professional boundaries. The physician must never engage in abusive, exploitative, or other inappropriate relationships or behaviour with a patient and must not engage in a sexual relationship with a current patient.

28. In order to provide care of the highest standards, 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.

29. This Code represents the physician's ethical duties. However, on some issues there are profound moral dilemmas concerning which physicians and patients may hold deeply considered but conflicting conscientious beliefs.

    The physician has an ethical obligation to minimise disruption to patient care. Physician conscientious objection to provision of any lawful medical interventions may only be exercised if the individual patient is not harmed or discriminated against and if the patient's health is not endangered.

The physician must immediately and respectfully inform the patient of this objection and of the patient's right to consult another qualified physician and provide sufficient information to enable the patient to initiate such a consultation in a timely manner.

Duties to other physicians, health professionals, students, and other personnel

30. The physician must engage with other physicians, health professionals and other personnel in a respectful and collaborative manner without bias, harassment, or discriminatory conduct. The physician must also ensure that ethical principles are upheld when working in teams.

31. The physician should respect colleagues' patient-physician relationships and not intervene unless requested by either party or needed to protect the patient from harm. This should not prevent the physician from recommending alternative courses of action considered to be in the patient's best interests.

32. The physician should report to the appropriate authorities conditions or circumstances which impede the physician or other health professionals from providing care of the highest standards or from upholding the principles of this Code. This includes any form of abuse or violence against physicians and other health personnel, inappropriate working conditions, or other circumstances that produce excessive and sustained levels of stress.

33. The physician must accord due respect to teachers and students.

Duties to society

34. The physician 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 both patients and health professionals.

35. Physicians play an important role in matters relating to health, health education, and health literacy. In fulfilling this responsibility, physicians must be prudent in discussing new discoveries, technologies, or treatments in non-professional, public settings, including social media, and should ensure that their own statements are scientifically accurate and understandable.

    Physicians must indicate if their own opinions are contrary to evidence-based scientific information.

36. The physician must support sound medical scientific research in keeping with the WMA Declaration of Helsinki and the WMA Declaration of Taipei.

37. The physician should avoid acting in such a way as to weaken public trust in the medical profession. To maintain that trust, individual physicians must hold themselves and fellow physicians to the highest standards of professional conduct and be prepared to report behaviour that conflicts with the principles of this Code to the appropriate authorities.

38. The physician should share medical knowledge and expertise for the benefit of patients and the advancement of health care, as well as public and global health.

Duties as a member of the medical profession

39. The physician should follow, protect, and promote the ethical principles of this Code. The physician should help prevent national or international ethical, legal, organisational, or regulatory requirements that undermine any of the duties set forth in this Code.

40. The physician should support fellow physicians in upholding the responsibilities set out in this Code and take measures to protect them from undue influence, abuse, exploitation, violence, or oppression.

WMA DECLARATION OF HELSINKI

- ETHICAL PRINCIPLES FOR MEDICAL RESEARCH INVOLVING HUMAN SUBJECTS -

Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964
and amended by the:
29th WMA General Assembly, Tokyo, Japan, October 1975
35th WMA General Assembly, Venice, Italy, October 1983
41st WMA General Assembly, Hong Kong, September 1989
48th WMA General Assembly, Somerset West, Republic of South Africa, October 1996
52nd WMA General Assembly, Edinburgh, Scotland, October 2000
53rd WMA General Assembly, Washington DC, USA, October 2002
(Note of Clarification added)
55th WMA General Assembly, Tokyo, Japan, October 2004
(Note of Clarification added)
59th WMA General Assembly, Seoul, Republic of Korea, October 2008
64th WMA General Assembly, Fortaleza, Brazil, October 2013

PREAMBLE

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

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

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

GENERAL PRINCIPLES

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

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

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

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

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

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

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

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

11. Medical research should be conducted in a manner that minimises possible harm to the environment.

12. Medical research involving human subjects must be conducted only by individuals with the appropriate ethics and scientific education, training and qualifications. Research on patients or healthy volunteers requires the supervision of a competent and appropriately qualified physician or other health care professional.

13. Groups that are underrepresented in medical research should be provided appropriate access to participation in research.

14. Physicians who combine medical research with medical care should involve their patients in research only to the extent that this is justified by its potential preventive, diagnostic or therapeutic value and if the physician has good reason to believe that participation in the research study will not adversely affect the health of the patients who serve as research subjects.

15. Appropriate compensation and treatment for subjects who are harmed as a result of participating in research must be ensured.

RISKS, BURDENS AND BENEFITS

16. In medical practice and in medical research, most interventions involve risks and burdens.

    Medical research involving human subjects may only be conducted if the importance of the objective outweighs the risks and burdens to the research subjects.

17. All medical research involving human subjects must be preceded by careful assessment of predictable risks and burdens to the individuals and groups involved in the research in comparison with foreseeable benefits to them and to other individuals or groups affected by the condition under investigation.

    Measures to minimise the risks must be implemented. The risks must be continuously monitored, assessed and documented by the researcher.

18. Physicians may not be involved in a research study involving human subjects unless they are confident that the risks have been adequately assessed and can be satisfactorily managed.

    When the risks are found to outweigh the potential benefits or when there is conclusive proof of definitive outcomes, physicians must assess whether to continue, modify or immediately stop the study.

VULNERABLE GROUPS AND INDIVIDUALS

19. Some groups and individuals are particularly vulnerable and may have an increased likelihood of being wronged or of incurring additional harm.

    All vulnerable groups and individuals should receive specifically considered protection.

20. Medical research with a vulnerable group is only justified if the research is responsive to the health needs or priorities of this group and the research cannot be carried out in a non-vulnerable group. In addition, this group should stand to benefit from the knowledge, practices or interventions that result from the research.

SCIENTIFIC REQUIREMENTS AND RESEARCH PROTOCOLS

21. Medical research involving human subjects must conform to generally accepted scientific principles, be based on a thorough knowledge of the scientific literature, other relevant sources of information, and adequate laboratory and, as appropriate, animal experimentation. The welfare of animals used for research must be respected.

22. The design and performance of each research study involving human subjects must be clearly described and justified in a research protocol.

The protocol should contain a statement of the ethical considerations involved and should indicate how the principles in this Declaration have been addressed. The protocol should include information regarding funding, sponsors, institutional affiliations, potential conflicts of interest, incentives for subjects and information regarding provisions for treating and/or compensating subjects who are harmed as a consequence of participation in the research study.

In clinical trials, the protocol must also describe appropriate arrangements for post-trial provisions.

RESEARCH ETHICS COMMITTEES

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

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

PRIVACY AND CONFIDENTIALITY

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

INFORMED CONSENT

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

26. In medical research involving human subjects capable of giving informed consent, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail, post-study provisions and any other relevant aspects of the study. The potential subject must be informed of the right to refuse to participate in the study or to with-

draw consent to participate at any time without reprisal. Special attention should be given to the specific information needs of individual potential subjects as well as to the methods used to deliver the information.

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

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

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

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

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

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

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

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

USE OF PLACEBO

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

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

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

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

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

POST-TRIAL PROVISIONS

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

RESEARCH REGISTRATION AND PUBLICATION AND DISSEMINATION OF RESULTS

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

36. Researchers, authors, sponsors, editors and publishers all have ethical obligations with regard to the publication and dissemination of the results of research. Researchers have a duty to make publicly available the results of their research on human subjects and are accountable for the completeness and accuracy of their reports. All parties should adhere to accepted guidelines for ethical reporting. Negative and inconclusive as well as positive results must be published or otherwise made publicly available. Sources of funding, institutional affiliations and conflicts of interest must be declared

in the publication. Reports of research not in accordance with the principles of this Declaration should not be accepted for publication.

UNPROVEN INTERVENTIONS IN CLINICAL PRACTICE

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

WMA DECLARATION OF SYDNEY ON THE DETERMINATION OF DEATH AND THE RECOVERY OF ORGANS

Adopted by the 22nd World Medical Assembly, Sydney, Australia, August 1968
and amended by the 35th World Medical Assembly, Venice, Italy, October 1983
and the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

Determination of death can be made on the basis of the irreversible cessation of all functions of the entire brain, including the brain stem, or the irreversible cessation of circulatory and respiratory functions. This determination will be based on clinical judgment according to accepted criteria, supplemented, if necessary, by standard diagnostic procedures, and it will be made by a physician.

Even without intervention, cell, organ and tissue activity in the body may continue temporarily after a determination of death. Cessation of all life at the cellular level is not a necessary criterion for determination of death.

The use of deceased donor organs for transplantation has made it important for physicians to be able to determine when mechanically-supported patients have died.

After death has occurred, it may be possible to maintain circulation to the organs and tissues of the body mechanically. This may be done to preserve organs and tissues for transplantation.

Prior to post-mortem transplantation, the determination that death has occurred shall be made by a physician who is in no way immediately involved in the transplantation procedure.

Following the determination of death, all treatment and resuscitation attempts may be ceased and donor organs may be recovered, provided that prevailing requirements of consent and other relevant ethical and legal requirements have been fulfilled. Physicians should follow the protocol on organ donation for deceased donors as outlined in the WMA Statement on Organ and Tissue Donation.

WMA DECLARATION OF TOKYO

- GUIDELINES FOR PHYSICIANS CONCERNING TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT IN RELATION TO DETENTION AND IMPRISONMENT -

Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006
and revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

It is the privilege of the physician to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

DECLARATION

1. The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

2. The physician shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. When providing medical assistance to detainees or prisoners who are, or who could later be, under interrogation, physicians should be particularly careful to ensure the

confidentiality of all personal medical information. A breach of the Geneva Conventions shall in any case be reported by the physician to relevant authorities.

4. As stated in WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment and as an exception to professional confidentiality, physicians have the ethical obligation to report abuses, where possible with the subject's consent, but in certain circumstances where the victim is unable to express him/herself freely, without explicit consent.

5. The physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals.

6. The physician shall not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened.

7. A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose.

8. Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially, as stated in WMA Declaration of Malta on Hunger Strikers. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner.

9. Recalling the 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, the World Medical Association supports, and encourages the international community, the National Medical Associations and fellow physicians to support, the physician and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

10. The World Medical Association calls on National Medical Associations to encourage physicians to continue their professional development training and education in human rights.

WMA DECLARATION OF LISBON ON THE RIGHTS OF THE PATIENT

Adopted by the 34th World Medical Assembly, Lisbon, Portugal, September/October 1981
and amended by the 47th WMA General Assembly, Bali, Indonesia, September 1995
and editorially revised by the 171st WMA Council Session, Santiago, Chile, October 2005
and reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015

PREAMBLE

The relationship between physicians, their patients and broader society has undergone significant changes in recent times. While a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to guarantee patient autonomy and justice. The following Declaration represents some of the principal rights of the patient that the medical profession endorses and promotes. Physicians and other persons or bodies involved in the provision of health care have a joint responsibility to recognize and uphold these rights. Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them.

PRINCIPLES

1. Right to medical care of good quality

   a. Every person is entitled without discrimination to appropriate medical care.

   b. Every patient has the right to be cared for by a physician whom he/she knows to be free to make clinical and ethical judgements without any outside interference.

   c. The patient shall always be treated in accordance with his/her best interests. The treatment applied shall be in accordance with generally approved medical principles.

   d. Quality assurance should always be a part of health care. Physicians, in particular, should accept responsibility for being guardians of the quality of medical services.

   e. In circumstances where a choice must be made between potential patients for a particular treatment that is in limited supply, all such patients are entitled to a fair selection procedure for that treatment. That choice must be based on medical criteria and made without discrimination.

f. The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

2. Right to freedom of choice

a. The patient has the right to choose freely and change his/her physician and hospital or health service institution, regardless of whether they are based in the private or public sector.

b. The patient has the right to ask for the opinion of another physician at any stage.

3. Right to self-determination

a. The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decisions.

b. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions. The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.

c. The patient has the right to refuse to participate in research or the teaching of medicine.

4. The unconscious patient

a. If the patient is unconscious or otherwise unable to express his/her will, informed consent must be obtained whenever possible, from a legally entitled representative.

b. If a legally entitled representative is not available, but a medical intervention is urgently needed, consent of the patient may be presumed, unless it is obvious and beyond any doubt on the basis of the patient's previous firm expression or conviction that he/she would refuse consent to the intervention in that situation.

c. However, physicians should always try to save the life of a patient unconscious due to a suicide attempt.

5. The legally incompetent patient

a. If a patient is a minor or otherwise legally incompetent, the consent of a legally entitled representative is required in some jurisdictions. Nevertheless the patient must be involved in the decision-making to the fullest extent allowed by his/her capacity.

b. If the legally incompetent patient can make rational decisions, his/her decisions must be respected, and he/she has the right to forbid the disclosure of information to his/her legally entitled representative.

c. If the patient's legally entitled representative, or a person authorized by the patient, forbids treatment which is, in the opinion of the physician, in the patient's best interest, the physician should challenge this decision in the relevant legal or other institution. In case of emergency, the physician will act in the patient's best interest.

6. Procedures against the patient's will

Diagnostic procedures or treatment against the patient's will can be carried out only in exceptional cases, if specifically permitted by law and conforming to the principles of medical ethics.

7. Right to information

a. The patient has the right to receive information about himself/herself recorded in any of his/her medical records, and to be fully informed about his/her health status including the medical facts about his/her condition. However, confidential information in the patient's records about a third party should not be given to the patient without the consent of that third party.

b. Exceptionally, information may be withheld from the patient when there is good reason to believe that this information would create a serious hazard to his/her life or health.

c. Information should be given in a way appropriate to the patient's culture and in such a way that the patient can understand.

d. The patient has the right not to be informed on his/her explicit request, unless required for the protection of another person's life.

e. The patient has the right to choose who, if anyone, should be informed on his/her behalf.

8. Right to confidentiality

a. All identifiable information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind must be kept confidential, even after death. Exceptionally, descendants may have a right of access to information that would inform them of their health risks.

b. Confidential information can only be disclosed if the patient gives explicit consent or if expressly provided for in the law. Information can be disclosed to other health care providers only on a strictly "need to know" basis unless the patient has given explicit consent.

c. All identifiable patient data must be protected. The protection of the data must be appropriate to the manner of its storage. Human substances from which identifiable data can be derived must be likewise protected.

9. Right to health education

Every person has the right to health education that will assist him/her in making informed choices about personal health and about the available health services. The education should include information about healthy lifestyles and about methods of prevention and early detection of illnesses. The personal responsibility of everybody for his/her own health should be stressed. Physicians have an obligation to participate actively in educational efforts.

10. Right to dignity

a. The patient's dignity and right to privacy shall be respected at all times in medical care and teaching, as shall his/her culture and values.

b. The patient is entitled to relief of his/her suffering according to the current state of knowledge.

c. The patient is entitled to humane terminal care and to be provided with all available assistance in making dying as dignified and comfortable as possible.

11. Right to religious assistance

The patient has the right to receive or to decline spiritual and moral comfort including the help of a minister of his/her chosen religion

WMA DECLARATION
ON
PRINCIPLES OF HEALTH CARE IN SPORTS MEDICINE

Adopted by the 34th WMA General Assembly, Lisbon, Portugal, September/October 1981
amended by the 39th WMA General Assembly, Madrid, Spain, October 1987
by the 45th WMA General Assembly, Budapest, Hungary, October 1993
by the 51st WMA General Assembly, Tel Aviv, Israel, October 1999
reaffirmed by the 185th WMA Council Session, Evian-les-Bains, France, May 2010
and amended by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

PREAMBLE

Sports medicine physicians are physicians concerned with the prevention and treatment of injuries and disorders that are related to participation in sports. In some countries, sports medicine physicians are recognized as medical specialists. They are trained to address issues associated with nutrition, sports psychology and substance misuse, and may also counsel athletes on injury prevention.

Considering the involvement of physicians in sports medicine, the World Medical Association (WMA) recommends ethical guidelines for sports medicine physicians, recognizing the special circumstances in which their medical care and health guidance is given.

Anabolic Agents and Performance Enhancing Drugs and Methods

The use of anabolic agents, performance enhancing drugs, pain killers and performance enhancing methods by athletes is contrary to the rules and ethical principles of athletic competition as set forth by most sports governing bodies. Performance enhancing drugs and methods have been associated with adverse health effects.

The sports medicine physician should be aware that methods, drugs or interventions which artificially modify blood constituents, biochemistry, genome sequence, gene expression or hormone levels and do not benefit patients, violate the basic principles of the WMA's Declaration of Geneva, which states: "the health and wellbeing of my patient will be my first consideration."

The WMA believes that the use of anabolic agents and performance enhancing drugs and methods is a threat to the health of athletes and is in conflict with the principles of medical ethics. The physician must oppose and refuse to administer or condone any means or method

which is not in accordance with medical ethics, or which might be harmful to the athlete using it. The physician must also inform athletes of potential health risks.

Examples of these drugs and methods include, but are not limited to:

- The use of drugs or other substances whatever their nature and route of administration, including central-nervous-system stimulants or depressants and procedures which artificially modify reflexes, alter a sense of well-being and/or general mental outlook.
- Procedures or therapeutics to mask pain or other protective symptoms if used to enable the athlete to take part in events or training activities when clinical signs make his or her participation inadvisable. This includes allowing participation in athletic activity when doing so would be dangerous to the athlete.
- Procedures or therapeutics used to mask the presence of other performance enhancing drugs or to induce rapid water or weight loss.
- Measures aimed at an unnatural improvement in or maintenance of endurance or oxygen carrying capacity during competition. This includes the manipulation of blood and/or blood components defined as the administration or reintroduction of blood or red blood cell products of any origin into the circulatory system, artificially enhancing the uptake, transport, or delivery of oxygen using chemicals such as erythropoietin, or other forms of intravascular manipulation to artificially increase red blood cell mass, unless medically indicated for the treatment of a documented disease or medical condition. Blood doping also exposes the athlete to unwarranted and potentially serious health risks.
- Use of anabolic agents including “designer steroids”, which are substances that are undetectable through the use of standard testing methods.
- Use of anabolic steroid precursors, including dietary supplements, that claim to provide “safe” steroid equivalents, but that metabolize in the body into anabolic steroids.
- Use of non-approved substances which have no current approval by any governmental regulatory health authority for human therapeutic use, for example, drugs under pre-clinical or clinical development, discontinued drugs, designer drugs or substances approved only for veterinary use.
- Use of peptide hormones, growth factors and related substances to increase red blood cell count, blood oxygenation or oxygen-carrying capacity.
- Use of hormone and metabolic modulators, which are substances to modify hormone activity by blocking the action or increasing the activity of a hormone.

Of special concern is the use of anabolic agents and steroid precursors in adolescents. Young users are considered particularly susceptible to potentially serious health problems during this physically and emotionally vulnerable period when their own hormonal cycles are changing.

In females, anabolic agents have been associated with a number of adverse effects, some of which appear to be permanent even when drug use is stopped. Physicians should strongly discourage using these products.

World Athletics Gender Rules for Classifying Female Athletes

World Athletics 2018 Eligibility Regulations for Female Classification[1] imposes an upper hormonal limit for athletes wishing to compete in the female category in certain disciplines of international athletics competitions.

The WMA opposes World Athletics' rules[2] requiring female athletes with differences in sex development to take drugs to reduce and maintain their natural level of blood testosterone in order to compete. The mere existence of a condition caused by a difference in sex development, in a person who has not expressed a desire to change that condition, does not constitute a medical indication for treatment. Medical treatment solely to alter athletic performance is unethical.

RECOMMENDATIONS

Sports medicine physicians have an obligation and duty to respect and comply with the ethical standards of the medical profession.
The sports medicine physician who cares for athletes has an ethical responsibility to recognize the special physical and mental demands placed upon athletes by their participation in athletic activities. The physician's duty is to preserve the athlete's mental and physical health and not solely to increase athletic performance.
When the sports participant is a professional athlete and derives livelihood from that activity, the physician should understand the occupational health aspects involved.
The sports physician should give his or her objective opinion about the athlete's state of fitness clearly and precisely, leaving no doubt as to his or her conclusions.
In all sporting events, it is the physician's duty to decide whether the athlete is medically fit to compete in an event. This decision cannot be delegated to other non-physician professionals.
In order to carry out his or her ethical obligations, the sports medicine physician's authority must be fully recognized and upheld, particularly when it concerns the health and safety of the athlete. Concern for the athlete's health and safety must override the interests of any third party.
The sports medicine physician is obligated to uphold the ethical principles of the medical profession. This includes the right to privacy and respect for the confidential nature of the patient-physician relationship. These principles and obligations should be supported by an agreement between the sports medicine physician and the athletic organization involved.

[1] Specifically, Rule 2.3 of Competition Rule 3.6, "Eligibility Regulations for the Female Classification."

[2] Specifically, Rule 2.3 of Competition Rule 3.6, "Eligibility Regulations for the Female Classification."

The sports medicine physician must oppose and refuse to administer any substance or condone any means or treatment method which is not in accordance with medical ethics and/or which might be harmful to the athlete using it. The physician must also inform athletes of potential health risks.

The sports medicine physician should be invited to participate in the design and modification of a sport's rules and regulations in order to protect the health and safety of athletes.

The sports medicine physician, with patient consent, should work cooperatively with the patient's personal physician, and keep him or her fully informed of the patient's current condition.

All physicians should recognize that the desire to enhance performance, appearance, and/or well-being is not limited to elite athletes. Amateur and recreational athletes, as well as adolescents, are also at risk of and subject to sociocultural pressures to misuse anabolic agents and performance enhancing drugs and methods. A harm-reduction approach with discussions focused on risks, harm minimization, prevention strategies, and health promotion is recommended.

WMA DECLARATION OF VENICE
ON
END OF LIFE MEDICAL CARE

Adopted by the 35th World Medical Assembly, Venice, Italy, October 1983
and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

When a patient is seriously ill and the restoration of health may not be possible, the physician and the patient are often faced with a complex set of decisions regarding medical treatment.

The end of life must be recognized and respected as an important part of a person's life.

Advances in medical science have improved the ability of physicians to address many issues associated with end-of-life care. While the priority of research to cure disease should not be compromised, more attention must be paid to developing palliative treatments and improving assessment and response to the physical, psychological, social and spiritual or existential components of terminal illnesses and other conditions at the end of life.

WMA remains firmly opposed to euthanasia and physician-assisted suicide, as set forth in the WMA Declaration on Euthanasia and Physician-Assisted Suicide.

Ethically-appropriate care at the end of life should routinely promote patient autonomy and shared decision-making, and be respectful of the values of the patient, his or her family or intimate associates, and surrogate(s). The WMA recognizes that attitudes and beliefs toward death and dying vary widely from culture to culture and among different religions, and palliative care resources are unevenly distributed. The approach to medical care at the end of life will be influenced significantly by these factors, and thus attempting to develop detailed universal guidelines on terminal care is neither practical nor wise. Therefore, the WMA articulates the following:

RECOMMENDATIONS

Pain and Symptom Management

1. Palliative care at the end of life is part of good medical care. The objective of palliative care is to maintain patient dignity and freedom from distressing symptoms. Care plans should emphasize keeping a patient as comfortable as possible and the patient's pain

controlled while recognizing the importance of attention to the social, psychological and spiritual needs of the patient, and his or her family and intimate associates.

2. The clinical management of pain in patients at the end of life is of paramount importance in terms of alleviating suffering. The WMA Resolution on Access to Adequate Pain Treatment (2020) makes recommendations for physicians and governments that optimize treatment of pain and other distressing symptoms. Physicians and National Medical Associations should promote the dissemination and sharing of information regarding pain management to ensure that all physicians involved in end-of-life care have access to best practice guidelines and the most current treatments and methods available. National Medical Associations should oppose laws or regulations that unduly inhibit physicians from providing intensive, clinically appropriate symptoms management for patients at the end of life in keeping with recognized best practices.

3. When a patient at the end of life experiences severe pain or other distressing clinical symptoms that do not respond to intensive, symptom-specific palliation, it can be appropriate to offer sedation to unconsciousness as an intervention of last resort. Sedation to unconsciousness must never be used to intentionally cause a patient's death and should be restricted to patients in the final stages of life. Thorough efforts should be made to obtain consent of the patient or the patient's surrogate(s).

4. Palliative care is often provided by multidisciplinary healthcare teams. When possible, the physician should be the leader of the team, being responsible, amongst other obligations, for diagnosis and medical treatment plans. A carefully kept medical record is of the utmost importance. The rationale for all symptom management interventions, including medications for symptom relief, should be documented in the medical record, including the degree and length of sedation and specific expectations for continuing, withdrawing, or withholding future life-sustaining treatments.

5. The health care team should promote collaborative care of the patient and offer bereavement support after the patient's death. The needs of children and families or intimate associates may require special attention and competence, both when children are patients and when they are dependents of patients.

Education and Research

6. Education of healthcare professionals should include the teaching of end-of-life medical care. Where it does not exist, the establishment of palliative medicine as a medical specialty should be considered. In countries where palliative medicine is not a recognized specialty, post-graduate training in palliative medicine can nevertheless improve the quality of palliative care provided.

7. Physician education should help to develop the skills necessary to increase the prevalence and quality of meaningful patient advance care planning for patients with life-threatening illness and the right of patients to use written advance directives that describe their wishes

and goals regarding care in the event that they are unable to communicate. Physicians should receive education to encourage their patients to formally document their goals, values and treatment preferences and to appoint a substitute health care decision maker with whom the patient can discuss in advance his or her values regarding health care and treatment.

8. Governments and research institutions are encouraged to invest additional resources in developing treatments to improve end-of-life care. This includes, but is not limited to, supporting research on general medical care, specific treatments, psychological implications and organization to improve end-of-life care.

9. When employing treatments, the physician must carefully consider the balance between the intended benefits to the patient and the potential harm. National Medical Associations should support the formulation of palliative treatment guidelines.

10. The physician must also communicate to the patient a willingness to discuss at any time the natural course of the disease and what to expect during the dying process, while also providing guidance about treatments and alternatives that could ease the patient's suffering, including palliative care or psychotherapy. If a patient indicates a desire to die or expresses suicidal thoughts, the physician has a duty to engage in open and confidential discussions with the patient to understand the motives and reasoning behind these thoughts.

11. Physicians should assist the dying patient in maintaining an optimal quality of life by controlling symptoms and addressing psychosocial and spiritual needs, to enable the patient to die with dignity and in comfort. Physicians should inform patients of the availability, benefits and other aspects of palliative care. Discussions about patient preferences should be initiated early, routinely offered to all patients and should be revisited regularly to explore any changes patients may have in their wishes, especially as their clinical condition changes. Information and communication among the patient, his or her family or intimate associates, surrogates and members of the health care team are one of the fundamental pillars of quality care at the end of life.

12. Physicians should endeavor to identify, understand and address the psychosocial and spiritual needs of their patients, especially as they relate to patients' physical symptoms. Physicians should try to ensure that psychological, social and spiritual resources are available to patients, their families and intimate associates, to help them deal with the anxiety, fear and grief associated with the end of life.

13. Physicians should encourage patients to designate a substitute decision-maker/surrogate to make decisions that are not expressed in an advance directive. In particular, physicians should discuss the patient's wishes regarding the approach to life-sustaining interventions as well as palliative measures that might have the additional effect of accelerating death. Because documented advance directives are sometimes not available in emergency situations, physicians should emphasize to patients the importance of discussing treatment preferences with individuals who are likely to act as substitute health care decision-

makers/surrogates. Whenever possible and consented to by the patient, the patient's substitue decision-makers/surrogates should be included in these conversations.

14. If a patient has decision-making capacity, his or her autonomous right to refuse any medical treatments or interventions must be respected even if the patient's life may be shortened. Physicians should make sure that the patient is adequately treated for pain and discomfort before consent for end-of-life care is obtained in order to ensure that unnecessary physical and mental suffering do not interfere with decision making. Laws regarding the decision-making capacity of minor patients vary greatly, but discussions with the family, and child, if possible, are encouraged.

15. Upon a patient's death, physicians may apply such means as are necessary to keep organs viable for transplantation, provided that they act in accordance with the ethical guidelines established in the WMA Declaration of Sydney on the Determination of Death and the Recovery of Organs. In addition, any transplantation must be in accordance with the principles in the WMA Statement on Organ and Tissue Donation.

WMA DECLARATION OF HONG KONG ON THE ABUSE OF THE ELDERLY

Adopted by the 41st World Medical Assembly, Hong Kong, September 1989
and editorially revised by the 126th WMA Council Session, Jerusalem, Israel, May 1990
and the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015

Elderly people may suffer pathological problems such as motor disturbances and psychic and orientation disorders. As a result of such problems, elderly patients may require assistance with their daily activities that can lead to a state of dependence. This may cause their families and the community to consider them to be a burden and to subsequently limit or deny care and services.

Abuse or neglect of the elderly can be manifested in a variety of ways: physical, psychological, financial and/or material, and medical. Variations in the definition of elder abuse present difficulties in comparing findings on the nature and causes of the problem. A number of preliminary hypotheses have been proposed on the etiology of elder abuse including: dependency on others to provide services; lack of close family ties; family violence; lack of financial resources; psychopathology of the abuser; lack of community support, and institutional factors such as low pay and poor working conditions that contribute to pessimistic attitudes of caretakers.

The phenomenon of elder abuse is becoming increasingly recognized by both medical facilities and social agencies. The first step in preventing elder abuse and neglect is to increase levels of awareness and knowledge among physicians and other health professionals. Once high-risk individuals and families have been identified, physicians can participate in the primary prevention of maltreatment by making referrals to appropriate community and social service centres. Physicians may also participate by providing support and information on high-risk situations directly to patients and their families. At the same time, physicians should employ care and sensitivity to preserve patient trust and confidentiality, particularly in the case of competent patients.

The World Medical Association therefore adopts the following general principles relating to abuse of the elderly.

GENERAL PRINCIPLES

1. The elderly have the same rights to care, welfare and respect as other human beings.

2. Physicians have a responsibility to help prevent the physical and psychological abuse of elderly patients.

3. Whether consulted by an aged person directly, a nursing home or the family, physicians should see that the patient receives the best possible care.

4. If physicians verify or suspect ill treatment, as defined in this statement, they should discuss the situation with those in charge, be it the nursing home or the family. If ill treatment is confirmed, or if death is considered to be suspicious, they should report the findings to the appropriate authorities.

5. To guarantee protection of the elderly in any environment there should be no restrictions on their right of free choice of a physician. National Medical Associations should strive to make certain that such free choice is preserved within the socio-medical system.

The World Medical Association also makes the following recommendations to physicians involved in treating the elderly, and urges all National Medical Associations to publicize this Declaration to their members and the public.

RECOMMENDATIONS

Physicians involved in treating the elderly should:

- make increased attempts to establish an atmosphere of trust with elderly patients in order to encourage them to seek medical care when necessary and to feel comfortable confiding in the physician;
- provide medical evaluation and treatment for injuries resulting from abuse and/or neglect;
- attempt to establish or maintain a therapeutic alliance with the family (often the physician is the only professional who maintains long-term contact with the patient and the family), while preserving to the greatest extent possible the confidentiality of the patient;
- report all suspected cases of elder abuse and/or neglect in accordance with local legislation;
- utilize a multidisciplinary team of caretakers from the medical, social service, mental health, and legal professions, whenever possible; and
- encourage the development and utilization of supportive community resources that provide in-home services, respite care, and stress reduction with high-risk families.

WMA DECLARATION OF MALTA ON HUNGER STRIKERS

Adopted by the 43rd World Medical Assembly, St. Julians, Malta, November 1991
and editorially revised by the 44th World Medical Assembly, Marbella, Spain, September 1992
and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 68th WMA General Assembly, Chicago, United States, October 2017

PREAMBLE

1. Hunger strikes occur in various contexts but they mainly give rise to dilemmas in settings where people are detained (prisons, jails and immigration detention centres). They are usually a form of protest by people who lack other ways of making their demands known. In refusing nutrition for a significant period, prisoners and detainees may hope to obtain certain goals by inflicting negative publicity on the authorities. Short-term food refusals rarely raise ethical problems. Prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians. Hunger strikers rarely wish to die but some may be prepared to do so to achieve their aims.

2. Physicians need to ascertain the individual's true intention, especially in collective strikes or situations where peer pressure may be a factor. An emotional challenge arises when hunger strikers who have apparently issued clear instructions not to be resuscitated reach a stage of cognitive impairment. The principle of beneficence urges physicians to resuscitate them but respect for individual autonomy restrains physicians from intervening when a valid and informed refusal has been made. This has been well worked through in many other clinical situations including refusal of life saving treatment. An added difficulty arises in custodial settings because it is not always clear whether the hunger striker's advance instructions were made voluntarily and with appropriate information about the consequences.

PRINCIPLES

3. Duty to act ethically. All physicians are bound by medical ethics in their professional contact with vulnerable people, even when not providing therapy. Whatever their role, physicians must try to prevent coercion or maltreatment of detainees and must protest if it occurs.

4. Respect for autonomy. Physicians should respect individuals' autonomy. This can involve difficult assessments as hunger strikers' true wishes may not be as clear as they appear. Any decisions lack moral force if made by use of threats, peer pressure or coercion. Hunger strikers should not forcibly be given treatment they refuse. Applying, instructing or assisting forced feeding contrary to an informed and voluntary refusal is unjustifiable. Artificial feeding with the hunger striker's explicit or necessarily implied consent is ethically acceptable.

5. ‘Benefit’ and ‘harm’. Physicians must exercise their skills and knowledge to benefit those they treat. This is the concept of ‘beneficence’, which is complemented by that of ‘non-maleficence’ or primum non nocere. These two concepts need to be in balance. ‘Benefit’ includes respecting individuals’ wishes as well as promoting their welfare. Avoiding ‘harm’ means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting. Beneficence does not necessarily involve prolonging life at all costs, irrespective of other determinants.

   Physicians must respect the autonomy of competent individuals, even where this will predictably lead to harm. The loss of competence does not mean that a previous competent refusal of treatment, including artificial feeding should be ignored.

6. Balancing dual loyalties. Physicians attending hunger strikers can experience a conflict between their loyalty to the employing authority (such as prison management) and their loyalty to patients. In this situation, physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is to the individual patient. They remain independent from their employer in regard to medical decisions.

7. Clinical independence. Physicians must remain objective in their assessments and not allow third parties to influence their medical judgement. They must not allow themselves to be pressured to breach ethical principles, such as intervening medically for non medical reasons.

8. Confidentiality. The duty of confidentiality is important in building trust but it is not absolute. It can be overridden if non-disclosure seriously and imminently harms others. As with other patients, hunger strikers’ confidentiality and privacy should be respected unless they agree to disclosure or unless information sharing is necessary to prevent serious harm. If individuals agree, their relatives and legal advisers should be kept informed of the situation.

9. Establishing trust. Fostering trust between physicians and hunger strikers is often the key to achieving a resolution that both respects the rights of the hunger strikers and minimises harm to them. Gaining trust can create opportunities to resolve difficult situations. Trust is dependent upon physicians providing accurate advice and being frank with hunger strikers about the limitations of what they can and cannot do, including situations in which the physician may not be able to maintain confidentiality.

10. Physicians must assess the mental capacity of individuals seeking to engage in a hunger strike. This involves verifying that an individual intending to fast is free of any mental conditions that would undermine the person’s ability to make informed health care decisions. Individuals with seriously impaired mental capacity may not be able to appreciate the consequences of their actions should they engage in a hunger strike. Those with treatable mental health problems should be directed towards appropriate care for their mental conditions and receive appropriate treatment. Those with untreatable conditions, including severe learning disability

or advanced dementia should receive treatment and support to enable them to make such decisions as lie within their competence.

11. As early as possible, physicians should acquire a detailed and accurate medical history of the person who is intending to fast. The medical implications of any existing conditions should be explained to the individual. Physicians should verify that hunger strikers understand the potential health consequences of fasting and forewarn them in plain language of the disadvantages. Physicians should also explain how damage to health can be minimised or delayed by, for example, increasing fluid and thiamine intake. Since the person's decisions regarding a hunger strike can be momentous, ensuring full patient understanding of the medical consequences of fasting is critical. Consistent with best practices for informed consent in health care, the physician should ensure that the patient understands the information conveyed by asking the patient what he or she understands.

12. A thorough examination of the hunger striker should be made at the start of the fast including measuring body weight. Management of future symptoms, including those unconnected to the fast, should be discussed with hunger strikers. Also, the person's values and wishes regarding medical treatment in the event of a prolonged fast should be noted. If the hunger striker consents, medical examinations should be carried out regularly in order to determine necessary treatments. The physical environment should be evaluated in order to develop recommendations for preventing negative effects.

13. Continuing communication between the physician and hunger strikers is essential. Physicians should ascertain on a daily basis whether individuals wish to continue a hunger strike and what they want to be done when they are no longer able to communicate meaningfully. The clinician should identify whether the individual is willing, in the absence of their demands being met, to continue the fast even until death. These findings must be appropriately recorded.

14. Sometimes hunger strikers accept an intravenous solution transfusion or other forms of medical treatment. A refusal to accept certain interventions must not prejudice any other aspect of the medical care, such as treatment of infections or of pain.

15. Physicians should talk to hunger strikers in privacy and out of earshot of all other people, including other detainees. Clear communication is essential and, where necessary, interpreters unconnected to the detaining authorities should be available and they too must respect confidentiality.

16. Physicians need to satisfy themselves that food or treatment refusal is the individual's voluntary choice. Hunger strikers should be protected from coercion. Physicians can often help to achieve this and should be aware that coercion may come from the authorities, the peer group, or others, such as family members. Physicians or other health care personnel may not apply undue pressure of any sort on the hunger striker to suspend the strike. Treatment or care of the hunger striker must not be conditional upon suspension of the hunger strike. Any restraint or pressure including but not limited to hand-cuffing, isolation, tying the hunger

striker to a bed or any kind of physical restraint due to the hunger strike is not acceptable.

17. If a physician is unable for reasons of conscience to abide by a hunger striker's refusal of treatment or artificial feeding, the physician should make this clear at the outset, and must be sure to refer the hunger striker to another physician who is willing to abide by the hunger striker's refusal.

18. When a physician takes over the case, the hunger striker may have already lost mental capacity so that there is no opportunity to discuss the individual's wishes regarding medical intervention to preserve life. Consideration and respect must be given to any advance instructions made by the hunger striker. Advance refusals of treatment must be followed if they reflect the voluntary wish of the individual when competent. In custodial settings, the possibility of advance instructions having been made under pressure needs to be considered. Where physicians have serious doubts about the individual's intention, any instructions must be treated with great caution. If well informed and voluntarily made, however, advance instructions can only generally be overridden if they become invalid because the situation in which the decision was made has changed radically since the individual lost competence.

19. If no discussion with the individual is possible and no advance instructions or any other evidence or note in the clinical records of a discussion exist, physicians have to act in what they judge to be in the person's best interests. This means considering the hunger strikers' previously expressed wishes, their personal and cultural values as well as their physical health. In the absence of any evidence of hunger strikers' former wishes, physicians should decide whether or not to provide feeding, without interference from third parties.

20. Physicians may rarely and exceptionally consider it justifiable to go against advance instructions refusing treatment because, for example, the refusal is thought to have been made under duress. If, after resuscitation and having regained their mental faculties, hunger strikers continue to reiterate their intention to fast, that decision should be respected. It is ethical to allow a determined hunger striker to die with dignity rather than submit that person to repeated interventions against his or her will. Physicians acting against an advanced refusal of treatment must be prepared to justify that action to relevant authorities including professional regulators.

21. Artificial feeding, when used in the patient's clinical interest, can be ethically appropriate if competent hunger strikers agree to it. However, in accordance with the WMA Declaration of Tokyo, where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a decision, he or she shall not be fed artificially. Artificial feeding can also be acceptable if incompetent individuals have left no unpressured advance instructions refusing it, in order to preserve the life of the hunger striker or to prevent severe irreversible disability. Rectal hydration is not and must never be used as a form of therapy for rehydration or nutritional support in fasting patients.

22. When a patient is physically able to begin oral feeding, every caution must be taken to ensure implementation of the most up to date guidelines of refeeding.

23. All kinds of interventions for enteral or parenteral feeding against the will of the mentally competent hunger striker are "to be considered as "forced feeding". Forced feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.

THE ROLE OF NATIONAL MEDICAL ASSOCIATIONS (NMAS) AND THE WMA

24. NMAs should organize and provide educational programmes highlighting the ethical dimensions of hunger strikes, appropriate medical approaches, treatments, and interventions. They shall make efforts to update physicians' professional knowledge and skills.

    NMAs should work to provide mechanisms for supporting physicians working in prisons/jails/immigration detention centers, who may often find themselves in conflict situations and, as stated in the WMA Declaration of Hamburg, shall support any physicians experiencing pressure to compromise their ethical principles.

    NMAs have a responsibility to make efforts to prevent unethical practices, to take a position and speak out against ethical violations, and to investigate them properly.

25. The World Medical Association will support physicians and NMAs confronted with political pressures as a result of defending an ethically justifiable position, as stated in the WMA Declaration of Hamburg.

WMA DECLARATION ON GUIDELINES FOR CONTINUOUS QUALITY IMPROVEMENT IN HEALTH CARE

Adopted by the 49th World Medical Assembly, Hamburg, Germany, November 1997
amended by the 60th WMA General Assembly, New Delhi, India, October 2009
and reaffirmed with minor revision by the 213th WMA Council Session, Tbilisi, Georgia, October 2019

PREAMBLE

The purpose of health care is to prevent, diagnose and treat illness and to maintain and to promote the health of the population. The goal of quality review in health care is continuous improvement of the quality of services provided for patients and the population, and of the ways and means of producing these services. The ultimate goal is to improve both individual patient outcomes and population health.

The obligation to continuously improve one's professional ability and to rigorously evaluate the methods one uses has long been a fundamental tenet of the ethical codes of physicians. According to these codes, a physician must always strive to maintain and increase his/her knowledge and skills. The physician shall recommend only examinations and treatments that are believed to be effective and appropriate according to the best available evidence-based medicine.

Physicians and health care institutions have an ethical and professional obligation to strive for continuous quality improvement of services and patient safety, as stated in particular in WMA International Code of Medical Ethics, the Lisbon Declaration on the Rights of the Patient and the Resolution on Standardisation in Medical Practice and Patient Safety. These guidelines are intended to articulate the ethical grounds for these obligations and to strengthen quality review practices.

Ethical guidelines for health care quality improvement matter to all physicians, as well as to institutions providing health care services for patients, those providing continuous quality improvement services to assist physicians and organizations, health care payers and regulators, patients, and every other stakeholder in the health care system.

THE OBLIGATION TO ESTABLISH STANDARDS FOR GOOD QUALITY WORK

Professionals, by definition, are responsible for specifying the standards that constitute good quality in their work and the processes needed for the evaluation of that quality.

Health professionals, therefore, must define high quality health care and determine the best methods of measuring the quality of care delivered.

THE OBLIGATION TO COLLECT DATA

In order to assess quality of care, it is necessary to obtain reliable data on the patients and populations served as well as on care processes and outcomes. Patient records, whether recorded on paper, digitally or in any other way, must be created written and preserved with care and, with attention to confidentiality requirements in accordance with the WMA Declaration of Taipei. Procedures, decisions and other matters connected with patients should be recorded in a format that will allow information for measuring specific standards to be available on a timely basis when needed.

THE ROLE OF PROFESSIONAL EDUCATION

Health care professionals should have adequate opportunities to maintain and develop their knowledge and skills by participating in continuing medical education and/or continuing professional development. Clinical guidelines based on professional standards for high quality care should be created and made easily available to those requiring them. Health care training should include specific instruction in quality improvement techniques, including opportunities for hands-on practice in measuring and improving quality. Health care institutions should create quality improvement systems for their own use and to ensure that instructions concerning such systems are followed.

Good quality work requires resources. Every effort should be made to make sure that adequate time and economic means are available for quality work.

ATTENTION TO INAPPROPRIATE USE OF SERVICES

Inappropriate use of health care services includes overuse, underuse and misuse. Quality measurement in health care should include a balanced set of measures in all three areas.

Overuse of services occurs when health care services are provided under circumstances in which the potential for harm exceeds the possible benefit. Physicians can improve quality by reducing overuse, thus sparing patients the unnecessary risk that results from inappropriate health services.

Underuse of services is the failure to provide health care services that would be likely to produce a favourable outcome for the patient. Physicians should strive to expand the use of beneficial health care services that are underused.

Misuse of services occurs when an incorrect diagnosis is made or when an appropriate service has been selected for a correct diagnosis but the patient does not receive the full potential benefit of the service because of a preventable adverse event. Misuse of services can be greatly reduced by using risk management and error prevention strategies.

MONITORING QUALITY: CLINICAL AUDITS

Active participation in critical self-evaluation, usually through clinical audit programs, is a

useful mechanism for healthcare professionals, including healthcare administrators and physicians, and the institutions in which they work, to improve the quality of their work. External independent examination and accreditation of the institution can also be of use, when carried out appropriately and with due attention to potential unintended effects.

Healthcare professionals and institutions should systematically record and reflect on adverse incidents and medical error for the purposes of learning and quality improvement. This should occur in an environment of trust (and confidentiality when appropriate) and to actively avoid a blame culture.

INTERNAL AND EXTERNAL QUALITY ASSESSMENT

At the individual level, a physician should continuously update their knowledge and skills and subject their level of ability to critical self-appraisal.

In organizations, the quality of health care can be assessed by both internal and external methods.

Health care institutions should create internal quality improvement systems for their own use and ensure that instructions concerning such systems are followed. These systems should include continuous conducting of internal clinical peer review and learning from adverse incidents, review examination and treatment methods and their attendant results, tracking of the organization's ability to react to quality data, and monitoring of patient feedback.

External quality review initiatives, such as external peer review and audit, should be carried out regularly and with a frequency corresponding to the evolution of the field or when there is special reason for external assessment. Any review should take into account risk adjustment of the patient population under consideration.

Whether internal or external, if the results of any quality assessment carry significant opportunities for benefit or threats of harms for the organization or individual being assessed, special attention must be paid to potential unintended and dangerous consequences of such quality assessments. It is especially important to monitor the results of quality improvement measurement and intervention strategies over time, with attention to their effects on especially vulnerable patient populations.

Protocols to be used for quality review should be replicable and transparent. Appeals mechanisms should be built into the protocols.

CONFIDENTIALITY OF PATIENT RECORDS

Patient records are an invaluable source of data for quality improvement. As with other uses of individually identifiable patient-based information, consent is usually required from the patient prior to use. If consent cannot reasonably be obtained, then all attempts should be made to ensure that medical records are anonymised or pseudonimised for use in quality improvement efforts. In every case, patient records used for quality improvement must only be accessible to those who need to see them for the purposes of quality improvement.

CONFIDENTIALITY OF PEER REVIEW

For peer review to be most effective, all parties involved must participate and recognize its importance. It is recommended that informed voluntary consent be obtained from those to be reviewed. Within a healthcare team, the work of each physician must be able to be evaluated. Information regarding an individual physician's evaluation should not be published without the consent of the physician concerned. It is recommended that consent be obtained prior to publishing information regarding an individual physician's evaluation.

A provider of services may inform his/her patients about the results of quality review.

If reviews are made available to the public, careful monitoring must be undertaken to track the effects, intended and unintended, of such public reporting of performance data.

ETHICAL REVIEW OF QUALITY IMPROVEMENT ACTIVITIES

National codes of medical ethics and ethical principles and guidelines that relate to continuous quality improvement, audit and clinical review must be followed.

Quality improvement should be an ongoing and integral part of the operations of every health care organization. As such, the majority of quality improvement projects will not require specific review by an ethics committee. If there are doubts about specific issues or if a project poses more than minimal risk compared to the existing processes for care, then the project should be referred to an appropriate ethics committee or institutional review board. When such formal ethical review is needed, it should be undertaken by a committee with members who are knowledgeable about quality improvement techniques.

COMPETENCE AND IMPARTIALITY OF THE REVIEWER

Those who conduct performance reviews must be competent in quality improvement techniques and in clinical audit as well as experienced in the clinical field relating to the review. Where medical care is being reviewed, the reviewer should be a physician whose knowledge and experience is accepted by those being reviewed.

The reviewer should be impartial and independent. Whilst he/she must be aware of the activities under review, he/she must be objective in the report and base conclusions on critical evaluation of observation and facts. Commercial or competitive matters should not be allowed to influence the content of the reviewer's report.

SEPARATION OF QUALITY REVIEWS AND SUPERVISION BY AUTHORITIES

Quality improvement of services and of health care systems is a requirement for every physician and health care institution. It is not supervision of professional activities by authorities and it must be kept independent of this. The results of performance reviews or audits of physician activities should be used by supervising authorities only subject to a

separate agreement between them and the physicians concerned unless national legislation mandates an alternative approach. These activities must be fully cognizant of the local legal framework and must not expose participating physicians to litigation.

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

Adopted by the 49th WMA General Assembly, Hamburg, Germany, November 1997
and reaffirmed by the 176th WMA Council Session, Berlin, Germany, May 2007
and reaffirmed with minor revision by the 207th WMA Council session, Chicago, United States, October 2017

PREAMBLE

1. On the basis of a number of international ethical declarations and guidelines subscribed to by the medical profession, medical doctors throughout the world are pro-hibited from countenancing, condoning or participating in the practice of torture or other forms of cruel, inhuman or degrading procedures for any reason.

2. Primary among these declarations are the World Medical Association's International Code of Medical Ethics, Declaration of Geneva, Declaration of Tokyo, and Resolu-tion on Physician Participation in Capital Punishment; the Standing Committee of European Doctors' Statement of Madrid; the Nordic Resolution Concerning Physician Involvement in Capital Punishment; and, the World Psychiatric Association's Decla-ration of Hawaii.

3. However, none of these declarations or statements addresses explicitly the issue of what protection should be extended to medical doctors if they are pressured, called upon, or ordered to take part in torture or other forms of cruel, inhuman or degrading treatment or punishment. Nor do these declarations or statements express explicit sup-port for, or the obligation to protect, doctors who encounter or become aware of such procedures.

RESOLUTION

4. The World Medical Association (WMA) hereby reiterates and reaffirms the responsibility of the organised medical profession:

   4.1 To encourage physicians to honour their commitment as physicians to serve humanity and to resist any pressure to act contrary to the ethical principles governing their dedication to this task;

   4.2 To support physicians experiencing difficulties as a result of their resistance to any such pressure or as a result of their attempts to speak out or to act against such inhuman procedures;

4.3 To extend its support and to encourage other international organisations, as well as the constituent members of the World Medical Association (WMA), to support physicians encountering difficulties as a result of their attempts to act in accordance with the highest ethical principles of the profession; and

4.4 To encourage physicians to report and document any acts of torture and other cruel, inhuman or degrading treatment or punishment they are aware of.

5. Furthermore, in view of the continued employment of such inhumane procedures in many countries throughout the world, and the documented incidents of pressure upon physicians to act in contravention to the ethical principles subscribed to by the profession, the WMA finds it necessary:

5.1 To protest internationally against any involvement of, or any pressure to involve, physicians in acts of torture and or other forms of cruel, inhuman or degrading treatment or punishment;

5.2 To support and protect, and to call upon its constituent members NMAs to support and protect, physicians who are resisting involvement in such inhuman procedures or who are documenting and reporting these procedures, or who are working to treat and rehabilitate victims thereof, as well as to secure the right to uphold the highest ethical principles including medical confidentiality;

5.3 To publicize information about and to support physicians reporting evidence of torture and to make known proven cases of attempts to involve physicians in such procedures;

5.4 To encourage its constituent members to take action so that physicians are held accountable before the law in case of complicity in acts of torture and other cruel, inhuman or degrading treatment or punishment; and

5.5 To encourage its constituent members to ask corresponding academic authorities to teach and investigate in all schools of medicine and hospitals the consequences of torture and its treatment, the rehabilitation of the survivors, the documentation of torture, and the professional protection described in this Declaration.

WMA DECLARATION OF OTTAWA ON CHILD HEALTH

Adopted by the 50th World Medical Assembly, Ottawa, Canada, October 1998
and amended by the 60th WMA General Assembly, New Delhi, India, October 2009
and by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Appropriate preventive, curative, rehabilitative and emergency care for mother and child;
- Prenatal and maternal care for the best possible health at birth and good postnatal care to ensure the best possible outcomes for mother and child;
- Respect for the privacy of children;
- Medical care for all children of asylum seekers and refugees;
- Specialized training necessary to enable caregivers to respond appropriately to the specific medical, physical, emotional and developmental needs of children & their families;
- Basic health care including developmental assessment, health promotion, recommended immunization, early detection of disease, access to medicines, oral and eye-health;
- Multidisciplinary (i.e. consisting of physicians, social workers, psychologists, therapists, occupational therapists, education specialists and others) and community-based mental health prevention, care and prompt referral for intervention when problems are identified;
- Priority access to emergency medical care for life-threatening conditions;
- Hospitalization when appropriate. Hospitals should provide access to parental facilities and policies for continuous parental care;
- Specialist diagnosis, care and treatment when needed;

- Rehabilitation services and supports within the community;
- Pain management and care and prevention (or minimization) of suffering;
- End of life care / Palliative care;
- Informed consent is necessary before initiating any diagnostic, therapeutic, rehabilitative, or research procedure on a child. In the majority of cases, the consent shall be obtained from the parent(s) or legal guardian, or, in some cases, by extended family, although the wishes of a competent child should be taken into account before consent is given. Where a child lacks competence and is able to express a view, his/her wishes should still be taken into account before consent is given. Where appropriate (e.g. reproductive health services), competent children should be allowed to consent to treatment without parental consent. In case of a life-threatening, and when competent children cannot give consent and parents/caregivers are not accessible, for treatment, consent should be presumed for life-saving treatment;
- The full range of sexual and reproductive health services for adolescents including access to abortion according to national legislation;
- Respect for the sexual and gender identity of the child. Harmful practices like genital mutilation or so-called conversion therapies must be forbidden;
- Social assistance and mechanisms to provide for universal access to health care are ensured for all particularly vulnerable children;
- The homeless, orphaned, asylum seeker, refugees and children from conflict zones should be provided with essential and emergency medical care without discrimination.

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

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

WMA DECLARATION OF EDINBURGH ON PRISON CONDITIONS AND THE SPREAD OF COMMUNICABLE DISEASES

Adopted by the 52nd WMA General Assembly, Edinburgh, Scotland, October 2000
and revised by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011
and by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

The WMA Declaration of Lisbon on the Rights of the Patient states 'Every person is entitled without discrimination to appropriate medical care'.

The Constitution of the World Health Organization states that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

Persons deprived of liberty ("prisoners") should receive the same standard of health care as people outside prisons. They have the same rights as all other people. This includes the right to humane treatment and appropriate medical care. The standards for the treatment of prisoners have been set down in a number of United Nations Declarations and Guidelines, in particular the Standard Minimum Rules for the Treatment of Prisoners – known as the Nelson Mandela Rules in its 2015 revised version, they are supplemented by the UN Bangkok Rules on women.

The term "persons deprived of liberty" refers to all regardless of the reason for their detention as well as of their legal status, from pre-trial detainees to sentenced persons.

It is the responsibility of the states to guarantee the right to life and health of persons deprived of liberty. This implies caring for them with the aim that prison does not become a determining factor of communicable disease.

The relationship between physician and persons deprived of liberty is governed by the same ethical principles as that between the physician and any other patient. However, the particular prison setting can lead to tensions within the patient/physician relationship as a result of the physician potentially being subject to pressure from authorities and seeming to be hierarchically subordinate to his/her employer, the prison service, and of the general attitude of society towards persons deprived of liberty.

Beyond the States responsibilities to treat all persons deprived of liberty with respect for their inherent dignity and value as human beings, there are strong public health reasons for ensuring the adequate implementation of the Nelson Mandela Rules. The high incidence of tuberculosis and other communicable diseases amongst prisoners in a number of countries reinforces the urgent need to consider public health as a critical element when designing new prison regimens, and for reforming existing penal and prison systems.

Individuals facing imprisonment are often from the most vulnerable sections of society. They may have had limited access to health care before imprisonment, may suffer worse health conditions that many other citizens and as a result may have a high risk of entering prison with undiagnosed, undetected and untreated health problems.

Overcrowding, lengthy confinement within tightly enclosed, poorly lit, badly heated and consequently poorly ventilated and often humid spaces are all conditions frequently associated with imprisonment and all of which contribute to the spread of communicable disease and ill-health. Where these factors are combined with poor hygiene, inadequate nutrition and limited access to adequate health care, prisons can represent a major public health challenge.

Keeping persons deprived of liberty in conditions that expose them to substantial medical risk, poses a serious humanitarian challenge. The most effective and efficient way to reduce disease transmission is to improve the prison environment.

It is the responsibility of states to dedicate sufficient resources to ensure adequate prison conditions, that prison health care is appropriate in relation to the size and needs of the prison population, and to define and implement sustainable health strategies to prevent communicable diseases transmission. The organization of health care in prison requires a suitable team of health personnel capable of detecting and treating communicable diseases as part of its essential mission to provide care and treatment to their patients in detention.

The increase in active tuberculosis in prison populations and the development of resistant, especially “multi-drug” and “extensively-drug” resistant forms of TB, as recognised by the World Medical Association in its Resolution on Tuberculosis, is reaching very high prevalence and incidence rates in prisons in some parts of the world. Likewise, the Covid-19 pandemic has severely impacted prisons with outbreaks reported around the world. Other conditions, such as hepatitis C and HIV disease, pose transmission risks from blood-borne spread, exchange of body fluids. Overcrowded prison conditions also promote the spread of sexually transmitted diseases, while intravenous drug use contributes to the spread of HIV as well as hepatitis B and C.

RECOMMENDATIONS

Recalling its Declaration of Lisbon on the Rights of the Patient, the World Medical Association calls on all relevant actors to take the necessary measures to guarantee the highest attainable standard of health for persons deprived of liberty, in particular:

Governments, prison and health authorities

1. To protect the rights of persons deprived of liberty according to the various United Nations instruments relating to conditions of imprisonment, in particular the Nelson Mandela Rules for the Treatment of Prisoners.

2. To allocate the necessary resources to health care in prisons, proportionate to the number and needs of the persons deprived of liberty and including adequate funding for health personnel and appropriate level of staffing of such personnel.

3. To define and implement robust health strategies that ensure a safe and healthy prison environment, through vaccination, hygiene, surveillance and other measures to prevent transmission of communicable diseases.

4. To guarantee that persons deprived of liberty with an infectious illness are treated with dignity and that their rights to health care are respected, in particular that they are not isolated, or placed in solitary confinement, as a response to their infected status, without adequate access to health care and the appropriate medical treatment.

5. To ensure that the conditions of detention, at any stage from arrest to sentencing or once sentenced, do not contribute to the development, worsening or transmission of diseases.

6. To ensure that diagnosis and treatment of non-communicable chronic disease and acute non-communicable illness and/or injury is reasonably and adequately treated so as to not cause undue burden on health personnel or increase risk of communicable disease spread due to prisoners with decompensated illness or injury.

7. To ensure the appropriate planning for and provision of continuing care as essential elements of prison health care, coordination of health services within and outside prisons facilitates, including continuity of care and epidemiological monitoring of prisoner patients when they are released.

8. To ensure that, upon admission to or transfer to a different prison, individuals' health status is reviewed within 24 hours of arrival to ensure continuity of care.

9. To avoid disruption of care within the institution, particularly when the prisoner is receiving opiate substitution treatment by continuing the prescribed treatment.

10. Imprisonment is unacceptable in cases where infection or the risk of transmission is the cause of deprivation of liberty. Imprisonment is not an effective way to prevent the transmission of infectious diseases, and further, it is a cause of concealment of the diagnosis due to fear, leading to greater aggregate dissemination.

11. To respect autonomy and responsibilities of physicians working in prisons who must observe principles of medical ethics to protect health of persons deprived of liberty.

12. To conduct independent and transparent investigations to prevent denial of health care to inmates in prison.

WMA constituent members and the medical profession

13. To work with national and local governments, and health and prison authorities to prioritize health and health care, including that for mental health issues, in prisons and to adopt strategies that ensure a safe and healthy prison environment.

14. In accordance with the ethical principles of the medical profession, to encourage physicians to report and document any deficiency in health care provision, leading to ill-treatments of persons deprived of liberty.

15. To support and protect physicians encountering difficulties as a result of their attempts to denounce deficiencies in prison health care provision.

16. To support improving prison conditions and prison systems from a viewpoint of health of persons deprived of liberty.

Physicians working in prisons

17. To report duly to the health authorities and professional organisations of their country any deficiency in health care, including that for mental health issues, provided to the persons deprived of liberty and any situation involving high epidemiological risk.

18. To follow national public health guidelines, where these are ethically appropriate, particularly concerning the mandatory reporting of infectious and communicable diseases.

WMA DECLARATION OF WASHINGTON ON BIOLOGICAL WEAPONS

Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002
and editorialiy revised by the 164th WMA Council Session, Divonne-les-Bains, France, May 2003
and reaffirmed by the 191st WMA Council Session, Prague, Czech Republic, April 2012

A. INTRODUCTION

1. The World Medical Association recognizes the growing threat that biological weapons might be used to cause devastating epidemics that could spread internationally. All countries are potentially at risk. The release of organisms causing smallpox, plague, anthrax or other diseases could prove catastrophic in terms of the resulting illnesses and deaths compounded by the panic such outbreaks would generate. At the same time, there is a growing potential for production of new microbial agents, as expertise in biotechnology grows and methods for genetic manipulation of organisms become simpler. These developments are of special concern to medical and public health professionals because it is they who best know the potential human suffering caused by epidemic disease and it is they who will bear primary responsibility for dealing with the victims of biological weapons. Thus, the World Medical Association believes that medical associations and all who are concerned with health care bear a special responsibility to lead in educating the public and policy makers about the implications of biological weapons and to mobilize universal support for condemning research, development, or use of such weapons as morally and ethically unacceptable.

2. Unlike the use of nuclear, chemical, and conventional weapons, the consequences of a biological attack are likely to be insidious. Their impact might continue with secondary and tertiary transmission of the agent, weeks or months after the initial epidemic. The consequences of a successful biological attack, especially if the infection were readily communicable, could far exceed those of a chemical or even a nuclear event. Given the ease of travel and increasing globalization, an outbreak anywhere in the world could be a threat to all nations.

3. A great many severe, acute illnesses occurring over a short span of time would almost certainly overwhelm the capacities of most health systems in both the developing and industrialized world. Health services throughout the world are struggling to meet the demands created by HIV/AIDS and antimicrobial-resistant organisms, the problems created by civil strife, refugees and crowded, unsanitary urban environments as well as the increased health needs of aging populations. Coping over a short period of time with large numbers of desperately ill persons could overwhelm entire health systems.

4. Actions can be taken to diminish the risk of biological weapons as well as the potentially harmful consequences of serious epidemics whatever their origin. International collaboration is needed to build a universal consensus that condemns the development, production, or use of biological weapons. Programs of surveillance are needed in all countries for the early detection, identification, and response to serious epidemic disease; health education and training is needed for professionals, civic leaders, and the public alike; and collaborative programs of research are needed to improve disease diagnosis, prevention, and treatment.

5. The proliferation of technology and scientific progress in biochemistry, biotechnology, and the life sciences provides the opportunity to create novel pathogens and diseases and simplified production methods for bioweapons. The technology is relatively inexpensive and, because production is similar to that used in biological facilities such as vaccine manufacturing, it is easy to obtain. Capacity to produce and effectively disperse biological weapons exists globally, allowing extremists (acting collectively or individually) to threaten governments and endanger peoples around the world. Nonproliferation and arms control measures can diminish but cannot completely eliminate the threat of biological weapons. Thus, there is a need for the creation of and adherence to a globally accepted ethos that rejects the development and use of biological weapons.

B. STRENGTHENING PUBLIC HEALTH AND DISEASE SURVEILLANCE SYSTEMS

1. A critical component in dealing with epidemic disease is a strong public health infrastructure. Investment in public health systems will enhance capacity to detect and to contain expeditiously, rare or unusual disease outbreaks, whether deliberately induced or naturally occurring. Core public health functions (disease surveillance and supporting laboratory services) are needed as a foundation for detection, investigation, and response to all epidemic threats. A more effective global surveillance program will improve response to naturally occurring infectious diseases and will permit earlier detection and characterization of new or emerging diseases.

2. It is especially important that physicians be alert to the occurrence of cases or clusters of unusual infectious diseases, to seek help from infectious disease specialists in diagnosis, and to report cases promptly to public health authorities. Because any physician may see only one or a few cases and may not recognize that an outbreak is occurring, cooperation between primary care physicians and public health authorities is especially important.

3. Public health officials, dealing with an epidemic, will require the cooperation of emergency management agencies, law enforcement officials, healthcare facilities, and a variety of community service organizations. For these different groups to work together effectively, advance planning will be important. In addition to developing surveillance activities for early detection and reporting, public health efforts should be directed toward educating primary caregivers and public health staff about potential agents that might be used, building laboratory capacity for rapid identification of biological agents, providing medical and hospital services as well as vaccines and drugs to control the epidemic.

C. ENHANCEMENT OF MEDICAL PREPAREDNESS AND RESPONSE CAPACITY

1. The first indication that a biological weapon may have been disseminated is likely to be the appearance of patients in the offices of practicing physicians, especially those in acute care settings. Physicians thus play a critical role in early detection of an outbreak and must be prepared to recognize and deal with diseases resulting from the use of biological weapons as well as other infectious disease agents and to promptly report suspicious illnesses and diseases to public health officials.

2. In the course of an epidemic, physicians will be directly involved with mass patient care, with mass immunization and antibiotic prophylaxis, with providing information to the public, and in a variety of hospital and community efforts to control the epidemic. Thus, physicians should participate with local and national health authorities to develop and implement disaster preparedness and response plans for intentional and natural infectious disease outbreaks.

D. BIOWEAPONS RESEARCH AND MEDICAL ETHICS

1. Rapid advances in microbiology, molecular biology, and genetic engineering have created extraordinary opportunities for biomedical research and hold great promise for improving human health and the quality of life. Better and more rapid diagnostic tools, novel vaccines, and therapeutic drugs can be foreseen. At the same time, there is concern about the possible misuse of research for the development of more potent biological weapons and the spread of new infectious diseases. It may be difficult to distinguish legitimate biomedical research from research by unscrupulous scientists with the malign purpose of producing more effective biological weapons.

2. All who participate in biomedical research have a moral and ethical obligation to consider the implications of possible malicious use of their findings. Through deliberate or inadvertent means, genetic modification of microorganisms could create organisms that are more virulent, are antibiotic-resistant, or have greater stability in the environment. Genetic modification of microorganisms could alter their immunogenicity, allowing them to evade natural- and vaccine-induced immunity. Advances in genetic engineering and gene therapy may allow modification of the immune response system of the target population to increase or decrease susceptibility to a pathogen or disrupt the functioning of normal host genes.

3. Research specifically for the purposes of creating biological weapons is to be condemned. As scientists and humanitarians, physicians have a societal responsibility to decry scientific research for the development and use of biological weapons and to express abhorrence for the use of biotechnology and information technologies for potentially harmful purposes.

4. Physicians and medical organizations have important societal roles in demanding a global prohibition on biological weapons and stigmatizing their use, guarding against unethical and illicit research, and mitigating civilian harm from use of biological weapons.

E. RECOMMENDATIONS

1. That the World Medical Association and National Medical Associations worldwide take an active role in promoting an international ethos condemning the development, production, or use of toxins and biological agents that have no justification for prophylactic, protective, or other peaceful purposes.

2. That the World Medical Association, National Medical Associations and healthcare workers worldwide promote, with the World Health Organization, the United Nations, and other appropriate entities, the establishment of an international consortium of medical and public health leaders to monitor the threat of biological weapons, to identify actions likely to prevent bioweapons proliferation, and to develop a coordinated plan for monitoring the worldwide emergence of infectious diseases. This plan should address: (a) international monitoring and reporting systems so as to enhance the surveillance and control of infectious disease outbreaks throughout the world; (b) the development of an effective verification protocol under the UN Biological and Toxin Weapons Convention; (c) education of physicians and public health workers about emerging infectious diseases and potential biological weapons; (d) laboratory capacity to identify biological pathogens; (e) availability of appropriate vaccines and pharmaceuticals; and (f) financial, technical, and research needs to reduce the risk of use of biological weapons and other major infectious disease threats.

3. That the World Medical Association urge physicians to be alert to the occurrence of unexplained illnesses and deaths in the community and knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations.

4. That the World Medical Association encourage physicians, National Medical Associations and other medical societies to participate with local, national, and international health authorities in developing and implementing disaster preparedness and response protocols for acts of bioterrorism and natural infectious disease outbreaks. These protocols should be used as the basis for physician and public education.

5. That the World Medical Association urge all who participate in biomedical research to consider the implications and possible applications of their work and to weigh carefully in the balance the pursuit of scientific knowledge with their ethical responsibilities to society.

WMA DECLARATION ON ETHICAL CONSIDERATIONS REGARDING HEALTH DATABASES AND BIOBANKS

Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002
and revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

1. The Declaration of Helsinki lays down ethical principles for medical research involving human subjects, including the importance of protecting the dignity, autonomy, privacy and confidentiality of research subjects, and obtaining informed consent for using identifiable human biological material and data.

2. In health care provision, health information is gathered by physicians or other members of the medical team to record health care events and to aid physicians in the on-going care of their patient.

3. This Declaration is intended to cover the collection, storage and use of identifiable data and biological material beyond the individual care of patients. In concordance with the Declaration of Helsinki, it provides additional ethical principles for their use in Health Databases and Biobanks.

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

4. A Health Database is a system for collecting, organising and storing health information. A Biobank is a collection of biological material and associated data. Biological material refers to a sample obtained from an individual human being, living or deceased, which can provide biological information, including genetic information, about that individual. Health Databases and Biobanks are both collections on individuals and population, and both give rise to the similar concerns about dignity, autonomy, privacy, confidentiality and discrimination.

5. Research using Health Databases and Biobanks can often significantly accelerate the improvement in the understanding of health, diseases, and the effectiveness, efficiency, safety and quality of preventive, diagnostic and therapeutic interventions. Health research represents a common good that is in the interest of individual patients, as well

as the population and the society.

6. Physicians must consider the ethical, legal and regulatory norms and standards for Health Database and Biobanks in their own countries as well as applicable international norms and standards. No national or international ethical, legal or regulatory requirement should reduce or eliminate any of the protections for individuals and population set forth in this Declaration.

   When authorized by a national law adopted through a democratic process in respect of human rights, other procedures could be adopted to protect the dignity, autonomy and privacy of the individuals. Such procedures are only acceptable when strict rules on data protection are implemented.

7. Consistent with the mandate of WMA, the Declaration is addressed primarily to physicians. The WMA encourages others who are involved in using data or biological material in Health Databases and Biobanks to adopt these principles.

ETHICAL PRINCIPLES

8. Research and other Health Databases and Biobanks related activities should contribute to the benefit of society, in particular public health objectives.

9. Respecting the dignity, autonomy, privacy and confidentiality of individuals, physicians have specific obligations, both ethical and legal, as stewards protecting information provided by their patients. The rights to autonomy, privacy and confidentiality also entitle individuals to exercise control over the use of their personal data and biological material.

10. Confidentiality is essential for maintaining trust and integrity in Health Databases and Biobanks. Knowing that their privacy will be respected gives patients and donors the confidence to share sensitive personal data. Their privacy is protected by the duty of confidentiality of all who are involved in handling data and biological material.

11. The collection, storage and use of data and biological material from individuals capable of giving consent must be voluntary. If the data and biological material are collected for a given research project, the specific, free and informed consent of the participants must be obtained in accordance with the Declaration of Helsinki.

12. If the data or biological material are collected and stored in a Health Database or a Biobank for multiple and indefinite uses, consent is only valid if the concerned individuals have been adequately informed about:

    - The purpose of the Health Database or Biobank;
    - The risks and burdens associated with collection, storage and use of data and

material;

- The nature of the data or material to be collected;
- The procedures for return of results including incidental findings;
- The rules of access to the Health Database or Biobank;
- How privacy is protected;
- The governance arrangements as stipulated in paragraph 21;
- That in case the data and material are made non-identifiable the individual may not be able to know what is done with their data/material and that they will not have the option of withdrawing their consent;
- Their fundamental rights and safeguards established in this Declaration; and
- When applicable, commercial use and benefit sharing, intellectual property issues and the transfer of data or material to other institutions or third countries.

13. In addition to the requirements set forth in the Declaration of Helsinki, when persons who were not able to consent, whose data and biological materials have been stored for future research, attain or regain the capacity to consent, reasonable efforts should be made to seek the consent of those persons for continued storage and research use of their data and biological materials.

14. Individuals have the right to request for and be provided with information about their data and its use as well as to request corrections of mistakes or omissions. Health Databases and Biobanks should adopt adequate measures to inform the concerned individuals about their activities.

15. Individuals have the right, at any time and without reprisal, to alter their consent or to ask for their identifiable data to be withdrawn from the Health Database and their biological material to be withdrawn from a Biobank. This applies to future use of the data and biological materials.

16. In the event of a clearly identified, serious and immediate threat where anonymous data will not suffice, the requirements for consent may be waived to protect the health of the population. An independent ethics committee should confirm that each exceptional case is justifiable.

17. The interests and rights of the communities concerned, in particular when vulnerable, must be protected, especially in terms of benefit sharing.

18. Special considerations should be given to the possible exploitation of intellectual property. Protections for ownership of materials, rights and privileges must be considered and contractually defined before collecting and sharing the material.

Intellectual property issues should be addressed in a policy, which covers the rights of all stakeholders and communicated in a transparent manner.

19. An independent ethics committee must approve the establishment of Health Databases and Biobanks used for research and other purposes. In addition the ethics committee must approve use of data and biological material and check whether the consent given at the time of collection is sufficient for the planned use or if other measures have to be taken to protect the donor. The committee must have the right to monitor on-going activities. Other ethical review mechanisms that are in accordance to par 6 can be established.

GOVERNANCE

20. In order to foster trustworthiness, Health Databases and Biobanks must be governed by internal and external mechanisms based on the following principles:
    - Protection of individuals: Governance should be designed so the rights of individuals prevail over the interests of other stakeholders and science;
    - Transparency: any relevant information on Health Databases and Biobanks must be made available to the public;
    - Participation and inclusion: Custodians of Health Databases and Biobanks must consult and engage with individuals and their communities.
    - Accountability: Custodians of Health Databases and Biobanks must be accessible and responsive to all stakeholders.

21. Governance arrangements must include the following elements:
    - The purpose of the Health Database or Biobank;
    - The nature of health data and biological material that will be contained in the Health Database or Biobank;
    - Arrangements for the length of time for which the data or material will be stored;
    - Arrangements for regulations of the disposal and destruction of data or material;
    - Arrangement for how the data and material will be documented and traceable in accordance with the consent of the concerned persons;
    - Arrangement for how the data and material will be dealt with in the event of change of ownership or closure;
    - Arrangement for obtaining appropriate consent or other legal basis for data or material collection;
    - Arrangements for protecting dignity, autonomy, privacy and preventing discrimination;

- Criteria and procedures concerning the access to and the sharing of the health data or biological material including the systematic use of Material Transfer Agreement (MTA) when necessary;
- The person or persons who are responsible for the governance;
- The security measures to prevent unauthorized access or inappropriate sharing;
- The procedures for re-contacting participants where relevant;
- The procedures for receiving and addressing enquiries and complaints.

22. Those professionals contributing to or working with Health Databases and Biobanks must comply with the appropriate governance arrangements.

23. Health Databases and Biobanks must be operated under the responsibility of an appropriately qualified professional assuring compliance with this Declaration.

24. The WMA urges relevant authorities to formulate policies and law that protect health data and biological material on the basis of the principles set forth in this document.

WMA DECLARATION ON PATIENT SAFETY

Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002,
reaffirmed by the 191st WMA Council Session, Prague, Czech Republic, April 2012,
and revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

Physicians strive to provide safe, high-quality health and medical care to patients.

Progress in medical and allied science and technology has transformed how modern medicine is delivered in advanced and complex health systems.

Inherent risks always exist in clinical medicine. Developments in modern medicine often reduce risk but may also introduce new or increased risks – some avoidable, others inherent.

Physicians and healthcare organisations should attempt to foresee these risks and manage them to the best of their ability.

Many health services continue to struggle with demand exceeding capacity, often with an inadequate infrastructure due to underinvestment by governments or other providers of healthcare. Patient safety is at risk where physicians work in systems under pressure.

Patient safety is affected by the working culture that physicians operate within. In many healthcare systems there is often a culture of blame, where individuals are targeted rather than examining wider organisational causes of error (such as resource constraints, workforce shortages, or systemic failures).

Many physicians fear being unfairly blamed for medical errors which may have been caused or exacerbated by systemic factors, and often feel unable to be open or raise concerns.

A workplace culture of learning assures and improves patient safety. Embedding a just and learning culture approach can be an antidote to cultures of blame and fear.

In a just and learning culture, the initial focus is on what went wrong when patient safety incidents took place, rather than seeking to determine who may individually be responsible.

Medical regulation and a fear of litigation can compromise physicians' ability to be open about medical error. A system where physicians feel unable to speak up, due to fear of personal recrimination, will compromise the identification of systemic causes of error or poor care and imped measures to improve patient safety.

Working in a system under pressure that has a culture of fear and blame can erode physician wellbeing. Physicians' performance in stressful working environments may be impaired, potentially leading to error or poor patient outcomes.

Improving physician wellbeing significantly improves productivity, care quality, patient safety and the sustainability of health services.

Positive cultures within workplaces are vital to minimize medical error, improve physician wellbeing and assure patient safety.

Principles

1. Physicians must ensure that patient safety is always considered during their medical decision-making.

2. Individuals and processes are rarely solely responsible for errors. Rather, separate elements combine and together produce a high-risk situation. Therefore, there should be a non-punitive culture for confidential reporting healthcare errors that focuses on preventing and correcting systems failures and not on individual or organization culpability.

3. A realistic understanding of the risks inherent in modern medicine requires physicians to cooperate with all relevant parties, including patients, to adopt a proactive systems approach to patient safety.

4. To create such an approach, physicians must continuously absorb a wide range of advanced scientific knowledge and continuously strive to improve medical practice.

5. All information that concerns a patient's safety must be shared with the patient and all relevant parties. However, patient confidentiality must be strictly protected.

6. When medical error or a patient safety incident occurs, investigations should always begin by fully reviewing the wider environment that the physician operates within to identify systemic factors and pressures that may have contributed to the error.

7. Where medical error is found to have been caused fully or partly by systemic factors, any judgement by the regulator(s) should also hold the healthcare providing organisation to account.

8. Regulators of healthcare providing organisations must promote and ensure positive, just, and learning workplace cultures, where physicians and patients feel supported and empowered to learn when adverse events occur.

9. Regulators have a responsibility to identify systemic and contextual constraints that impact on patient safety, including a lack of resources and infrastructure.

RECOMMENDATIONS

Recognizing the importance of system pressures, workplace culture, physician wellbeing, and healthcare regulation on patient safety, the WMA recommends that its Constituent members:

1. promote policies on patient safety to all physicians in their countries;
2. encourage individual physicians, other health care professionals, patients and other relevant individuals and organizations to work together to establish systems that secure patient safety;
3. encourage the development of effective models to promote patient safety through continuing medical education/continuing professional development;
4. cooperate with one another and exchange information about adverse events, including errors, their solutions, and "lessons learned" to improve patient safety;
5. demand that the investigation of medical error and patient safety incidents always consider wider contextual and systemic factors or pressures;
6. demand that healthcare providing organisations foster a culture of learning, support and improvement that facilitates patient safety;
7. work to ensure that the regulation of the medical profession encourages and supports patient safety;
8. support regulation that works to prevent medical error, promoting good practice and learning among individuals and organisations providing healthcare;
9. work to ensure healthcare environments have the necessary resources, infrastructure, and workforce to support patient safety.

WMA DECLARATION
ON
MEDICAL ETHICS AND ADVANCED MEDICAL TECHNOLOGY

Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002
and revised by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012

It is essential to balance the benefits and risks for persons inherent in the development and application of advanced medical technology. Maintaining this balance is entrusted to the judgment of the physician.

Therefore:

Medical technology should be used to promote health. Patient safety should be fully considered by the physician in the development and application of medical technology.

In order to foster physicians' ability to provide appropriate medical care and having sufficient knowledge of medical technology efforts must be made to ensure the provision of comprehensive medical education focusing on the safe and effective use and development of medical technology.

WMA DECLARATION
ON
THE RELATION OF LAW AND ETHICS

Adopted by the 164th WMA Council Session, Divonne-les-Bains, France, May 2003
and adopted as a Declaration by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

Ethical Values and legal principles are usually closely related, but ethical obligations typically exceed legal duties. In some cases, the law mandates unethical conduct. The fact that a physician has complied with the law does not necessarily mean that the physician acted ethically.

When law is in conflict with medical ethics, physicians should work to change the law. In circumstances of such conflict, ethical responsibilities supersede legal obligations.

WMA DECLARATION OF REYKJAVIK - ETHICAL CONSIDERATIONS REGARDING THE USE OF GENETICS IN HEALTH CARE

Adopted by the 56th WMA General Assembly, Santiago, Chile, October 2005
and amended by the 60th WMA General Assembly, New Delhi, India, October 2009
and by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

PREAMBLE

Genetics contributes to the growing understanding of the causes, developments, classifications and treatments of diseases. The use of genetics is increasing, moving from the identification of monogenic diseases and use in cancer treatment towards predicting risks of multifactorial diseases and manipulation of individual genes. In these ways, the use of genetics does and increasingly will create great value at an individual as well as at a societal level. However, the use of genetic information about individuals also raises issues concerning confidentiality, privacy and the risk of psychological distress, stigmatization, and discrimination.

This declaration provides recommendations for the use of medical genetics that respects the ethical challenges that such use entails. It is primarily aimed at the use of genetics in the provision of health care. The collection, storage and use of genetic data beyond the individual care of patients should adhere to the principles put forward in the WMA Declaration of Taipei on Ethical Considerations regarding Health Databases and Biobanks. The use of genetics in medical research involving human subjects, including research on identifiable human material and data, should adhere to the principles put forward in the WMA Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects.

This Declaration should be read as a whole and each of its constituent paragraphs should be applied with consideration of all other relevant paragraphs. The declaration should be updated in accordance with developments in the field of genetics.

Genetic information has characteristics that are ethically significant. Individually, these characteristics can also be found in other types of health care information. However, the combination of these characteristics makes genetic information particularly sensitive. This sensitivity – combined with the intense interest in genetic information from many different stakeholders – underscores the importance of respecting the fundamental principles of medical ethics, particularly the patient's right to autonomy, confidentiality, privacy and benefit in relation to generating, storing, using or sharing genetic information.

Central among the ethically significant characteristics are:

- Genetic information is identifying for an individual.

- Genetic analysis can generate extensive and detailed information about an individual.
- Genetic analysis may generate additional findings.
- The full significance of the information generated by genetic analysis is not yet known.
- Genetic information about an individual cannot be fully anonymized, and de-identified genetic information may be re-identified.
- Genetic data contains information not only about the individual who has undergone testing, but also about individuals who are genetically related to the tested individual.
- Genetic testing of one individual may entail that the physician asks for access to health care information about – or genetic testing of – genetically related persons (family members).

ETHICAL PRINCIPLES

1. Benefit

Genetic testing in the context of healthcare provision should primarily be done for the benefit of the patient being tested.

2. Relevance

Genetics test should not be wider in scope than what is relevant for the purpose of the test.

3. Informed consent

a. Genetic testing should only be done with the informed consent of the individual or his/her legal guardian. Genetic testing for predisposition to disease should be performed on children only if there are clear clinical indications and being aware of the test results would be in the best interests of the child.

b. The consent process must include providing the patient with understandable, accurate and adequate information about the following:

- The purpose, nature and benefits of the test.
- The risks, burdens and limitations of the test.
- The nature and significance of the information to be generated by the test.
- The procedures for return of results including additional findings and future discoveries.
- The options for responding to the results, including possible treatments.
- How, where, and for how long the test results, data and biological samples will be stored, and who can gain access to current and future results.
- The possible secondary uses of the information generated by the test
- The measures protecting confidentiality, privacy and autonomy, including data security measures
- The procedures for managing results that have implications for genetically related persons
- When applicable, commercial use and benefit sharing, intellectual property issues and the transfer of data or material to third parties.

4. Additional findings (secondary and incidental findings)

a. A genetic test may generate additional findings that are not related to the primary purpose of the test, also referred to as secondary or incidental findings. Procedures for handling such findings should be determined before the test, and information about these procedures should be communicated to the patient as part of the consent process.

b. The principles for managing additional findings must include consideration for:

- The patient's preferences regarding the management of additional findings.
- The significance of the additional findings for the patient's health and other interests.
- The significance of the findings for the health and other interests of persons who are genetically related to the patient.
- The scientific validity of the additional findings.
- The strengths of the evidence for the correlation between the additional findings and health related risks for the patient.
- The degree to which the additional findings are actionable, medically or otherwise.

5. Genetic counselling

a. Appropriate genetic counselling should always be offered when genetic tests or genetics-based treatments are offered or performed and for the interpretation of results. Counselling should enable the patient to make informed decisions according to their own values and interests. Counselling must not be biased by the personal values of the counsellor. The individual's right not to be tested should be protected, and if the individual has been tested, there should be no obligation for the individual to act on the results of the test.

b. Medical students and physicians should receive education and training in genetic counselling, particularly counselling related to pre-symptomatic diagnosis of disease.

6. Confidentiality

Like all medical records, information from genetic testing or genetic therapy must be kept strictly confidential and must not be revealed to third parties in identifiable form without the consent of the individual tested. Third parties, to whom results may in certain circumstances be released, are identified in paragraph 15.

7. Informing third parties

In the case of a test result that may have implications for third parties such as close relatives, the individual tested should be encouraged to discuss the results of the test with such third parties. In cases where not disclosing the results involves an expected harm that is serious and unavoidable except by disclosure, and clearly greater than the harm likely to result from disclosure, the physician may reveal necessary information to such third parties without the consent of the patient but should usually discuss this with the patient first. If the physician has access to an ethics committee, it is preferable to consult such a committee prior to revealing information to third parties.

8. Data protection

The collection, storage and use of genetic data requires the highest level of data protection.

9. Discrimination

No individual or group must be discriminated against in any way based on genetic makeup, including the fields of human rights, employment and insurance. This protection should apply to those individuals who have undergone genetic testing or genetic therapy as well as those individuals about whom genetic information can be inferred. Particular care should be taken to protect vulnerable individuals and groups.

10. Cost of testing

The decision to include genetic analysis as part of medical care can introduce significant cost for the patient and the health care system. Therefore, such a decision should always be based on the expectation that the costs of the analysis are justified by the benefits for the patient.

11. Reliability and limitations

a. The identification of disease-related genes has led to an increase in the number of available genetic tests, analyses and treatments. As the number, types and complexity of these increase, great care must be taken to ensure their reliability, accuracy and quality and to inform patients about their limitations.

b. The benefit of a genetic test for an individual may depend on the availability of information about the relevant background population. Medical professionals should be aware of the scope and the limitations of genetic background data and health information stored in databases used in providing clinical genetic testing services.

12. Direct-to-consumer tests

If genetic tests are offered directly to consumers for medical purposes, they must meet the same technical, professional, legal and ethical standards as tests offered by certified laboratories and must be in accordance with the recommendations put forward in this statement. In particular, providers of direct-to-consumer tests must provide understandable, accurate and adequate information about the reliability and limitations of their services.

13. Clinical use of data from research

For research projects that involve genetic testing, and where the participant can be identified, the research participant must be informed about the possibility of findings that indicate a serious threat to the health of the participant. If there are such findings, the participant should be offered a referral to genetic counseling and appropriate medical intervention.

14. Gene therapy and editing

Gene therapy and editing represents a combination of techniques used to manipulate disease related genes. The use of these techniques should adhere to the following

guidelines:

The use of gene therapy and somatic genome editing should conform to standards of medical ethics and professional responsibility.

Patient autonomy should be respected, and informed consent should always be obtained. This informed consent process should include disclosure of the risks of gene therapy and editing, including the fact that the patient may have to undergo multiple rounds of gene therapy, the risk of an immune response, the potential problems arising from the use of viral vectors and off-target genome effects.

Gene therapy and editing should only be undertaken after a careful analysis of the risks and benefits involved and an evaluation of the perceived effectiveness of the therapy, as compared to the risks, side effects, availability and effectiveness of other treatments.

Gene editing of germline cells has scientifically unresolved risks and should not be clinically applied. This does not preclude testing gene editing or other similar research.

15. Cloning

Cloning includes both therapeutic cloning, namely the cloning of individual stem cells to produce a healthy copy of a diseased tissue or organ for transplant, and reproductive cloning, namely the cloning of an existing human to produce a genetic duplicate of that human. The WMA opposes reproductive cloning of humans.

WMA DECLARATION OF SEOUL ON PROFESSIONAL AUTONOMY AND CLINICAL INDEPENDENCE

Adopted by the 59th WMA General Assembly, Seoul, Korea, October 2008
And amended by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

The WMA reaffirms the Declaration of Madrid on professionally-led regulation.

The World Medical Association recognises the essential nature of professional autonomy and physician clinical independence, and states that:

1. Professional autonomy and clinical independence are essential elements in providing quality health care to all patients and populations. Professional autonomy and independence are essential for the delivery of high-quality health care and therefore benefit patients and society.
2. Professional autonomy and clinical independence describe the processes under which individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue or inappropriate influence by outside parties or individuals.
3. Medicine is highly complex. Through lengthy training and experience, physicians become medical experts weighing evidence to formulate advice to patients. Whereas patients have the right to self-determination, deciding within certain constraints which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations.
4. Physicians recognize that they must take into account the structure of the health system and available resources when making treatment decisions. Unreasonable restraints on clinical independence imposed by governments and administrators are not in the best interests of patients because they may not be evidence based and risk undermining trust which is an essential component of the patient-physician relationship.
5. Professional autonomy is limited by adherence to professional rules, standards and the evidence base.
6. Priority setting and limitations on health care coverage are essential due to limited resources. Governments, health care funders (third party payers), administrators and Managed Care organisations may interfere with clinical autonomy by seeking to impose rules and limitations. These may not reflect evidence-based medicine principles, cost-effectiveness and the best interest of patients. Economic evaluation studies may be undertaken from a funder's not a users' perspective and emphasise cost-savings rather than health outcomes.
7. Priority setting, funding decision making and resource allocation/limitations

processes are frequently not transparent. A lack of transparency further perpetuates health inequities.

8. Some hospital administrators and third-party payers consider physician professional autonomy to be incompatible with prudent management of health care costs. Professional autonomy allows physicians to help patients make informed choices, and supports physicians if they refuse demands by patients and family members for access to inappropriate treatments and services.
9. Care is given by teams of health care professionals, usually led by physicians. No member of the care team should interfere with the professional autonomy and clinical independence of the physician who assumes the ultimate responsibility for the care of the patient. In situations where another team member has clinical concerns about the proposed course of treatment, a mechanism to voice those concerns without fear of reprisal should exist.
10. The delivery of health care by physicians is governed by ethical rules, professional norms and by applicable law. Physicians contribute to the development of normative standards, recognizing that this both regulates their work as professionals and provides assurance to the public.
11. Ethics committees, credentials committees and other forms of peer review have long been established, recognised and accepted by organised medicine as ways of scrutinizing physicians' professional conduct and, where appropriate, may impose reasonable restrictions on the absolute professional freedom of physicians.
12. The World Medical Association reaffirms that professional autonomy and clinical independence are essential components of high-quality medical care and the patient-physician relationship that must be preserved. The WMA also affirms that professional autonomy and clinical independence are core elements of medical professionalism.

WMA DECLARATION OF DELHI
ON
HEALTH AND CLIMATE CHANGE

Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009
and amended by the 68th WMA General Assembly, Chicago, United States, October 2017

PREAMBLE

1. Human influence on the climate system is clear, and recent emissions of green-house gases are the highest in history. Recent climate changes have had widespread impacts on human and natural systems.

2. Compelling evidence substantiates the numerous health risks posed by climate change, which threaten all countries. These include more frequent and potentially more severe heatwaves, droughts, floods and other extreme weather events including storms and bushfires. Climate change, especially warming, is already leading to changes in the environment in which disease vectors flourish. There is reduced availability and quality of potable water, and worsening food insecurity leading to malnutrition and population displacement. Climate Change is universal but its effects are uneven and many of the areas most affected are least able to manage the challenges it poses.

3. Tackling climate change offers opportunities to improve health and wellbeing both because of the health co-benefits of low carbon solutions and because mitigation and adaptation may allow action on all the social determinants of health. Transition to renewable energy, the use of active transport, and dietary change including a reduction in consumption of beef and other animal products, may all contribute to improving health and wellbeing.

4. The social determinants of health are those factors that correlate to health through exposure before and after people are born and as they grow live, and work. They vary between and within countries. Those with generally the poorest health and lowest life and health expectancy will be least able to adapt to the adverse effects of climate change thereby exacerbating adverse social determinants of health.

5. Climate change research and surveillance are important. The WMA supports studies that describe the patterns of disease attributed to climate change, including the impacts of climate change on communities and households; the burden of known and emergent disease caused by climate change, and those diseases

projected to occur with new development activities (Health Impacts Assessment). Such studies should also define the most vulnerable populations.

6. The Paris Agreement highlights a transition to a new model of global collaboration to address climate change and is an opportunity for the health sector to contribute to climate action. It includes a series of actions to be undertaken by each party to achieve a long-term goal of keeping the increase in global average temperature to less than 1.5 C above pre-industrial levels. Whether or not individual states are parties to the Paris agreement, NMAs have an obligation to consider the effects of climate change on the planet and on human, animal, and environmental sustainability and to take action as follows.

RECOMMENDATIONS

7. The World Medical Association and its Constituent Members:

- Urge national governments and non-state actors to recognize the serious health consequences of climate change and to adopt strategies to adapt to and mitigate its effects;

- Urge national governments to ensure the fulfilment of national commitments to international agreements, including both mitigation and adaptation measures as well as action on losses and damage;

- Urge national governments to provide climate financing that includes designated funds to support the strengthening of health systems, and health and climate co-benefit policies and, provide sufficient global, regional and local financing for climate mitigation, adaptation measures, disaster risk reduction, and the attainment of the Sustainable Development Goals (SDGs);

- Urge national governments to facilitate the active participation of health sector representatives in the creation and implementation of climate change preparedness plans and emergency planning and response on local, national and international levels;

- Urge national governments to provide for the health and wellbeing of people displaced by environmental causes including those becoming refugees due to the consequences of climate change;

- Asks national governments to invest in public health and climate change research to ensure of better understanding of adaptation needs and health co-benefits at the national level;

- Urge national governments to facilitate collaboration between the Ministry of Health and other ministries to ensure that health is considered in their national commitments and sustainable strategies.

8. National Medical Associations and their physician members should:

    - Advocate for sustainable, environmentally responsible low-carbon practices across the health sector to reduce the environmental impact of health care facilities and practices;

    - Prepare for the infrastructure disruptions that accompany health emergencies, in particular by planning in advance for the delivery of services and increased patient care demands during these crisis situations;

    - Encourage and support advocacy for environmental protection and greenhouse gas emissions reductions including through emissions trading systems and/or carbon taxes;

    - Become educated as to the health effects of climate change and be prepared to treat and manage them in individual patients;

    - Promote medical research into improved use of antibiotherapy to be able to respond, in the future, to the new infectious diseases linked to climate change.

9. The WMA and its Constituent Members should:

    - Encourage sustainable low-carbon living respectful of planetary limits including active lifestyle and sustainable production and consumption patterns;

    - Seek to build professional and public awareness of the importance of the environment and climate change to personal, community and societal health;

    - Work towards the integration of key climate change concepts and competencies in undergraduate, graduate and continuing medical education curricula;

    - Collaborate with the WHO and other stakeholders as appropriate, to produce educational and advocacy materials on climate change for national medical associations, physicians, other health professionals, as well as the general public;

    - Advocate for their respective governments to finance, promote research into the effects of climate change on health and collaborate with NGOs and other health professionals;

    - Work collaboratively with government, NGOs, businesses, civil societies and others to create alert systems to ensure that health care systems and physicians are aware of climate-related events as they unfold, and receive timely accurate information regarding the management of emerging health events;

    - Have climate change as a priority issue on their agendas and actively participate in the creation of policies and initiatives that mitigate the effects of

climate change on health.

10. The WMA urges National Medical Associations to:

- Work with health-care institutions, and individual physicians to adopt climate policies and act as role models by reducing their carbon emissions;

- Recognize environmental factors as a key social determinants of health (SDH), and encourage governments to foster collaboration between the health and non-health sectors in addressing these determinants.

WMA DECLARATION OF MADRID
ON
PROFESSIONALLY-LED REGULATION

Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009
and revised by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

The WMA reaffirms the Declaration of Seoul on professional autonomy and clinical independence of physicians.

The medical profession must play a central role in regulating the conduct and professional activities of its members, ensuring that their professional practice is in the best interests of citizens.

The regulation of the medical profession plays an essential role in ensuring and maintaining public confidence in the standards of care and of behaviour that they can expect from medical professionals. That regulation requires very strong independent professional involvement.

Physicians aspire to the development or maintenance of systems of regulation that will best protect the highest possible standards of care for all patients. Professionally led models can provide an environment that enhances and assures the individual physician's right to treat patients without interference, based on his or her best clinical judgment. Therefore, the WMA urges its constituent members and all physicians to work with regulatory bodies and take appropriate actions to ensure effective systems are in place. These actions should be informed by the following principles:

1. Physicians are accorded a high degree of professional autonomy and clinical independence, whereby they are able to make recommendations based on their knowledge and experience, clinical evidence and their holistic understanding of the patient including his/her best interests without undue or inappropriate outside influence. This is expounded in more detail in the Declaration of Seoul.

2. The regulation of the profession must be proportionate and facilitative and not be burdensome, and be based on a model that applies to every physician equally and that protects and benefits patients and is based upon an ethical code. The planning and delivery of all types of health care is based upon an ethical model and current evidence-based medical knowledge by which all physicians are governed. This is a core element of professionalism and protects patients. Physicians are best qualified to judge the actions of their peers against such normative standards, bearing in mind relevant local circumstances.

3. The medical profession has a continuing responsibility to be strongly involved in regulation or self-regulating. Ultimate control and decision-making authority must

include physicians, based on their specific medical training, knowledge, experience and expertise. In countries where Professionally led regulation is in place physicians must ensure that this retains the confidence of the public. In countries that have a mixed regulation system physicians must seek to ensure that it maintains professional and public confidence.

4. Physicians in each country are urged to consider establishing, maintaining and actively participating in a proportionate, fair, rigorous and transparent system of professionally-led regulation. Such systems are intended to balance physicians' rights to exercise medical judgment freely with the obligation to do so wisely and temperately.

5. National Medical Associations must do their utmost to promote and support the concept of well-informed and effective regulation amongst their membership and the public. To ensure that any potential conflicts of interest between their representative and regulatory roles are avoided they must ensure separation of the two processes and pay rigorous attention to a transparent and fair system of regulation that will assure the public of its independence and fairness.

6. Any system of professionally-led regulation must enhance and ensure:
   - the delivery of high quality safe and competent healthcare to patients
   - the competence of the physician providing that care the professional, including ethical, conduct of all physicians
   - the protection of society and the rights of patients
   - the promotion of trust and confidence of patients, their families and the public
   - the quality assurance of the regulation system
   - the maintenance of trust by patients and society
   - the development of solutions to potential conflicts of interest
   - a commitment to wide professional responsibilities

7. To ensure that the patient is offered quality continuing care, physicians should participate actively in the process of Continuing Professional Development, including reflective practice, in order to update and maintain their clinical knowledge, skills and competence. Employers and management have a responsibility to enable physicians to meet this requirement.

8. The professional conduct of physicians must always be within the bounds of the Code of Ethics governing physicians in each country. National Medical Associations must promote professional and ethical conduct among physicians for the benefit of patients, and ethical violations must be promptly recognized, reported to the relevant regulatory authority and acted upon. Physicians are obligated to intervene in a timely manner to ensure that impaired colleagues do not put patients or colleagues at risk and receive appropriate assistance from a physician health program or appropriate training enabling a return to active practice.

9. The regulatory body should, when the judicial or quasi-judicial processes are complete, and assuming that a case is found against the physician, publish their findings and include details of the remedial action taken. Lessons learned from every case should, to the extent possible, be extracted and used in professional education processes.The regulation process should ensure that the incorporation of such lessons

is, as far as possible, seamless.

10. National Medical Associations are urged to assist each other in coping with new and developing challenges including potential threats to professionally-led regulation. The ongoing exchange of information and experiences between National Medical Associations is essential for the benefit of patients.

11. Whatever judicial or regulatory process a country has established, any judgment on a physician's professional conduct or performance must incorporate evaluation by the physician's professional peers who, by their training, knowledge and experience, understand the complexity of the medical issues involved.

12. An effective and responsible system of professionally-led regulation must not be self-serving or internally protective of the profession. National Medical Associations should assist their members in understanding that professionally-led regulation, in countries where that system exists, must maintain the safety, support and confidence of the general public, including their health-related rights, as well as the honour of the profession itself.

WMA DECLARATION OF MONTEVIDEO ON DISASTER PREPAREDNESS AND MEDICAL RESPONSE

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011

In the last decade, the attention of the world has been drawn to a number of severe events which seriously tested and overwhelmed the capacity of local healthcare and emergency medical response systems. Armed conflicts, terrorist attacks and natural disasters such as earthquakes, floods and tsunamis in various parts of the world have not only affected the health of people living in these areas but have also drawn the support and response of the international community. Many National Medical Associations have sent groups to assist in such disaster situations.

According to the World Health Organization (WHO) Center for Research on the Epidemiology of Disasters (CRED), the frequency, magnitude, and toll of natural disasters and terrorism have increased throughout the world. In the previous century, about 3.5 million people were killed worldwide as a result of natural disasters; about 200 million were killed as a result of human-caused disasters (e.g., wars, terrorism, genocides). Each year, disasters cause hundreds of deaths and cost billions of dollars due to disruption of commerce and destruction of homes and critical infrastructure.

Population vulnerability (e.g. due to increased population density, urbanization, aging) has increased the risk of disasters and public health emergencies. Globalization, which connects countries through economic interdependencies, has led to increased international travel and commerce. Such activity has also led to increased population density in cities around the world and increased movement of people to coastal areas and other disaster-prone regions. Increases in international travel may speed the rate at which an emerging infectious disease or bioterrorism agent spreads across the globe. Climate change and terrorism have emerged as important global factors that can influence disaster trends and thus require continued monitoring and attention.

The emergence of infectious diseases, such as H1N1 influenza A and severe acute respiratory syndrome (SARS), and the recent arrival of West Nile virus and monkey pox in the Western hemisphere, reinforces the need for constant vigilance and planning to prepare for and respond to new and unexpected public health emergencies.

The growing likelihood of terrorist-related disasters affecting large civilian populations affects all nations. Concern continues about the security of the worldwide arsenal of nuclear, chemical, and biological agents as well as the recruitment of people capable of manufacturing or deploying them. The potentially catastrophic nature of a "successful" terrorist attack configures an event that may demand a disproportionate amount of resources and healthcare professionals preparedness. Natural disasters such as tornadoes, hurricanes,

floods, and earthquakes, as well as industrial and transportation-related catastrophes, are far more common and can also severely stress existing medical, public health, and emergency response systems.

In light of recent world events, it is increasingly clear that all physicians need to become more proficient in the recognition, diagnosis, and treatment of mass casualties under an all-hazards approach to disaster management and response. They must be able to recognize the general features of disasters and public health emergencies, and be knowledgeable about how to report them and where to get more information should the need arise. Physicians are on the front lines when dealing with injury and disease-whether caused by microbes, environmental hazards, natural disasters, highway collisions, terrorism, or other calamities. Early detection and reporting are critical to minimize casualties through astute teamwork by public- and private-sector health and emergency response personnel.

The WMA, representing the doctors of the world, calls upon its members to advocate for the following:

- To promote a standard competency set to ensure consistency among disaster training programs for physicians across all specialties. Many NMAs have disaster courses and previous experiences in disaster response. These NMAs can share this knowledge and advocate for the integration of some standardized level of training for all physicians, regardless of specialty or nationality.

- To work with national and local governments to establish or update regional databases and geographic mapping of information on health system assets, capacities, capabilities, and logistics to assist medical response efforts, domestically and worldwide, when needed. This could include information on local response organizations, the condition of local hospitals and health system infrastructures, endemic and emerging diseases, and other important public health and clinical information to assist medical response in the event of a disaster. In addition, systems for communicating directly with physicians and other front line health care providers should be identified and strengthened.

- To work with national and local governments to ensure the developing and testing of disaster management plans for clinical care and public health including the ethical basis for delivering such plans.

- To encourage governments at national and local levels to work across normal departmental and other boundaries in developing the necessary planning.

The WMA could serve as a channel of communication for NMAs during such times of crisis, enabling them to coordinate activities and work together.

WMA DECLARATION ON LEPROSY CONTROL AROUND THE WORLD AND ELIMINATION OF DISCRIMINATION AGAINST PERSONS AFFECTED BY LEPROSY

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011
and reaffirmed with minor revisions by the 218th Council session (online), London, United Kingdom, October 2021

Leprosy is a widespread public health problem, with approximately 200.000 new cases diagnosed annually worldwide. It is a curable disease and after starting treatment, the chain of transmission is interrupted. Leprosy is a disease that have been inadequately addressed from the point of view of investments in research and medical treatment.

The World Medical Association recommends to all National Medical Associations to defend the right of the people affected with leprosy and members of their families, that they should be treated with dignity and free from any kind of prejudice or discrimination. Physicians, health professionals and civil society should be engaged in combating all forms of prejudice and discrimination. Research centers should acknowledge leprosy as a major public health problem and continue to research this disease since there are still gaps in understanding its patho-physiological mechanisms. These gaps in knowledge may be overcome through the allocation of resources to new research, which will contribute to more efficient control worldwide. Medical schools, especially in countries with high prevalence of leprosy, should enhance its importance in the curriculum. The public, private, and civil sectors should unify their best efforts in order to disseminate information that would counteract prejudice towards leprosy and that acknowledges its curability.

WMA DECLARATION OF OSLO
ON
SOCIAL DETERMINANTS OF HEALTH

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011
and the title (Statement to Declaration) changed by the 66th WMA General Assembly, Moscow, Russia, October 2015
amended by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

Achieving health equity for all requires strong commitment from governments, the health care sector, health professionals and the international community among others. The UN Sustainable Development Goals (SDG)[1] specifically aims to ensure healthy lives and promote well-being for all at all ages (goal 3), to ensure inclusive and equitable education and promote lifelong learning opportunities for all (goal 4) and to reduce inequality within and among countries (goal 10). In the *WMA Statement on Access to Health Care*, the WMA stresses the importance of health care access for all and suggests ways to act on inadequate access and health inequalities. The WMA further supports and promotes the introduction of adequate Universal Health Coverage in all countries. Universal Health Coverage will improve access to appropriate health care for all and thus promote awareness of and action on the social determinants of health.

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

The work on social determinants goes far beyond this focus on proximate causes and considers the "causes of the causes". For example, smoking, obesity, alcohol, sedentary lifestyle are all causes of illness. A social determinants approach addresses the causes of

these causes; and in particular how they contribute to social inequities in health. This approach focuses not only on individual behaviors but seeks to address the social and economic circumstances that give rise to premature poor health, throughout the life course. The voice of the medical profession has been and continues to be important in tackling these causes of the causes.

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

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

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

RECOMMENDATIONS

1. The WMA and National Medical Associations should take an active role in combating social and health inequities and barriers to obtaining health care, striving to enable physicians to provide equal, high quality health care to all. Adequate Universal Health Coverage in all countries should be a core objective as it will help reduce health inequity.

2. The WMA can add significant value to the global efforts to address the social determinants of health by helping physicians, other health professionals and National Medical Associations to understand what the emerging evidence shows and what works in different circumstances. WMA can call on physicians to lobby more effectively within their countries and across international borders and ensure that medical knowledge and skills are shared.

3. The WMA should help to gather data on successful initiatives and help to engage physicians and other health professionals in sharing experiences and implementing new and innovative solutions.

4. The WMA should work with National Medical Associations to promote education to medical students and physicians on health inequity and the social determinants of health, and to put pressure on national governments and international bodies to take the appropriate steps to minimise health inequity and these root causes of premature poor health.

5. The WMA and National Medical Associations should encourage governments and international bodies to take action on and implement specific policies and tools addressing health inequity and the social determinants of health. Some governments have taken initial steps to reduce health inequity by taking action on the social determinants of health; local areas have drawn up plans of action; there are good examples of general practice that work across sectors improving the quality of people's lives and hence reduce health inequity. The WMA should gather examples of good practice from its members and promote further work in this area.

WMA DECLARATION ON ALCOHOL

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015
and revised by the 68th WMA General Assembly, Chicago, United States, October 2017

PREAMBLE

1. The burden of disease and injury associated with alcohol consumption is a critical challenge to global public health and development around the world. The World Medical Association offers this declaration on alcohol as its commitment to reducing excessive alcohol consumption and as a means to support its members in promulgating harm-reduction policies and other measures.

2. There are significant health, social and economic problems associated with excessive alcohol use. Overall, there are causal relationships between alcohol consumption and more than 200 types of disease and injury including traffic fatalities. The harmful use of alcohol kills approximately 3.3 million people every year (5.9 % of all deaths worldwide), and is the third leading risk factor for poor health globally, accounting for 5.1 % of disability-adjusted life years lost. Beyond the numerous chronic and acute health effects, alcohol use is associated with widespread social, mental and emotional consequences. The problem has a special magnitude among young people and adolescents who are beginning to consume alcohol at earlier ages, and the risk to their physical, mental and social health is of concern.

3. Although alcohol consumption is deeply rooted in many societies, alcohol cannot be considered an ordinary beverage or consumer commodity. It is a substance that causes extensive medical, psychological and social harm by means of physical toxicity, intoxication and dependence.

   There is increasing evidence that genetic vulnerability to alcohol dependence is a risk factor for some individuals. Foetal alcohol syndrome and foetal alcohol effects, preventable causes of intellectual disability, result from alcohol consumption during pregnancy.

   Adolescence is a stage of significant vulnerability because the neurological development is not complete and alcohol has a negative impact on it. Growing scientific evidence has demonstrated the harmful effects of consumption prior to adulthood on the brains, mental, cognitive and social functioning of youth and increased likelihood of adult alcohol dependence and alcohol related problems among those who drink before full physiological maturity. Regular alcohol

consumption and binge drinking in adolescents can negatively affect school performance, increase participation in crime and adversely affect sexual performance and behaviour.

4. Effective alcohol harm-reduction policies and measures will include legal and regulatory measures that target overall alcohol consumption in the population, as well as health and social policy interventions that specifically target high-risk drinkers, vulnerable groups and harms to people affected by those who consume alcohol, e.g. domestic violence.

   When developing policies it should be taken into account that the majority of alcohol-related problems in a population are associated with harmful or hazardous drinking by non-dependent 'social' drinkers, particularly when intoxicated. This is particularly a problem of young people in many regions of the world who drink with the intent of becoming intoxicated.

5. There are many evidence-based alcohol policies and prevention programmes that are effective in reducing the health, safety and socioeconomic problems attributable to harmful use of alcohol. International public health advocacy and partnerships are needed to strengthen and support the ability of governments and civil society worldwide to commit to, and deliver on, reducing the harmful use of alcohol through effective interventions, including action on social determinants of health.

   Health professionals in general and physicians in particular have an important role to play in preventing, treating and mitigating alcohol-related harm, and in using effective preventive and therapeutic interventions.

   The World Medical Association encourages and supports the development and implementation of evidence-based national alcohol policies by promoting and facilitating partnerships, information exchange and health policy capacity building.

POLICY OBJECTIVES

In developing alcohol policies, the WMA recommends the following broad objectives:

6. Strengthen health systems to identify and improve a country's capacity to develop policy and lead actions that target excessive alcohol consumption.

7. Promote the development and evaluation in all countries of national alcohol strategies which are comprehensive, evidence-based and include measures to address the supply, distribution, sale, advertising, sponsorship and promotion of alcohol. The WHO 'best buys' cost-effective policies should be particularly promoted, such as (i) increasing alcoholic beverage taxes, (ii) regulating the availability of alcoholic beverages, (iii) restricting marketing of alcoholic beverages and (iv) drink-driving countermeasures. Strategies should be routinely reviewed and updated.

8. Through government health departments, accurately measure the health burden associated with alcohol consumption through the collection of sales data, epidemiological data, and per capita consumption figures.

9. Support and promote the role of health and medical professionals in early identification, screening and treatment of harmful alcohol use.

10. Dispel myths and dispute alcohol control strategies that are not evidence-based.

11. Reduce the impact of harmful alcohol consumption in at risk populations.

12. Foster multi-disciplinary collaboration and coordinated inter-sectoral action.

13. Raise awareness of alcohol-related harm through public education and information campaigns.

14. Promote social determinants of health approach in fighting harmful alcohol consumption.

REOMMENDATIONS

he following priorities are suggested for WMA members, National Medical Associations and governments when developing integrated and comprehensive policy and legislative responses.

15. Regulate affordability, accessibility and availability

15.1 Pricing policies

Evidence from epidemiological and other research demonstrates a clear link between the price of alcohol and levels of consumption, especially amongst young drinkers and those who are heavy alcohol users.

Therefore, action is needed to increase alcohol prices, through volumetric taxation of products based on their alcohol strength, and other proven pricing mechanisms, to reduce alcohol consumption, particularly in heavy drinkers and high-risk groups.

Setting a minimum unit price at a level that will reduce alcohol consumption is a strong public health measure, which will both reduce average alcohol consumption throughout the population and be especially effective in heavy drinkers and young drinkers.

15.2 Accessibility and availability

Regulate access to, and availability of, alcohol by limiting the hours and days of sale, the number and location of alcohol outlets and licensed premises, and the imposition of a minimum legal drinking age. Governments should tax and control the production and

consumption of alcohol, with licensing that emphasises public health and safety and empowers licensing authorities to control the total availability of alcohol in their jurisdictions. Governments should also control importation and sale of illegal alcohol across borders.

Public authorities must strengthen the prohibition of selling to and by minors and must systematically request proof of age before alcohol can be purchased in shops or bars.

16. Regulation of non-commercial alcohol

The production and consumption of non-commercial forms of alcohol, such as home brewing, illicit distillation, and illegal diversion alcohol to avoid taxes, should be curtailed using appropriate taxing and pricing mechanisms.

17. Regulation of alcohol marketing

Alcohol marketing should be restricted to prevent the early adoption of drinking by young people and to minimise their alcohol consumption. Regulatory measures range from wholesale bans and restrictions on measures that promote excessive consumption, to restrictions on the placement and content of alcohol advertising and sponsorship that are attractive to young people. There is evidence that industry self-regulation and voluntary codes are ineffective at protecting vulnerable populations from exposure to alcohol marketing and promotion.

Increase public awareness of harmful alcohol consumption through mandatory product labelling that clearly states alcoholic content in units, advice on recommended drinking levels and a health warning, supported by public awareness campaigns.

In conjunction with other measures, social marketing campaigns should be implemented together with the media to educate the public about harmful alcohol use, to adopt driving while intoxicated policies, and to target the behaviour of specific populations at high risks of harm.

18. The role of health and medical services in prevention

Health, medical and social services professionals should be provided with the training, resources and support necessary to prevent harmful use of alcohol and treat people with alcohol dependence, including routinely providing brief interventions to motivate high-risk drinkers to moderate their consumption. Health professionals also play a key role in education, advocacy and research.

Specialised treatment and rehabilitation services should be available in due time and affordable for alcohol dependent individuals and their families.

Together with national and local medical societies, specialty medical organizations, concerned social, religious and economic groups (including governmental, scientific, professional, nongovernmental and voluntary bodies, the private sector, and civil society) physicians and other health and social professionals can work to:

18.1 Reduce harmful use of alcohol, especially among young people and pregnant women, in the workplace, and when driving;

18.2 Increase the likelihood that everyone will be free of pressures to consume alcohol and free from the harmful and unhealthy effects of drinking by others;

18.3 Promote evidence-based prevention strategies in schools and communities;

18.4 Assist in informing the public of alcohol related harm and demystifying the myth of health enhancing properties of alcohol.

Physicians have an important role in facilitating epidemiologic and health service data collection on the impact of alcohol with the aim of prevention and promotion of public health. Data collection must respect the confidentiality of health data of individual patients.

19. Driving while intoxicated measures

Key deterrents should be implemented for driving while intoxicated, which include a strictly enforced legal maximum blood alcohol concentration for drivers of no more than 50mg/100ml, supported by social marketing campaigns and the power of authorities to impose immediate sanctions.

These measures should also include active enforcement of traffic safety measures, random breath testing, and legal and medical interventions for repeat intoxicated drivers.

20. Limit the role of the alcohol industry in alcohol policy development

The commercial priorities of the alcohol industry are in direct conflict with the public health objective of reducing overall alcohol consumption. Internationally, the alcohol industry is frequently included in alcohol policy development by national authorities, but the industry is often active in opposing and weakening effective alcohol policies. Ineffective and non-evidence-based alcohol control strategies promoted by the alcohol industry and the social organisations that the industry sponsors should be countered. The role of the alcohol industry in the reduction of alcohol-related harm should be confined to their roles as producers, distributors and marketers of alcohol, and not include alcohol policy development or health promotion.

21. Convention on Alcohol Control

Promote consideration of a Framework Convention on Alcohol Control similar to that of the WHO Framework Convention on Tobacco Control.

22. Exclude alcohol from trade agreements

Furthermore, in order to protect current and future alcohol control measures, advocate for alcohol to be classified as an extra-ordinary commodity and that measures affecting the

supply, distribution, sale, advertising, sponsorship, promotion of or investment in alcoholic beverages be excluded from international trade agreements.

23. Action against positive media messaging

It is important to act on the impact of media messages on beliefs, intentions, attitudes and social norms. Well-designed media campaigns can have direct effects on behavior. The media also influence the social conception of a problem, and indirectly influence political decision-making on measures for intervention on alcohol.

WMA DECLARATION OF CHICAGO ON QUALITY ASSURANCE IN MEDICAL EDUCATION

Adopted by the 68th WMA General Assembly, Chicago, United States, October 2017

PREAMBLE

he goals of medical education are to prepare practitioners to apply the latest scientific knowledge to promote health, to prevent and cure human diseases, and to impart the ethical standards governing the thought and behavior of physicians. All physicians have a responsibility to themselves, the profession, and their patients to maintain high standards for basic medical education.

Well-planned and well-executed quality assurance programs are essential to ensuring that medical schools meet these goals and expectations. There are many threats to the quality of basic medical education. The ability to deliver a high standard of education can be affected by the availability of infrastructure, clinical resources, faculty, and finances. Also, the growth of basic medical education globally, with a rapid increase in the number of medical schools in some countries, raises concerns about the quality of graduates. A well-developed quality assurance program allows schools to identify and address conditions that threaten the quality of their basic medical education. Such programs need to be implemented as far as possible at medical schools around the world.

BACKGROUND

Standards developed by and for a medical school are designed to reflect what the school believes to be important quality measures. Institutional reviews using such internally-developed standards can ensure that the school's missions are being met and that students are being prepared to achieve the desired outcomes. The presence of an institutional quality assurance program that uses its own defined criteria and is supported by knowledgeable personnel can be important to ensure educational program quality over time.

However, a better outcome will more likely be achieved by also including a second dimension of review that includes an external perspective. A national quality assurance system includes the use of standards of quality that are developed and approved at the national or regional level. Evaluating a medical school based on what a country or region expects of its basic medical educational programs leads to a higher and more consistent level of student preparation.

Unless compliance with standards set by a national evaluation system is required of medical schools, there is no guarantee that schools will undertake an internal evaluation or correct problems that interfere with educational quality. The World Medical Association (WMA) recognises the need for and importance of sound global standards for assuring the quality of basic medical education programs.

An accreditation/recognition system is a quality assurance mechanism that is increasingly common around the world. Accreditation/recognition systems are based on standards of educational quality that are developed to meet national needs and that use valid, reliable, and widely-accepted processes to assess the attainment of these standards by schools. After evaluating compliance with standards, cooperation and coordination among various stakeholder groups within and external to a medical school is needed to implement solutions to the problems identified.

PRINCIPLES FOR ACCREDITATION SYSTEMS

An accreditation system reviews educational programs or institutions using a pre-determined (typically national) set of process and outcome standards. The accreditation systems that exist around the world differ in several ways. In some countries, accreditation of medical schools has been occurring for decades; in other countries, accreditation is relatively new. Participation in accreditation is either mandatory or voluntary for medical schools and reviews take place over different intervals.

Accreditation is defined as the evaluation of educational programs or institutions based on a clear and specific set of standards. Accreditation guidelines should be articulated as standards that have been created with national needs in mind and with the input of relevant stakeholder groups within the country.

Certain general principles should form the basis for an accreditation system to ensure that the process is valid and decisions related to educational program quality are trustworthy. These principles include transparency, absence of conflict of interest, and reliability/consistency. Transparency means that the accreditation standards and processes are known to and understood by schools, evaluators, and decision-makers. To reduce the potential for conflict of interest, evaluators and decision-makers should have no ties to the institution being evaluated or to other institutions that may affect their ability to make a judgment free from positive or negative bias. Reliability and consistency require a common understanding of what constitutes compliance with standards and that, as far as possible, this understanding is applied consistently in reviews and decisions across schools.

Accreditation standards are measurable, but need not be quantitative. Standards are normally developed for both the process and the outcomes of a medical education program. Specific information should be identified to evaluate compliance. For example, the standards related to process could address the objectives for and structure of the curriculum; the qualifications of entering students and teaching faculty; and the availability of resources for program support, including adequate finances, sufficient faculty, and an appropriate educational infrastructure for the scientific and clinical phases of training. The outcomes of the medical education program are then evaluated to

determine if graduates have been adequately prepared based on the school's objectives.

In order to be most effective, standards used in accreditation need to be widely disseminated and thoroughly explicated so that medical schools, evaluators, and decision-makers share a common understanding of their meaning and the expectations for compliance. For the sake of process effectiveness and transparency, the medical school faculty, the evaluators who review the medical schools' compliance with accreditation standards, and the decision-makers who determine accreditation status will require training.

Institutions will have achieved their objectives if they have continually complied with accreditation standards and when internal monitoring becomes a formal responsibility for one or more individuals within the medical school who have access to relevant quality-linked information (e.g., the results of student satisfaction surveys and student performance data). Ongoing review of some or all accreditation standards allows schools to correct problem areas before they are identified as part of the formal accreditation review and ensures that educational program quality remains high.

If an accreditation review identifies areas where improvement is needed, a medical school should promptly correct the deficiencies. The accreditation/recognition body normally sets a timeline for follow-up by the end of which the educational program should be able to demonstrate the actions that have been taken and the outcomes that have been achieved. This may require the medical school/university to provide financial resources and to provide faculty time, effort, and adequate infrastructure, to make the needed corrections.

To assist schools in addressing identified deficiencies, support and consultation could be provided by the staff of the accrediting body or other trained individuals. To avoid conflict of interest, those who provide consultation should not take part in accreditation reviews or in decisions about accreditation status.

RESPONSIBILITIES OF STAKEHOLDERS GROUPS WITHIN AND EXTERNAL TO MEDICAL SCHOOLS

The creation of an accreditation system that meets the principles for validity and trustworthiness requires actions by a variety of stakeholder groups, such as:

- Entities that sponsor accrediting bodies (e.g., governments, medical associations) need to ensure that the accrediting body is appropriately funded and staffed for its activities. Funding may come from the sponsors and/or from the accrediting body's ability to generate its own funding from accreditation review fees. Accrediting bodies in certain countries may require additional funding and staffing to address the increase in the number of medical schools.

- It is advisable for school leadership to encourage an environment that values educational quality assurance activities. Faculty should be given time and recognition for their participation in program evaluation and accreditation activities, and medical students should be prepared and encouraged to provide feedback on all relevant aspects of the medical education program.

RECOMMENDATIONS

The WMA calls upon National Medical Associations (NMAs)to encourage medical schools to develop quality assurance programs regarding ongoing review of educational program quality.

The WMA urges NMAs to support and promote the ongoing development of national and regional accreditation/recognition systems for medical schools. These systems should be designed and led by physicians in collaboration with experienced medical educators and with input from other relevant experts.

The WMA calls upon NMAs to urge national governmental and private-sector policy-makers to ensure that the national accreditation system has adequate and appropriate resources for its activities. This includes sufficient and consistent funding to support the infrastructure and staffing of the accrediting body.

The WMA recommends that accreditation systems use nationally-relevant standards applied consistently by trained evaluators and decision-makers when reviewing medical schools.

The WMA encourages NMAs to advocate to policy-makers that participation in the national accreditation system should be required for all medical schools within a country.

The WMA calls upon NMA's to urge national accreditation systems to participate in external reviews of their policies, practices, and standards. This may include seeking recognition by the World Federation for Medical Education (WFME). Recognised accrediting bodies and similar organisations are urged to establish a forum for discussion and collaboration among national accrediting bodies to share best practices and mechanisms to overcome challenges.

Physicians should be encouraged to lead and actively participate in national accreditation activities as evaluators and decision-makers and in quality assurance activities at their own medical schools.

WMA DECLARATION
ON
FAIR TRADE IN MEDICAL PRODUCTS AND DEVICES

Adopted by the 68th WMA General Assembly, Chicago, United States, October 2017

PREAMBLE

1. Every year trillions of dollars are spent on medical supplies globally. Little consideration is given to the conditions in which they are made, nor to the impact on the people who make them.

2. Abuses of labour standards, evidence of modern slavery, and unethical working conditions have been uncovered in the manufacture of many medical products bound for health systems around the world. Evidence shows that many supplies used in the healthcare sector are produced in unhealthy, unsafe and unfair working conditions. Widescale abuses have been reported in numerous manufacturing sites – from uniforms, to latex gloves, to disposable surgical instruments – international labour core conventions are persistently disregarded, and the use of child labour is widespread.

3. The global healthcare community should not condone unethical trade practices that are detrimental to global health and encourage modern slavery. Healthcare organisations and professionals around the world must insist that the goods they use are not produced at the expense of the health of workers in the global community.

4. It is important to maintain trading with developing countries to ensure jobs and livelihoods, and commitment to the UN sustainable development goals. These goals provide an overarching opportunity for sustained action to be taken by health professionals in protecting human health globally.

5. As enshrined in the UN Guiding Principles on Business and Human rights (June 2011) – applicable to all States- businesses have a responsibility to minimise human rights violations in their supply and procurement chains, irrespective of whether the business contributed directly to the violation, and a duty to adequately address any abuses that do occur.

6. Introduction of fair and ethical trade in health service purchasing should be used to secure improvement in the health system supply chains. Modern approaches to addressing labour rights abuses focus on models of ‘ethical procurement’.

7. Ethical procurement refers to the steps that purchasing organisations, such as hospitals, take to improve the pay and conditions of people involved in the supply of goods and services. It asks purchasers to systematically assess the risk of labour rights abuses in the goods they procure, and to push for improvement where necessary. This includes

working with companies throughout the supply chain to help workers exercise fundamental rights such as the right to safe and decent working conditions. This model aims to make international trade work better for poor and otherwise disadvantaged people.

RECOMMANDATIONS

8. Recognizing this, the World Medical Association and its national medical association members on behalf of their physician members, support and commit to the following actions:

    - Call upon purchasing bodies, to develop a fair and ethical purchasing policy for medical goods to promote good working conditions and eradicate modern slavery throughout the supply chains of the products purchased within the health sector.

    - Promote multiple health product production sources throughout the world.

National medical associations

9. National medical associations should advocate for labour/ human rights to be protected throughout the global supply chains of products used in their healthcare systems.

10. National medical associations should work with their members to promote fair and ethical trade in the health sector.

11. National medical associations should support community action and initiatives with to promote ethical working conditions across the health sector as a whole.

12. National medical associations should harness government support to formulate national guidance and/or policy on fair and ethical trade in healthcare purchasing.

Physicians

13. Physicians should play a leadership role in integrating considerations of labour standards into purchasing decisions within healthcare organisations.

14. Physicians should raise awareness of the issues, and promote the development of fair and ethically produced medical goods, amongst colleagues and those working with health systems.

WMA DECLARATION
ON
EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

Adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.

For the purpose of this declaration, euthanasia is defined as a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's own voluntary request. Physician-assisted suicide refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death.

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.

Separately, the physician who respects the basic right of the patient to decline medical treatment does not act unethically in forgoing or withholding unwanted care, even if respecting such a wish results in the death of the patient.

WMA DECLARATION OF CORDOBA ON PATIENT-PHYSICIAN RELATIONSHIP

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

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

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

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

A technologization of medicine, sometimes leading to a mechanistic view of health care, neglecting human considerations;

The dilution of trustworthy relationships between people in our societies, which negatively influences healthcare relationships;

A primary focus on economic aspects of medical care to the detriment of other factors, posing sometimes difficulties to establish genuine relationships of trust between the physician and the patient.

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

RECOMMENDATIONS

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

1. Reaffirm that professional autonomy and clinical independence are essential components of high-quality medical care and medical professionalism, protecting the right of the patients to receive the health care they need.

2. Urge all actors involved in the regulation of the patient-physician relationship (governments and health authorities, medical associations, physicians, and patients) to defend, protect and strengthen the patient-physician relationship, based of high-quality care, as a scientific, health, cultural and social heritage.

3. Call on Constituent Members and individual physicians to preserve this relationship as the fundamental core of any medical action centred on a person, to defend the medical profession and its ethical values, including compassion, competence, mutual respect, and professional autonomy, and to support patient-centred care.

4. Reaffirm its opposition to interference from governments, other agents and institutional administrations in the practice of medicine and in the Patient-physician

5. Reaffirm its dedication to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.

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

WMA DECLARATION ON PSEUDOSCIENCE AND PSEUDOTHERAPIES IN THE FIELD OF HEALTH

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

DEFINITIONS

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

PREAMBLE

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

Pseudosciences and pseudotherapies represent a complex system of theories, assumptions, assertions and methods erroneously regarded as scientific, they may cause some patients to perceive a cause-and-effect relationship between pseudotherapies and the perception of improvement, hence they may be very dangerous and are unethical.

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

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

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

There is a risk that patients abandon effective proved-to-be effective medical treatments or prevention measures in favour of practices that have not demonstrated therapeutic value, sometimes leading to treatment failure for critical conditions that may even lead to death.

There are frequent likelihood of dangerous delays and loss of opportunity in the application of medicines, procedures and techniques recognised and endorsed by the scientific medical community as evidence-based effective interventions.

They may cause patients to suffer financial damages psychological-physical traumas, and go against the dignity of people, threatening their moral integrity.

Unproven therapies may contribute to the rising costs of healthcare procedures.

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

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

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

RECOMMENDATIONS

Thus, the WMA makes the following recommendations:

National Health Authorities

1. Appropriate and rigorous regulation commensurate with best practices is necessary to address the risks and reduce the potential harms arising from pseudotherapies and pseudoscience.

2. National authorities and healthcare systems should decline approval of and reimbursement of costs providing pseudotherapies.

3. In collaboration with professional medical organizations, scientific societies and patients' associations, national authorities should develop public campaign raising awareness on the risk of pseudotherapies and pseudosciences.

WMA Constituent members and the medical profession

4. WMA constituent members and the medical profession must recognize and be aware of the risks of pseudotherapies and pseudosciences.

5. Pseudotherapies and pseudosciences should not be regarded as medical specialties recognized by the scientific community and legally endorsed as a specialist or sub-

specialist pseudoscience.

6. All acts of professional intrusion , pseudoscience and pseudotherapy activities that put public health at risk must be reported to the competent authorities, including misleading advertising and unaccredited healthcare websites that offer services and/or products and that put the health of patients at risk, yet patient confidentiality has to be respected. The role of the general and specialized media for transparency and truthfulness in increasing critical public scientific awareness is essential.

7. Constituent members should work with governments to establish the highest level of protection for patients treated with pseudotherapies/pseudosciences. When such a practice is found to be harmful or unethical to apply, there should be a system in place to either immediately stop or substantially restrict any given treatment classified as complementary and/or alternative in order to protect public health.

Physicians

8. With the support of the relevant organizations and authorities involved in the governance and regulation of the medical profession, physicians must continue to practice medicine as a service based on the application of critical scientific current knowledge, specialist skills and ethical behaviour and to maintain their skills up to date on developments in their professional field.

9. For the patient's safety and quality of care, the physician must have the freedom to prescribe, while respecting scientific evidence and the standard of care.

10. The patient must be kept duly informed about the available therapy options, their effectiveness and risks, and be able to participate in the best therapeutic decision-making. Good communication, mutual trust and person-centered healthcare are cornerstones of the physician-patient relationship. Patients and physicians should and must be able to discuss the risks of pseudoscience and pseudotherapies. Health education is fundamental.

11. Physicians should be educated to identify pseudoscience/pseudotherapies, logical fallacies, and cognitive biases and counsel their patients accordingly. They should be aware that some patient groups, such as patients with cancer, psychiatric illnesses or serious chronic diseases, as well as children, are particularly vulnerable to the risks associated with using pseudotherapies.

12. When obtaining the patient's history (anamnesis), the physician should inquire about all therapeutic measures (proven or otherwise) the patient has been exposed or is still exposed to. If necessary, the physician should inform the patient on potential harms associated with the previous use of Pseudotherapies and pseudosciences.

13. The physician must inform the patient that complementary treatment is not a therapeutic alternative or substitute for a validated main medical treatment.

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

WMA DECLARATION OF BERLIN ON RACISM IN MEDICINE

Adopted by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

Racism is rooted in the false idea that human beings can be ranked as superior or inferior based on inherited physical traits. This harmful social construct has no basis in biological reality; however, racist policies and ideas have been used throughout history and are still used to perpetuate, justify, and sustain unequal treatment.

Despite the fact that races do not exist in the genetic sense, in some cultures racial categories are used as a form of cultural expression or identity, or a means of reflecting shared historical experiences. This is one aspect of the concepts of "ethnicity" or "ancestry".

Acknowledging that the words "race" and "racial" have different connotations in different linguistic and cultural contexts, these terms are used throughout this document to denote socially constructed categories and not a biological reality.

While the false conflation of racial categories with inherent biological or genetic traits has no scientific basis, the detrimental impact racial discrimination has on historically marginalized and minoritized communities is well documented. The experience of racism in all its forms – for example, interpersonal, institutional, and systemic – is recognized as a social determinant of health and a driving force behind persistent health inequities, as noted in the WMA Declaration of Oslo on Social Determinants of Health. These inequities can be compounded by other factors like national origin, age, gender, sexual orientation, religion, socioeconomic status, disabilities, and more. Individuals subjected to racism are often also affected negatively by other social determinants of health.

Racially motivated violence and overt bias, housing and employment discrimination, education and health care inequity, environmental injustice, daily microaggressions, pay gaps, and the legacy of intergenerational trauma experienced by those who are subjected to racism are just some of the many factors that may impact health and illustrate why racism poses a serious threat to public health. These and other structural barriers faced by historically marginalized communities can lead to disproportionate rates of infant and maternal mortality and certain illnesses, mental health struggles, poorer health outcomes, as well as shorter life expectancies.

Racism in medicine

With the WMA Declaration of Geneva, the Physician's Pledge, the physician vows to respect the dignity of all patients, to respect teachers, colleagues, and students, and to "not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between [the physician's] duty and [the] patient."

Nonetheless, racism in all its forms also exists in medicine throughout the world and has a direct impact on patients and their health. Systemic racial disparities in access to care and health resources at a global and local scale can translate to disparities in health outcomes.

At the interpersonal level, prejudice and stereotypes held and acted upon by medical professionals can lead them to be reluctant to see patients or dismissive of symptoms from patients from marginalized communities, which can result in suboptimal communication, as well as inappropriate or delayed treatment. Racism can hinder or undermine the foundation of trust that is essential to a successful patient-physician relationship.

Physicians from marginalized communities also face racism from patients, other physicians, and health professionals. This can take the form of bullying, harassment, and professional undermining in the workplace. These distressing experiences may not only impact the physician's health and well-being, but consequently the physician's performance. They may also leave marginalized physicians less confident to raise concerns about patient safety for fear of being blamed or suffering adverse consequences. Large and growing racial disparities in adequate professional treatment and advancement opportunities can have an impact on physicians' career trajectories.

Furthermore, systemic racism can create barriers to entry to the medical profession for certain historically excluded groups, leading to a lack of representation, which may contribute to adverse health outcomes for patients. These barriers are caused by a variety of factors, including implicit and explicit bias in admissions and hiring practices, a dearth in inclusive professional environments, and lifelong racial disparities in educational funding.

A medical profession that is representative of the population is crucial to addressing health disparities among patients.

Racism in medical education

In medical education, implicit and explicit bias not only impact the admissions process, but also the curriculum, faculty development, and how marginalized students are treated and assessed. Non-inclusive and harmful learning environments can leave minoritized students with an increased risk of anxiety and depression. In addition, learning materials and curricula often do not reflect a diversity of experiences, imagery, and disease presentations and fail to address the issue of racism in medicine head-on.

Racism in medical research / medical journals

Structural racism also influences participation and therefore inclusivity in medical research. Historical examples of unethical experimentation or research in the absence of informed consent on marginalized communities have led to a high level of mistrust of the medical establishment. On the other hand, exclusion of marginalized groups from clinical trials results in a lack of data about how certain drugs, treatments, or health conditions might impact individuals in those groups. A lack of racial data transparency can lead to a lack of understanding about how racial disparities lead to health inequities. It can also jeopardize the potential of artificial intelligence to reveal and override biases in medicine. Algorithms are only as inclusive as the health and technology professionals who create them.

Furthermore, medical journals – the gatekeepers of evidence-based research – have generally been remiss in addressing the issue of racism and its impact on health inequities, as well as in addressing underrepresentation among journal decision makers and authors.

DECLARATION

Therefore, the World Medical Association

- condemns unequivocally racism in all its forms and wherever and whenever it occurs;
- declares racism to be a public health threat;
- acknowledges that racism is structural and deeply engrained in health care;
- asserts that racism is based on a social construct with no basis in biological reality and that any effort to claim superiority by exploiting racist assumptions is unethical, unjust, and harmful;
- recognizes that the experience of racism is a social determinant of health and responsible for persistent health inequities;
- commits to actively promote equity and diversity in medicine and to strive for an inclusive and equitable health environment.

RECOMMENDATIONS

The WMA urges its members and all physicians to:

1. enact the above-mentioned declaration in their own organizations;
2. acknowledge the harmful impact of racism on the health and well-being of marginalized communities and act upon it;
3. promote equitable access to health and other societal resources locally, nationally and on a global scale;

4. commit to actively work to dismantle racist policies and practices in health care and advocate for antiracist policies and practices that support equity in health care and social justice;

5. implement organizational and institutional changes to foster diversity in the medical profession and the organizations that support it;

6. support and, where possible, implement admissions and curriculum changes in medical education that promote inclusivity and raise awareness about the harmful impact of racism on health;

7. promote just and safe learning environments in medical education;

8. promote equitable access to quality medical and public health education;

9. center the experiences of physicians from underrepresented communities to ensure the visibility of role models and foster a feeling of inclusivity and empowerment among prospective students from historically marginalized communities;

10. ensure safe, supportive, and respectful work environments for all physicians, including those from historically marginalized communities;

11. establish channels for physicians and students of medicine to safely report cases of racially motivated harassment or bias;

12. enact disciplinary measures against perpetrators of racial harassment or bias in the medical profession and implement measures to prevent such harassment and discrimination, to protect those who suffer from it and to eliminate it from the medical field;

13. take measures to identify research gaps and promote evidence-based research on the health impact of racism;

14. encourage medical journals to amplify the voices of medical researchers and health experts from underrepresented and historically excluded communities;

15. make all efforts to promote representation in ethically conducted clinical trials in accordance with the WMA Declaration of Helsinki as a means of advancing health equity;

16. promote further research on the impact of racism in the health system.

WMA DECLARATION OF BERLIN ON DISCRIMINATION AGAINST ELDERLY INDIVIDUALS WITHIN HEALTHCARE SETTINGS

Adopted by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

The ageing of the population due to increased life expectancy is one of the main challenges of many health systems given the increasing amount of resources needed to provide healthcare for the elderly population. This puts a strain on these systems, since ageing often causes a higher demand for care, with a high dependence on medical, pharmaceutical and hospital services. On the other hand, older people are perceived as recipients of help, care and financial support, which is inaccurate, as they make significant contributions to the well-being of their environment, which has a high social value.

The increase in longevity must be accompanied by appropriate quality-of-care standards, promoting health, reducing risk factors, and providing accessible and sustainable quality health and social services that are accessible, affordable, sustainable and which are of quality.

Biological age should never be used as a basis for discrimination, although it can be a relevant factor in medical decision-making. Reference to age can therefore be professionally sound.

Health discrimination in elderly patients

Elderly individuals experience all kinds of discrimination with one of the main types of discrimination being related to health. The elderly may be perceived as a burden on the healthcare systems and their financial sustainability. Elderly individuals are not uniquely responsible for the increase in healthcare costs in developed countries. There are other factors that play a key role in healthcare costs, such as the improvement in standards of living, accessibility to health services, quality of care and the use of new technologies.

Rationing of certain costly and time-consuming diagnostic or therapeutic procedures or particular settings that have a certain more expensive intensity of care is more common in the elderly population. Clinical trials often exclude patients of a certain age, even if they meet the criteria for enrolment.

Age has become a barrier when putting patients forward for certain interventions. The reasons tend to be physical; however, these may be underpinned by economic motivations, such as the recovery time being higher which increases the length of hospital stay, or by arguing that there are scarce resources and that elderly people have a shorter life expectancy.

There is consensus that from a physiological and psychological point of view, the determining factors for health in ageing patients are intrinsically linked to gender; therefore, the solutions need to address the differences between genders in order to reduce inequalities.

Health discrimination experienced by elderly individuals may have a negative impact on their physical, mental and social well-being and contributes to deterioration in their quality of life, loss of autonomy, confidence, safety and an active lifestyle, in turn, decreasing their levels of health. Is therefore a complex topic that requires the involvement of professionals, institutions, healthcare systems and authorities. Dealing with such discrimination requires awareness and coordination aided by moral and legal principles.

The need for a holistic approach

Healthcare systems do not always adapt to the changing population needs, as may occur with some hospitals, designed to care for adult patients with acute illnesses yet not elderly patients with chronic illnesses.

An increase in longevity must be accompanied by the highest quality-of-care standards, and should promote health, reduce risk factors, and provide accessible, sustainable and quality health and social services. Emphasis should be on patient-focused medicine that heals, cares for, alleviates and comforts.

The ethical duty of physicians

In line with the WMA Declaration of Geneva, physicians must strive to improve the health, well-being and quality of life for all patients without any forms of discrimination towards the elderly.

RECOMMENDATIONS

Recalling its Declarations of Geneva and of Lisbon on the Rights of the Patient, and its Statement on Ageing, the WMA makes the following recommendations:

To governments, medical associations and physicians

1. As priority actions, to defend the human rights and health of all individuals, including the elderly, as well as to ensure that their dignity is respected;

To governments

2. Develop appropriate and non-discriminatory healthcare policies for the elderly based on the efficient use of available healthcare resources;

3. To establish measures to eradicate discrimination against elderly individuals in healthcare;
4. Provide sufficient resources which ensure adequate healthcare for elderly individuals;

To the WMA, its members and the medical profession in general

5. To commit to eliminating all forms of discrimination due to health and age;
6. Promote training for primary care physicians on how to approach health problems in elderly individuals;
7. Promote development of the geriatric specialty or supplementary post-graduate training and increase of the number of physicians in this field, an increase of the number of physicians in this speciality and an adequate number of geriatric departments in hospitals and consultants, in order to ensure the availability of comprehensive care for elderly individuals;
8. Raise awareness and take action against discrimination of elderly individuals;
9. Promote ethical, responsible, effective and efficient practices for treating the elderly;
10. To set ethical standards that aim to prevent discrimination against any individual due to age;
11. To actively try to include elderly patients in medical scientific research;

To physicians

12. Not limit or impede patients' autonomy on the basis of their age;
13. Provide healthcare of scientific and human quality according to good medical practice to all patients, without any discrimination;
14. Not apply limitations solely based on age in protocols for diagnosis and treatment;
15. To report any discrimination against the elderly that is observed in healthcare.

WMA REGULATIONS
IN
TIMES OF ARMED CONFLICT AND OTHER SITUATIONS OF VIOLENCE

Adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956
and edited by the 11th World Medical Assembly, Istanbul, Turkey, October 1957
and revised by the 35th World Medical Assembly, Venice, Italy, October 1983
and the 55th WMA General Assembly, Tokyo, Japan, October 2004
and editorially revised by the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006
and revised by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012

GENERAL GUIDELINES

Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as stated in the International Code of Medical Ethics of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; in all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics.

The primary task of the medical profession is to preserve health and save life. Hence it is deemed unethical for physicians to:

- Give advice or perform prophylactic, diagnostic or therapeutic procedures that are not justifiable for the patient's health care;
- Weaken the physical or mental strength of a human being without therapeutic justification;
- Employ scientific knowledge to imperil health or destroy life;
- Employ personal health information to facilitate interrogation;
- Condone, facilitate or participate in the practice of torture or any form of cruel, inhuman or degrading treatment.

During times of armed conflict and other situations of violence, standard ethical norms apply, not only in regard to treatment but also to all other interventions, such as research. Research involving experimentation on human subjects is strictly forbidden on all persons deprived of their liberty, especially civilian and military prisoners and the population of occupied countries.

The medical duty to treat people with humanity and respect applies to all patients. The physician must always give the necessary care impartially and without discrimination on the basis of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing or any other similar criterion.

Governments, armed forces and others in positions of power should comply with the Geneva Conventions to ensure that physicians and other health care professionals can provide care to everyone in need in situations of armed conflict and other situations of violence. This obligation includes a requirement to protect health care personnel and facilities.

Whatever the context, medical confidentiality must be preserved by the physician. However, in armed conflict or other situations of violence, and in peacetime, there may be circumstances in which a patient poses a significant risk to other people and physicians will need to weigh their obligation to the patient against their obligation to other individuals threatened.

Privileges and facilities afforded to physicians and other health care professionals in times of armed conflict and other situations of violence must never be used other than for health care purposes.

Physicians have a clear duty to care for the sick and injured. Physicians should recognise the special vulnerability of some groups, including women and children. Provision of such care should not be impeded or regarded as any kind of offence. Physicians must never be prosecuted or punished for complying with any of their ethical obligations.

Physicians have a duty to press governments and other authorities for the provision of the infrastructure that is a prerequisite to health, including potable water, adequate food and shelter.

Where conflict appears to be imminent and inevitable, physicians should, as far as they are able, ensure that authorities are planning for the protection of the public health infrastructure and for any necessary repair in the immediate post-conflict period.

In emergencies, physicians are required to render immediate attention to the best of their ability. Whether civilian or combatant, the sick and wounded must receive promptly the care they need. No distinction shall be made between patients except those based upon clinical need.

Physicians must be granted access to patients, medical facilities and equipment and the protection needed to carry out their professional activities freely. Such access must include patients in detention centres and prisons. Necessary assistance, including unimpeded passage and complete professional independence, must be granted.

In fulfilling their duties and where they have the legal right, physicians and other health care professionals shall be identified and protected by internationally recognized symbols such as the Red Cross, Red Crescent or Red Crystal.

Hospitals and health care facilities situated in areas where there is either armed conflict or other situations of violence must be respected by all combatants and media personnel. Health care given to the sick and wounded, civilians or combatants, cannot be used for publicity or propaganda. The privacy of the sick, wounded and dead must always be res-

pected. This includes visits from important political figures for media purposes and also when important political figures are among the wounded and the sick.

Physicians must be aware that, during armed conflict or other situations of violence, health care becomes increasingly susceptible to unscrupulous practice and the distribution of poor quality / counterfeit materials and medicines, and attempt to take action on such practices.

The WMA supports the collection and dissemination of data related to assaults on physicians, other health care personnel and medical facilities, by an international body. Such data are important to understand the nature of such attacks and to set up mechanisms to prevent them. Assaults against medical personnel must be investigated and those responsible must be brought to justice.

CODE OF CONDUCT: DUTIES OF PHYSICIANS WORKING IN ARMED CONFLICT AND OTHER SITUATIONS OF VIOLENCE

Physicians must in all circumstances:

- Neither commit nor assist violations of international law (international humanitarian law or human rights law);
- Not abandon the wounded and sick;
- Not take part in any act of hostility;
- Remind authorities of their obligation to search for the wounded and sick and to ensure access to health care without unfair discrimination;
- Advocate and provide effective and impartial care to the wounded and sick (without reference to any ground of unfair discrimination, including whether they are the "enemy");
- Recognise that security of individuals, patients and institutions are a major constraint to ethical behaviour and not take undue risk in the discharge of their duties;
- Respect the individual wounded or sick person, his / her will, confidence and his / her dignity;
- Not take advantage of the situation and the vulnerability of the wounded and sick for personal financial gain;
- Not undertake any kind of experimentation on the wounded and sick without their real and valid consent and never where they are deprived of liberty;
- Give special consideration to the greater vulnerability of women and children in armed conflict and other situations of violence and to their specific health-care needs;
- Respect the right of a family to know the fate and whereabouts of a missing family member whether or not that person is dead or receiving health care;
- Provide health care for anyone taken prisoner;
- Advocate for regular visits to prisons and prisoners by physicians, if such a mechanism is not already in place;
- Denounce and act, where possible, to put an end to any unscrupulous practices or distribution of poor quality/counterfeit materials and medicines;

- Encourage authorities to recognise their obligations under international humanitarian law and other pertinent bodies of international law with respect to protection of health care personnel and infrastructure in armed conflict and other situations of violence;
- Be aware of the legal obligations to report to authorities the outbreak of any notifiable disease or trauma;
- Do anything within their power to prevent reprisals against the wounded and sick or health care;
- Recognise that there are other situations where health care might be compromised but in which there are dilemmas.

Physicians should to the degree possible:

- Refuse to obey an illegal or unethical order;
- Give careful consideration to any dual loyalties that the physician may be bound by and discuss these dual loyalties with colleagues and anyone in authority;
- As an exception to professional confidentiality, and in line with WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment and the Istanbul Protocol[1], denounce acts of torture or cruel, inhuman or degrading treatment of which physicians are aware, where possible with the subject's consent, but in certain circumstances where the victim is unable to express him/herself freely, without explicit consent;
- Listen to and respect the opinions of colleagues;
- Reflect on and try to improve the standards of care appropriate to the situation;
- Report unethical behaviour of a colleague to the appropriate superior;
- Keep adequate health care records;
- Support sustainability of civilian health care disrupted by the context;
- Report to a commander or to other appropriate authorities if health care needs are not met;
- Give consideration to how health care personnel might shorten or mitigate the effects of the violence in question, for example by reacting to violations of international humanitarian law or human rights law.

[1] Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, OHCHR, 1999

WMA STATEMENT
ON
MEDICALLY-INDICATED TERMINATION OF PREGNANCY

Adopted by the 24th World Medical Assembly, Oslo, Norway, August 1970
and amended by the 35th World Medical Assembly, Venice, Italy, October 1983
the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

PREAMBLE

1. Medically-indicated termination of pregnancy refers only to interruption of pregnancy due to health reasons, in accordance with principles of evidence-based medicine and good clinical practice. This Declaration does not include or imply any views on termination of pregnancy carried out for any reason other than medical indication.
2. Termination of pregnancy is a medical matter between the patient and the physician. Attitudes toward termination of pregnancy are a matter of individual conviction and conscience that should be respected.
3. A circumstance where the patient may be harmed by carrying the pregnancy to term presents a conflict between the life of the foetus and the health of the pregnant woman. Diverse responses to resolve this dilemma reflect the diverse cultural, legal, traditional, and regional standards of medical care throughout the world.

RECOMMENDATIONS

1. Physicians should be aware of local termination of pregnancy laws, regulations and reporting requirements. National laws, norms, standards, and clinical practice related to termination of pregnancy should promote and protect women's health, dignity and their human rights, voluntary informed consent, and autonomy in decision-making, confidentiality and privacy. National medical associations should advocate that national health policy upholds these principles.
2. Where the law allows medically-indicated termination of pregnancy to be performed, the procedure should be performed by a competent physician and only in extreme cases by another qualified health care worker, in accordance with evidence-based medicine principles and good medical practice in an approved facility that meets required medical standards.
3. The convictions of both the physician and the patient should be respected.
4. Patients must be supported appropriately and provided with necessary medical and psychological treatment along with appropriate counselling if desired.

5. Physicians have a right to conscientious objection to performing an abortion; therefore, they may withdraw while ensuring the continuity of medical care by a qualified colleague. In all cases, physician must perform those procedures necessary to save the woman's life and to prevent serious injury to her health.
6. Physicians must work with relevant institutions and authorities to ensure that no woman is harmed because medically-indicated termination of pregnancy services are unavailable.

WMA STATEMENT ON BOXING

Adopted by the 35th World Medical Assembly, Venice, Italy, October 1983
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and revised by the 68th WMA General Assembly, Chicago, United States, October 2017

1. Boxing is a dangerous sport. Unlike other sports, its basic intent is to produce bodily harm by specifically targeting the head. The main medical argument against boxing is the risk of chronic traumatic encephalopathy (CTE), also known as chronic traumatic brain injury (CTBI), and dementia pugilistica or "punch-drunk" syndrome. Other injuries caused by boxing can lead to loss of sight, loss of hearing, and fractures. Studies show that boxing is associated with devastating short-term injuries and chronic neurological damage on the participants in the long term.

2. The past few decades have witnessed vigorous campaigns by national medical bodies to have all forms of boxing abolished. In the absence of such a ban, a series of boxing tragedies worldwide has pressured various sports regulatory bodies to adopt a variety of rules and standards to enhance the safety of boxers.

3. Despite regulation of boxing in various countries, injuries and death still occur as a result of boxing related head trauma, indicating that regulation does not provide adequate protection to participants.

4. In addition to regulated boxing, unchecked and unsupervised boxing competitions (bareknuckle battles or "street fights") still take place in many parts of the world. This underground boxing puts at risk the lives and health of a significant number of persons who participate in these fights.

5. Health and safety concerns in boxing extend to other professional sports where boxing is a component, such as mixed martial arts (MMA), kickboxing etc. For this reason, the recommendations in this statement should be applied to these sports as well.

6. The WMA believes that boxing is qualitatively different from other sports because of the injuries it causes and that it should be banned.

7. Until a full ban is achieved the WMA urges that the following measures be implemented:

7.1 Boxing must be regulated and all boxers licensed. Boxers should be provided with written information on the risks of participating in boxing.

7.2 No children (as per country-specific definition) should be permitted to participate in boxing.

7.3 A national registry of all amateur and professional boxers, including sparring partners, should be established in each country where boxing is allowed. The registry should record the results of all matches, including technical knockouts, knockouts, and other boxing injuries, and compile injury records for individual boxers. All boxers should be followed up for a period of at least twenty years to document long-term outcomes.

7.4 All boxers should undergo a baseline medical examination, which should include neurological assessment, including brain imaging, at the beginning of their careers. Medical and neurological assessments should also be performed before and after each event. Boxers who do not pass the examination must be reported to the national registry and must not be allowed to participate in future matches.

7.5 Personal protective equipment recommendations (such as size and weight of gloves, head gear and gum shields) should take into consideration medical recommendations.

7.6 A physician serving at a boxing match has a professional responsibility to protect the health and safety of the contestants. To that end, the physician should receive specialized training in athlete evaluation, especially traumatic brain injury assessment. The physician's judgment should be governed only by medical considerations, and the physician must be allowed to stop any match in progress to examine a contestant and to terminate a match that, in the physician´s opinion, could result in serious injury.

7.7 Funding and sponsorship of boxing should be discouraged, and TV coverage of boxing events should be age restricted and include a warning statement on the risks of boxing.

WMA STATEMENT
ON
CHILD ABUSE AND NEGLECT

Adopted by the 36th World Medical Assembly, Singapore, October 1984
and amended by the 41st World Medical Assembly, Hong Kong, September 1989
42nd World Medical Assembly, Rancho Mirage, CA., USA, October 1990
44th World Medical Assembly, Marbella, Spain, September 1992
47th WMA General Assembly, Bali, Indonesia, September 1995
and the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and 67th WMA General Assembly, Taipei, Taiwan, October 2016
and revised by the 68th WMA General Assembly, Chicago, United States, October 2017

OVER-ARCHING PRINCIPLE

1. The welfare of children[1] is of paramount importance. Health professionals should put the welfare of children at the centre of all decision-making related to the child and act in the best interests of children in all of their interactions with children, young people, families, policy-makers and other professionals.

INTRODUCTION

2. One of the most destructive manifestations of family violence and upheaval is child abuse[2] in all its forms. Prevention, protection, early identification, suitable interventions and comprehensive treatment of child abuse victims remain challenging for the world medical community. The World Medical Association (WMA) has called for increased health support of children living on the streets in its Statement on Supporting Health Support to Street Children, but it is also important to address the root causes of child abuse in all its forms.[3]

3. Definitions of child abuse vary from culture to culture. Unfortunately, cultural rationalizations for harmful behaviour toward children may be accepted all too readily as proof that the treatment of children is neither abusive nor harmful. For instance, the work contribution of children in the everyday lives of families and in society should be recognized and encouraged only as long as it also contributes to the child's own development. In contrast, exploitation of children in the labour market deprives them of their childhood and of educational opportunities and endangers their present and future health. The WMA considers such exploitation of children a serious form of child abuse in all its forms.

4. For the purposes of this Statement, the various forms of child abuse include emotional abuse, physical abuse, sexual abuse, child trafficking, child exploitation and child neglect. Child neglect represents a failure of a parent, or other person legally responsible for a child's welfare, to provide for the child's basic needs and an adequate level of care.

RECOMMENDATIONS

The WMA recognizes that child abuse in all its forms is a world health problem and recommends that National Medical Associations adopt the following guidelines for physicians:

5. Physicians have both a unique and special role in identifying and helping abused children and their families.

6. All physicians should be educated about the paramount importance of the welfare of children.

7. Physicians must be aware of and observe local laws regarding consent to undertake examinations of children. Physicians must act in the best interests of children in all of their interactions with children, young people, families, policy-makers and other professionals.

8. Collaboration with an experienced multidisciplinary team is strongly recommended for the physician. Such a team is likely to include physicians, social workers, child and adult psychiatrists, developmental specialists, psychologists and attorneys. When participation in a team is not possible or such a team is not available, the physician must consult with other medical, social, law enforcement and mental health personnel as appropriate.

9. Primary care physicians, family practitioners, internists, paediatricians, emergency medicine specialists, surgeons, psychiatrists and other specialists who treat children must acquire knowledge and skills in the physical, psychological and emotional assessment of child abuse in all its forms, the assessment of child development and parenting skills, the utilization of community resources, and the physician's legal responsibilities.

10. All physicians who treat children, and those adults with caring responsibilities for children, should be aware of the principles of the UN Convention on the Rights of the Child as well as relevant national protective legal provisions applying to children and young people.

11. The medical evaluation of children who are suspected of having been abused should be performed by physicians skilled in both paediatrics and abuse evaluation. The medical evaluation needs to be tailored to the child's age, injuries, and condition and may include blood testing, a trauma radiographic survey, and developmental and behavioural screenings. Follow up radiographs are strongly urged in some children who present with serious, apparently abusive injuries.

12. The medical assessment and management of sexually abused children includes a complete history and physical examination, as physical and sexual abuses often occur together; examination of the genitalia and anus; the collection and processing of evidence, including photographs; and the treatment and/or prevention of pregnancy and venereal disease. Specific attention should be paid to the child's right to privacy.

13. It is essential for the physician to understand and be sensitive to the following: the quality of relationships between care-givers; disciplinary actions or styles used within the child's home; economic stresses on the family; emotional stresses or issued

experienced by members of the family; mental health problems exhibited by any members of the family; violence between the care-givers or other members of the family; substance use and abuse, including alcohol and legal and illegal drugs; and any other forms of stress that could relate to child abuse in all its forms.

14. All physicians need to be aware that all forms of abuse of children by other children can occur. Recognition that this may be a result of prior or current abuse of the alleged abuser must be at the forefront of the physician's mind when such situations are suspected or encountered.

15. The signs of abuse are often subtle, and the diagnosis may require comprehensive, careful interviews with the child, parent(s), care-givers, and siblings. Inconsistencies among explanation(s) and characteristics of the injury(s), such as the severity, type and age, should be documented and further investigated.

16. In any child presenting to a medical facility, the emergent medical and mental health needs should be addressed first. If abuse is suspected, safety needs must be addressed prior to discharge from the facility. These measures should include:

    - Reporting all suspected cases to child protective services;
    - Hospitalizing any abused child needing protection during the initial evaluation period;
    - Informing the parents of the suspicion of abuse or diagnosis of abuse if it is safe to do so; and
    - Reporting the child's injuries to child protective services or other relevant authorities.

17. If hospitalization is required, a prompt evaluation of the child's physical, emotional and developmental problems is necessary. This comprehensive assessment should be conducted by physicians with expertise or through a multidisciplinary team of experts with specialized training in child abuse.

18. If child abuse is suspected, the physician should discuss with the parent(s) the fact that child abuse is in the differential diagnosis of their child's problem. Advice may be required from child protective services.

19. During discussions with the parent(s), guardians, or care-givers it is essential that the physician maintain objectivity and avoid accusatory or judgmental statements in interactions with the parent(s) or individual(s) responsible for the child's care.

20. It is essential that the physician record the history and examination findings in the medical chart contemporaneously during the evaluation process. Injuries should be documented using photographs, illustrations, and detailed descriptions. The medical record often provides critical evidence in court proceedings.

21. Physicians should participate at all levels of prevention by providing prenatal and postnatal family counselling, identifying problems in child rearing and parenting, and advising about family planning and birth control.

22. Public health measures such as home visits by nurses and other health professionals, anticipatory guidance by parents, and well-infant and well-child examinations should be encouraged by physicians. Programs that improve the child's general health also tend to prevent child abuse in all its forms and should be supported by physicians and

their representative bodies.

23. Physicians should recognize that child abuse and neglect is a complex problem and more than one type of treatment or service may be needed to help abused children and their families. The development of appropriate treatment requires contributions from many professions, including medicine, law, nursing, education, psychology and social work.

24. Physicians should promote the development of innovative programs that will advance medical knowledge and competence in the field of child abuse and neglect. Inclusion of on-going reviews of knowledge, skills and competency in relation to protecting the rights of children and young people, promoting their health and well-being and the recognition of and response to suspected cases of child abuse and neglect is crucial in professional educational programs. Physicians should obtain education on child neglect and abuse in all its forms during training as medical students.

25. In the interests of the child, patient confidentiality may be waived in cases of child abuse. The first duty of a doctor is to protect his or her patient if victimization is suspected. No matter what the type of abuse (including physical abuse, emotional abuse, sexual abuse, trafficking, exploitation or neglect), an official report must be made to the appropriate authorities.

26. Inclusion of on-going reviews of knowledge, skills and competency in relation to protecting the rights of children and young people, promoting their health and well-being and the recognition of and response to suspected cases of child abuse in all its forms and neglect is crucial in professional educational programmes.

27. The undergraduate medical curriculum must include a mandatory course on child abuse, in all its forms, within the paediatrics program, that can be developed within postgraduate and continuing medical education for those intending to work within this field.

---

[1] The United Nations Convention on the Rights of the Child defines a child as anyone who has not reached their 18th birthday.
[2] Child abuse and Child maltreatment are used synonymously in this Statement.
[3] Neglect is the persistent failure to meet a child's basic needs, likely to result in the serious impairment of a child's health, well-being or development.

WMA STATEMENT
ON
FREEDOM TO ATTEND MEDICAL MEETINGS

Adopted by the 36th World Medical Assembly, Singapore, October 1984
and reaffirmed with minor revision by the 215th WMA Council Session (online), Cordoba, Spain, October 2020

Professional independence and professional freedom are indispensable to physicians to enable them to give appropriate health care to their patients. Therefore, there should be no barriers, whether philosophical, religious, racial, political, geographic, physical or of any other nature to prevent physicians from participating in professional activities that will enable them to acquire the information, knowledge, skills and techniques required to provide appropriate health care to their patients.

In as much as the purpose of the WMA is to serve humanity by endeavoring to achieve the highest international standards in medical education, medical science, medical art and medical ethics, and health care for all people of the world, there should accordingly be no barriers which will prevent physicians from attending meetings of the WMA, or other medical meetings, wherever such meetings are convened.

WMA STATEMENT
ON
NON-DISCRIMINATION IN PROFESSIONAL MEMBERSHIP AND ACTIVITIES OF PHYSICIANS

Adopted by the 37th World Medical Assembly, Brussels, Belgium, October 1985
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and revised by the 66th WMA General Assembly, Moscow, Russia, October 2015

The World Medical Association is in favour of equality of opportunity in medical association activities, medical education and training, employment, and all other medical professional endeavours regardless of any factors of discrimination.

The World Medical Association is unalterably opposed to the denial of membership privileges and responsibilities in National Medical Associations to any duly registered physician because of any factors of discrimination.

The World Medical Association calls upon the medical profession and all individual members of National Medical Associations to exert every effort to prevent any instance in which such equal rights, privileges or responsibilities are denied.

WMA STATEMENT
ON
ACCESS TO HEALTH CARE

Adopted by the 40th World Medical Assembly, Vienna, Austria, September 1988
and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 68th WMA General Assembly, Chicago, United States, October 2017

PREAMBLE

1. Health is not simply the absence of illness, but is also more than a state of physical, psychological and social flourishing, and includes an individual's ability to adapt to physical, social and mental adversity. It is affected by many factors, including access to health care and especially the Social Determinants of Health (SDH), and its restoration is similarly multidimensional. Society has an obligation to make access to an adequate level of care available to all its members, regardless of ability to pay.

2. Health care professionals regularly confront the effects of lack of access to adequate care and health inequality and have a corresponding responsibility to contribute their expertise to work with governments at local, regional and national levels to ensure they understand the Social Determinants of Health and integrate reduction of factors leading to inequality into all policies. Health care policies should suggest ways to eliminate health inequality.

3. Access to health care is an important factor in reducing the short, medium and long term consequences of poor health, caused by adverse social and other conditions. Access is itself multidimensional, and is constrained by factors including health human resources, training, finance, transportation, geographical availability, freedom of choice, public education, quality assurance and technology.

GUIDELINES

Health Human Resources

4. The delivery of health care is highly dependent upon the availability of trained health care workers. The training should not only include socio-medical competencies, but particularly emphasize an understanding of how the social determinants of health affect people's health outcomes.

   The distribution of health care workers varies widely as do the demographics in most countries, where an ageing population forms a huge challenge for the years to come. There is global mal-distribution. While all countries train health care workers, global movement, especially from less to better developed countries, is leading to continuing shortages. The development of ethical recruitment codes may help to reduce inappropriate recruitment activities by states. Ethical recruitment codes should also be applied to commercial recruitment agencies.

5. Research is needed to determine the best mix of different health care workers for different clinical settings to meet the needs of populations. Mal-distribution within countries should be addressed by seeking methods of attracting health care workers to rural and remote areas, or other underserved regions, at least for a part of their careers. Innovative concepts should be explored to make working in underserved areas interesting; punitive and coercive recruiting methods must not be used. Recruiting students who express a wish to return to their home area may help to alleviate this problem.

Training

6. Primary training of health care workers has to be appropriate, accessible and of good quality, which makes the training costly, with the country of origin meeting this cost. Workers move to continue with secondary training, including higher professional training and specialisation for physicians, and also to earn more money that may be remitted home to support the family and community.

7. The ambition for self-improvement is understandable; efforts to increase retention of health care workers should include consideration of encouraging a return to the home country, with use of the new skills and knowledge to improve health care access.

8. Countries should not actively recruit from other states. Even when they do so passively, this recruitment should take place in accordance with ethical standards and the WMA Statement on Ethical Guidelines for the International Migration of Health Care workers.

Finance

9. Access to care is essential for the whole population. Methods of financing care are for each country to decide, according to their own resources, health and social priorities, and health needs. Countries should develop revenue systems that reduce reliance on out-of-pocket payments and private health insurance as these increase inequalities between population groups.

10. No single system of finance is ideal for every country; the exact balance needs to be locally decided. In making decision about financing systems governments must understand the essential nature of health care, the absolute requirement that it be available to all, based upon clinical need and not on the ability to pay, and that access can be constrained by financial fears. Eligibility for care does not ensure access, especially if co-payment schemes exclude those with the fewest financial resources.

11. Innovative means should be used to provide comprehensive health care, including partnerships with private providers and commercial entities, who may be able to provide elements of specialised care. In doing so states must ensure that this does not limit specialised care to the wealthiest proportion of their population nor should this be seen as a preference for a private health care model.

12. Decisions to limit access to elements of health care should be done on the basis of objective information, based on the best available scientific data about the efficacy

and safety of health care services. It must include public debate about, and acceptance of, the concepts involved. Nothing should be introduced which discriminates against the elderly or vulnerable populations.

13. The public should have access to clear information on the health care resources available to them and how they may be accessed. Specific processes should be established to ensure that poverty or illiteracy will never be a barrier to access care.

Vulnerable and hard to reach people

14. There are groups of people in every country who are hard to reach with health care messages, and who often seek health care late in the progress of disease.

15. A variety of methods should be used to ensure hard to reach people are aware of the availability of health care, without direct cost, including methods to reduce fear and other barriers to access.

16. Where specific vulnerabilities such as learning disabilities or sensory impairments exist, solutions should include identifying and dealing with those vulnerabilities.

17. Health care workers have a duty to provide care that is free from any form of unfair discrimination.

Transportation

18. Health care facilities should be situated in locations that are easy to access. This may mean working with local transportation providers to ensure formal and informal public transport routes pass the facilities. Consideration should be made to making health care facilities more accessible by active transport methods. Especially in rural and remote locations, patients may travel considerable distances to attend the facilities.

19. Patients who need referral to secondary and specialized care should be provided with access to transportation. Those needing help with accessing primary care should also receive support. Transportation should also be offered to isolated rural patients who require a level of care that can be found only in metropolitan medical centres. Telemedicine can sometimes be an acceptable substitute for transportation of patients.

Geographical availability

20. Working with other health providers, including traditional birth attendants, may provide assistance. They should be integrated into the health care system, offered training, and be assisted to offer care that is safe and effective and that includes referral where necessary. This does not extend to the state health care system providing or funding care which is not evidence based, including so-called complementary therapies.

Freedom of choice

21. The freedom to choose care providers, and the options of care they offer is an essential element of care in every system. It requires the ability to understand that

choice, and the freedom to choose a provider from among alternatives.

22. Barriers to freedom of choice may lie in access to financial resources, understanding of the options, and in cultural geographic, or other factors. Access to information about the available options is crucial in making an appropriately informed choice.

23. The health authorities should ensure that all populations understand how to access care, and should seek to ensure that populations have access to objective information about the availability of different health care suppliers.

24. Once individuals access care through a particular provider or physician they should be given opportunities to consider the clinical options open to them; access to systematically available information resources is an essential element supporting choice.

Public education

25. General education is a determinant of health; the better educated a person is, generally the better their health likelihood. When ill-health presents, prior education may be a determinant of the speed at which the person accesses health care. Education also aids individuals to make appropriate choices about the care options they access.

26. Specific education about health matters can be an important adjunct to lifestyle planning. While education alone does not, for example, stop people from smoking, using drugs or alcohol, it can aid in decision making about risk behaviour.

27. A general level of health literacy assists patients to make choices among different options for treatment, and to comply or co-operate with the requirements of that treatment. It will also improve self-care and the appropriateness of self-referral.

28. Educational programs that assist people in making informed choices about their personal health and about the appropriate uses of both self-care and professional care should be established. These programs should include information about the costs and benefits associated with alternative courses of treatment within the context of modern medicine; the use of professional services that permit early detection and treatment or prevention of illnesses; personal responsibilities in preventing illnesses; and the effective use of the health care system. Physicians should actively participate, wherever appropriate, in such educational efforts and must be provided with adequate resources to enable them to undertake such education.

29. Public education also assists governments by increasing understanding of public health measures, including taxation of tobacco, banning of human consumption of some products, and restrictions on individual freedoms because of health concerns. When legislative or other regulatory mechanisms are to be imposed by governments, a campaign of public education and explanation must be undertaken to gain public understanding and voluntary compliance.

Quality assurance

30. Quality assurance mechanisms should be part of every system of health care

delivery. Physicians share responsibility for assuring the quality of health care and must not allow other considerations to jeopardize the quality of care provided.

Technology

31. Technology is playing an increasing role in the provision of health care services. Capital purchase prices are high because of the need for specific logistical services, including skilled technicians and adequate facilities. Advanced technologies are not available in all locales; access to their benefits must be well planned to ensure they benefit all patients in need, not simply those local to advanced technology centres.

Extraordinary circumstances

32. In extraordinary circumstances, including armed conflicts and major natural events such as earthquakes, physicians have a specific duty to ensure that policy makers protect access to care, especially for those most vulnerable and least able to move to more secure areas.

RECOMMENDATIONS

33. Social Determinants of Health greatly affect access to health care as well as directly impacting on health. Physicians should work with governments to ensure they are able to take effective action on SDH.

34. Access to health care requires systematic consideration to ensure appropriate conditions are met. These include:

    34.1 Having an appropriate, universal, solidaristic and equitable health system, adequately resourced facilities, being available throughout a country, providing health centers and their professional staff with sufficient and sustainable financing, with individuals being treated on the basis of need and not on the ability to pay.

    34.2 Patient choice should include which facility to access.

    34.3 Access to adequate information for all is essential for making choices and for co-operating with health care providers.

    34.4 Education is both a social determinant and a key factor in co-operation with health care provision, fostering responsible self-care with accessible support.

    34.5 Health care professionals should be free to move around the world, especially to access educational and professional opportunities. This mobility must not damage resource availability, especially in resource poor countries.

    34.6 Physicians must be provided with transparent and efficient ethical criteria for working in overcrowded or underserved areas.

    34.7 Provision of health care requires action by government at all levels, working with populations to ensure that people understand the benefit of this care and are able to access it.

34.8 Physicians have an important role in ensuring that health care planning makes clinical sense, is communicated well to the population being served, and that patients are not endangered by inadequate resources, poor planning or other system flaws.

34.9 Physicians are aware of the health system and this forces them to play a socially conscious role regarding the social determinants of health and access to health care by themselves or through their representative medical associations.

34.10 Medical associations should work with their members to promote access to health care systems that equitably support the needs of populations.

WMA STATEMENT
ON
THE ROLE OF PHYSICIANS IN ENVIRONMENTAL ISSUES

Adopted by the 40th World Medical Assembly, Vienna, Austria, September 1988
revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and reaffirmed by the 203rd WMA Council Session, Buenos Aires, Argentina, April 2016

INTRODUCTION

1. The effective practice of medicine increasingly requires that physicians and their professional associations turn their attention to environmental issues that have a bearing on the health of individuals and populations.

2. More than ever, due to diminishing natural resources, these problems relate to the quality and protection of resources necessary to maintain health and indeed sustain life itself. In concrete terms, the key environmental issues are as follow:

    a. The degradation of the environment, which must be halted as a matter of urgency so that resources essential to life and health - water and pure air - remain accessible to all.

    b. The ongoing contamination of our reserves of fresh water with hydrocarbons and heavy metals, along with the contamination of ambient and indoor health by toxic agents, which have serious medical consequences, especially in the poorest segments of the globe. Moreover, the greenhouse effect with its concomitant proven rise in temperature should drive our discussions forward and prepare us for increasingly serious environmental and public health consequences.

    c. The need to control the use of non-renewable resources such as topsoil, which should constantly be at the forefront of our minds, as should the importance of safeguarding this vital heritage so that it can be passed on to future generations.

    d. The need to mobilise resources beyond national frontiers and to co-ordinate global solutions for the planet as a whole, so as to formulate a unified strategy to confront these worldwide medical and economic problems.

    e. The foremost objective is to increase awareness of the vital balance between environmental resources on the one hand, and on the other, biological essentials for the health of everyone everywhere.

3. Our growing awareness of these issues today has, however, failed to prevent an in-

crease in our societies' negative impact on the environment, e.g., melting of glaciers and increasing desertification, nor has it halted the over-exploitation of natural resources, e.g. pollution of rivers and seas, air pollution, deforestation and diminishing arable land. In this context, the migration of people from disadvantaged or developing countries, together with the emergence of new diseases, exacerbates the lack of socio-economic policies in many parts of the world. From a medical point of view, growth of the population and irresponsible destruction of the environment are unacceptable, and medical organizations throughout the world should redouble their efforts, not only to speak out about these problems, but also to suggest solutions.

PRINCIPLES

1. In their role as representatives of physicians, medical associations are duty bound to grapple with these environmental issues. They have a duty to produce analytical studies that include the identification of problems and current international regulations on environmental issues, as well as their impact on the field of health.

2. As physicians operate within the framework of ethics and medical deontology, the environmental regulations advocated should not seek to limit individual autonomy, but rather to enrich the quality of life for all and to perpetuate life-forms on the planet.

3. The WMA should therefore act as an international platform for research, education, and advocacy to help further sustain the environment and its potential to promote health.

4. Thus, when new environmental diseases or syndromes are identified, the WMA should help coordinate the scientific/medical discussions on the available data and their implications for human health. It should foster the development of consensus thinking within medicine, and help to stimulate preventive measures, accurate diagnosis and treatment of these emerging disorders.

5. The WMA should therefore provide a framework for the international co-ordination of medical associations, NGOs, research clinicians, international health organizations, decision-makers and funding providers, in their examination of the human health effects of environmental problems, their prevention, remediation and treatment for individuals and communities.

WMA STATEMENT ON HEALTH HAZARDS OF TOBACCO PRODUCTS AND TOBACCO-DERIVED PRODUCTS

Adopted by the 40th World Medical Assembly, Vienna, Austria, September 1988
revised by the 49th WMA General Assembly, Hamburg, Germany, November 1997
the 58th WMA General Assembly, Copenhagen, Denmark, October 2007
the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011
and the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

Over 80 percent of the world's 1.3 billion smokers live in low- and middle-income countries. Smoking and other forms of tobacco use adversely affect every organ system in the body, and are major causes of cancer, heart disease, stroke, chronic obstructive pulmonary disease, fetal damage, and many other conditions. Smokers have up to a 50% higher risk of developing severe disease and death from COVID-19. Eight million deaths occur worldwide each year due to tobacco and tobacco- derived products. Tobacco will kill one billion people in the 21st century unless effective interventions are implemented.

Exposure to secondhand smoke occurs anywhere the burning of tobacco products occurs in enclosed spaces. There is no safe exposure level to secondhand smoke, which causes millions of deaths each year. It is especially damaging to children and pregnant patients. On May 29, 2007, the WHO called for a global ban on smoking at work and in enclosed public places to eliminate secondhand smoke and encourage people to quit.

The phenomenon known as "thirdhand smoke" occurs when nicotine and other chemical residues occur on indoor surfaces from smoking, which can persist long after the smoke itself has cleared. It is increasingly recognized as a potential danger, especially to children, who not only inhale fumes released by these residues but also ingest residues that get on their hands after crawling on floors or touching walls and furniture.

World Health Organization Action

With the hope of mitigating the effects of tobacco use, the World Health Organization (WHO) Member States unanimously adopted the WHO Framework Convention on Tobacco Control (WHO FCTC) in 2003. In force since 2005, it currently has 182 parties covering more than 90 percent of the world's population. Further strengthening implementation of the milestone treaty is specifically included in the 2030 Agenda for Sustainable Development Goals (SDG) as

Target 3.a. The WMA has long supported the WHO FCTC (see WMA Resolution on Implementation of the WHO Framework Convention on Tobacco Control). The Protocol to Eliminate Illicit Trade in Tobacco Products, the first protocol to the WHO FCTC, was adopted in 2012 in response to the growing international illicit trade in tobacco products. The objective of the Protocol is the elimination of all forms of illicit trade in tobacco products, in accordance with the terms of Article 15 of the WHO FCTC.

New and Emerging Nicotine Products

The WMA Statement on Electronic Cigarettes and Other Electronic Nicotine Delivery Systems outlines the still-unknown risks associated with these products. The use of e-cigarettes by young people has risen dramatically, and in some regions is more popular than tobacco smoking. Nicotine exposure, no matter how it is delivered, can affect brain development and lead to addiction.

New and rediscovered forms of tobacco and nicotine ingestion are also emerging, including:

- dissolvable tobacco, from sweet, candy-like lozenges that contain tobacco and nicotine that are held in the mouth, chewed, or sucked until they dissolve;
- snus, a finely ground form of moist snuff that that contains carcinogens and is usually packaged in small pouches;
- hookahs, a water pipe that burns tobacco mixed with flavors such as honey, molasses or fruit, where the smoke is inhaled through a long hose. The WHO reports that one hookah smoking session is the same as smoking 100 cigarettes, largely due to the length of time a user smokes;
- bidis, flavored cigarettes that are unfiltered and deliver up to five times more nicotine than regular cigarettes, and clove cigarettes (also called Kreteks) also deliver more nicotine, carbon monoxide, and tar than regular cigarettes;
- other heated tobacco products that typically use an electronic heating element to heat specially designed sticks, plugs, or capsules containing tobacco. The heat releases nicotine (and other chemicals) that can then be inhaled into the lungs, but the tobacco does not get hot enough to burn. These devices are not the same as e-cigarettes, and
- Nicotine pouches, tobacco free pouches of nicotine with different flavors which are placed in the mouth.

Pregnant Patients and Children

Smoking or using nicotine during pregnancy is linked with a range of poor birth outcomes including low birth weight and preterm birth, restricted head growth, placental problems, increased risk of still birth and increased risk of miscarriage. Breathing secondhand smoke

during pregnancy also increases the risk of having a low-birth-weight baby, and babies who are exposed to secondhand smoke have an increased risk of Sudden Infant Death Syndrome.

Health and developmental consequences among children have also been linked to prenatal smoke exposure, including poorer lung function, (including coughs, colds, bronchitis and pneumonia), persistent wheezing, asthma and visual difficulties such as strabismus, refractive errors and retinopathy. Children who breathe more secondhand smoke have more ear infections, coughs, colds, bronchitis and pneumonia. Children who grow up with parents who smoke are themselves more likely to smoke and to have long term health effects similar to adults who smoke.

Health Equity

Health equity in tobacco prevention and control focuses on the opportunity for all people to live a healthy life, regardless of their race, level of education, gender identity, sexual orientation, occupation, geographic location, or disability status. Tobacco control programs, including evidence-based cessation services, can work toward health equity by focusing efforts on decreasing the prevalence of tobacco use, and second-hand and thirdhand smoke exposure, and by improving access to tobacco control resources, among populations experiencing greater tobacco-related health and economic burdens.

Tobacco Industry Marketing

The tobacco industry spends billions of dollars annually around the globe on advertising, promotion and sponsorship. The tobacco industry's manipulative and predatory marketing tactics increase consumption of its products and replace smokers who quit or die. By investing huge sums of money in low- and middle-income countries, the industry hopes to increase the social acceptability of tobacco and tobacco companies. The tobacco industry has also long employed strategies targeting children, from developing special packaging or candy-flavored cigarettes and e-cigarette cartridges, and has used the internet, text messaging and youth-oriented social networking sites to advertise sponsored events or promotions.

The best strategy to combat the tobacco industry's marketing tactics is to adopt and enforce comprehensive bans on tobacco advertising, promotion and sponsorship, as set forth in the WHO FCTC.

The tobacco industry claims that it is committed to determining the scientific truth about the health effects of tobacco, both by conducting internal research and by funding external research through jointly funded industry programs. However, the industry has consistently denied, withheld, and suppressed information concerning the deleterious effects of tobacco smoking.

Tobacco companies also manipulate the public's attitude about their reputation and have often engaged in so-called 'corporate social responsibility', which are activities to promote their products while portraying themselves as good corporate citizens.

RECOMMENDATIONS

The WMA recommends that national governments:

1. Increase taxation of tobacco and tobacco-derived products, which is the single most effective tobacco control measure to reduce tobacco use according to the World Health Organization (WHO). Taxation is also a highly cost-effective and inexpensive tool. Increased revenues should be used for prevention programs, evidence-based cessation programs and services, and other health care measures.

2. Urge the WHO to add tobacco cessation medications with established efficacy to the WHO's Model List of Essential Medicines.

3. Ratify and fully implement the WHO Framework Convention on Tobacco Control.

4. Implement comprehensive regulation of the manufacture, sale, distribution, and promotion of tobacco and tobacco-derived products, including total bans on tobacco advertising, promotion and partnership, including abroad. Require plain packaging of tobacco products (as set forth in the WMA Resolution on Plain Packaging of Cigarettes, e-Cigarettes and Other Smoking Products), and packaging that includes prominent written and pictorial warnings about health hazards of tobacco.

5. Prohibit smoking in all enclosed public places, including public transportation, prisons, airports and on airplanes. Require all medical schools, biomedical research institutions, hospitals, and other health care facilities to prohibit smoking, and the use of smokeless tobacco and other tobacco-derived products on their premises.

6. Prohibit the sale, distribution, and accessibility of cigarettes and other tobacco products to children and adolescents. Ban the production, distribution and sale of candy products that depict or resemble tobacco products.

7. Prohibit all government subsidies for tobacco and tobacco-derived products and assist tobacco farmers in switching to alternative crops. Exclude tobacco products from international trade agreements, and work to curtail or eliminate illegal trade in tobacco and tobacco-derived products and the sale of smuggled tobacco products.

8. Provide for research into the prevalence of tobacco use and the effects of tobacco and tobacco-derived products on the health status of the population.

The WMA recommends that national medical associations:

9. Refuse funding or educational materials from the tobacco industry, and urge medical schools, research institutions, and individual researchers to do the same.

10. Adopt policies opposing smoking and the use of tobacco and tobacco-derived products and publicize the policy. Endorse or promote clinical practice guidelines on the treatment of tobacco use and dependence.

11. Prohibit smoking, including use of smokeless tobacco and vaping, in national medical association premises and at all business, social, scientific, and ceremonial meetings of national medical associations, in line with the decision of the World Medical Association to impose a similar ban.

12. Develop, support, and participate in programs to educate the profession and the public about the health hazards of tobacco use (including addiction) and exposure to secondhand smoke.

13. Introduce or strengthen educational programs for medical students and physicians to prepare them to identify and treat tobacco dependence in their patients.

14. Speak out against the shift in focus of tobacco marketing from developed to less developed nations, from adults to youth, and urge national governments to do the same.

15. End investment in companies or firms producing or promoting the use or sale of tobacco or tobacco-derived products. Divest current assets that support tobacco production or promotion.

The WMA recommends that physicians:

16. Be positive role models by not using tobacco or tobacco-derived products, and by acting as spokespersons to educate and raise the awareness of the public about the deleterious health effects of tobacco use and the benefits of tobacco-use cessation.

17. Support widespread access to evidence-based treatment for tobacco dependence through individual patient encounters, counseling, pharmacotherapy, cessation classes, telephone quit-lines, web-based cessation services, and other appropriate means.

18. Recognize that tobacco and second-hand smoke exposure to adult tobacco use cause harm to children. Special efforts should be made by physicians to:

    - promote tobacco-free environments for children
    - target parents and pregnant patients who smoke for tobacco cessation interventions
    - promote programs that contribute to the prevention and decreased use of tobacco and tobacco-derived products by youth
    - support policies that control access to and marketing of tobacco and tobacco-derived products and make pediatric tobacco-control research a higher priority.

WMA STATEMENT
ON
ANIMAL USE IN BIOMEDICAL RESEARCH

Adopted by the 41st World Medical Assembly, Hong Kong, September 1989
revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and reaffirmed by the 203rd WMA Council Session, Buenos Aires, Argentina, April 2016

PREAMBLE

1. Biomedical research is essential to the health and well-being of our society. Advances in biomedical research have dramatically improved the quality and prolonged the duration of life throughout the world. However, the ability of the scientific community to continue its efforts to improve personal and public health is being threatened by a movement to eliminate the use of animals in biomedical research. This movement is spearheaded by groups of radical animal rights activists whose views are considered to be far outside mainstream public attitudes and whose tactics range from sophisticated lobbying, fund-raising, propaganda and misinformation campaigns to violent attacks on biomedical research facilities and individual scientists. These violent attacks are carried out by a relatively small number of activists compared with those who use peaceful means of protest, but they have profound and wide-ranging effects.

2. The magnitude of violent animal rights activities is staggering, and these activities take place in many different parts of the world. Various animal rights groups have claimed responsibility for the bombing of cars, institutions, stores, and the private homes of researchers.

3. Animal rights violence has had a chilling effect on the scientific community internationally. Scientists, research organizations, and universities have been intimidated into altering or even terminating important research efforts that depend on the use of animals. Laboratories have been forced to divert thousands of research dollars for the purchase of sophisticated security equipment. Young people who might otherwise pursue a career in biomedical research are turning their sights to alternative professions.

4. Despite the efforts of many groups striving to protect biomedical research from radical animal activism, the response to the animal rights movement has been fragmented, underfunded, and primarily defensive. Many groups within the biomedical community are hesitant to take a public stand about animal activism because of fear of reprisal. As a result, the research establishment has been backed into a defensive posture. Its motivations are questioned, and the need for using animals in research is re-

peatedly challenged.

5. While properly designed and executed research involving animals is necessary to enhance the medical care of all persons, we recognize also that humane treatment of research animals must be ensured. Appropriate training for all research personnel should be prescribed and adequate veterinary care should be available. Experiments must comply with any rules or regulations promulgated to govern humane handling, housing, care, treatment and transportation of animals.

6. International medical and scientific organizations must develop a stronger and more cohesive campaign to counter the growing threat to public health posed by animal activists. Leadership and coordination must be provided. In addition, there must be a clear understanding of the rights of animals who are part of medical research, and the obligations of those who undertake it.

The World Medical Association therefore affirms the following principles:

1. Animal use in biomedical research is essential for continued medical progress.

2. The WMA Declaration of Helsinki requires that biomedical research involving human subjects should be based, where appropriate, on animal experimentation, but also requires that the welfare of animals used for research be respected.

3. Humane treatment of animals used in biomedical research is essential and research facilities should be required to comply with all guiding principles for humane treatment. Education about these principles should be provided to all researchers in training.

4. Animals should only be used in biomedical research when it is clear that their use is required to achieve an important outcome, and where no other feasible method is available.

5. Duplication of animal experiments should not occur unless scientifically justified.

6. The use of animals for the futile testing of cosmetic products and their ingredients, alcohol and tobacco should not be supported.

7. Although rights to free speech should not be compromised, the anarchistic element among animal right activists should be condemned.

8. The use of threats, intimidation, violence, and personal harassment of scientists and their families should be condemned internationally.

9. A maximum coordinated effort from international law enforcement agencies should be sought to protect researchers and research facilities from activities of a terrorist nature.

WMA STATEMENT ON INJURY CONTROL

Adopted by the 42nd World Medical Assembly, Rancho Mirage, CA., USA, October 1990
and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

njuries are the leading cause of death and disability in children and young adults, destroying the health, livelihoods and lives of millions of people each year. Causes of injury include, among others, acts of violence against oneself or others, traffic crashes, falls, poisonings, drowning, and burns. Yet many injuries are preventable. Injury control should be recognized as a public health priority requiring coordination among health, transportation and social service agencies in each country. Physician participation and leadership through medicine, education and advocacy is necessary to ensure the success of such injury control programmes.

As the World Health Organization states in Injuries and Violence: The Facts, the rate of injury is far from uniform around the world. Indeed, about 90% of injury-related deaths occur in low- and middle-income countries. Within countries, injury rates vary by social class as well. The impoverished face more dangerous living and working conditions than the more affluent. For example, buildings in poorer communities are more likely to be older and in need of repair. Poor communities are also plagued by much higher rates of homicide. What's more, people living in poverty also have less access to quality emergency care and rehabilitation services. Greater attention must be given to these root causes of injuries.

The World Medical Association urges National Medical Associations to work with appropriate public and private agencies to develop and implement programmes to prevent and treat injuries. Included in the programmes must be efforts to improve medical treatment and rehabilitation of injured patients. Research and education on injury control must be increased, and international cooperation is a vital and necessary component of successful programmes.

National Medical Associations should recommend that the following basic elements be incorporated in their countries' programmes:

EPIDEMIOLOGY

The initial activity of such programmes must be the acquisition of more adequate data on which to base priorities, interventions and research. An effective injury surveillance system should be implemented in each country to gather and integrate information. A consistent and accurate system for coding injuries must be implemented by hospitals and health agencies. There should also be international uniformity in the coding of injury severity.

PREVENTION

Injury prevention requires education and training to teach and persuade people to alter their behaviour in order to reduce their risk of injury. Laws and regulations based on scientifically sound methods of preventing injuries may be appropriate for effecting changes in behaviour (for example, the use of seatbelts and protective helmets). These laws must in turn be strictly enforced. An effective injury surveillance system as mentioned above will help determine how to target further preventive efforts. Urban and traffic planning should support safe environments for the residents.

BIOMECHANICS

A better understanding of the biomechanics of injury and disability could inform the development of improved safety standards and regulations of products and their designs.

TREATMENT

Injury management at the scene of the occurrence must be enhanced by an effective system of communication between first responders and health professionals at hospitals to facilitate decision-making. Rapid and safe transportation to the hospital should be provided. An experienced team of trauma practitioners should be available at the hospital. There should also be adequate equipment and supplies available for the care of the injured patient, including immediate access to a blood bank. Education and training of medical practitioners in trauma care must be encouraged to assure optimal technique by an adequate number of physicians at all times.

REHABILITATION

Trauma victims need continuity of care emphasizing not only survival but also the identification and preservation of residual functions. Rehabilitation to restore biological, psychological and social functions must be undertaken in an effort to allow the injured person to achieve maximal personal autonomy and an independent lifestyle. Where feasible, community integration is a desirable goal for people chronically disabled by injury. Rehabilitation may also require changes in the patient's physical and social environment.

WMA STATEMENT ON TRAFFIC INJURY

Adopted by the 42nd World Medical Assembly, Rancho Mirage, CA., USA, October 1990
and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

Serious injuries and mortality in road collisions are a public health problem with consequences similar to those of major diseases such as cancer and cardiovascular disease. Worldwide, about 1.2 million persons are killed each year on the roads, and an additional 20-50 million are injured. By 2020, road traffic injuries are expected to be the third largest contributor to the global burden of disease and injury.

In addition to the immeasurable personal and social price paid by road crash victims and their relatives, traffic injury has a significant economic impact. The economic costs of traffic injury and disability, including emergency and rehabilitative health care, costs of disability and disability adjusted life years (DALYs), amount to 1% of the GDP of poorer countries and 1.5-2% of wealthier countries. Much of this burden is borne by the health sector.

Road injuries continue to increase in many countries, particularly in low- and middle-income nations which currently account for 85% of all road traffic deaths, and are the second leading cause of death among youth worldwide.

Most traffic injuries could be prevented by better countermeasures. Combating traffic injury is the shared responsibility of groups and individuals at the international, national, and community levels, including governments, NGOs, industry, public health professionals, engineers and law enforcement personnel.

Speed is widely recognized as the most important determinant of road safety, affecting both the likelihood that a crash will occur and the severity of a crash. On average, an increase in speed of 1 km/h is associated with a 3% higher risk of a crash involving injury and a 5% higher risk of serious or fatal injury.

However, efforts to decrease road crashes and injury also require a “systems approach” that recognizes and addresses the many factors that contribute to the risk of traffic crashes and resulting injury, including human, vehicle and road design variables.

Preventing traffic injury requires addressing the social determinants of health—the social, economic, environmental, and political factors in society that influence a population’s

health. Low- and middle-income countries, where there is less safe infrastructure, fewer minimum standards on vehicle safety, and poorer quality emergency care, experience the greatest number of traffic injuries. In this way, human, vehicular and environmental factors interact before, during and after a collision. Intervention at each of these stages will help reduce crashes and injury. Effective intervention requires public education as well as professional involvement in the fields of engineering, law enforcement and medical care.

Pre-collision intervention is aimed at preventing crashes and reducing risk factors. Examples include preventing drivers from driving when fatigued (especially drivers of heavy vehicles), distracted or under the influence of drugs or alcohol. Necessary policies may include prohibiting the use of hand-held cellular phones and night curfews or graduated licensing for young drivers. Pre-collision intervention also includes setting vehicle design standards that ensure that vehicles are roadworthy and cannot be driven at excessive speeds. Other interventions include setting and enforcing appropriate speed limits, installing speed cameras, and optimizing road design and layout to prevent crashes.

A second level of intervention is aimed at preventing or reducing injury during the crash. Such interventions include: enforcing the use of seat belts and child restraints; requiring helmets for cyclists; manufacturing vehicles equipped with safety devices and crash-protective design; lowering and enforcing speed limits; and removing heavy, rigid objects such as concrete or metal dividers, light posts and abutments from the sides of roads.

Post-crash intervention is aimed at maximizing life-saving and injury-reducing treatment and includes improved pre-hospital and emergency trauma care and rehabilitation.

RECOMMENDATIONS

1. The WMA supports the findings and key recommendations of the WHO's 2015 Report on road traffic injury prevention and calls for their implementation by its member National Medical Associations and their governments and relevant bodies.
2. Physicians must view traffic injury as a public health problem and recognize their responsibility in fighting this global problem.
3. National Medical Associations and their member physicians should work to persuade governments and policy makers of the importance of this issue and should assist in adapting empirical and scientific information into workable policies.
4. National Medical Associations and physicians should be key players in public education and should include road safety in health promotion activities.
5. Physicians should be involved in the collection and analysis of data regarding road crashes and concomitant injuries, including injury surveillance systems.
6. Physicians should work toward changing the public attitude of road travel, including pressing for improved public transportation, bicycle paths and proper sidewalks to encourage less car use and the adoption of healthier options such as walking and cycling.

7. Physicians should address the human factor and medical reasons for road crashes, including, but not limited to, the use of prescription drugs or medical conditions that may impair driving ability, and explore ways to prevent and reduce the severity of injuries.
8. Physicians should lobby for the implementation and enforcement of the measures listed above, which have been shown to decrease the risk and severity of vehicle crashes, and the evaluation of their impact.
9. National Medical Associations and their member physicians should encourage the research and development of improved training systems and medical care at all stages, including effective communication and transport systems to locate and evacuate the victims, emergency medical care systems to provide life-saving first aid services, and expert trauma and rehabilitative care, and should lobby for increased resources to help provide these services.

WMA STATEMENT ON ADOLESCENT SUICIDE

Adopted by the 43rd World Medical Assembly, Malta, November 1991
and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

The past several decades have witnessed a dramatic change in causes of adolescent mortality. Previously, adolescents mostly died of natural causes, whereas they now more likely die from preventable causes. Part of this change has been a worldwide rise in adolescent suicide rates in both developed and developing countries. In the adolescent population, suicide is currently one of the leading causes of death. Suicides are probably under-reported due to cultural and religious stigma attached to self-destruction and to an unwillingness to recognize certain traumas, such as some automobile accidents, as self-inflicted.

Adolescent suicide is a tragedy that affects not only the individual but also the family, peers and larger community in which the adolescent lived. Suicide is often experienced as a personal failure by parents, friends and physicians who blame themselves for not detecting warning signs. It is also viewed as a failure by the community, serving as a vivid reminder that modern society often does not provide a nurturing, supportive and healthy environment in which children can grow and develop.

Factors contributing to adolescent suicide are varied and include: affective disorders, trauma, emotional isolation, low self-esteem, excessive emotional stress, eating disorders, harassment (school bullying, cyber bullying and sexual harassment), romantic fantasies, thrill-seeking, drug and alcohol abuse, the availability of firearms and other agents of self-destruction, and media reports of other adolescent suicides, which may inspire copycat acts. In addition, the prolonged exposure to electronic media, which predominantly affects adolescents through their use of computer games and social media, can contribute to social isolation, school failure and malaise amongst young people.

Youth within correctional facilities are at a higher risk for suicide than the general population, yet they have fewer resources available to them. The lack of resources makes it difficult to identify those at risk for suicide.

The incidence of adolescent suicide is observed to be greater in the “first peoples” of some nations. The reasons for this are complex.

The health care of adolescents is best achieved when physicians provide comprehensive

services, including both medical and psychosocial evaluation and treatment. Continuous, comprehensive care provides the physician the opportunity to obtain the information necessary to detect adolescents at risk for suicide or other self-destructive behaviour. This service model also helps to build a socially supportive patient-physician relationship that may moderate adverse influences adolescents experience in their environment.

In working to prevent adolescent suicide, the World Medical Association recognizes the complex nature of adolescent bio-psycho-social development; the changing social world faced by adolescents; and the introduction of new, more lethal, agents of self-destruction. In response to these concerns, the World Medical Association recommends that National Medical Associations adopt the following guidelines for physicians. In doing so, we recognise that many other players – parents, governmental agencies, schools, communities, social services – also have important roles in this area.

RECOMMENDATIONS

1. All physicians should receive, during medical school and postgraduate training, education in child psychiatry and adolescent bio-psycho-social development, including education in the risk factors for suicide.
2. Physicians should be trained to identify early signs and symptoms of physical, emotional, and social distress of adolescent patients. They should also be trained to identify the signs and symptoms of psychiatric disorders, like depression, bipolar disorder and substance use disorders, that may contribute to suicide as well as other self-destructive behaviours.
3. Physicians should be taught how and when to assess suicidal risk in their adolescent patients.
4. Physicians should be taught and keep up-to-date on the treatment and referral options appropriate for all levels of self-destructive behaviours of their adolescent patients. The physicians with the most significant training in adolescent suicide are child and adolescent psychiatrists, so the patient should be referred to one if available.
5. Physicians should also collaborate with other relevant stakeholders, such as social workers, school officials, and psychologists who bear expertise in child and adolescent behavior.
6. When caring for adolescents with any type of trauma, physicians should consider the possibility that the injuries might have been self-inflicted.
7. When caring for adolescents who demonstrate deterioration in thinking, feeling or behaviour, the possibility of substance abuse and addiction should be considered, and the threshold should be low for urine toxicology assessment.
8. Health care systems should facilitate the establishment of mental health consultation services aimed at preventing suicide and should pay for the socio-medical care given to patients who have attempted suicide. Services should be tailored to the specific needs of adolescent patients.

9. Epidemiological studies on suicide, its risk factors and methods of prevention should be conducted, and physicians should keep up-to-date with such studies.
10. When caring for adolescents with psychiatric disorders or risk factors for suicide, physicians should educate parents or guardians to watch for the signs of suicide and educate them about the options for evaluation.
11. Physicians should advocate for the identification of at risk groups of adolescents with the mobilization of specifically targeted resources directed at prevention and risk reduction.

WMA STATEMENT
ON
ALCOHOL AND ROAD SAFETY

Adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992
and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

INTRODUCTION

Deaths and injuries resulting from road crashes and collisions are a major public health problem. The World Health Organization's 2015 Global status report on road safety indicates that the total number of road traffic deaths per year has reached 1.25 million worldwide, with the highest road traffic fatality rates in low-income countries.

Driving while under the influence of alcohol has caused a large number of the deaths and injuries resulting from road crashes. The prevalence of drinking and driving is increasing worldwide each year.

A change in the behaviour of road users with regard to alcohol consumption would appear to be the most promising approach to preventing traffic deaths and injuries. Measures forbidding driving while under the influence of alcohol will lead to a considerable improvement in road safety and an appreciable reduction in the number of dead and injured.

CONSEQUENCES OF DRINKING AND DRIVING

Driving a vehicle implies the acceptance of a certain number of risks. The careful driver will always be aware of the risks but also ensure that the level of risk never rises to an unacceptable level. Alcohol not only impairs one's ability to drive, but it also alters a driver's subjective assessment of risk so that he or she drives more recklessly.

Irrespective of the amount of alcohol consumed, the maximum concentration of alcohol in the body is reached:after half an hour when taken

- on an empty stomach;
- after an hour when taken with a meal.

On the other hand, it takes the body a long time to eliminate alcohol. An individual in good health eliminates alcohol at a rate that reduces blood alcohol concentration by 0.1 to 0.15 gram/litre/hour. Thus, one's driving ability remains impaired long after he or she has stopped drinking.

Alcohol abuse has both short- and long-term neurological and psychiatric consequences that can endanger road safety.

Certain drugs interact negatively with alcohol, and in particular some combinations are known to reduce alertness. When drugs, whether legal or illegal, are taken with alcohol, the effect of the latter is intensified. This mixture can trigger mental dysfunctions that are extremely dangerous for road users. Physicians should be educated and informed about these pharmacological facts.

RECOMMENDATIONS

1. The WMA reaffirms its commitments to work for reducing excessive alcohol consumption and for fostering harm-reduction policies and other measures (WMA Declaration on Alcohol, October 2015.)

2. Physicians and National Medical Associations should play an active role in promoting and advocating for the development of evidence-based government policies to reduce alcohol use and driving:

Policy interventions

3. At the present time, permitted blood alcohol levels while driving vary from country to country. Even small amounts of alcohol have a direct effect on the brain, with disturbances noted at levels as low as 0.3 grams per litre. Therefore, it would be desirable to lower the maximum permissible level of blood alcohol to a minimum, but not above 0.5 grams per litre, which is low enough to allow the average driver to retain the ability to assess risk.

4. The especially high prevalence in certain countries of driving while under the influence of alcohol may justify more coercive policies, which physicians and National Medical Associations should play an active role in supporting. For example, the driver may be declared unfit to drive for a period of time sufficient to ensure he or she will no longer be a threat to road safety in the future.

5. Government officials should consider implementing restrictions on the sale or affordability of alcohol, perhaps through taxation, licensing systems, and/or limits on the days and hours of sale. Restrictions on the promotion of alcoholic beverages, including advertising and event sponsorship, should also be considered.

6. A minimum legal age for alcohol purchase and consumption should be adopted in each country. Government officials should consider implementing a separate, lower or zero blood alcohol content law for young drivers.

7. There should be strict consequences to selling alcoholic beverages to individuals under the age to purchase and consume alcohol. These laws should be properly enforced.

8. Any driver who has been in a road traffic crash must undergo a blood alcohol concentration test or a breath test.

9. The practice of random driver testing for breath alcohol levels should become more widespread, and there should be further research into other ways to test urine, breath

and saliva to identify impaired drivers and prevent subsequent operation of motor vehicles.

10. Devices that prevent individuals with an unauthorised level of blood alcohol from starting the engine of or operating the vehicle should be developed and experimented with.

Educational interventions

11. Educational interventions should promote moderation and responsibility in the consumption of alcohol and seek to reduce the likelihood that someone will consume alcohol and drive afterwards.

12. The information dispensed by physicians and other health professionals should be aimed at making everyone aware of the dangers of driving under the influence of alcohol. When physicians and other health professionals issue fitness-to-drive certificates, they can use this opportunity to educate road users and pass on a message of prevention and personal responsibility.

13. In most countries, road crashes linked to alcohol consumption affect adolescents and young adults to a disproportionately high degree, and every available resource should be mobilised to reduce their consumption of alcohol. The problem of alcohol consumption in adolescents and young adults and its relation to road safety should be addressed in the school curricula so that a responsible attitude becomes the norm.

Clinical and rehabilitative interventions

14. Physicians should also be involved in reducing the likelihood of impaired driving by participating in the detoxification and rehabilitation of drunk drivers. These initiatives should be based on a detailed analysis of the problem as it manifests itself within each country or culture. Generally speaking, however, alcoholism is a medical condition with concomitant psychological or social and interpersonal difficulties that affect the family, work or social environment.

15. Alcoholic subjects should be given access to rehabilitation services. When drivers are found to have excess alcohol in their blood (or their breath), other factors linked to their excessive drinking should be examined and included in a rehabilitation programme. These rehabilitation programmes should be publicly funded.

16. Road crashes linked to the consumption of alcohol can be considered as possible predictors of other addictive and violent behaviours. This should be taken into consideration in the medical treatment of the patient.

Community interventions

17. Strategies should be developed by relevant stakeholders to ensure safe transportation home in situations where alcohol consumption occurs.

18. Eliminating alcohol from the workplace and in situations where consumers must drive should be a goal of organizational policies. The promotion of non-alcoholic drinks is an important tool to facilitate these policies.

WMA STATEMENT ON NOISE POLLUTION

Adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992
amended by the 58th WMA General Assembly, Copenhagen, Denmark, October 2007
and reaffirmed with minor revision by the 207th WMA Council session, Chicago, United States, October 2017

PREAMBLE

Given growing environmental awareness and knowledge of the impact of noise on health, the psyche, performance and well-being, environmental noise is becoming a serious public health threat. The World Health Organization (WHO) describes noise as the principal environmental nuisance in industrial nations.

Noise affects people in various ways. Its effects relate to hearing, the vegetative nervous system, the psyche, spoken communication, sleep and performance. Since noise acts as a stressor, an increased burden on the body leads to higher energy consumption and greater wear. It is thus suspected that noise can primarily favour diseases in which stress plays a contributory role, such as cardiovascular diseases, which can then be manifested in the form of hypertension, myocardial infarction, angina pectoris, or even apoplexy.

The effects in the psychosocial field are likewise dramatic. The stress caused by environmental noise is a central concern, not only in the industrial nations, but increasingly also in the developing countries. Owing to the continuous and massive growth of traffic volumes, both on the roads and in the air, the stress caused by environmental noise has increased steadily in terms of both its duration and the area affected.

Similarly, occupational noise generates increasingly work-related hearing impairment.

Damage to hearing caused by leisure-time noise is also of growing concern. The most common source of noise in this context is music, to which the ear is exposed by different audio media at different places (portable music players, stereo systems, discotheques, concerts). The risk of suffering hearing damage is underestimated by most people, or even consciously denied. The greatest issue (or aspect) lies in creating awareness of the problem in the high-risk group – which generally means young people. In this respect, the legislature is called upon to intervene and reduce the potential for damage by introducing sound level limiters in audio playback units and maximum permissible sound levels at music events, or by banning children's toys that are excessively loud or produce excessive noise levels.

In keeping with its socio-medical commitment, the World Medical Association is issuing a statement on the problem of noise pollution with the aim of making a contribution to the fight against environmental noise through more extensive information and more acute awareness.

RECOMMENDATIONS

The World Medical Association calls upon the National Medical Associations to:

1. Inform the public, especially persons affected by environmental noise, as well as policy and decision makers, of the dangers of noise pollution.

2. Call upon ministers of transport and urban planners to develop alternative concepts that are capable of countering the growing level of environmental noise pollution.

3. Advocate appropriate statutory regulations for combating environmental noise pollution.

4. Support enforcement of noise pollution legislation and monitor the effectiveness of control measures.

5. Inform young people of the risks associated with listening to excessively loud music, such as that which emanates, for example, from portable music players, use of stereo systems with earphones, audio systems in cars, and attendance at rock concerts and discotheques.

6. Prompt the educational authorities to inform pupils at an early stage regarding the effects of noise on people, how stress due to environmental noise can be counteracted, the role of the individual in contributing to noise pollution, and the risks associated with listening to excessively loud music.

7. Provide information about risks of damage to hearing that arise in the private sector as a result of working with power tools or operating excessively loud motor vehicles.

8. Emphasize to those individuals who are exposed to excessive levels of noise in the workplace the importance of protecting themselves against irreducible noise.

9. Call upon the persons responsible for occupational safety and health in businesses to take further action to reduce noise emission, in order to ensure protection of the health of employees at the workplace.

WMA STATEMENT
ON
BODY SEARCHES OF PRISONERS

Adopted by the 45th World Medical Assembly, Budapest, Hungary, October 1993
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

1. The World Medical Association adopts this statement for the purpose of providing guidance for National Medical Associations as they develop guidelines for their members.

2. Physician participation in body cavity searches for purposes of law enforcement or public safety involves complex issues of patient rights, informed consent, physicians' fiduciary obligations (dual loyalty matters) and their responsibilities to contribute to public health. A request to conduct a body cavity search puts the physician in the untenable position of potentially violating the ethical standards of his/her profession. Physician participation should be in exceptional cases only.

3. There are several types of searches of prisoners carried out within the detention system. These will include searches for contraband and searches for items immediately dangerous to the prisoner and those around him/her. Searches range from the least invasive "pat-down" searches to the most invasive strip searches (including examination of the mouth) and body cavity searches.

4. The prison systems in many countries mandate body cavity searches of prisoners. Such searches, which include rectal and pelvic (vaginal) examination, may be performed when an individual initially enters the prison population and thereafter whenever the individual is permitted to have direct personal contact with someone outside the prison population. They may also be undertaken when there is a reason to believe a breach of security or of prison regulations has occurred. For example, when a prisoner is taken to Court for a hearing, or to the hospital for treatment, or to work outside the prison, the prisoner, upon returning to the institution, may be subjected to a body cavity search that will include all body orifices. Where prisoners have direct contact with visitors – family members or otherwise – prison rules may also require body cavity searches. The purpose of the search is primarily security-related, to prevent contraband, such as weapons or drugs, from entering the prison.

5. These searches are performed for security reasons and not for medical or health-

related reasons. They should only be done by someone with appropriate training. In most cases this will mean someone working within the detention system who has been trained to perform safely such searches. This person should not be a physician except under unusual and specific circumstances.

6. A physician's obligation to provide medical care to the prisoner can be compromised by an obligation to participate in the prison's security system. A physician should seek to be as far removed from performing body searches as possible. Any directive to search should be separated from the physician's broad general medical care duties in order to protect the patient/physician relationship.

7. In exceptional cases the detaining authority, may indicate that a search be performed by a physician. The physician, will decide whether medical participation is necessary, and act accordingly and ethically.

8. If the search could, if carried out by someone with lesser skills, cause harm, for example if the prisoner is a pregnant, or has severe haemorrhoids, then this non-medical procedure may be performed by a physician to protect the prisoner from harm. In such a case the physician should explain this to the prisoner. The physician should also explain to the prisoner that s/he is performing this search not as a physician caring for the patient, but for patient safety and as required by the detention authorities for which the normal patient/doctor relationship does not exist. The physician should inform the prisoner that the usual conditions of medical confidentiality do not apply during this procedure and the results of the search will be revealed to the authorities. If a physician is properly mandated by an authority and agrees to perform a body cavity search on a prisoner for reasons of patient safety, the authority should be informed that it is necessary for this procedure to be done in a humane manner.

9. If the search is conducted by a physician, it should not be done by any physician who will subsequently provide medical care to the prisoner.

10. Forced examinations are not ethically acceptable, and physicians must not perform them. If the prisoner acquiesces to a search, the doctor, or other individual carrying out the body cavity search, should ensure that the prisoner is fully aware of what will be done, including the facilities in which the search will be performed.

11. Searches should be performed humanely, and, where possible, in a private, confidential setting respecting the prisoner. The person performing the search should be of the same gender as the prisoner being searched. When applicable, transgender persons should be asked first with which gender they identify.

12. The World Medical Association urges all governments and public officials with responsibility for public safety to recognize that invasive searches are serious assaults on a person's privacy and dignity, and they also carry some risk of physical and psychological injury. The World Medical Association urges that, to

the extent feasible without compromising public security, the following recommendations be followed:

- Alternate methods be used for routine screening of prisoners, including ultrasound and other scans, and body cavity searches be used only as a last resort;
- Squatting over mirrors to examine the anus while making the prisoner bear down, a degrading procedure with questionable reliability, must be banned;
- If a body cavity search must be conducted, the responsible public official must ensure that the search is conducted humanely by personnel who are of the same gender as the prisoner and who possess sufficient medical and skills to safely perform the search;
- The same responsible authority must ensure that the individual's privacy and dignity be guaranteed.
- Physician participation in body cavity searches should be in exceptional cases only. In these cases, the duty to search should be separated from the physician's delivery of medical care.

13. Finally, the World Medical Association urges all governments and responsible public officials to provide body searches that are performed by a qualified physician whenever warranted by the individual's physical condition. A specific request by a prisoner for a physician shall be respected, so far as possible.

14. In specific cases, it may be the detaining authority, which requires a search be performed by a physician, for the well-being of this prisoner. The physician, in such a case, will decide whether medical participation is indeed necessary, and act accordingly and ethically.

WMA STATEMENT ON FEMALE GENITAL MUTILATION

Adopted by the 45th World Medical Assembly, Budapest, Hungary, October 1993
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

The World Medical Association joins with other international agencies in condemning the practice of genital mutilation or cutting of women and girls, regardless of the level of mutilation, and opposes the participation of physicians in these practices.

Stopping female genital mutilations (FGM) requires action on strict enforcement of laws prohibiting the practice, medical and psychological care for women who are victims and prevention of FGM by education, risk assessment, early detection and engagement with community leaders.

FGM is a common practice in more than 30 countries of the world, including some in Africa, Asia and the Middle East. The phrase FGM is used to convey a number of different forms of surgery, mutilation or cutting of the female external genitalia. The term female circumcision is no longer used as it suggests equivalence with male circumcision, which is both inaccurate and counterproductive. Most girls undergo FGM/C between the ages of 7 and 10. There is no medical necessity for any such cutting, which is often performed by an unqualified individual in un-hygienic surroundings.

FGM of any type is a violation of the human rights of girls and women, as it is a harmful procedure performed on a child who cannot give valid consent. As a result of migration a growing number of girls living outside countries where the practice is common are being affected.

Respecting the social norms of immigrants is increasingly posing problems for physicians and the wider community.

Because of its impact on the physical and mental health of women and children, and because it is a violation of human rights, FGM is a matter of concern to physicians. Physicians worldwide are confronted with the effects of this traditional practice. They may be asked to perform this mutilating procedure or to restore the result of mutilating "surgery" on women after childbirth has reopened the introitus.

There are various forms of FGM, classified by WHO.[1] It can be a primary procedure for young girls, usually between 5 and 12 years of age, or a secondary one, e.g., after childbirth. The extent of a primary procedure may vary: from an incision in the foreskin of the clitoris, up to the maximally mutilating so-called pharaonic infibulation which involves partly removing the clitoris and labia minora and stitching up of the labia majora so that only a small opening remains to allow the passage of urine and menstrual blood. The majority of procedures performed are somewhere in between these two extremes.

While the term female circumcision is no longer used it remains useful, familiar and readily accessible in the context of physician/patient consultations in some cases.

FGM has no health benefits and harms girls and women in many ways, regardless of which procedure is performed. Research shows grave permanent damage to health, including: haemorrhage, infections, urinary retention, injury to adjacent organs, shock and very severe pain. Long-term complications include severe scarring, chronic bladder and urinary tract infections, urologic and obstetric complications, and psychological and social problems. FGM has serious consequences for sexuality and how it is experienced, including the loss of capacity for orgasm. There are also many complications during childbirth including expulsion disturbances, formation of fistulae, and traumatic tears of vulvar tissue.

There are a number of reasons given for the continuation of the practice of FGM: custom, community tradition (preserving the virginity of young girls and limiting the sexual expression of women) and as part of a girl's initiation into womanhood. These reasons do not justify the considerable damages to physical and mental health.

None of the major religions supports this practice, which is otherwise often wrongly linked to religious beliefs. FGM is a form of violence usually perpetuated on young women and girls and represents a lack of respect for their individuality, freedom and autonomy.

Physicians may be faced with parents seeking a physician to perform FGM, or they may become aware of parents who seek to take girls to places where the practice is commonly available. They must be prepared to intervene to protect the girl.

Medical associations should prepare guidance on how to manage these requests which may include invoking local laws that protect children from harm and may include involving police and other agencies.

When patients who have undergone FGM give birth, physicians may receive requests to restore the results of the FGM. They should be confident in handling such requests and supported with appropriate educational material that will enable them to discuss with the patient the medically approved option of repairing the damage done by FGM and by childbirth. Physicians also have a responsibility to have a discussion with the spouse of the patient, with the consent of the patient, who might otherwise seek "restoration" of the FGM, if not given a full explanation of the harm that is done by FGM.

There is a growing tendency for physicians and other health care professionals in some

countries to perform FGM because of a wish to reduce the risks involved. Some practitioners may believe that medicalization of the procedure is a step towards its eradication. Performing FGM is a breach of medical ethics and human rights, and involvement by physicians may give it credibility. In most countries performing this procedure is a violation of the law.

Governments in several countries have developed legislation, such as prohibiting FGM in their criminal codes.

RECOMMENDATIONS

1. Taking into account the psychological needs and 'cultural identity' of the people involved, physicians should explain the dangers and consequences of FGM and discourage performing or promoting FGM. Physicians should integrate women's health promotion and counselling against FGM into their work.
2. Physicians should assist in educating health professionals and work with local community, cultural and social leaders to educate them about the adverse consequences of FGM. They should support persons who want to end FGM and the establishment of community programmes designed to outlaw the practice, offering medical information about its damaging effects as necessary.
3. There are active campaigns against FGM that are led by women leaders and heads of state in Africa and elsewhere. These campaigns have issued strong statements against the practice.
4. Physicians should work with groups such as these and others who manage pregnant women including midwives, nurses and traditional birth attendants, to ensure all practitioners have standardized and sensitive information about FGM.
5. Physicians should cooperate with any preventive legal strategy when a child is at risk of undergoing FGM.
6. National Medical Associations should stimulate public and professional awareness of the damaging effects of FGM.
7. National Medical Associations should ensure that FGM education and awareness are part of its advocacy to prevent violence against women and girls.
8. National Medical Associations should work with opinion leaders, encouraging them to become active advocates against FGM.
9. National Medical Associations should stimulate government action in preventing the practice of FGM. This should include sustained advocacy programmes and the development of legislation prohibiting FGM.
10. NMAs must prohibit involvement by physicians in the practice of FGM, including re-infibulation after childbirth. Physicians should be encouraged to perform reconstructive surgery on women who have undergone FGM. Physicians should seek to ensure the provision of adequate (and non-judgemental) medical and psychological care for women who have undergone FGM.

11. Physicians should be aware that the risk of FGM might be a justification for overriding patient confidentiality, and allow disclosure to social or other relevant services to protect a child from serious harm.

[1] FGM can be classified into four types: clitoridectomy, excision, infibulation and other harmful procedures such as pricking, piercing, incising, scraping and cauterizing the genital area.

WMA STATEMENT
ON
PATIENT ADVOCACY AND CONFIDENTIALITY

Adopted by the 45th World Medical Assembly, Budapest, Hungary, October 1993
revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and reaffirmed by the 203rd WMA Council Session, Buenos Aires, Argentina, April 2016

PREAMBLE

Medical practitioners have an ethical duty and a professional responsibility to act in the best interests of their patients without regard to age, gender, sexual orientation, physical ability or disability, race, religion, culture, beliefs, political affiliation, financial means or nationality.

This duty includes advocating for patients, both as a group (such as advocating on public health issues) and as individuals.

Occasionally, this duty may conflict with a physician's other legal, ethical and/or professional duties, creating social, professional and ethical dilemmas for the physician.

Potential conflicts with the physician's obligation of advocacy on behalf of his or her patient may arise in a number of contexts:

1. Conflict between the obligation of advocacy and confidentiality - A physician is ethically and often legally obligated to preserve in confidence a patient's personal health information and any information conveyed to the physician by the patient in the course of his or her professional duties. This may conflict with the physician's obligation to advocate for and protect patients where the patients may be incapable of doing so themselves.

2. Conflict between the best interest of the patient and employer or insurer dictates - Often there exists potential for conflict between a physician's duty to act in the best interest of his or her patients, and the dictates of the physician's employer or the insurance body, whose decision may be shaped by economic or administrative factors unrelated to the patient's health. Examples of such might be an insurer's instructions to prescribe a specific drug only, where the physician believes a different drug would better suit a particular patient, or an insurer's denial of coverage for treatment that a physician believes is necessary.

3. Conflict between the best interests of the individual patient and society - Although the physician's primary obligation is to his or her patient, the physician may, in certain circumstances, have responsibilities to a patient's family and/or to society

as well. This may arise in cases of conflict between the patient and his or her family, in the case of minor or incapacitated patients, or in the context of limited resources.

4. Conflict between the patient's wishes and the physician's professional judgment or moral values - Patients are presumed to be the best arbiters of their best interests and, in general, a physician should advocate for and accede to the wishes of his or her pa-tient. However, in certain instances such wishes may be contrary to the physician's professional judgment or personal values.

RECOMMENDATION

1. The duty of confidentiality must be paramount except in cases where the physician is legally or ethically obligated to disclose such information in order to protect the wel-fare of the individual patient, third parties or society. In such cases, the physician must make a reasonable effort to notify the patient of the obligation to breach confi-dentiality, and explain the reasons for doing so, unless this is clearly inadvisable (such as where telling the patient would exacerbate a threat). In certain cases, such as gene-tic or HIV testing, physicians should discuss with their patients, prior to performing the test, instances in which confidentiality might need to be breached.
   A physician should breach confidentiality in order to protect the individual patient only in cases of minor or incompetent patients (such as certain cases of child or elder abuse) and only where alternative measures are not available. In all other cases, confidentiality may be breached only with the specific consent of the patient or his/ her legal representative or where necessary for the treatment of the patient, such as in consultations between medical practitioners.
   Whenever confidentiality must be breached, it should be done so only to the extent necessary and only to the relevant party or authority.

2. In all cases where a physician's obligation to his or her patient conflicts with the administrative dictates of the employer or the insurer, a physician must strive to change the decision of the employing/insuring body. His or her ultimate obligation must be to the patient.
   Mechanisms should be in place to protect physicians who wish to challenge decisions of employers/insurers without jeopardizing their jobs, and to resolve disagreements between medical professionals and administrators with regard to allocation of re-sources.
   Such mechanisms should be embodied in medical practitioners' employment con-tracts. These employment contracts should acknowledge that medical practitioners' ethical obligations override purely contractual obligations related to employment.

3. A physician should be aware of and take into account economic and other factors before making a decision regarding treatment. Nonetheless, a physician has an obliga-tion to advocate on behalf of his or her patient for access to the best

available treat-ment.
In all cases of conflict between a physician's obligation to the individual patient and the obligation to the patient's family or to society, the obligation to the individual pa-tient should typically take precedence.

4. Competent patients have the right to determine, on the basis of their needs, values and preferences, what constitutes for them the best course of treatment in any given situa-tion. Unless it is an emergency situation, physicians should not be required to participate in any procedures that conflict with their personal values or professional judgment. In such non-emergency cases, the physician should explain to the patient his or her in-ability to carry out the patient's wishes, and the patient should be referred to another physician, if required.

WMA STATEMENT
ON
MEDICAL ETHICS IN THE EVENT OF DISASTERS

Adopted by the 46th WMA Gener al Assembly, Stockholm, Sweden, September 1994
and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 68th WMA General Assembly, Chicago, United States, October 2017

PREAMBLE

1. According to International Federation of Red Cross and Red Crescent Societies (IFRC) a disaster is a sudden, calamitous event that seriously disrupts the functioning of a community or society and causes human, material, and economic or environmental losses that exceed the community's or society's ability to cope using its own resources. Though often caused by nature, disasters can have human origins.

   This definition excludes situations arising from conflicts and wars, whether international or internal, which give rise to other problems in addition to those considered in this paper.

2. Disasters often result in substantial material damage, considerable displacement of people, many victims and significant social disruptions. Adequate preparation would make major consequences less likely and less severe and protect people especially the most vulnerable.

   This document will focus particularly on the medical aspects of disasters. From a medical standpoint, disaster situations are characterized by an acute and unforeseen imbalance between resources and the capacity of medical professionals, and the needs of survivors who are injured whose health is threatened, over a given period of time.

3. Disasters, irrespective of cause, share several common features:

   3.1. Their sudden and unexpected but often predictable occurrence, demanding prompt action;

   3.2. Material or natural damage making access to the survivors difficult and/or dangerous;

   3.3. Displacement or movement of often large numbers of people;

   3.4. Adverse effects on health due to various reasons such as physical injuries and high

energy trauma, direct and indirect consequences of pollution, the risks of epidemics and emotional and psychological factors as well as factors such as reduced access to food, potable water, shelter, health care and other health determinants;

3.5. A context of insecurity sometimes requiring police or military measures to maintain order; and

3.6. Media coverage, and the use of social media.

4. Disasters require multifaceted responses involving many different types of relief ranging from transportation and food supplies to medical services. Physicians are likely to be part of coordinated operations involving other responders such as law enforcement personnel. These operations require an effective and centralized authority to coordinate public and private efforts.

   Rescue workers and physicians are confronted with exceptional circumstances, which require the continued need of a professional and ethical standard of care. This is to ensure that the treatment of disaster survivors conforms to basic ethical tenets and is not influenced by other motivations. Inadequate and/or disrupted medical resources on site and a large number of people injured in a short time present specific ethical challenges.

RECOMMENDATIONS

5. Medical profession is at the service of the patients and society at all times and in all circumstances. Therefore, the physicians should be firmly committed to addressing the health consequences of disasters, without excuse or delay.

6. The World Medical Association (WMA) reaffirms its Declaration of Montevideo on Disaster Preparedness and Medical Response (2011) recommending the development of adequate training of physicians, accurate mapping of information on health system assets and advocacy towards governments to ensure planning for clinical care.

7. The WMA recalls the primary necessity to ensure the personal safety of physicians and other responders during the event of disasters (Declaration on the Protection of Health Care Workers in situation of Violence, 2014).

   Physicians and other responders must have access to appropriate and functional equipment, both medical and protective.

8. Furthermore, the WMA recommends the following ethical principles and procedures with regard to the physician's role in disaster situations:

   8.1 A system of triage may be necessary to determine treatment priorities. Despite triage often leading to some of the most seriously injured receiving only symptom control

such as analgesia, such systems are ethical provided they adhere to normative standards. Demonstrating care and compassion despite the need to allocate limited resources is an essential aspect of triage.

Ideally, triage should be entrusted to authorized, experienced physicians or to physician teams, assisted by a competent staff. Since cases may evolve and thus change category, it is essential that the official in charge of the triage regularly assesses the situation.

8.2 The following statements apply to treatment beyond emergency care:

8.2.1 It is ethical for a physician not to persist, at all costs, in treating individuals "beyond emergency care", thereby wasting scarce resources needed elsewhere. The decision not to treat an injured person on account of priorities dictated by the disaster situation cannot be considered an ethical or medical failure to come to the assistance of a person in mortal danger. It is justified when it is intended to save the maximum number of individuals. However, the physician must show such patients compassion and respect for their dignity, for example by separating them from others and administering appropriate pain relief and sedatives, and if possible ask somebody to stay with the patient and not to leave him/her alone.

8.2.2 The physician must act according to the needs of patients and the resources available. He/she should attempt to set an order of priorities for treatment that will save the greatest number of lives and restrict morbidity to a minimum.

8.3 Relation with the patients

8.3.1 In selecting the patients who may be saved, the physician should consider only their medical status and predicted response to the treatment, and should exclude any other consideration based on non-medical criteria.

8.3.2 Survivors of a disaster are entitled to the same respect as other patients, and the most appropriate treatment available should be administered with the patient's consent.

8.4 Aftermath of disaster

8.4.1 In the post-disaster period the needs of survivors must be considered. Many may have lost family members and may be suffering psychological distress. The dignity of survivors and their families must be respected.

8.4.2 The physician must make every effort to respect the customs, rites and religions of the patients and act in impartiality.

8.4.3 As far as possible, detailed records should be kept, including details of any difficulties encountered. Identification of patients, including the deceased should be recorded.

8.5 Media and other third parties

Physicians should take into consideration that in any disaster media is present. The work of the media should be respected and facilitated as appropriate in the circumstances. If needed, physicians should be empowered to restrict the entrance of reporters and other media representatives to the medical premises. Appropriately trained personnel should handle media relations.

The physician has a duty to each patient to exercise discretion and to seek to ensure confidentiality when dealing with third parties. The physician must also exercise caution and objectivity and respect the often emotional and politicized atmosphere surrounding disaster situations. Any and all media especially filming must only occur with the explicit consent of each patient who is filmed. With regard to social media use, physicians must adhere to these same standards of discretion and respect for patient privacy.

8.6 Duties of paramedical personnel

The ethical principles that apply to physicians in disaster situations should also apply to other health care workers.

8.7 Training

The World Medical Association recommends that disaster medicine training be included in the curricula of university and post-graduate courses in medicine.

8.8 Responsibility

8.8.1 The World Medical Association calls upon governments and insurance companies to cover both civil liability and any personal damages to which physicians might be subject when working in disaster or emergency situations. This should also include life and disability coverage for physicians who die or are harmed in the line of duty.

8.8.2 The WMA requests that governments:

- Ensure the preparedness of healthcare system to serve in disaster settings.
- Share all information related to public health timely and accurately.
- Accept the participation of demonstrably qualified foreign physicians, where

needed, without discrimination on the basis of factors such as affiliation (e.g. Red Cross, Red Crescent, ICRC, and other qualified organizations), race, or religion.

- Give priority to the rendering of medical services over anything else that might delay necessary treatment of patients.

WMA STATEMENT
ON
ETHICAL ISSUES CONCERNING PATIENTS WITH MENTAL ILLNESS

Adopted by the 47th WMA General Assembly, Bali, Indonesia, September 1995
and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 66th WMA General Assembly, Moscow, Russia, October 2015

PREAMBLE

Historically, many societies have regarded patients with mental illness as a threat to those around them rather than as people in need of support and care. In the absence of effective treatment, to prevent self-destructive behaviour or harm to others, many persons with mental illness were confined to asylums for all or part of their lives.

Today, progress in psychiatric treatment allows for better care of patients with mental illness. Efficacious drugs and psychosocial interventions offer outcomes ranging from complete recovery to remission for varying lengths of time.

The adoption in 2006 of the United Nations Convention on the Rights of Persons with Disabilities constituted a major step towards viewing them as full members of society with the same rights as everyone else. It is the first comprehensive human rights treaty of the 21st century. It aims to promote, protect and reinforce the human rights and dignity of all persons with disabilities, including those with mental impairments.

Persons with major mental illnesses and those with learning disability have the same right to preventive services and interventions to promote health as others members of the community, for which they often have greater need because they are more likely to live unhealthy lifestyles.

Patients with psychiatric morbidity may also experience non- psychiatric illness. Persons with mental illness have the same right to health care as any other patient. Psychiatrists and health care professionals who provide mental health services should refer patients to other appropriate professionals when patients need medical care. Health care professionals should never decline to provide needed medical care solely because the patient has a mental illness.

Physicians have the same obligations to all patients, including patients with mental illness. Psychiatrists or other physicians who treat patients with mental illness must adhere to the same ethical standards as any physician.

The physician's primary obligation is to the patient and not to serve as agents of society,

except in circumstances when a patient presents clear danger to himself/ herself or others due to mental illness.

PHYSICIANS' ETHICAL PRINCIPLES

The stigma and discrimination associated with psychiatry and the mentally ill should be eliminated. Stigma and discrimination may discourage people in need from seeking medical care, thereby aggravating their situation and placing them at risk of emotional or physical harm.

Physicians have a responsibility to respect the autonomy of all patients. When patients who are being treated for mental illness have decision-making capacity, they have the same right to make decisions about their care as any other patient. Because decision-making capacity is specific to the decision to be made and can vary over time, including as a result of treatment, physicians must continually evaluate the patient's capacity. When a patient lacks decision-making capacity, physicians should seek consent from an appropriate surrogate in accordance with applicable law.

The therapeutic relationship between physician and patient is founded on mutual trust, and physicians have a responsibility to seek patients' informed consent to treatment, including patients who are being treated for mental illness. Physicians should inform all patients of the nature of the psychiatric or other medical condition, and the expected benefits, outcomes and risks of treatment alternatives.

Physicians should always base treatment recommendations on their best professional judgment and treat all patients with solicitude and respect, regardless of the setting of care. Physicians who practice in mental health facilities, the military, or correctional institutions may have concurrent responsibilities to society that create conflicts with the physician's primary obligation to the patient. In such situations, physicians should disclose the conflict of interest to minimize possible feelings of betrayal on the patient's part.

Involuntary treatment or hospitalization of persons with mental illness is ethically controversial. While laws regarding involuntary hospitalization and treatment vary worldwide, it is generally acknowledged that this treatment decision without the patient's informed consent or against the patient's will is ethically justifiable only when: (a) a severe mental disorder prevents the individual from making autonomous treatment decisions; and/or (b) There is significant likelihood that the patient may harm him/her self or others. Involuntary treatment or hospitalization should be exceptional and physicians should utilize it only when there is good evidence that it is medically appropriate and necessary and should ensure that the individual is hospitalized for the shortest duration feasible under the circumstances. Wherever possible and in accordance with local laws, physicians should include an advocate for the rights of that patient in the decision process.

Physicians must protect the confidentiality and privacy of all patients. When legally required to disclose patient information, the physician should disclose only the minimum relevant information necessary and only to an entity legally authorized to request or require the information. When databanks allow access to or transfer of information from

one authority to another confidentiality must be respected and such access or transfer must comply fully with applicable law.

The participation of individuals with psychiatric illness in research needs to be in full accordance with the Declaration of Helsinki's recommendations.

Physicians must never use their professional position to violate the dignity or human rights of any individual or group, and should never allow their personal desires, needs, feelings, prejudices or beliefs to interfere with a patient's treatment. Physicians must never abuse their authority or take advantage of a patient's vulnerability.

RECOMMENDATION

The World Medical Association and National Medical Associations are encouraged to:

- Publicize this Statement and affirm the ethical foundations for treatment of patients with mental illness;
- While doing so, call for full respect – at all times – of the dignity and human rights of patients with mental illness;
- Raise awareness of physicians' responsibilities to support the well-being and rights of patients with mental illness;
- Promote recognition of the privileged relationship between patient and physician based on trust, professionalism and confidentiality;
- Advocate for appropriate resources to meet the needs of persons with mental illness.

WMA STATEMENT
ON
PHYSICIANS AND PUBLIC HEALTH

Adopted by the 47th WMA General Assembly, Bali, Indonesia, September 1995
and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

The health of a community or population is determined by several factors that go beyond traditionally understood causes of disease. Social determinants of health include factors that affect behavioural lifestyle choices; the physical, psychosocial and economic environments in which individuals live; and the health services available to people. Public health involves monitoring, assessing and planning a variety of programs and activities targeted to the identified needs of the population, and the public health sector should have the capacity to carry out those functions effectively to optimise community health. A key tenet of public health policy should be inclusivity and health equity; public health agencies must pay specific attention to populations and communities whose social, economic, and political conditions put them at greater risk of poor health than the general population.

Physicians and their professional associations have an ethical and professional responsibility to act in the best interests of patients at all times. This involves collaboration with public health agencies to integrate medical care of individual patients with a broader promotion of the health of the public.

The key functions of public health agencies are:

1. Health promotion:

    - Working with health care providers to inform and enable the general public to take an active role in preventing and controlling disease, adopting healthful lifestyles, and using medical services appropriately;
    - Assuring that conditions contributing to good health, including high-quality medical services, safe water supplies, good nutrition, an unpolluted atmosphere, and opportunities for exercise and recreation are accessible for the entire population;
    - Working with the responsible public authorities to create healthy public policy and supportive environments in which healthy behavioural choices are the easy choices, and to develop human and social capital.
    - Prevention: assuring access to screening and other preventive services and curative care to the entire population.

2. Protection: monitoring and protecting the health of communities against communicable diseases and exposure to toxic environmental pollutants, occupational

hazards, harmful products, and poor quality health services. This function includes the need to set priorities, establish essential programs, obtain requisite resources and assure the availability of necessary public health laboratory services.

3. Surveillance: identifying outbreaks of infectious disease and patterns of chronic disease and injury and establishing appropriate control or prevention programmes;

4. Population Health Assessment: assessing community health needs and marshalling the resources for responding to them, and developing health policy in response to specific community and national health needs.

The specific programs and activities carried out in each jurisdiction (local or national) will depend on the problems and needs identified, the organization of the health care delivery system, the types and scope of the partnerships developed and the resources available to address the identified needs.

Public health agencies benefit greatly from the support and close cooperation of physicians and their professional associations. The health of a community or a nation is measured by the health of all its residents, and the preventable health problems that affect an individual person affect the health and resources of the community. The effectiveness of many public health programs, therefore, depends on the active collaboration of physicians and their professional associations with public health agencies and other governmental and nongovernmental agencies.

The medical sector and the public health sector should effectively co-operate on the dissemination of public health information and education programs that promote healthful lifestyles and reduce preventable risks to health, including those from the use of tobacco, alcohol and other drugs; sexual activities that increase the risk of HIV transmission and sexually transmitted diseases; poor diet and physical inactivity; and inadequate childhood immunization levels. For example, health education can substantially reduce infant morbidity and mortality (e.g. through the promotion of breast-feeding and providing nutrition education to parents together with providing supportive conditions, both at work and in the community).

The formal responsibility of public health agencies is primarily disease surveillance, investigation and control. These activities cannot be conducted effectively, however, without the active cooperation and support of physicians at the community level who are aware of individual and community illness patterns and can notify health authorities promptly of problems that might require further investigation and action. For example, physicians can help identify populations at high risk for particular diseases, such as tuberculosis, and report cases of communicable diseases such as measles, whooping cough, or infectious causes of diarrhoea, as well as cases of exposure to lead or other toxic chemicals and substances in the community or work place. Close collaboration between public health agencies and physicians as well as other health professionals is critical for an efficient disease monitoring system.

Regardless of the effectiveness of existing public health programs in a jurisdiction, professional medical associations should be aware of unmet health needs in their

communities and nations and advocate for activities, programs and resources to meet those needs. These efforts might be in areas of public education for health promotion and disease prevention; monitoring and controlling environmental hazards; identifying and publicising adverse health effects resulting from social problems, such as interpersonal violence or social practices that affect health; or identifying and advocating for services such as improvements in emergency treatment preparedness.

In jurisdictions in which basic public health services are not being provided adequately, medical associations must work with other health agencies and groups to establish priorities for advocacy and action. For example, in a country or area with limited resources in which potable water and sewage facilities are not available to most residents, these needs should be given priority over medical technologies that would provide service to only a small portion of the population.

Some health-related issues are extremely complex and involve multiple levels of response. For example, those diagnosed with high blood lead levels need not only appropriate medical treatment, but the source of contamination must also be determined, and measures need to be taken to eliminate the danger. At times policies that promote public health create concern because of their potential economic impact. For example, strong opposition to the potential economic impact of tobacco control policies could come from regions or groups that derive significant revenue from growing or processing tobacco. However, economic concerns should not deter a strong public health advocacy program against the use of tobacco products. The promotion of tobacco products should be rigorously opposed, and every effort should be made to reduce tobacco consumption in both developed and developing countries.

Physicians and their associations should collaborate with political authorities and other organizations to encourage the media to send positive messages for health education regarding diet, drug use, sexually transmitted diseases, cardiovascular risk, etc.

Medical associations should ask their members to educate their patients on the availability of public health services.

WMA STATEMENT
ON
RESISTANCE TO ANTIMICROBIAL DRUGS

Adopted by the 48th WMA General Assembly, Somerset West, South Africa, October 1996
and amended by the 59th WMA General Assembly, Seoul, Korea, October 2008
by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

PREAMBLE

AMR is a growing threat to global public health that transcends national boundaries and socioeconomic divisions. AMR affects human, animal and environmental health. It is a multi-faceted problem of crisis proportions with significant economic, health, and human implications.

Addressing the threat of antimicrobial resistance is a fundamental global health priority, and the responsibility of all countries.

Antimicrobial drugs form an essential component of modern medicine, ensuring that complex procedures, such as surgery and chemotherapy, can be performed with lower risk.

AMR threatens the effective prevention and treatment of an increasing range of infections caused by bacteria, parasites, viruses and fungi.

AMR occurs when microorganisms develop the ability to resist the actions of antimicrobial drugs (such as antibiotics, antifungals, antivirals, antimalarials, and anthelmintics).

Infections caused by bacteria that are resistant to multiple classes of antibiotic are increasingly being documented.

While AMR is a natural evolutionary phenomenon, it is exacerbated by the overuse and misuse of antimicrobials in medicine, as well as in veterinary practice and agriculture, and can be exacerbated when antimicrobials are given as growth promoters in animals or used to prevent diseases in healthy animals.

The emergence and spread of AMR is further enhanced by lack of access to effective drugs, access to antibiotics “over the counter” in some countries, the availability of substandard and falsified products, misuse of antibiotics in food production, increased global travel, medical tourism and trade, and the poor application of infection control measures.

Another major cause of AMR is the release of antibiotics into the environment. This can occur as either as a result of poor manufacturing practices, the improper disposal of unused medication, human and animal excretion, and the inadequate disposal of human

and animal corpses.

In many countries, particularly in low-and middle-income countries, access to effective antimicrobials as well as complementary technologies including vaccines and diagnostics continues to remain a significant challenge, furthering AMR.

The ramifications of resistance manifest themselves not just in the impact on human health, but also in potentially heavy economic costs. The World Health Organization (WHO) has warned that resistance has reached alarming levels in many parts of the world, and that a continued increase in resistance could lead to 10 million people dying per year and a reduction of 2-3.5% in global gross domestic product by 2050.

At the rate at which resistance is growing globally, it poses a significant threat to successfully achieving the UN Sustainable Development Goals and undermines efforts to reduce health inequalities. Without harmonized and coordinated cross-sector action on a global, scale, the world is heading towards a post-antibiotic era in which common infections and minor injuries can once again kill.

AMR has reached great prominence at the highest political levels including the UN General Assembly, and the agenda of the G7 and G20.

There is a need for an effective 'one health' approach to minimize unnecessary or inappropriate use of antimicrobials and to prevent and control the transmission of existing resistance. A 'one health' approach recognizes that action is required across human medicine, veterinary practice and agriculture.

RECOMMENDATIONS

Global

1. The primary prevention of community and healthcare associated infections is necessary to reduce the demand for antibiotics. Addressing the social determinants of infectious disease, such as poor living conditions and sanitation, will have co-benefits of reducing health inequalities and tackling AMR.
2. Nations have varying resources available to combat antimicrobial resistance, and must cooperate with the WHO, Food and Agriculture Organization and World Organization for Animal Health that support the WHO Global Action Plan on AMR which provides the framework for national action plans.
3. The World Medical Association and its constituent members should advocate for:

    - investment in the surveillance of drug resistant infections across human health, veterinary medicine, agriculture, fishing industry, and food production, and international cooperation for data-sharing procedures to improve global responses;
    - the WHO and other UN agencies should examine the role of international travel and trade agreements on the development of antimicrobial resistance, and promote measures in those agreements to act as safeguards against the globalisation of drug resistant pathogens in our food supply;
    - the WHO should continue to encourage the use of Trade Related Aspects of

Intellectual Property Rights (TRIPS) flexibilities to help ensure affordable access to quality medicines and oppose the proliferation of 'TRIPS-plus' provisions within trade agreements, which restrict the use of TRIPS flexibilities and limit their effectiveness;
- the widespread application of verifiable technology such as track-and-trace systems to ensure the authenticity of pharmaceutical products;
- equitable access to, and appropriate use of, existing and new quality-assured antimicrobial medicines. This requires effectively applying the Access, Watch and Reserve lists of the WHO Essential Medicines program. For the WHO global action plan and national action plans to be effective, access to health facilities, health care professionals, veterinarians, knowledge, education and information are vital;
- greater use of vaccinations which will reduce the burden of infectious disease, reducing the need for antibiotics and therefore limiting the emergence of resistance;
- for global health organisations and governments to scale up their action and coordination in promoting appropriate antibiotic use and work together to reduce AMR using a One Health approach, which recognises that human, animal and environmental health is inextricably linked. to reduce the spread of resistance.

4. The World Medical Association and its constituent members should encourage their governments to:

    - fund more basic and applied research directed toward the development of innovative antimicrobial agents, diagnostic tools and vaccines (innovative antimicrobial vaccines), and on the appropriate and safe use of such therapeutic tools;
    - ensure parity between financial and technical resources towards the development of innovative antimicrobial medicines, vaccines, and diagnostics as well as innovative infection control and prevention methods across human health, veterinary, and agricultural sectors;
    - support Research and Development efforts for novel antimicrobial agents, vaccines, and rapid diagnostic methods that are needs-driven and guided by the principles outlined in the UN Declaration on AMR, adopted in September 2016, including affordability, effectiveness, efficiency, and equity [1];
    - initiate regulatory measures to control the environmental pollution that allows the spread of antibiotic- resistant genes across soil, water and air;
    - educate a sufficient number of clinical infectious disease specialists in every country, which is a fundamental requirement for tackling antimicrobial resistance and hospital-acquired infections.

National

1. National medical associations should urge their governments to:

    - require that antimicrobial agents be available only through a prescription provided by healthcare professionals and/or veterinary professionals and

dispensed or sold by professionals;
- to initiate national campaigns to raise awareness among the public of the harmful consequences of overuse and misuse of antibiotics. This should be supported through the introduction of national targets to raise public awareness;
- to support professional societies, civil society, and healthcare delivery systems to pilot and adopt proven behaviour change strategies to ensure appropriate use of antibiotics;
- to ensure access to appropriate and fit-for-purpose point-of-care diagnostics in hospitals and clinics to support decision making and prevent inappropriate prescribing of antibiotic;
- to mandate the collection of data on antibiotic use, prescriptions, prices, resistance patterns, and trade in both the healthcare and agricultural sectors. This data should be made publicly accessible;
- promote effective programs of antimicrobial stewardship and training on the appropriate use of antimicrobials agents, and infection control;
- actively pursue the development of a national surveillance system for the provision of antimicrobials and for antimicrobial resistance. Data from this system should be linked with or contributed to the WHO's global surveillance network;
- monitoring of antimicrobial use in food producing animals must be sufficiently granular to ensure accountability.

2. National medical associations should:

- encourage medical schools and continuing medical education programs to renew their efforts to educate physicians, who can in turn inform their patients, about the appropriate use of antimicrobial agents and appropriate infection control practices, including antibiotic use in the outpatient setting;
- support the education of their members in areas of AMR, including antimicrobial stewardship, rational use of antimicrobials, and infection control measures including hand hygiene;
- advocate for the publishing and communication of local information relating to resistance patterns, clinical guidelines and recommended treatment options for physicians;
- in collaboration with veterinary authorities, encourage their governments to introduce regulations to reduce the use of antimicrobials in agriculture, in particular food producing animals, including restrictions on the routine use of antimicrobials for both prophylaxis and growth promotion, and on the use of classes of antimicrobial that are critically important in human medicine;
- support regulation that prevents conflicts of interest among veterinarians, such as roles where veterinarians both prescribe and sell antibiotics;
- consider the use of social media to educate and promote the proper use and disposal of antibiotic medications;
- encourage parents to comply with the national recommended immunization schedules for children. Adults should also have easy access to vaccines against influenza and pneumococcal infections among others.

Local

1. Health professionals and health systems have a vital role in preserving antimicrobial medicines.
2. Physicians should:

    - have access to high-quality and reliable, evidence-based information free of conflict of interest and actively participate in and lead antimicrobial stewardship programs in their hospitals, clinics and communities to optimise antibiotic use;
    - raise awareness amongst their patients about antimicrobial therapy, its risks and benefits, the importance of adherence with the prescribed regimen, infection prevention practices, and the problem of AMR;
    - promote and ensure adherence hygiene measures (especially hand hygiene) and other infection prevention practices.

WMA STATEMENT ON FAMILY VIOLENCE

Adopted by the 48th WMA General Assembly, Somerset West, South Africa, October 1996
editorially revised by the 174th WMA Council Session, Pilanesberg, South Africa, October 2006
amended by the 61st WMA General Assembly, Vancouver, Canada, October 2010
and by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

PREAMBLE

Family violence is a grave universal public health and human rights problem that affects individuals, regardless of age, gender, sexual orientation, racial/ethnic background, culture, religion, socio-economic status or any other factor.

Though definitions vary, the term family violence is generally applied to the physical, sexual, verbal, economic, spiritual, psychological or emotional abuse, or neglect of a person by someone with whom the victim is physically, financially, emotionally or socially related and/or dependent.

Although the causes of family violence are complex, a number of contributing factors are known, such as lack of basic education, lack of economic independence/poverty, underlying and/or undiagnosed mental health issues, substance abuse (particularly alcohol), stress, rigid gender roles, poor parenting skills, interpersonal conflicts within the family, the perpetrator's experience of maltreatment and family violence as a child, or familial social isolation.

Family violence has adverse physical, mental, emotional and psycho-social consequences on the individual and negatively impacts the health and wellbeing of the affected individual. There may also be socio-economic impacts as well as impacts on a witness of family violence, the family and community. These adverse effects could be short-term/immediate or long-term/chronic. They include physical harm/injuries, death, impact on reproductive health/miscarriage, dysfunctional families, educational disruptions and poor academic performance, sexually transmitted diseases, juvenile delinquency, professional disruptions and loss of employment, social exclusions and homelessness, insomnia, anxiety, depression, resort to substance abuse and crime, post-traumatic stress disorder, and suicide. Victims can become perpetrators of family violence and violent acts against non-intimates (intergenerational transmission of violence).

The World Medical Association (WMA) firmly condemns all forms of violence and reaffirms its policies on Violence against Women and Girls, Child Abuse and Neglect, the Abuse of the Elderly, and Violence and Health.

RECOMMENDATIONS

Governments and National Health Authorities

WMA urges governments to:

1. Strengthen the sense of social responsibility, develop and enforce policies, legal frameworks, and national plans with allocated budget for the prevention and elimination of family violence, as well as for protection of victims and witnesses of family violence.
2. Address the root causes of violence in relation to social determinants of health and to promote health equity. This should include addressing gender inequality and other harmful societal practices.
3. Recognize that times of intense individual and/or national stress increase the risk of family violence and ensure that appropriate resources are publicized and made available during such times.
4. Provide tools to recognize, act upon and if necessary report cases of family violence.
5. Develop data collection systems on family violence, that holistically include vital aspects of family violence such as mortality, morbidity, injuries, family or community environment, risk factors, costs of interventions, loss in productivity, legal costs among others.
6. Provide secure private reporting mechanisms and safe havens to protect the individual from feelings of guilt and shame to avoid stigma and retaliation.
7. Require a guideline that indicates how to act on suspicion of family violence and what interventions are available. Reporting should only be done when, in the opinion of the physician, doing so will not endanger the individual experiencing the violence. If possible, this should be done in consultation with the individual experiencing the violence.
8. Institute and promote high-quality research programs to provide a strong evidence base on the multiple facets of family violence such as the magnitude, risk profiles, underlying factors, and the complex interplay of factors, as well as cross comparisons among settings, countries and regions.
9. Develop and offer family violence services to those experiencing family violence, including policy and legal accompaniments, case management, advocacy, counselling, safe housing and safety planning.

10. Encourage multi-stakeholder constructive collaboration between sectors, disciplines, as well as governmental and nongovernmental bodies, including traditional and religious institutions, to eliminate and prevent family violence.

WMA constituent members and the medical profession

WMA constituent members should:

1. Encourage coordination of action against family violence between and among components of the health care system, criminal justice systems and law enforcement authorities, including family and juvenile courts, and victims' services organizations.
2. Encourage and facilitate research to understand the prevalence, risk factors, outcomes and optimal care for victims of family violence.
3. Promote advocacy, public and professional awareness creation, and community education programs on family violence.
4. Encourage managers of public and private health facilities to provide educational materials in reception/patient waiting rooms and emergency departments, to offer patients and clients general information about family violence, as well as to inform them about available integrated and professionally good local services that can be accessed.
5. Advocate for inclusion of courses on violence, including family violence, in the academic curricula for undergraduate and postgraduate medical education.
6. Promote capacity building and Continuous Medical Education programs for physicians, on prevention of family violence.
7. Advocate for rehabilitation, counseling, and therapy to those who either cause, experience or are exposed to the violent acts, especially traumatized children.
8. Encourage adequate undergraduate family medicine education and training in family dynamics, including the medical, sociological, psychological and preventive aspects of all types of family violence.

Physicians

In the light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to recognize and offer assistance to patients harmed by family violence and abuse.

Physicians should:

1. Routinely consider and be sensitive to signs indicating the need for further evaluations about current or past abuse as part of their general health screening or in response to suggestive clinical findings, as physicians are often the first to suspect family violence.
2. Be acquainted on ways to take an appropriate and culturally sensitive history of current and past abuse and be acutely aware of the need to maintain confidentiality and a trusting patient-physician relationship in cases of family violence.
3. Be aware of social, community and other services useful for victims, and in some cases, perpetrators of violence and refer to and use these routinely to support victims, witnesses and/or perpetrators of family violence.
4. Report suspected violence against children and other family members to appropriate protection and security services in keeping with applicable requirements, and take necessary measures to ensure that victims and witnesses of violence are not at risk.
5. Be encouraged to participate in coordinated community activities that seek to reduce the burden and impact of family violence.
6. Be encouraged to embrace patient-centred, community specific care, and to develop impartial attitudes toward those involved in family violence.

WMA STATEMENT ON FAMILY PLANNING AND THE RIGHT OF A WOMAN TO CONTRACEPTION

Adopted by the 48th WMA General Assembly, Somerset West, South Africa, October 1996
amended by the 58th WMA General Assembly, Copenhagen, Denmark, October 2007
and reaffirmed with minor revision by the 207th WMA Council session, Chicago, United States, October 2017

PREAMBLE

The WMA recognizes that unwanted pregnancies and pregnancies that are too closely spaced can have a serious adverse effect on the health of a woman and of her children. These adverse effects can include the premature deaths of women. Existing children in the family can also suffer starvation, neglect or abandonment resulting in their death or impaired health, when families are unable to provide for all their children. Social functioning and the ability to reach their full potential can also be impaired.

The WMA recalls its Declaration of Ottawa on Child Health, and supports the universal health rights of all children worldwide.

The WMA recognizes the benefits for women who are able to control their fertility. They should be helped to make such choices themselves, as well as in discussion with their partners. The ability to do so by choice and not chance is a principal component of women's physical and mental health and social well-being.

Access to adequate fertility control methods is not universal; many of the poorest women in the world have the least access. Knowledge about how their bodies work, information on how to control their fertility and the materials necessary to make those choices are universal and basic human rights for all women.

The Sustainable Development Goals 5, target 6 calls for the "universal access to sexual and reproductive health and reproductive rights…".

RECOMMENDATIONS

The WMA recommends that National Medical Associations:

- Promote family planning education by working with governments, NGOs and others to provide secure and high-quality services and assistance;
- Demand from governments to ensure that such information, materials, products and services are available without regard to nationality, creed, race, religion or socioeconomic status.

WMA STATEMENT ON WEAPONS OF WARFARE AND THEIR RELATION TO LIFE AND HEALTH

Adopted by the 48th WMA General Assembly, Somerset West, South Africa, October 1996
and editorially revised by the 174th WMA Council Session, Pilanesberg, South Africa, October 2006
and revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

Recalling its Declaration of Washington on Biological Weapons, its Resolution on the Prohibition of chemical weapons and its Statement on Nuclear Weapons, the World Medical Association condemns the use of any forms of weapons – conventional, biological, chemicals and nuclear weapons – which has the potential to bring immense human suffering and substantial death together with catastrophic effects on the earth's ecosystem, a reduction of the world food supply and increased poverty. The use of such weapons against human beings is in opposition with physicians' duties and responsibilities to preserve life.

When nations enter into warfare or into weapons development, they do not usually consider the effects of the use of weapons on the health of individual non-combatants and on public health in general, either in the short or in the longer term.

Nevertheless the medical profession is required to deal with both the immediate and long term health effects of warfare, and in particular with the effects of different forms of weaponry including the threat of nuclear, chemical and biological warfare.

The potential for scientific and medical knowledge to contribute to the development of new weapons systems, targeted against specific individuals, specific populations or against body systems, is considerable. This includes the development of weapons designed to target anatomical or physiological systems, including vision, or which use knowledge of human genetic similarities and differences to target weapons.

There are no current and commonly used criteria to measure weapons effects on health. International Humanitarian Law states that weapons that cause injuries, which would constitute "unnecessary suffering or superfluous injury", are illegal. These terms are not defined and require interpretation against objective criteria for the law to be effective.

Physicians can aid in developing criteria for weapons that cause injury or suffering so extreme as to invoke the terms of International Humanitarian Law.

Such criteria could aid lawyers in the use of International Humanitarian Law, allow assessment of the legality of new weapons currently in development against an agreed,

objective system of assessment of their medical effects, and identify breaches of the Law once it is developed.

Physician involvement in the delineation of such objective criteria is essential if it is to become part of the legal process. However, it must be recognised that physicians are firmly opposed to any use of weapons against human beings.

RECOMMENDATIONS

The WMA believes that the development, manufacture and sale of weapons for use against human beings are abhorrent. To support the prevention and reduction of weapons injuries, the WMA:

- Supports international efforts to define objective criteria to measure the effects of current and future weapons, which could be used to stop the development, manufacture, sale and use of those weapons;
- Calls on National Medical Associations to urge national governments to cooperate with the collection of such data as are necessary for establishing objective criteria;
- Calls on National Medical Associations to support and encourage research into the global public health effects of weapons use, and to publicise the results of that research, both nationally and internationally. This will ensure that both governments and the public are aware of the long-term health consequences of weapons use on non-combatant individuals and populations.

WMA PROPOSAL
FOR
A UNITED NATIONS RAPPORTEUR ON THE INDEPENDENCE AND INTEGRITY OF HEALTH PROFESSIONALS

Adopted by the 49th WMA General Assembly, Hamburg, Germany, November 1997
and reaffirmed by the 176th WMA Council Session, Berlin, Germany, May 2007

The British Medical Association (BMA) requests that the World Medical Association (WMA) supports a proposal, put forward by a network of medical organizations* concerned with human rights issues, for the establishment of a new UN post of rapporteur on the independence and integrity of health professionals.

It is envisaged that the role of the rapporteur will supplement the work already done by a series of existing UN rapporteurs on issues such as torture, arbitrary execution, violence against women, etc. The new rapporteur would be charged with the task of monitoring that doctors are allowed to move freely and that patients have access to medical treatment, without discrimination as to nationality or ethnic origin, in war zones or in situations of political tension. The role of the proposed rapporteur is detailed on pages two, three and four of this submission.

The original proposal was drawn up by a lawyer, Cees Flinterman, who is a professor of constitutional and international law at the University of Limburg, Maastricht, in The Netherlands. It has the support of a range of doctors' organizations listed below*, whose interests are in protection of human rights and protection of doctors who act impartially in conflict situations. This group will be consulting widely and acting with the help of the International Commission of Jurists to interest the United Nations in this proposal.

The Council of the BMA supported this proposal after debate in 1996. It would lend considerable weight to the campaign if the WMA would also support this concept whose fundamental aim is to protect doctors and their patients in war situations and other cases where medical independence may come under threat from political or military factions.

PROPOSAL FOR A RAPPORTEUR ON THE INDEPENDENCE AND INTEGRITY OF HEALTH PROFESSIONALS

Goals

accepting that in many situations of political conflict (such as civil or international war) or political tension (such as during suspension of civil rights in a government-declared state of emergency), health professionals are often the first people outside military of government circles to have detailed knowledge of human rights violations, including viola-tions of the right of populations to access medical treatment, a network of physicians is anxious that a range of national and international reporting mechanisms be established to achieve the following goals:

1. To monitor the role of health professionals working in situations where either their rights to give, or the rights of their patients to receive, treatment are threatened;

2. To make appeals for the protection of health professionals when they are in danger solely because of their professional or human rights activities;

3. To defend patients who are in danger of suffering human rights violations solely because of seeking medical treatment;

4. To encourage reporting of human rights violations by health professionals;

5. To analyse information about health professionals voluntarily adopting discriminatory practices. The group consider that existing UN reporting mechanisms need expansion. Key among proposals for new mechanisms is the development of a new UN rapporteur's post which would link together relevant information emerging from other existing UN mechanisms and also suggest where other useful local and national reporting networks could be developed in the long-term. Therefore, on the basis of materials prepared by the Law Department at the University of Limburg, Maastricht and circulated by the Dutch medical group, the Johannes Wier Foundation, the group is campaigning for a new post of UN Rapporteur of the Independence and Integrity of Health Professionals.

Defining the Role

The potential role of a UN Rapporteur need not be exhaustively defined in advance since the experience of the individual and the practical applicability of the goals must have an influence.

It should include the following:

- Receive, evaluate, investigate and report allegations of repression directed at health professionals or intended to prevent individuals receiving medical care. The rapporteur should be a clearing house for reports from individuals, groups of doctors, NGOs etc. and as well as simply receiving information, should pro-actively seek our information, including on-site visits.
- To build upon existing principles as found in humanitarian lay and the codes of medical ethics applicable in armed conflicts to develop specific guidelines on the subject of medical impartiality in relation to the treatment of patients in situations of political or armed conflict.
  The World Medical Association and national medical association should be encouraged to disseminate such information to health professionals during their training. Arising also form such guidance should be the institution of mechanisms to help health professionals protect themselves in situations where human rights are at risk.
- The rapporteur should also have a consultative role, seeking the views of international and national professional associations, human rights bodies and humanitarian organizations with regards to the protection of health professionals and the defence of the right to treat patients impartially.
- The rapporteur should investigate reports of health professionals voluntarily transgressing guidelines about impartiality and non-discrimination.

Issues within the Remit

- The fundamental concern is to protect the nature of the doctor-patient relationship from unjustified external interference although it will also include voluntary transgressing of impartiality by health professionals. The rapporteur's role will be to ensure the independence, integrity and impartiality of health professionals.

  Ensuring these aims requires analysis of whether:
  - the treatment decisions of health professionals can be carried out without coming into conflict with improper pressure from authorities;
  - the physical integrity and ability of health professionals to act in accordance with their professional principles are both protected;
  - health professionals are able to provide treatment on the basis of patient need;
  - people in need of medical treatment are able to access it safely;
  - health professionals are ensured their freedom of movement, in the capacity as medical care providers, and be able to have access to people in need of medical services.

Monitoring the degree to which external pressures influence negatively the provision of medical treatment will be within the remit of the rapporteur.

- The remit will be global.
- For lack of a reporting mechanism, health professionals are often disempowered form taking action on violations of patient rights. One of the issues of the rapporteur to monitor would be the introduction of national or local legislation, civil or military regulations or other rules prohibiting or limiting the provision of medical or nursing care to certain categories of patient.
- It will be within the remit of the rapporteur to bring the evidence or reports of violations of medical impartiality, including those in health professionals cooperating voluntarily, to responsible bodies in the medical field and to the governments concerned.
- Blanket restrictions on the medical or nursing services to be provided to members of vulnerable groups, such as refugees, asylum seekers, prisoners, minority ethnic groups, should be among the issues monitored by the rapporteur. The rapporteur should contribute to the empowerment of the health professionals to resist collectively the erosion of such patients' rights.
- Threats, intimidation or pressures on health professionals to discriminate against patients on the basis solely of non-medical related considerations such as ethics, religious or racial affiliation should be investigated even if the threats do not materialize into action.
- Reports of health professionals being harassed or detained simply because of their profession or because of the exercise of professional skills will be investigated by the rapporteur. Similarly repressive measures designed to prevent health professionals reporting infringements of medical integrity will be investigated. Measures to encourage health professionals actively to document and report such violations should be put forward by the rapporteur in consultation with other bodies.
- Reports of patients being impeded or discouraged from gaining access to the available medical treatment will be investigated.

Issues Outside the Remit

Just as important as defining what is within the rapporteur's remit is the matter of clarifying those issues which fall outside it. We anticipate that this too will become clearer as practice and experience develop. In the meantime, however, we suggest that:

- health professionals in every country should be educated about the ethical responsibilities they owe to patients and potential patients. Whereas such education is not within the remit of the rapproteur, acting as a resource for advice about medical impartiality would be within the rapporteur's remit. In the long term this function should ideally be dealt with by delegation through medical schools, professional bodies and voluntary national networks;
- while government measures to regulate aspects of care, (such as the equitable distribution of medical resources of the prioritizing of treatment on basis of need) would not generally be a matter for monitoring for the rapporteur, extreme measures likely to result in the disenfranchising of groups of patients from medical or nursing services would be monitored and investigated;
- governments' indiscriminate failure to provide health promotion or treatment to many or all sectors of the community does not fall within the remit of the rapporteur;
- since a principal concern is to ensure access to medical treatment by patients who need and want it, the voluntary decision of some individuals or patient groups to exclude themselves (for example on religious or cultural grounds) from orthodox medicine does not fall within the remit of the rapporteur.

* organizations participating in the network include: Amnesty International; British Medical Association; Centre for Enquiry into Health & Allied Themes (Bombay); Graza Community Mental Health; International Committee of the Red Cross; Physicians for Human Rights (in Denmark, Israel, South Africa, the UK, & the USA); Turkish Medical Association; and, the Johannes Weir Foundation.

WMA STATEMENT
ON
PHYSICIANS CONVICTED OF GENOCIDE, WAR CRIMES OR CRIMES AGAINST HUMANITY

Adopted by the 49th WMA General Assembly, Hamburg, Germany, November 1997
reaffirmed by the 176th WMA Council Session, Berlin, Germany, May 2007
and amended by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

SCOPE AND DEFINITIONS

The scope of this Statement includes the following specified crimes: genocide, war crimes, and crimes against humanity, as defined by the Rome Statute of the International Criminal Court.

PREAMBLE

- Physicians are bound by medical ethics to dedicate themselves to the good of their patients. Physicians who have been convicted of genocide, war crimes or crimes against humanity[1], have violated medical ethics, human rights and international law and are therefore unworthy of practising medicine.
- In accordance with the principle of the presumption of innocence, only physicians who have been convicted of the specified crimes should be declared unworthy of practising medicine.

DISCUSSION

1. Physicians seeking to work in any country are subject to the regulations of that country's relevant authorities or jurisdiction. The duty to demonstrate suitability to practice medicine rests with the person seeking licensure.
2. Physicians who have been convicted of genocide, war crimes or crimes against humanity must not be allowed to practise in another country or jurisdiction.
3. The relevant licensing authorities must ensure both that physicians have the required qualifications and that they have not been convicted of genocide, war crimes or crimes against humanity.
4. Physicians who have been convicted of the specified crimes have sometimes been able to leave the country in which these crimes were committed and obtain a licence to practise medicine from the relevant licensing authority in another

country.

5. This practice is contrary to the public interest, damaging to the reputation of the medical profession, and may be detrimental to patient safety.

RECOMMENDATIONS

1. The WMA recommends that physicians who have been convicted of the specified crimes be denied a license to practice medicine and membership to national medical associations by the relevant regulatory and licensing authority of that jurisdiction.
2. The WMA recommends that relevant regulatory and licensing authorities use their own authority to inform themselves, in so far as is possible, if verifiable allegations of participation in genocide, war crimes or crimes against humanity have been made against physicians, while at the same time respecting the presumption of innocence.
3. National Medical Associations must be sure that a thorough investigation into those allegations is performed by an appropriate authority.
4. The WMA recommends that national medical associations ensure that there is efficient communication amongst themselves and that where possible and appropriate they inform relevant national regulatory and licensing authorities of physicians' convictions of genocide, war crimes, or crimes against humanity.

[1] As defined by the Rome Statute of the International Criminal Court.

WMA STATEMENT
ON
ACCESS OF WOMEN AND CHILDREN TO HEALTH CARE

Adopted by the 49th WMA General Assembly, Hamburg, Germany, November 1997
and amended by the 59th WMA General Assembly, Seoul, Korea, October 2008
by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019 and
by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

PREAMBLE

For centuries, women and girls worldwide have suffered from gender inequality and an uneven balance of power between men and women. Historically based gender bias has led to women and girls being restricted in their access to, inter alia, employment, education and health care.

Gender inequality creates dangers in medical treatment. When both genders are not offered equal quality treatment and care for the same medical complaints or when different manifestations of disease are not considered based on sex, patient outcomes will suffer.

In addition, in some countries, female healthcare providers have been prevented from, or face barriers to practicing their profession or being promoted to leadership positions due to religious and/or cultural convictions, or discrimination based on the intersecting grounds of sex and religion/ethnicity. A lack of gender representation and diversity within the medical profession may lead to female patients and their children not having equitable access to health care.

Discrimination against girls and women damages their health expectation. It serves as a barrier to accessing health services, affects the quality of health services provided, and reinforces exclusion from society for women and girls. For example, the education of girls positively affects their health and well-being as adults. Education also improves the chances of their children surviving infancy and contributes to the overall well-being of their families. Conversely, secondary discrimination due to social, religious and cultural practices – which diminishes women's freedom to make decisions for themselves and to access employment and healthcare opportunities – has a negative impact on health expectation.

National laws, policies and practices can also foster and perpetuate discrimination in health care settings, prohibiting or discouraging women and girls from seeking the broad range of health care services they may need. Evidence demonstrates the harmful health and human rights impacts of such laws. For example, in some countries and due to national laws,

legislations or social norms, women and girls lack decision-making power about their own medical treatment, surgery, childbearing or contraception.

Addressing discrimination in health care settings will contribute to the achievement of many of the United Nations Sustainable Development Goads (SDGs), ensuring that no woman or girl is left behind. It is fundamental to securing progress towards SDG 3, Good health and wellbeing, including achieving universal health coverage and ending the AIDS and tuberculosis epidemics; SDG 4, Quality education; SDG 5, Gender equality and women's empowerment; SDG 8, Decent work and inclusive economic growth; SDG 10, Reduced inequalities; and SDG 16, Peace, justice and strong institutions.

Gender is a social determinant of health and health problems may manifest themselves differently in men and women. There is a need to address the differences in health and unequal health care between men and women, including both the biological and socio-cultural dimensions.

Access to healthcare, including both therapeutic and preventative strategies, is a fundamental human right. This imposes an obligation on government to ensure that these human rights are fully respected and protected. Gender inequalities must be addressed and eradicated in all aspects of healthcare.

Machine learning, predictive algorithms and artificial intelligence (AI) in healthcare are expected to drastically change the way healthcare is practiced and managed. For example, AI could change the way in which diseases such as cancer are diagnosed and treated. However, even with the introduction of AI in healthcare, resource limitations may prevent most women globally from accessing such healthcare. In order not to amplify any gender inequalities, information being programmed into artificial intelligence algorithms being created to inform medical diagnoses and management must take into account the specific health considerations of women, for example women may present with different symptoms to men.

The WMA Declaration of Geneva establishes the physician's respect for human dignity and that it should not allow considerations of gender to come between "my duties and my patients."

RECOMMENDATIONS

Therefore, the World Medical Association urges its constituent members to:

1. Promote the equal human right of health for women and children;
2. Categorically condemn violations of the basic human rights of women and children, including violations stemming from social, political, religious, economic and cultural practices;

3. Insist on the rights of all women and children to full and adequate medical care, especially where religious, social, and cultural restrictions or discrimination may hinder access to such medical care, and promote women's and children's health and access to health as human rights;
4. Advocate for parity of health insurance premiums and coverage to ensure that women's access to care is not impeded by prohibitively high expenses;
5. Governments have an obligation to ensure that the information being programmed into artificial intelligence algorithms being created to inform medical diagnoses and management must include a representative sample of data from women to ensure the gender inequality gap is not amplified further.
6. Ensure universal access to sexual and reproductive healthcare;
7. Promote the provision of pre-conception, prenatal and maternal care, and post-natal care including immunization, nutrition for proper growth and healthcare development for children.
8. Advocate for educational, employment and economic opportunities for women and for their access to information about healthcare and health services.
9. Work towards the achievement of the human right to gender equality of opportunity and gender equality of treatment.

WMA STATEMENT ON NUCLEAR WEAPONS

Adopted by the 50th World Medical Assembly, Ottawa, Canada, October 1998
and amended by the 59th WMA General Assembly, Seoul, Korea, October 2008
and by the 66th WMA General Assembly, Moscow, Russia, October 2015
and revised by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

PREAMBLE

The WMA Declarations of Geneva, of Helsinki and of Tokyo make clear the duties and responsibilities of the medical profession to preserve and safeguard the health of the patient and to dedicate itself to the service of humanity. Therefore, and in light of the catastrophic humanitarian consequences that any use of nuclear weapons would have, and the impossibility of a meaningful health and humanitarian response, the WMA considers that it has a duty to work for the elimination of nuclear weapons. To achieve a world free of nuclear weapons is a necessity.

RECOMMENDATIONS

Therefore, the WMA:

1. Condemns the development, testing, production, stockpiling, transfer, deployment, threat and use of nuclear weapons;

2. Requests all governments to refrain from the development, testing, production, stockpiling, transfer, deployment, threat and use of nuclear weapons and to work in good faith towards the elimination of nuclear weapons;

3. Advises all governments that even a limited nuclear war would bring about immense human suffering and substantial death toll together with catastrophic effects on the earth's ecosystem, which could subsequently decrease the worlds food supply and would put a significant portion of the world's population at risk of famine;

4. Is deeply concerned by plans to retain indefinitely and modernize nuclear arsenals; the absence of progress in nuclear disarmament by nuclear-armed states; and the growing dangers of nuclear war, whether by intent, including cyberattack, inadvertence or accident;

5. Welcomes the Treaty on the Prohibition of Nuclear Weapons, and joins with others in

the international community, including the Red Cross and Red Crescent movement, International Physicians for the Prevention of Nuclear War, the International Campaign to Abolish Nuclear Weapons, and a large majority of UN member states, in calling, as a mission of physicians, on all states to promptly sign, ratify or accede to, and faithfully implement the Treaty on the Prohibition of Nuclear Weapons; and

6. Requests that all National Medical Associations join the WMA in supporting this Declaration, use available educational resources to educate the general public and to urge their respective governments to work urgently to prohibit and eliminate nuclear weapons, including by joining and implementing the UN Treaty on the Prohibition of Nuclear Weapons.

WMA STATEMENT ON MEDICAL CARE FOR MIGRANTS

Adopted by the 50th WMA General Assembly, Ottawa, Canada, October 1998
reaffirmed by the 59th WMA General Assembly, Seoul, Korea, October 2008
amended by the 61st WMA General Assembly, Vancouver, Canada, October 2010
and by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

PREAMBLE

For the purpose of this Statement, in line with the International Organisation for Migration index, "migrant" is an umbrella term reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons.

The WMA considers health to be a basic need, a human right, and one of the essential drivers of economic and social development.

According to the World Health Organisation, universal access to health implies that all people and communities have access to comprehensive health services, without barriers or discrimination, according to their needs, within the framework of equitable and supportive health systems.

Recalling the WMA Declaration of Geneva, the WMA underlines every physician's duty to not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to interfere with the physician's duty to his or her patient.

The WMA underlines that physicians should offer help in medical emergencies in accordance with the WMA International Code of Medical Ethics.

Taking into account the WMA Declaration of Ottawa on Child Health and the WMA Statement on Medical Age Assessment of Unaccompanied Minor Asylum Seekers, the WMA reiterates that children should enjoy special protection, including the right to adequate health care without discrimination.

These fundamental WMA principles also echo the principles laid down in the Universal Declaration of Human Rights, the United Nations Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights.

The WMA Declaration of Lisbon on the Rights of the Patient declares that every person is entitled without discrimination to appropriate medical care. However, national legislation varies and is often not in accordance with this fundamental principle.

At any time, large numbers of migrants are seeking protection, fleeing from natural disasters, desperate poverty, violence and other injustices and abuses with potentially very harmful effects to mental and physical health.

Recalling the WMA statement on Armed Conflicts and the WMA declaration on Health and Climate Change, the WMA recognizes that climate change, natural disasters, warfare, armed conflicts and other emergencies, including continuous civil strife, unrest and violence, will inevitably lead to the displacement of people from their homes.

The WMA is concerned by the precarious situation of certain categories of migrants, such as refugees, asylum seekers, refused asylum seekers, undocumented migrants and displaced persons, whose access to health care is often undermined, and where physicians are required in some countries to intervene outside the scope of their medical duty, in contradiction with medical ethics.

Bearing in mind the above-mentioned principles, international conventions and WMA policies, the WMA advocates a strong and continued engagement of physicians in the defence of human rights and dignity of all people including migrants worldwide, while making the following recommendations for its constituent members and individual physicians:

RECOMMENDATIONS

WMA constituent members should:

- Prioritize the medical care of human beings above any other personal, material, economic, or political interest.
- Actively support and promote the right of all people to receive medical care on the basis of clinical need alone and speak out against legislation and practices that contradict this fundamental right.
- Call for governments to reach political agreements that facilitate the availability of sufficient resources for the delivery of adequate and coordinated health services to migrant populations, including in refugee camps where the conditions of living make them more susceptible to the spread of disease and viruses.

- Urge governments to ensure access to safe and adequate living conditions and essential services to all migrants, even with support from the donor agencies and/or philanthropists if needed.
- Promote equality, solidarity and social justice, guaranteeing access of migrants and refugees to health and social services.
- Implement policies, actions and commitments that promote the health of all, without discrimination, addressing the social determinants of health related to migrants and refugees.

Physicians:

- Have a duty to provide appropriate medical care, based solely on clinical need, regardless of the civil or political status of the patient.
- Should speak out against legislation and practices that prevent the fulfilment of this duty.
- Cannot be compelled to participate in any punitive or judicial action against migrants, including refugees, asylum seekers, refused asylum seekers, undocumented migrants and or displaced persons, or to withhold medically necessary treatment, or to administer any non-medically justified diagnostic measure or treatment, such as sedatives to facilitate easy deportation from the country or relocation.
- Must be allowed adequate time and be provided with sufficient resources, including interpretation services, to assess the physical and psychological condition of migrants, including refugees, asylum seekers, refused asylum seekers, undocumented migrants and displaced persons.

WMA STATEMENT
ON
PATENTING MEDICAL PROCEDURES

Adopted by the 51st World Medical Assembly, Tel Aviv, Israel, October 1999
and amended by the 60th WMA General Assembly, New Delhi, India, October 2009
and reaffirmed by the 212th WMA Council Session, Santiago, Chile, April 2019

PREAMBLE

1. Under the law of some jurisdictions medical procedures are patentable. Patents on medical procedures are often called medical procedure patents. A medical procedure patent or patent claim is one that only confers rights over procedural steps and does not confer rights over any new devices.
2. Over 80 countries prohibit medical procedure patents. The practice of excluding medical procedures from patentability is consistent with the Uruguay Round of Amendments to the General Agreements on Tariffs and Trade Agreement on Trade Related Aspects of International Property Rights (GATT-TRIPs), which states: "Members may also exclude from patentability: (a) diagnostic, therapeutic and surgical methods for the treatment of humans or animals" (Article 27).
3. The purpose of patents is to encourage private investment in research and development. However, physicians, particularly those who work in research institutions, already have incentives to innovate and improve their skills. These incentives include professional reputation, professional advancement, and ethical and legal obligations to provide competent medical care (International Code of Medical Ethics, 17.A). Physicians are already paid for these activities, and public funding is sometimes available for medical research. The argument that patents are necessary to spur invention of medical procedures, and that without procedure there would be fewer beneficial medical procedures for patients, is not particularly persuasive when these other incentives and financing mechanisms are available.
4. Another argument is that patents are necessary, not so much for invention but for product development. This argument also is not persuasive in the case of medical procedure patents. Unlike device development, which requires investment in engineers, production processes, and factories, development of medical procedures consists of physicians attain-ing and perfecting manual and intellectual skills. As discussed above, physicians already have both obligations to engage in these professional activities as well as rewards for doing so.
5. Whether or not it is ethical to patent medical devices does not bear directly on whether it is ethical for physicians to patent medical procedures. Devices are manufactured and disseminated by companies, whereas medical procedures are "produced and disseminated" by physicians. Physicians have ethical or legal obligations to patients and professional obligations towards each other, which companies do not have. Having particular ethical obliga-tions is part of what defines medicine as a profession.

6. There is no a priori reason to believe that those holding medical procedure patents would make patented medical procedures widely available. Patentees might attempt to maximize their profits by making the procedure widely available through nonexclusive licensing with low fees. Alternatively, they might attempt to maximize profits by limiting avail-ability of the procedure and charging higher prices to those for whom the procedure is extremely important and who have the means to pay.
7. Competition between organizations providing health care could provide incentives for some organizations to negotiate exclusive licenses, or licenses which sharply limit who else could practice the procedure. Such a license might provide the organization with an advantage in attracting patients, if the organization could advertise that it was the only organization in a region which could provide a particularly desirable service. Thus, at least some of the time patentees will probably limit access to patented medical procedures.
8. Medical procedure patents may negatively affect patient care. If medical procedure patents are obtained, then patients' access to necessary medical treatments might diminish and thereby undermine the quality of medical care. Access could diminish for the following reasons:

    - the cost of medical practice would likely increase because of licensing and royalty fees, and because the cost of physicians' insurance would likely increase to cover patent litigation expenses.
    - some physicians capable of performing the patented procedure might not obtain licenses to perform it. The number of licensed physicians might be restricted because certain physicians cannot or will not pay the licensing fees or royalties, or because the patentee refuses to make the license widely available. Limiting the number of licenses would, in some circumstances, limit patients' choice of physicians.
    - The presence of patents may prevent physicians from undertaking even those procedures which do not infringe. It may also deter a physician from introducing new or modified procedures into his or her practice. Devices can be labelled if they are patented, but procedures cannot, and therefore it is not immediately obvious whether what one is doing infringes somebody else's medical procedure patent. However, lack of knowledge is no defence against patent infringement, so if a physician is uncertain he or she may simply refrain from performing the procedure.

9. Enforcement of medical procedure patents can also result in invasion of patients' privacy or in the undermining of physicians' ethical obligation to maintain the confidentiality of patients' medical information. Where physicians practice in small groups or as sole practi-tioners, the most expedient methods for a patentee to identify instances of infringement might be to look through patients' medical records or to interview patients. Removing obvious identifiers for the record review would not guarantee confidentiality, because identity can often be "reconstructed" with very few pieces of information. This would be parti-cularly true in small towns or small practices.
10. Physicians have ethical obligations both to teach skills and techniques to their

colleagues, and to continuously learn and update their own skills. Medical procedure patents can undermine these obligations. Once a patent has issued on a procedure, the procedure would be fully disclosed (this is one requirement for obtaining a patent); however, those without licenses would not be able to practice it. Limiting who can practice the procedure undermines the spirit of the ethical mandate to teach and disseminate knowledge. It also undermines the obligation to update one's skills, because it does not do much good to acquire skills which cannot be used legally.

11. The obligation to teach and impart skills may also be impaired if the possibility of patents causes physicians to delay publishing new results or presenting them at conferences. Physicians may be inclined to keep new techniques secret while waiting to complete a patent application. This is because public use of a procedure, or publication of a description of the procedure, prior to applying for a patent may invalidate the application.
12. Physicians also have an ethical obligation not to permit profit motives to influence their free and independent medical judgment (International Code of Medical Ethics, 17.A). For physicians to pursue, obtain, or enforce medical procedure patents could violate this requirement. Physicians holding patents or licenses for procedures might advocate for the use of those procedures even when they are not indicated, or not the best procedure under the circumstances. Physicians who are not licensed to perform a particular procedure might advocate against that procedure, even when it is the best procedure under the circumstances.
13. Finally, physicians' professional obligations to practice their profession with conscience and dignity (Declaration of Geneva) might be violated by the enforcement of medical procedure patents. The spectacle of physicians suing each other on a regular basis is unlikely to enhance the standing of the profession.

POSITION

14. The World Medical Association

- states that physicians have an ethical responsibility to make relevant scientific information available to colleagues and the public, when possible.
- states that the patenting of medical procedures poses serious risks to the effective practice of medicine by potentially limiting the availability of new procedures to patients.
- considers that the patenting of medical procedures is unethical and contrary to the values of the medical profession that should guide physicians' service to their patients and relations with their colleagues.
- encourages national medical associations to make every effort to protect physicians' incentives to advance medical knowledge and develop new medical procedures.

WMA STATEMENT
ON
THE RELATIONSHIP BETWEEN PHYSICIANS AND PHARMACISTS IN MEDICINAL THERAPY

Adopted by the 51st World Medical Assembly, Tel Aviv, Israel, October 1999
and amended by the 61st WMA General Assembly, Vancouver, Canada, October 2010
and reaffirmed with minor revisions by the 215th Council session (online), Cordoba, Spain, October 2020

PREAMBLE

The goal of pharmacological treatment is to improve patients´ health and quality of life. Optimal pharmacological treatment should be safe, effective and efficient. There should be equity of access to this kind of treatment and an accurate and up-to-date information base that meets the needs of patients and practitioners.

Pharmacological treatment has become increasingly complex, often requiring the input of a multi-disciplinary team to administer and monitor the chosen therapy. In the hospital setting the inclusion of a clinical pharmacist in such a team is increasingly common and helpful. The right to prescribe medicine should be competency based and ideally the responsibility of the physician.

Physicians and pharmacists have complementary and supportive responsibilities in achieving the goal of providing optimal pharmacological treatment. This requires communication, respect, trust and mutual recognition of each other's professional competence. Access by both physicians and pharmacists to the same accurate and up-to-date information base is important to avoid providing patients with conflicting information.

Physicians and pharmacists must provide quality service to their patients and ensure safe use of drugs. Therefore, collaboration between these professions is imperative, including with respect to the development of training and in terms of information sharing with one another and with patients. It is necessary to keep an open and continued dialogue between physicians' and pharmacists' representative organizations in order to define each profession's respective functions and promote the optimal use of drugs within a framework of transparency and cooperation, all in the best interests of patients.

The Joint Statement on Counterfeiting Medical Products of the World Health Professions Alliance (WHPA) states that physicians and pharmacists share the same priority of identifying, investigating and eliminating counterfeit medicines, in which both physicians and pharmacists play a crucial role.

Patients are best served when pharmacists and physicians collaborate, recognizing and respecting each other's roles, to ensure that medicines are used safely and appropriately to achieve the best outcome for the patient's health.

THE PHYSICIAN'S RESPONSIBILITIES

1. Diagnosing diseases on the basis of the physician's education and specialized skills and competence.

2. Assessing the need for pharmacological treatment and prescribing the corresponding medi-cines in consultation with patients, pharmacists and other health care professionals, when appropriate.
3. Providing information to patients about diagnosis, indications and treatment goals, as well as action, benefits, risks and potential side effects of pharmacological treatment. In the case of off-label prescriptions the patient must be informed about the character of the pre-scription.

4. Monitoring and assessing response to pharmacological treatment, progress toward thera-peutic goals, and, as necessary, revising the therapeutic plan in collaboration with pharma-cists, other health professionals and, when appropriate, caregivers.

5. Providing and sharing information in relation to pharmacological treatment with other health care practitioners.

6. Leading the multi-disciplinary team of health professionals responsible for managing com-plex pharmacological treatment.

7. Maintaining adequate records for each patient, according to the need for therapy and in compliance with legislation respecting confidentiality and protecting the patient’s data.

8. Where practically possible, actively participating in establishing electronic drug delivery systems within their workplace and supporting those systems with their professional knowledge.

9. Maintaining a high level of knowledge of pharmacological treatment through continuing professional development.

10. Ensuring safe procurement and storage of medicines that the physician is required to supply or permitted to dispense.

11. Reviewing prescription orders to identify interactions, allergic reactions, contra-indica-tions and therapeutic duplications.

12. Reporting adverse reactions to medicines to health authorities, in accordance with national legislation.

13. Monitoring and limiting, where appropriate, prescriptions of medications that may have addictive properties.

14. Documenting adverse reactions to medicines in the patient’s medical record.

THE PHARMACIST'S RESPONSIBILITIES

15. Ensuring safe procurement, adequate storage and dispensing of medicines in compliance with the relevant regulations.

16. Providing information to patients, which may include the information leaflet, name of the medicine, its purpose, potential interactions and side effects, as well as correct usage and storage.
17. Reviewing prescription orders to identify interactions, allergic reactions, contra-indications and therapeutic duplications. Concerns should be discussed with the prescribing phy-sician but the pharmacist should not change the prescription without consulting the prescriber.

18. Discussing medicine-related problems or concerns with regard to the prescribed medicines when appropriate and when requested by the patient.

19. Advising patients, when appropriate, on the selection and the use of non-prescription medicines and the patient's management of minor symptoms or ailments. Where self-medication is not appropriate, advising patients to consult their physician for diagnosis and treatment.

20. Participating in multi-disciplinary teams concerning complex pharmacological treatment in collaboration with physicians and other health care providers, typically in a hospital setting.

21. Reporting adverse reactions to medicines to the prescribing physician and to health authorities in accordance with national legislation.

22. Providing and sharing general as well as specific medicine-related information and advice with the public and health care practitioners.

23. Maintaining a high level of knowledge of pharmacological treatment through continuing professional development.

WMA STATEMENT
ON
SAFE INJECTIONS IN HEALTH CARE

Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002
revised with minor revisions by the 192nd WMA Council, Bangkok, Thailand, October 2012
and reaffirmed with minor revisions by the 221st WMA Council Session, Berlin, Germany, October 2022

PREAMBLE

According to the World Health Organization, billions of injections are administered worldwide each year in health care and many of them are unsafe.

The most common diseases acquired from unsafe injections are hepatitis B, hepatitis C and HIV.

Physicians are involved in the prescription and/or administration of injections. Therefore, they are in a prime position to bring about changes in behaviour, which could lead to the appropriate and safe use of injections.

The WMA recognizes that unsafe injections result from inadequate education, the overuse of therapeutic injections and unsafe injection practices, including the use of unsterilized or inadequately sterilized needles, the re-use of syringes, the misuse equipment and supplies or inappropriate disposal of sharps waste.

Unsafe injections are a waste of precious healthcare resources and can easily be prevented through integrated interventions, developing effective local, national and regional promotion strategies.

Physician attitudes and inappropriate practice standards may be important determinants in the overuse of "therapeutic" injections incorrectly assuming that patients' satisfaction depends on injection prescription or accepting incentives for unnecessary use of them.

Behavior change among patients and health professionals needs to be developed to decrease injection overuse and achieve injection safety.

Safe injection practices prevent harm to the recipient, the provider and the community, while avoiding the widespread of different pathogens that can result from unsafe injections such as hepatitis B and C and HIV. In this sense, it is a necessary component of prevention for these infections.

RECOMMENDATIONS

Taking into consideration that reducing unsafe injections in healthcare involves different parties, the WMA calls:

Constituent Members to

1. Cooperate with their national governments or other appropriate authorities to develop effective policies on the safe and suitable use of injections, including appropriate financing, the assessment of current injection practices and the development of an integrated plan;

2. Develop a plan that supports the provision of adequate supplies of injection equipment, measures to enforce proper standards of sterilization where needed, the management of sharps waste, and education programs to deter the overuse of injections as well as promote safe injection practices;

Physicians worldwide to

3. Educate patients on equivalent action and efficacy of non-injectable medications;

4. Prescribe non-injectable medication whenever possible and promote the use of non-injectable medication that are viable alternatives;

5. Use injectable medications only if safe and appropriate and administer injections in a way that does not harm the recipient, the provider and the community;

6. Ensure that only waste disposal containers for sharp objects be used to safely dispose of used surgical material (e.g. needles, blades, etc.), that the covers of sharp instruments not be re-utilised, and, if possible, use auto-disable syringes

7. Raise awareness regarding the risks involved with unsafe injections and help bring about behaviour changes in patients and health professionals to promote safe and appropriate injections. Education in this area should emphasise that needles should not be re-sheathed.

WMA STATEMENT ON SELF-MEDICATION

Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002
reaffirmed by the 191st WMA Council Session, Prague, Czech Republic, April 2012
and reaffirmed with minor revisions by the 221st WMA Council Session, Berlin, Germany, October 2022

PREAMBLE

This statement aims to provide guidance on responsible self-medication.

Medicinal products can generally be divided into two separate categories: prescription and non-prescription medicines. This classification may differ from country to country. The national authorities must assure that medicines, categorized as non-prescription medicines, are sufficiently safe not to be harmful to health.

Prescription medicines are those which are only available to individuals on prescription from a physician or other authorized health professionals following a consultation. Prescription medicines are not safe for use except under the supervision of the health professional because of toxicity, other potential or harmful effects (e.g. addictiveness), the method of use, or the collateral measures necessary for use.

Responsible self-medication, as referred in this document, is the use of a registered or monographed medicine legally available without a physician's prescription, either on an individual's own initiative or following advice of a healthcare professional. The use of prescription medicines without a prior medical prescription is not part of responsible self-medication.

RECOMMENDATIONS

1. The safety, efficacy and quality of non-prescription medicines must be proved according to the same principles as prescription medicines.

2. Given the risk of using unprescribed medicine and/or irresponsible self-medication, the WMA recommends the following:

For individuals

3. Patients should inform their physicians or other healthcare professionals concerned whenever they self-medicate in conjunction with other prescribed medication. A course of treatment may combine self-medication and prescription medication, either concurrently or sequentially. The patient must be informed about possible interactions between prescription medicines and non-prescription medicines. For this reason, the patient should be encouraged to inform the health professional about his / her self-medication.

4. In self-medication, the individual bears primary responsibility for the use of self-medication products. Special caution must be exercised when vulnerable groups such as children, elderly people or pregnant women use self-medication.

5. If individuals choose to use self-medication, they should be able:

    - to recognize the symptoms they are treating;
    - to determine that their condition is suitable for self-medication;
    - to choose an appropriate self-medication product;
    - to follow the directions for use of the product as provided in the product labelling.

For health professionals

6. Physicians and other health professionals concerned must educate patients about the potential risks involved in self-medication and its appropriate use, and instructions them to seek further medical advice if they are unsure. This is particularly important where self-medication is inappropriate for certain conditions the patient may suffer from.

7. Information to the patients should include a warning against pseudoscience and pseudo therapies, which have no scientific basis, as stated in the WMA Declaration on Pseudoscience and Pseudotherapies in the field of health.

8. Health professionals should encourage patients to carefully read a product's label and leaflet (if provided), to seek further advice if necessary, and to recognize circumstances in which self-medication is not, or is no longer, appropriate.

9. Pharmacists have a professional responsibility to recommend that patients seek medical attention, especially when in case of symptoms that warrant them to do so or if patients ask for medication that can be only be given to them after prescription.

10. Health professionals should seek to identify potentially relevant self-medication during medical consultations, drug dispensing at the pharmacy and during home-based nursing interventions.

For other stakeholders

11. Governments should recognize and enforce the distinction between prescription and non-prescription medicines and ensure that the users of self-medication are well informed and protected from possible harm or negative long-term effects.

12. Manufacturers are obliged to follow the various codes or regulations already in place to ensure that information provided to consumers is appropriate in style and content. This refers in particular to the labelling, advertising and all notices concerning non-prescription medicines.

13. Advertising and marketing of non-prescription medicines should be responsible, provide clear and accurate information and exhibit a fair balance between benefit and risk information. Promotion and marketing should not encourage irresponsible self-medication, purchase of medicines that are inappropriate, or purchases of larger quantities of medicines than are necessary.

14. Pharmacovigilance for self-medication should be organized and reinforced by both governments and the industry to control the risks associated with self-medication.

For all

15. All parties involved in self-medication should treat medicines (prescription and non-prescription) as special products. Standard precautions should be followed in terms of safe storage and usage, in accordance with professional advice.

16. All parties involved in self-medication should be aware of the benefits and risks of any self-medication product. The benefit-risk balance should be communicated in a fair, rational manner without overemphasizing either the risks or the benefits.

WMA STATEMENT
ON
SEX SELECTION ABORTION AND FEMALE FOETICIDE

Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002
reaffirmed by the 191st WMA Council Session, Prague, Czech Republic, April 2012
and revised by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

The WMA is gravely concerned that female foeticide and sex selection abortion is commonly practiced in certain countries.

The WMA denounces female foeticide and sex selection abortion as a totally unacceptable example form of gender discrimination.

The WMA holds that sex selection abortion for reasons of gender preference is discriminatory, where it is solely due to parental preference and where there are no health implications for the foetus or the woman.

The World Medical Association calls on National Medical Associations:

- To denounce the practice of female foeticide and the use of sex selection abortion for gender preference and;
- To advise their governments accordingly.

WMA STATEMENT ON WOMEN'S RIGHTS TO HEALTH CARE AND HOW THAT RELATES TO THE PREVENTION OF MOTHER-TO-CHILD HIV INFECTION

Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002
amended by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013
and by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

PREAMBLE

Since the start of the global HIV epidemic, women and girls in many regions have been disproportionately affected by HIV. Young women (aged 15-24), and adolescent girls (aged 10-19) in particular, account for a disproportionate number of new HIV infections.

Gender inequality contributes to the spread of HIV. It can increase infection rates and reduce the ability of women and girls to cope with the illness. Often, they have less information about HIV and fewer resources to take preventive measures. Sexual violence, a widespread violation of women's rights, exacerbates the risk of HIV transmission.

Many women and girls living with HIV struggle with stigma and exclusion, aggravated by their lack of rights. Women widowed by AIDS or living with HIV may face property disputes with in-laws, complicated by limited access to justice to uphold their rights. Regardless of whether they themselves are living with HIV, women generally assume a disproportionate burden of care for others who are sick from or dying of AIDS, along with the orphans left behind. This, in turn, can reduce prospects for education and employment. It can also significantly reduce prevention of mother-to-child transmission (PMTCT) efforts and strategies.

Access to healthcare, including both preventative and therapeutic strategies, is a fundamental human right. This imposes an obligation on government to ensure that these human rights are fully respected and protected. Gender inequalities must be addressed and eradicated. This should impact every aspect of healthcare.

The promotion and protection of the reproductive rights of women are critical to the ultimate success of confronting and resolving the HIV/AIDS pandemic.

RECOMMENDATIONS

The WMA requests all national member associations to encourage their governments to undertake and promote the following actions:

1. Develop empowerment programs for women of all ages to ensure that women are better supported and free from discrimination. Such programs should include universal and free access to reproductive health education and life skills training,
2. Develop programme to provide HIV testing and post-exposure prophylaxis in the form of antiretrovirals to all survivors of assault.
3. Governments must provide universal access to antiviral therapy and treatment to all HIV infected women, protecting their health, and in the case of pregnant women, preventing mother to child transmission.
4. Provide universal HIV testing of all pregnant women, with patient notification of the right of refusal, as a routine component of perinatal care, and such testing should be accompanied by privacy protection, basic counseling and awareness of appropriate treatment, if necessary.
5. Patient notification should be consistent with the principles of informed consent. Universal and free access to antiretroviral therapy must also be provided to all HIV-positive pregnant women in order to prevent mother to child transmission of HIV.

WMA STATEMENT ON FORENSIC INVESTIGATIONS OF THE MISSING

Adopted by the 54th WMA General Assembly, Helsinki, Finland, September 2003
and amended by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013

PREAMBLE

Over the last three decades, forensic investigations into the whereabouts and fate of people killed and missing as a result of armed conflict, other situations of violence and catastrophes, have made an important contribution to humanitarian action on behalf of victims, including [the deceased and] bereaved families. Forensic investigations have also helped in achieving justice and reparations for victims.

In 2003 the International Conference on The Missing and their Families, organized by the International Committee of the Red Cross (ICRC), adopted a set of recommendations to help prevent people going missing, and resolve the cases of those already missing, as a result of armed conflicts and other situations of violence. The recommendations include ethical, scientific and legal principles that must apply to forensic investigations in the search, recovery, management and identification of human remains. These principles have since been further developed by the ICRC's forensic services and they provide a framework for humanitarian forensic action in situations of armed conflicts, other situations of violence and catastrophes.[1] The principles also ensure the proper and dignified management and identification of the dead, and help provide answers to the bereaved.

National Medical Associations have a role in promoting these principles and encouraging compliance with them, and for ensuring the highest possible ethical, scientific and legal standards in forensic investigations aimed at addressing the humanitarian consequences of armed conflicts, other situations of violence and catastrophes.

In many countries NMAs will not have a role in certifying the qualifications and experience of forensic medical practitioners. NMAs should draw the attention of practitioners to the best practice guidelines produced by the ICRC, the United Nations and Interpol, and recommend or, where possible, require compliance with those standards.

RECOMMENDATIONS

The WMA calls upon all NMAs to help ensure that, when its members take part in forensic investigations for humanitarian and human rights purposes, such investigations are established with a clear mandate based upon the highest ethical, scientific and legal

standards, and conform with the principles and practice of humanitarian forensic action developed by the ICRC.

The WMA calls upon NMAs to develop expertise in the principles collated by the different authorities on forensic investigations for humanitarian and human rights purposes, including those developed by the ICRC to prevent new cases and resolve those of existing missing persons, and to assist their members in applying these principles to forensic investigations worldwide.

The WMA calls upon NMAs to disseminate the principles that should apply to such investigations, including those developed by the ICRC, and to attempt to ensure that physicians refuse to take part in investigations that are ethically or otherwise unacceptable.

The WMA calls upon NMAs to help ensure compliance by forensic medical practitioners with the principles enshrined in international humanitarian law for the dignified and proper management, documentation and identification of the dead, and, where possible, providing answers to the bereaved.

The WMA invites NMAs to be mindful of academic qualifications and ethical understanding, ensuring that forensic doctors practice with competence and independence.

[1] The ICRC defines catastrophes as disasters beyond expectations. See: M. Tidball-Binz, *Managing the dead in catastrophes: guiding principles and practical recommendations for first responders*. International review of the Red Cross, Vol 89 Number 866 June 2007; 421- 442

WMA STATEMENT
ON
ADVANCE DIRECTIVES ("LIVING WILLS")

Adopted by the 54th WMA General Assembly, Helsinki, Finland, September 2003
and reaffirmed by the 194th WMA Council Session, Bali, Indonesia, April 2013

A. PREAMBLE

1. An advance directive is a written and signed document or a witnessed verbal statement whereby persons record their wishes regarding the medical care they wish to receive, or not receive, if they become unconscious or otherwise unable to express their will.

2. This type of document may have different names in different countries (e.g., "living will" or "biological wills"). The acceptability and legal status of such directives may differ from one country to another, depending on social, cultural and religious and other factors.

3. The majority of persons who draw up such directives are particularly concerned about excessive, ineffective or prolonged therapeutic interventions in the terminal phases of life, in situations where there is clear and irreversible physical or mental degeneration.

4. The *WMA Declaration of Lisbon on the Rights of the Patient* states that "If the patient is unconscious and if a legally entitled representative is not available but a medical intervention is urgently needed, consent of the patient may be presumed unless it is obvious and beyond any doubt on the basis of the patient's previous firm expression or conviction that he/she would refuse consent to the intervention in that situation."

B. RECOMMENDATIONS

1. A patient's duly executed advance directive should be honoured unless there are reasonable grounds to suppose that it is not valid because it no longer represents the wishes of the patient or that the patient's understanding was incomplete at the time the directive was prepared. If the advance directive is contrary to the physician's convictions, provisions should be made to transfer the care of the patient to another consenting physician.

2. If the physician is uncertain about the validity of an advance directive to terminate life-prolonging treatment, he/she should consult family members or legal guardians of the patient concerned and should seek advice from at least one other

physician or the relevant ethics committee. The family members or legal guardians should be designated in the advance directive, be trustworthy and willing to testify as to the intention(s) expressed in the advance directive by the signatory. The physician should consider any relevant legislation concerning substitute decision making for incompetent patients.

3. Patients should be advised to review their advance directives periodically.

4. In the absence of an advance directive or a legally designated substitute decision maker, physicians should render such treatment as they believe to be in the patient's best interests.

WMA STATEMENT ON ETHICAL GUIDELINES FOR THE INTERNATIONAL MIGRATION OF HEALTH WORKERS

Adopted by the 54th WMA General Assembly, Helsinki, Finland, September 2003
and revised by the 65th WMA General Assembly, Durban, South Africa, October 2014

PREAMBLE

The WMA acknowledges that temporary stays of physicians in other countries help both the receiving and the sending countries to exchange medical knowledge, skills and attitudes. The exchange of medical professionals is therefore beneficial for the development of medicine and healthcare systems and in general deserves the support of national medical associations as well as governments.

The WMA Statement on Medical Manpower - 1 (1983, 1986) called upon all National Medical Associations to work with their governments towards solutions to the emerging problems related to the medical workforce.

The WMA Resolution on the Medical Workforce (1998) identified the major components of the medical workforce situation that need to be taken into account when developing a national workforce policy.

For several decades many governments, employers and medical associations have misinterpreted demographical data regarding the number of physicians that are required. Young people seeing employment as physicians have often been seriously affected by poor medical workforce planning.

In many countries, including the wealthiest ones, there is a shortage of physicians. A major reason for the shortage is a failure to educate enough physicians to meet the needs of the country. Other reasons for the net loss of physicians are the recruitment of physicians to other professions, early retirement and emigration, and the problems of combining professional and family responsibilities, all of which are often due to poor working conditions for physicians.

Some countries have traditionally solved their need for physicians by recruiting medical graduates from other countries. This practice continues today.

The flow of international migration of physicians is generally from poorer to wealthier countries. The poorer countries bear the expense of educating the migrating physicians and receive no recompense when they enter other countries. The receiving countries gain a valuable resource without paying for it, and in the process they save the cost of educating their own physicians.

Physicians do have valid reasons for migrating, for example, to seek better career opportunities and to escape poor working and living conditions, which may include the pursuit of more political and personal freedoms and other benefits.

RECOMMENDATIONS

1. National medical associations, governments and employers should exercise utmost care in utilizing demographic data to make projections about future requirements for physicians and in communicating these projections to young people contemplating a medical career.

2. Every country should do its utmost to educate an adequate number of physicians, taking into account its needs and resources. A country should not rely on immigration from other countries to meet its need for physicians.

3. Every country should do its utmost to retain its physicians in the profession as well as in the country by providing them with the support they need to meet their personal and professional goals, taking into account the country's needs and resources.

4. Countries that wish to recruit physicians from another country should only do so in terms of and in accordance with the provisions of a Memorandum of Understanding entered into between the countries.

5. Physicians should not be prevented from leaving their home or adopted country to pursue career opportunities in another country.

6. Countries that recruit physicians from other countries should ensure that recruiters provide full and accurate information to potential recruits on the nature and requirements of the position to be filled, on immigration, administrative and contractual requirements, and on the legal and regulatory conditions for the practice of medicine in the recruiting country, including language skills.

7. Physicians who are working, either permanently or temporarily, in a country other than their home country should be treated fairly in relation to other physicians in that country (for example, equal opportunity career options and equal payment for the same work).

8. Nothing should prevent countries from entering into bilateral agreements and agreements of understanding, as provided for in international law and with due cognizance of international human rights law, so as to effect meaningful cooperation on health care delivery, including the exchange of physicians.

9. The WHO Global Code of Practice on the International Recruitment of Health Personnel (May 2010) was established to promote voluntary principles and practices for the ethical international recruitment of health professionals and to facilitate the strengthening of health systems. The Code takes into account the rights, obligations and expectations of source countries and migrant health professionals. The WMA was involved in the drafting of the Code and supports its implementation.

10. The WHO Code states that international recruitment should be “conducted in accordance with the principles of transparency, fairness and promotion of sustainability of health systems in developing countries.”

11. The monitoring and information-sharing system established by the WHO should be robustly supported with the goal of international cooperation. Stakeholders should regularly collate and share data, which should be monitored and anlaysed by the WHO. The WHO should provide substantive critical feedback to governments. Information should be shared about how to overcome challenges encountered.

WMA STATEMENT ON VIOLENCE AND HEALTH

Adopted by the 54th WMA General Assembly, Helsinki, Finland, September 2003
reaffirmed by the 59th WMA General Assembly, Seoul, Korea, October 2008
and revised by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

PREAMBLE

Violence is defined as "the intentional use of physical force or power, threatened or actual, against oneself, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.''

Violence is multi-dimensional, has multiple driving factors, and can be physical, sexual, psychological or exerted through acts of deprivation or neglect.

The World Medical Association (WMA) has developed policies condemning different forms of violence. These include statements on Violence Against Women and Girls, Family Violence, Child Abuse and Neglect, Abuse of the Elderly, Adolescent Suicide, Violence in the Health Sector by Patients and those close to them, Protection of Health Care Workers in Situation of Violence, WMA Declaration on Alcohol and the WMA Statement on Armed-Conflicts.

Violence is a manifestation of the health, socio-economic, policy, legal, and political conditions of a country. It occurs in all social classes and is strongly associated with leadership failure and poor governance, and social determinants such as unemployment, poverty, health and gender inequality, and poor access to educational opportunities.

Despite regional and country-wide disparities in the scale and burden of violence, along with the under reporting of data, it is evident that violence results in fatal and non-fatal consequences. These include the devastation of individual, family, and community life, as well as disruption of the social, economic, and political development of nations.

Violence impacts the economy because of increased health and administrative expenditures by the criminal justice, law enforcement, and social welfare systems. It also has negative impact on a nation's productivity because of a loss in human capital and the productivity of the workforce.

IMPACT ON HEALTH

The effects of violence on health vary and can be life-long. Health consequences include physical disability, depression, post-traumatic stress disorder and other mental health challenges, unwanted pregnancies, miscarriages, and sexually transmitted infections.

Behavioral risk factors such as substance use, which can give rise to violent behaviour, are also risk factors for cancer, cardiovascular and cerebrovascular diseases.

Direct victims of violence are prone to traumatizing experiences such as physical, sexual and psychological abuse, and may be unwilling or unable to disclose or report their experiences to appropriate authorities due to shame, cultural taboo, fear of societal stigma or reprisal, and the justice system's undue delay in dispensing justice.

In institutions such as healthcare facilities, violence is often interpersonal in nature, and may be perpetrated against patients by healthcare workers, or against health care workers by patients and their caregivers, or among healthcare personnel in the form of bullying, intimidation, and harassment.

Additionally, healthcare professionals and healthcare facilities are increasingly subjected to violent attacks. Such violence and targeted attacks on healthcare facilities, healthcare personnel, and the sick and wounded are in direct breach of medical ethics, international humanitarian and human rights laws.

Though many countries are increasingly accepting the need to institute violence prevention programs in their respective jurisdictions, the field of violence prevention and management still faces many challenges. Challenges include inadequate or non-existent reporting of data, inadequate investment in violence prevention programs and support services for victims of violence, and failure to enforce existing laws against violence, including measures to restrict access to alcohol.

Recognizing that violence remains a significant public health challenge which is multi-dimensional and preventable in nature, and affirming the pre-eminent role of physicians as role models, and in the care and support of victims of violence, the WMA commits itself to act against this global scourge.

RECOMMENDATIONS

WMA encourages its constituent members to:

1. Educate and advise political and public office holders at all levels of government with appropriate and adequate knowledge and scientific evidence on the benefits of investing more resources in violence prevention.
2. Advocate for and support good governance based on the rule of law,

transparency, and accountability.

3. Conduct and support effective media campaigns to inform and raise the public's awareness on the burden and consequences of violence and the need to prevent it.
4. Raise public awareness of international laws, norms, and ethical codes that mandate the protection of healthcare workers and facilities in times of peace and conflict.
5. Advocate for and promote the inclusion of courses on violence and its prevention in academic curricula, including those for undergraduate and postgraduate medical training and Continuing Medical Education (CME).
6. Consider organizing capacity building and CME programs for physicians on violence prevention, caring for victims of violence, emergency preparedness and response, and early recognition of signs of interpersonal and sexual violence.

The WMA urges governments to:

1. Work towards achieving a zero-tolerance for violence, through prevention programs, establishment of violence prevention and victim support clinics, establishment of safe domestic violence shelters, increased public and private investment in public safety, security, and strengthening of health and educational institutions.
2. Encourage collaborative action on violence prevention, with integrated violence prevention and victim support in health care institutions.
3. Promote social justice and equity by eliminating inequities and inequalities that may create the conditions for violence.
4. Focus on addressing social determinants of health through the creation and improvement of socio-economic, educational and health infrastructure and opportunities, and elimination of adverse and oppressive cultural attitudes and practices and all forms of inequality or discrimination on the basis of gender, creed, ethnic origin, nationality, political affiliation, race, sexual orientation, social standing, disease or disability.
5. Secure the enactment and enforcement of policies and laws on violence prevention, protection and support of victims of violence, and punishment of offenders.
6. Strengthen institutions concerned with public safety and security.
7. Develop policies and enforce legislations that regulate access to alcohol.
8. Develop and implement effective legal frameworks that protect individuals and entities that deliver healthcare. Such frameworks should guarantee the protection of physicians and other healthcare professionals, as well as the free and safe access of healthcare personnel and patients to health care facilities.
9. Support comprehensive research studies on the nature and character of the various forms of violence, including the effectiveness of response strategies, to

assist them in the preparation and implementation of policies, laws and strategies on violence prevention, protection and support of victims, and punishment of perpetrators.

10. Initiate and foster multi-stakeholder involvement and collaboration among relevant bodies and organizations at global, national, state and local levels, in the development, implementation and promotion of violence prevention and management strategies, including engagement of traditional, religious, and political leaders.
11. Develop robust multi-sectoral partnerships at local, state and national levels with violence prevention made a priority concern in all government ministries, including health, education, labour, and defense ministries.
12. Institute a Safe Care Initiative that guarantees the safety and security of physicians and other healthcare workers, patients, healthcare facilities, and the uninterrupted delivery of healthcare services in times of peace and conflict.
13. The initiative should include the following components:
    - Routine violence risk audit.
    - Efficient and effective violence surveillance and reporting mechanisms.
    - Transparent and timely investigation of all reported cases of violence.
    - A system for protecting patients and healthcare personnel who report cases of violence.
    - Legal support for physicians and other healthcare workers subjected to violence in the workplace.
    - Establishment of security posts in healthcare facilities as deemed necessary.
    - Financial coverage for injured medical personnel and other healthcare workers.
    - Compensated time off for injured medical personnel and other healthcare workers.

WMA STATEMENT CONCERNING THE RELATIONSHIP BETWEEN PHYSICIANS AND COMMERCIAL ENTERPRISES

Adopted by the 55th WMA General Assembly, Tokyo, Japan, October 2004
and amended by the 60th WMA General Assembly, New Delhi, India, October 2009
and by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

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

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

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

RECOMMENDATIONS

Medical conferences

1. These guidelines related to medical conferences apply, where pertinent, to corporation events, such as educational events, and promotional activities including for items of medical utility, sponsored by a commercial enterprise.

2. Physicians may attend medical conferences, sponsored in whole or in part by a commercial entity if these conform to the following principles:
   - The main purpose of the conference is the exchange of professional or scientific information for the benefit of patient care.
   - Hospitality during the conference is secondary to the professional exchange of information and does not exceed what is locally customary and generally acceptable.
   - Physicians do not receive payment directly from a commercial entity to cover travelling expenses, room and board at the conference for themselves or an accompanying person or compensation for their time unless provided for by law and/or the policy of their National Medical Association, or unless it is a reasonable honorarium for speaking at the conference.
   - The name of a commercial entity providing financial support is publicly disclosed in order to allow the medical community and the public to fairly evaluate the information presented. In addition, conference organizers and lecturers are transparent and disclose any financial affiliations that could potentially influence educational activities or any other substantial outcome that may result from the conference.
   - In accordance with the WMA Guidelines on Promotional Mass Media Appearances by Physicians, presentation of material by a physician should be scientifically accurate, give a balanced review of possible treatment options, and not be influenced by the sponsoring organization.

3. In addition, a conference can be recognized for purposes of continuing medical education/ continuing professional development (CME/CPD) only if it conforms to the following principles:
   - The commercial entities acting as sponsors, such as pharmaceutical companies or enterprises in the medical devices sector, have no influence on the content, presentation, choice of lecturers, or publication of results.
   - Funding for the conference is accepted only as a contribution to the general costs of the meeting.
   - The independence of the contents of the conference is guaranteed.

Gifts

4. To preserve the trust between patients and physicians, physicians should decline:
   - cash, cash equivalents and other gifts for personal benefit from a commercial entity
   - gifts designed to influence clinical practice, including direct prescription incentives.
5. Physicians may accept:
   - Promotional aids provided that the gift is of minimal value and is not connected to any stipulation that the physician uses certain instruments, medications or materials or refers patients to a certain facility.
   - Cultural courtesy gifts on an infrequent basis according to local standards if the gift is of minimal value and not related to the practice of medicine.

Research

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

Affiliations with Commercial Entities

7. A physician may not enter into an affiliation with a commercial entity, such as consulting or membership on an advisory board unless the affiliation conforms to the following principles:
   - The affiliation does not compromise the physician's integrity.
   - The affiliation does not conflict with the physician's obligations to his or her

patients.

- The affiliation or other relationship with a commercial entity is fully disclosed in all relevant situations, such as lectures, personal appearances, articles, reports and influential contributions to the mission of medical associations or other non-profit health entities.

WMA STATEMENT ON WATER AND HEALTH

Approved by the 55th WMA General Assembly, Tokyo, Japan, October 2004
and revised by the 65th WMA General Assembly, Durban, South Africa, October 2014
and by the 68th WMA General Assembly, Chicago, United States, October 2017

PREAMBLE

1. An adequate supply of fresh (i.e. clean potable and uncontaminated) water is essential for individual and public health, as well as being a social determinant of health. It is central to living a life in dignity and health and upholding human rights. Many individuals, families and communities do not have access to such a supply, and even in those places where there is an abundance of fresh water, it is threatened by pollution, activities such as industry and waste, inadequate or ineffective sanitation and other negative forces.

2. A recent review of the evidence demonstrates that inadequate access to clean water, sanitation and soap for hand washing is the norm in many healthcare facilities worldwide, even in normal operating conditions. Natural and manmade major events, including war, reduce access to clean water still further.

3. In keeping with its mission to serve humanity by endeavouring to achieve the highest international standards in health care for all people in the world, the World Medical Association has developed this statement to encourage all those responsible for health to consider the importance and work towards achieving universal access to of water, sanitation and hygiene for individual and public health

4. Hygiene, sanitation and water (HSW) are important determinants of health. And key intervention strategies for reducing preventable morbidity, mortality and health care costs. The health sector, and physicians in particular, play a key role in ensuring such determinants are properly managed.

CONSIDERATIONS

5. Water-borne diseases account for a large proportion of mortality and morbidity, especially in developing countries. These problems are accentuated in times of disasters such as conflicts nuclear and man-made accidents with oil and/or chemicals, earthquakes, epidemics, droughts and floods.

6. Anthropogenic changes to ecosystems, lowered retention by the earth's surface, and the limitation of the inherent capacity of nature to filter dirt from the water are causing increasing damage to the natural environment, especially the water

environment. Fracking for fossil fuels may have a significant effect on ground water as does the accumulation of micropollutant substances including pharmaceuticals and pesticides.

7. The commodification of water, whereby it is provided for profit rather than as a public service, has potentially significant negative implications for access to an adequate supply of drinking water.

8. The development of sustainable infrastructure for the provision of safe water and adequate sanitation contributes greatly to sound public health and national well-being. Curtailing infectious diseases and other ailments that are caused by unsafe water lowers the burden of health care costs and improves productivity. This creates a positive ripple effect on national economies

9. Water as a vital and necessary resource for life has become scarce in many parts of the world and therefore must be used reasonably and with care.

10. Water and effective sanitation are assets that are shared by humanity and the earth. Thus, water-related issues should be addressed collaboratively by the global community.

11. Water, sanitation and hygiene are essential to the safe and effective provision of health care services, and are fundamental to public health.

RECOMMENDATIONS

12. The WMA encourages National Medical Associations, health authorities and physicians to support all measures related to improving access to adequate, safe water and health including:

    12.1. International and national programmes to provide ready access to safe drinking water at low cost, or free, to every human on the planet and to prevent the pollution of water supplies.

    12.2. International, national, local and regional programmes to provide access to sanitation and to prevent the degradation of water resources.

    12.3. Research on the relationship between water pollution, water supply systems, including wastewater treatment, and health.

    12.4. The development of plans for providing potable water and proper wastewater disposal during emergencies. These will vary according to the nature of the emergency, but may include on-site water disinfection, identifying sources of water, and back-up power to run pumps.

    12.5. Preventive measures to secure safe water, sanitation and good hygiene for all health care institutions, including after the occurrence of natural disasters, especially earthquakes. Such measures should include the development of

infrastructure and training programs to help health care institutions cope with such crises. The implementation of continued emergency water supply programs should be done in conjunction with regional authorities and with community involvement.

12.6. More efficient use of water resources by each nation. The WMA especially urges hospitals and health institutions to examine their impact on sustainable water resources and to adhere to the highest safety standards for drug and medical waste disposal from healthcare settings.

12.7. Preventive measures and emergency preparedness to save water from pollution.

12.8. The promotion of the universal access to clean and affordable water and sanitation as a human right[1] and as a common good of humanity.

12.9. Instruction on the link between hygiene supported by hand washing, and ill health prevention are health promotion and health education measures and requires work by government and health agencies, especially where access to water has previously been too limited for persons to exploit it for hygiene purposes.

12.10. The establishment of a real-time alert system accessible to both the local population and to tourists providing information about the risks of contamination of water in a particular area.

[1] In 2010, the United Nations General Assembly and the Human Rights Council explicitly recognized the human right to water and sanitation, derived from the right to an adequate standard of living as stipulated in article 11 of the International Covenant on Economic, Social and Cultural Rights and other international human rights treaties. Hence, it is part of international human rights law.

WMA STATEMENT ON DRUG SUBSTITUTION

Adopted by the 56th WMA General Assembly, Santiago, Chile, October 2005
and reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015

INTRODUCTION

1. The prescription of a drug represents the culmination of a careful deliberative process between physician and patient aimed at the prevention, amelioration or cure of a disease or problem. This deliberative process requires that the physician evaluate a variety of scientific and other data including costs and make an individualized choice of therapy for the patient. Sometimes, however, a pharmacist is required to substitute a different drug for the one prescribed by the physician. The World Medical Association has serious concerns about this practice.

2. Drug substitution can take two forms: generic substitution and therapeutic substitution.

3. In generic substitution, a generic drug is substituted for a brand name drug. However, both drugs have the same active chemical ingredient, same dosage strength, and same dosage form.

4. Therapeutic substitution occurs when a pharmacist substitutes a chemically different drug for the drug that the physician prescribed. The drug substituted by the pharmacist belongs to the same pharmacologic class and/or to the same therapeutic class. However since the two drugs have different chemical structures, adverse outcomes for the patient can occur.

5. The respective roles of physicians and pharmacists in serving the patient's need for optimal drug therapy are outlined in the WMA Statement on the Working Relationship between Physicians and Pharmacists in Medicinal Therapy.

6. The physician should be assured by national regulatory authorities of the bioequivalence and the chemical and therapeutic equivalence of prescription drug products from both multiple and single sources. Quality assurance procedures should be in place to ensure their lot-to-lot bioequivalence and their chemical and therapeutic equivalence.

7. Many considerations should be addressed before prescribing the drug of choice for a particular indication in any given patient. Drug therapy should be individualized based on a complete clinical patient history, current physical findings, all relevant laboratory data, and psychosocial factors. Once these primary considerations are met, the physician should then consider comparative costs of similar drug products available to best serve the patient's needs. The physician should select the type and quantity of drug product that he or she considers to be in the best medical and financial interest of the patient.

8. Once the patient gives his or her consent to the drug selected, that drug should not be changed without the consent of the patient and his or her physician. Failure to follow this principle can result in harm to patients. On behalf of patients and physicians alike, National Medical Associations should do everything possible to ensure the implementation of the following recommendations:

RECOMMENDATIONS

1. Physicians should become familiar with specific laws and/or regulations governing drug substitution where they practise.

2. Pharmacists should be required to dispense the exact chemical, dose, and dosage form prescribed by the physician. Once medication has been prescribed and begun, no drug substitution should be made without the prescribing physician's permission.

3. If substitution of a drug product occurs, the physician should carefully monitor and adjust the dose to ensure therapeutic equivalence of the drug products.

4. If drug substitution leads to serious adverse drug reaction or therapeutic failure, the physician should document this finding and report it to appropriate drug regulatory authorities.

5. National Medical Associations should regularly monitor drug substitution issues and keep their members advised on developments that have special relevance for patient care. Collection and evaluation of information reports on significant developments in this area is encouraged.

6. Appropriate drug regulatory bodies should evaluate and ensure the bioequivalence and the chemical and therapeutic equivalence of all similar drug products, whether generic or brand-name, in order to ensure safe and effective treatment.

7. National Medical Associations should oppose any action to restrict the freedom and the responsibility of the physician to prescribe in the best medical and financial interest of the patient.

8. National Medical Associations should urge national regulatory authorities to declare therapeutic substitution illegal, unless such substitution has the immediate prior consent of the prescribing physician.

WMA STATEMENT
ON
GENETICS AND MEDICINE

Adopted by the 56th WMA General Assembly, Santiago, Chile, October 2005
and amended by the 60th WMA General Assembly, New Delhi, India, October 2009

PREAMBLE

1. In recent years, the field of genetics has undergone rapid change and development. The areas of gene therapy and genetic engineering and the development of new technology have presented possibilities inconceivable only decades ago.

2. The Human Genome Project opened new spheres of research. Its applications also proved useful to clinical care, by allowing physicians to utilize knowledge of the human genome in order to diagnose future disease as well as to individualize drug therapy (pharmacogenomics).

3. Because of this, genetics has become an integral part of primary care medicine. Whereas at one time, medical genetics was devoted to the study of relatively rare genetic disorders, the Human Genome Project has established a genetic contribution to a variety of common diseases. It is therefore incumbent upon all physicians to have a working knowledge of the field.

4. Genetics is an area of medicine with enormous medical, social, ethical and legal implications. The WMA has developed this statement in order to address some of these concerns and provide guidance to physicians. These guidelines should be updated in accordance with developments in the field of genetics.

MAJOR ISSUES:

Genetic testing

5. The identification of disease-related genes has led to an increase in the number of available genetic tests that detect disease or an individual's risk of disease. As the number and types of such tests and the diseases they detect increases, there is concern about the reliability and limitations of such tests, as well as the implications of testing and disclosure. The ability of physicians to interpret test results and counsel their patients has also been challenged by the proliferation of knowledge.

6. Genetic testing may be undergone prior to marriage or childbearing to detect the presence of carrier genes that might affect the health of future offspring. Physicians should actively inform those from populations with high incidence of certain genetic

diseases about the possibility of pre-marital and pre-pregnancy testing, and genetic counselling should be made available to those individuals or couples who are considering such testing.

7. Genetic counselling and testing during pregnancy should be offered as an option. In cases where no medical intervention is possible following diagnosis, this should be explained to the couple prior to their decision to test.

8. In recent years, with the advent of IVF, genetic testing has been extended to pre-implantation genetic diagnosis of embryos (PGD). This can be a useful tool in cases where a couple has a high chance of conceiving a child with genetic disease.

9. Since the purpose of medicine is to treat, in cases where no sickness or disability is involved, genetic screening should not be employed as a means of producing children with pre-determined characteristics. For example, genetic screening should not be used to enable sex selection unless there is a gender-based illness involved. Similarly, physicians should not countenance the use of such screening to promote non-health related personal attributes.

10. Genetic testing should be done only with informed consent of the individual or his/her legal guardian. Genetic testing for predisposition to disease should be performed only on consenting adults, unless there is treatment available for the condition and the test results would facilitate earlier instigation of this treatment.

11. Valid consent to genetic testing should include the following factors:

    - The limitations of genetic testing, including the fact that the presence of a specific gene may denote predisposition to disease rather than the disease itself and does not definitively predict the likelihood of developing a certain disease, particularly in multi-factorial disorders.
    - The fact that a disease may manifest itself in one of several forms and in varying degrees. Information about the nature and predictability of information received from the tests.
    - The benefits of testing including the relief of uncertainty and the ability to make informed choices, including the possible need to increase or reduce regular screenings and checkups and to implement risk reduction measures.
    - The implications of a positive result and the prevention, screening and/or treatment possibilities.
    - The possible implications for the family members of the patient involved.

12. In the case of a positive test result that may have implications for third parties such as close relatives, the individual tested should be encouraged to discuss the results of the test with such third parties. In cases where not disclosing the results involves a direct and imminent threat to the life or health of an individual, the physician may reveal the results to such third parties, but should usually discuss this with the patient first. If the physician has access to an ethics committee, it is preferable to consult such a committee prior to revealing results to third parties.

Genetic counselling

13. Genetic counselling is generally offered prior to marriage or conception, in order to predict the likelihood of conceiving an affected child, during pregnancy, in order to determine the condition of the fetus, or to an adult, in order to determine susceptibility to a certain disease.

14. Individuals at higher risk for conceiving a child with a specific disease should be offered genetic counselling prior to conception or during pregnancy. In addition, adults at higher risk for various diseases such as cancer, mental illness or neuro-degenerative diseases in which the risk can be tested for, should be made aware of the availability of genetic counselling.

15. Because of the scientific complexity involved in genetic testing as well as the practical and emotional implications of the results, the WMA sees great importance in educating and training medical students and physicians in genetic counselling, particularly counselling related to pre-symptomatic diagnosis of disease. Independent genetic counsellors also have an important role to play. The WMA acknowledges that there can be very complex situations requiring the involvement of medical genetics specialists.

16. In all cases where genetic counselling is offered, it should be non-directive and protect the individual's right not to be tested.

17. In cases of counselling prior to or during pregnancy, the prospective parents should be given information to provide the basis for an informed decision regarding child-bearing, but should not be influenced by the physicians' personal views in this matter and physicians should be careful not to substitute their own moral judgment for that of the prospective parents. In cases where a physician is morally opposed to contracep-tion or abortion, he/she may choose not to provide these services but should alert pro-spective parents that a potential genetic problem exists and make note of the option of contraception or abortion as well as treatment alternatives, relevant genetic tests, and the availability of genetic counselling.

Confidentiality of results

18. Like all medical records, the results of genetic testing should be kept strictly confidential, and should not be revealed to outside parties without the consent of the individual tested. Third parties to whom results may in certain circumstances be released are identified in paragraph 12.

19. Physicians should support the passage of laws guaranteeing that no individual shall be discriminated against on the basis of genetic makeup in the fields of human rights, employment and insurance.

Gene therapy and genetic research

20. Gene therapy represents a combination of techniques used to correct defective genes that cause disease, especially in the fields of oncology, hematology and immune disorders. Gene therapy is not yet an active current therapy but is still in a stage of clini-

cal investigation. However, with the continued development of this field, it should proceed according to the following guidelines:

- Gene therapy performed in a research context should conform to the requirements of the Declaration of Helsinki while therapy performed in a treatment context should conform to standards of medical practice and professional responsibility.
- Informed consent should always be obtained from the patient undergoing the therapy. This informed consent should include disclosure of the risks of gene therapy, including the fact that the patient may have to undergo multiple rounds of gene therapy, the risk of an immune response, and the potential problems arising from the use of viral vectors.
- Gene therapy should only be undertaken after a careful analysis of the risks and benefits involved and an evaluation of the perceived effectiveness of the therapy, as compared to the risks, side effects, availability and effectiveness of other treatments.

21. It is currently possible to undertake screening of an embryo in order to provide stem cell or other therapies for an existing sibling with a genetic disorder. This may be considered acceptable medical practice where no evidence exists that the embryo is being created exclusively for this purpose.

22. Genetic discoveries should be shared as much as possible between countries so as to benefit humankind and reduce duplication of research and the risk inherent in research in this area.

23. The mapping of human genomes must be anonymous but the information acquired will apply to every human being. The genetic information should be general property. Therefore, no patents should be given for the human genome or parts of it.

24. In the case of genetic research performed on large, defined population groups, efforts should be made to avoid potential stigmatization.

Cloning

25. Recent developments in science have led to the cloning of a mammal and raise the possibility of such cloning techniques being used in humans.

26. Cloning includes both therapeutic cloning, namely the cloning of individual stem cells in order to produce a healthy copy of a diseased tissue or organ for transplant, and reproductive cloning, namely the cloning of an existing mammal to produce a duplicate of such mammal. The WMA currently opposes reproductive cloning, and in many countries it is considered to pose more of an ethical problem than therapeutic cloning.

27. Physicians should act in accordance with the codes of medical ethics in their countries regarding the use of cloning and be mindful of the law governing this activity

WMA STATEMENT ON MEDICAL LIABILITY

Adopted by the 56th WMA General Assembly, Santiago, Chile, October 2005
reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015
and amended by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

PREAMBLE

In this statement the World Medical Association (WMA) addresses issues related to medical liability claims and the implications of defensive medicine. The laws and legal systems in each country, as well as the social traditions, social welfare and economic conditions of the country, will affect the relevance of some portions of this statement for some countries, but do not detract from its fundamental importance.

A culture of medical liability litigation is growing in some countries, increasing health care costs, restraining access to health care services, and hindering efforts to improve patient safety and health care quality. In other countries, medical liability claims are less prevalent, but National Medical Associations (NMAs) in those countries should be aware of the issues and circumstances that could result in an increase in the frequency and severity of medical liability claims brought against physicians.

Many medical liability systems divert scarce health care resources away from direct patient care, research, and physician training. The lawsuit culture has also blurred the distinction between negligence and unavoidable adverse outcomes. This has led to undue reliance on litigation and other dispute resolution systems to distinguish between the two, and a culture that enables the pursuit of cases without genuine merit in the interest of financial gain. Such a culture breeds cynicism and distrust in both the medical and legal systems with damaging consequences to the patient-physician relationship.

An increase in the frequency and severity of medical liability claims may result, in part, from one or more of the following circumstances:

- Advances in medical knowledge and medical technology that have enabled physicians to achieve treatment results that were not possible in the past, but that may involve considerable risks.
- Pressures on physicians by private managed care, other healthcare organizations or government-managed health care systems to limit the costs of medical care.

- Confusing the right of access to health care, which is attainable, with the right to achieve and maintain health, which cannot be guaranteed.
- The role of the media, advocacy groups and even regulatory bodies in fostering mistrust of physicians by questioning their ability, knowledge, behaviour, and management of patients, and by encouraging patients to submit complaints against physicians.

A growing culture of litigation and an increase in medical liability claims may result, among other things, in a rise in defensive medicine, defined as "the practice of ordering medical tests, procedures, or consultations of doubtful clinical value in order to protect the prescribing physician from malpractice suits."[1] Depending on the situation, defensive medicine may entail active behaviour, such as performing tests and procedures that are not clinically indicated or prescribing unnecessary hospitalization, or passive behaviour, such as avoiding high-risk patients or avoiding potentially beneficial but risky procedures.

A distinction must be made between harm caused by medical negligence, defined as failure to conform to the standard of care in treating the patient, and harm caused by adverse outcomes occurring in the course of medical care provided in accordance with appropriate standards of care.

Compensation for patients suffering a medical injury should be determined differently for injuries caused by negligence than for adverse outcomes that may occur during medical care, unless there is an alternative system in place such as a no-fault system.

The laws of each jurisdiction should provide the procedures for establishing liability and for determining the amount of compensation to be awarded to the patient in those cases where negligence is proven.

Criminalizing medical judgment interferes with appropriate medical decision making and is a disservice to patients.

The mounting evidence of preventable deaths as a result of medical error has led for experts to call for improved safety measurements in hospitals. With this in mind, investigations should take into account the wider context, identifying systemic failings, with recommendations for change, in order to improve patient safety.

RECOMMENDATIONS

The WMA:

[1] "Defensive medicine." Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary/defensive%20medicine. Accessed 12 Mar. 2020

1. Makes an urgent call to all national governments to ensure the existence of a reliable system of medical justice in their respective countries. Legal systems should ensure that patients are protected against harmful practices, and physicians are protected against unmeritorious lawsuits.

2. Demands that investigations consider the complete context, in order to identify systemic failings.

3. Encourages health care providers to develop systems which improve the quality of patient-safety practices.

NMAs should consider the following activities to encourage fair and equitable treatment for both physicians and patients:

4. Educate and instruct physicians to have clear and detailed documentation of patient records.

5. Develop appropriate remedial training for physicians found to be deficient in knowledge or skills.

6. Encourage NMAs and Specialist Interest Groups to produce updated protocols and guidelines to guide medical professionals and staff.

7. Inform the public, physicians, and government of the dangers that various manifestations of defensive medicine may pose. These include:
    - an increase in health care costs;
    - an undermining of the doctor-patient relationship;
    - the commission of unnecessary test or treatments;
    - the avoidance of high-risk treatments;
    - the over-prescription of medications;
    - the disaffection of young physicians for certain higher risk specialties and
    - the reluctance by or avoidance of physicians or hospitals to treat higher-risk patients.

8. Educate the public as to the possible occurrence of adverse medical outcomes, and increased fees, and establish simple procedures to allow patients to receive explanations in such cases and to be informed of the steps that must be taken to seek resolution, if appropriate.

9. Encourage medical workplaces to break the culture of blame in the wake of medical errors or adverse outcomes and advocate for confidentiality of quality assurance processes in order to enable physicians to practice medicine to the best of their ability free from the threat of medical liability litigation and discipline.

10. Advocate for legal protection for physicians when patients are injured by adverse results not caused by any negligence.

11. Develop emotional and practical support for physicians involved in adverse events.

12. Participate in the development of the laws and procedures applicable to medical liability claims, with special emphasis on highlighting the difference between errors and adverse outcomes.

13. Actively oppose meritless or frivolous claims.

14. Explore innovative alternative dispute resolution procedures for efficiently resolving medical liability claims, such as mediation and arbitration.

15. Require physicians to have adequate medical liability insurance coverage or other resources against medical liability claims, paid by the practitioners themselves or by their employer.

16. Encourage the development of voluntary, confidential, and legally protected internal systems for reporting adverse outcomes or medical errors for the purpose of analysis and for making recommendations on reducing errors and improving patient safety and health care quality.

17. Advocate against the increasing criminalization or penal liability of medical judgment in consideration of adverse events. Aside from truly negligent behaviour or intentional misconduct, most adverse events are the result of unintentional human error, system failures, or uncontrollable circumstances and should not brand the physician with criminal motive or behaviour.

18. Support the principles set forth in the WMA's Declaration of Madrid on Professional Autonomy and Self-Regulation.

WMA STATEMENT ON ASSISTED REPRODUCTIVE TECHNOLOGIES

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

Assisted Reproductive Technology [ART] encompasses a wide range of techniques designed primarily to aid individuals unable to conceive without medical assistance.

ART is defined as any fertility treatments in which either gametes or embryos are handled.

Assisted reproductive technologies may raise profound ethical and legal issues. Views and beliefs on assisted reproductive technologies vary both within and among countries and are subject to different regulations in different countries.

Central to much of the debate in this area are issues around the moral status of the embryo, the way in which ART is viewed morally, societally and religiously, the child/ren born from ART, and the rights of all participants involved, i.e. donors, surrogates, the child/ren and the intended parents are just some of the issues central to the debate in ART. Whilst consensus can be reached on some issues, there remain fundamental differences of opinion that are more difficult to resolve.

Assisted conception differs from the treatment of illness in that the inability to become a parent without medical intervention is not always regarded as an illness. Notwithstanding, the inability to conceive may also be as a result of prior illness.

In many jurisdictions, the process of obtaining consent must follow a process of information giving and the offer of counselling and might also include a formal assessment of the patient in terms of the welfare of the potential child.

Faced with the progress of new technologies of assisted reproduction, physicians should keep in mind that not everything that is technically feasible is ethically acceptable. Genetic manipulation that does not have a therapeutic purpose is not ethical, nor is the manipulation on the embryo or foetus without a clear and beneficial diagnostic or therapeutic purpose.

RECOMMENDATIONS

1. Physicians involved in providing assisted reproductive technologies should always consider their ethical responsibilities towards all parties involved in a reproductive plan, which may include the future child/ren, donor, surrogate or parents. If there is compelling evidence that a future child, donor, surrogate or parent would be exposed to serious harm, treatment should not be provided.

2. As with all other medical procedures, physicians have an ethical obligation to limit their practice to areas in which they have relevant expertise, skill, and experience and to respect the autonomy and rights of patients.

3. In practice this means that informed consent is required as with other medical procedures; the validity of such consent is dependent upon the adequacy of the information offered to the patient and their freedom to make a decision, including freedom from coercion or other pressures or influences to decide in a particular way.

4. The consent process should include providing the participant/s with understandable, accurate and adequate information about the following:

    - The purpose, nature, procedure, and benefits of the assisted reproductive technology that will be used.
    - The risks, burdens and limitations of the assisted reproductive technology that will be used.
    - The success rates of the treatment and possible alternatives, such as adoption.
    - The availability of psychological support for the duration of the treatment and, in particular, if a treatment is unsuccessful.
    - The measures protecting confidentiality, privacy and autonomy, including data security measures.

5. The following should be discussed during the informed consent process:

    - Detailed medical risks;
    - whether or not all biological samples involved in ART, including but not limited to donor eggs, sperm, gametes and genetic information, may be used for research purposes;
    - The risks of multiple donations and donating at multiple clinics;
    - Confidentiality and privacy issues;
    - Compensation issues.

6. Donors, surrogates and any resulting child/ren seeking assisted reproductive technologies are entitled to the same level of confidentiality and privacy as for any other medical treatment.
7. Assisted reproductive technology involves handling and manipulation of human gametes and embryos. There are different levels of concern with the handling of such material, yet there is general agreement that such material should be subject to specific safeguards to protect from inappropriate, unethical, or illegal use.
8. Physicians should uphold the principles in the WMA Statement on Stem Cell Research, WMA Statement on Human Genome Editing, the WMA Declaration of Helsinki, and the WMA Declaration of Reykjavik – Ethical Considerations Regarding the Use of Genetics in Health Care.
9. Physicians should, where appropriate, provide ART in a non-discriminatory manner. Physicians should not withhold services based on nonclinical considerations such as marital status.

Multiple pregnancies

10. Replacement of more than one embryo will raise the likelihood of more than one embryo implanting. This is offset by the increased risk of premature labour and other complications in multiple pregnancies, which can endanger the health of both the mother and child/ren. Practitioners should follow professional guidance on the maximum number of embryos to be transferred per treatment cycle.

11. If multiple pregnancies occur, selective termination or fetus reduction will only be considered on medical grounds and with the consent of all participants involved to increase the chances of the pregnancy proceeding to term, provided this is compatible with applicable laws and codes of ethics.

Donation

12. Donation should follow counselling and be carefully controlled to avoid abuses, including coercion or undue influence of potential donors. Explicit instructions should be provided about what will be done with any donated samples if the donor is known to have died prior to implantation.

13. The WMA holds the view that gamete donation should at best not be commodified, thus serving a humanitarian benefit.

14. To ensure appropriate controls and limits on methods used to encourage donations, this must be done in a manner that complies with national law and ethical guidance. Physicians should advocate for and contribute to such ethical guidance if it does not exist.

15. Due to the widespread use of genetic technology and registries, it has become possible to identify donors, despite clinics and donors' attempts to maintain strict confidentiality. A

child/ren born as a result of donation may in future contact donors. Potential donors must be made aware of this possibility as part of the consent process.

16. Where a child is born following donation, families should be encouraged and supported to be open with the child about this, irrespective of whether or not domestic law entitles the child to information about the donor. This may require the development of supportive materials, which should be produced to a national normative standard.

Surrogacy

17. Where a woman is unable, for medical reasons, to carry a child to term, surrogate pregnancy may be used to overcome childlessness unless prohibited by national law or the ethical rules of the National Medical Association or other relevant organizations. Where surrogacy is legally practiced, great care must be taken to protect the interests of all parties involved.

18. Prospective parents and surrogates should receive independent and appropriate legal counsel.

19. Medical tourism for surrogacy purposes should be discouraged.

20. Commercial surrogacy should be condemned. However, this must not preclude compensating the surrogate mother for necessary expenses.

21. The rights of surrogate mothers must be upheld, and great care must be taken to ensure that they are not exploited. The rights of surrogate mothers include, but are not limited to:

    - Having her autonomy respected;
    - Where appropriate, having health insurance;
    - Being informed about any medical procedure and the potential side effects;
    - Where possible, choosing her medical team if side effects develop;
    - Having psychological help at any point during the pregnancy;
    - Having medical expenses such as doctor visits, the actual birthing process, fertilization and any examinations related to the surrogacy covered by the intended parent/s;
    - Loss if income covered if unable to work during the pregnancy;
    - Receiving the compensation and/or reimbursements agreed to in any legal agreement

Pre-implantation Genetic Diagnosis (PGD)

22. Pre-implantation genetic diagnosis (PGD) and pre-implantation genetic screening (PGS) may be performed on early embryos to search for the presence of genetic or chromosomal abnormalities, especially those associated with severe illness and very premature death, and for other ethically acceptable reasons, including identifying those embryos most likely to implant successfully in women who have had multiple spontaneous abortions.

23. It is recommended to encourage screening for infectious diseases in sperm donors and to determine whether to inform donors of positive tests.

24. Physicians must never be involved with sex selection unless it is used to avoid a serious sex-chromosome related condition, such as Duchenne's Muscular Dystrophy.

Research

25. Physicians have an ethical duty to comply with such regulation and to help inform public debate and understanding of these issues.

26. Research on human gametes and embryos should be carefully controlled and monitored and in accordance with all applicable national laws and ethical guidelines.

27. Views and legislation differ on whether embryos may be created specifically for, or in the course of, research. Physicians should act in accordance with the declarations of Taipei and Helsinki, as well as all applicable local laws and ethical and professional standards advice.

28. The principles of the Convention on Human Rights and Biomedicine should be followed.

WMA STATEMENT
ON
AVIAN AND PANDEMIC INFLUENZA

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and amended by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

PREAMBLE

Pandemic influenza occurs approximately three or four times every century. It usually occurs when a novel influenza A virus emerges that can easily be transmitted from person-to-person, to which humans have little or no immunity. Infection control and social distancing practices can help slow down the spread of the virus. Vaccine development can be challenging as the pandemic strain may not be accurately predicted. Adequate supplies of antivirals are key for treatment of specific at-risk population and controlling further spread of the outbreak.

Avian influenza is a zoonotic infection of birds and poultry, and can cause sporadic human infections. Birds act as reservoir and shed the virus in their feces, mucous and saliva. In addition, a new pandemic virus could develop if a human became simultaneously infected with avian and human influenza viruses, resulting in gene swapping and a new virus strain for which there may be no immunity. Humans are infected if they are exposed through the mouth, eyes, or from the inhalation of virus particles. Limited evidence of human to human transmission has been reported as well.

This statement alongside with WMA Statement on Epidemics and Pandemics provides guidance to National Medical Associations and physicians on how they should be involved in their respective country's pandemic influenza planning and how to respond to Avian Influenza or pandemic influenza.

RECOMMENDATIONS

Avian Influenza

- In the event of an avian influenza outbreak, the following measures should be taken:
- Sources of exposure should be avoided when possible as this is the most effective prevention measure.
- Personal protective equipment should be used and hand hygiene practices emphasized for personnel handling poultry as well as members of the healthcare

team.

- All infected/exposed birds should be destroyed with proper disposal of carcasses, and rigorous disinfection or quarantine of farms.
- Stockpiles of vaccines and antivirals should be maintained for use during an outbreak.
- Antiviral medications such as neuraminidase inhibitors may be used for treatment.

Pandemic Influenza Preparedness

WHO and National Public Health Officials:

- The coordination of the international response to an influenza pandemic is the responsibility of the World Health Organization (WHO). The WHO currently uses an all-hazards risk based approach, to allow for a coordinated response based on varying degrees of severity of the pandemic.

The WHO should:

- Offer technical and laboratory assistance to affected countries if needed and continuously monitor activity levels of potential pandemic influenza strains continuously, ensuring that the designation of "Public Health Emergency of International Concern" is done in a timely manner if needed.
- Monitor and coordinate processes by which governments share biological materials including virus strains, to facilitate the production of and ensure access to vaccines globally.
- Communicate available information on influenza activity of concern as early as possible to allow for a timely response.

National governments are urged to develop National Action plans to address the following points:

- Ensure that there is adequate local capacity for diagnosis and surveillance to allow continuous monitoring of influenza activity around the country.
- Consider the surge capacity of hospitals, laboratories, and public health infrastructure and improve them if necessary.
- Identify legal and ethical frameworks as well as governance structures in relation to the pandemic planning.
- Identify the mechanisms and the relevant authorities to initiate and escalate interventions to slow the spread of the virus in the community such as school closures, quarantine, border closures etc.
- Prepare risk and crisis communication strategies and messages in anticipation of

public and media fear and anxiety.

- Governments are also urged to share biological materials namely virus strains and others, to facilitate the production and ensure access to vaccines globally.
- Ensure that diagnostics and surveillance efforts are continued and that adequate vaccine and antiviral stockpiles are established.
- Establish protocols to manage patients in the community, carry out triage in healthcare facilities, provide ventilation management, and handle infectious waste.
- Allocation of vaccine doses, antivirals and hospital beds should be coordinated with experts.
- Priority for vaccination should be given to the highest risk groups including those required to maintain essential services, including health care services.
- Guidance and timely information to regional health departments, health care organizations, and physicians.
- Preparation for an increase in demand for healthcare services and absences of health care providers especially if clinical severity of the illness is high. In such cases prioritization and coordination of available resources is essential. This may include tapping into private sector capacity where state resources are insufficient.
- Ensure adequate funding is allocated for pandemic preparedness and response as well as its health and social consequences.
- Make sure that mechanisms are in place to ensure the safety of healthcare facilities, personnel and the supply chains for vaccines and antivirals
- Promote and fund research to develop vaccines and effective treatments with lasting effects against influenza.
- Encourage collaboration between human and veterinary medicine in the prevention, research and control of avian influenza.

National Medical Associations are urged to:

- Delineate their involvement in the national pandemic influenza preparedness plan, which may include increasing capacity building amongst physicians, participating in guideline development and communication with healthcare professionals.
- Help educate the public about avian and pandemic influenza.
- When feasible, coordinate with other healthcare professionals' organizations as well as other NMAs to identify common issues and congruent policies related to pandemic influenza preparedness and response.
- Consider implementing support strategies for members involved in the response including mental health services, facilitation of health emergency response teams, and locum relief.

- Advocate before and during a pandemic, for allocation of adequate resources to meet foreseeable and emerging needs of healthcare, patients and the general public.
- Encourage health personnel to protect themselves by vaccination.
- Develop their own organization-specific business contingency plans to ensure continued support of their members.

Physicians:

- Must be sufficiently knowledgeable about pandemic influenza and transmission risks, including local, national and international epidemiology.
- Should implement infection control practices and vaccination, to protect themselves as well as other staff members during seasonal and pandemic influenza outbreaks.
- Must participate in local/regional pandemic influenza preparedness planning and training.
- Should develop contingency plans to deal with possible disruptions in essential services and personnel shortages.

WMA STATEMENT
ON
HIV/AIDS AND THE MEDICAL PROFESSION

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and amended by the 68th WMA General Assembly, Chicago, United States, October 2017

INTRODUCTION

1. HIV/AIDS, a chronic manageable disease, is a global pandemic that has created unprecedented challenges for physicians and health infrastructures.

   In addition to representing a staggering public health crisis, HIV/AIDS is also fundamentally a human rights issue.

   Many factors drive the spread of the disease, such as poverty, homelessness, illiteracy, prostitution, human trafficking, drug (substance) abuse, stigma, discrimination and gender-based inequality.

   These social, economic, legal and human rights factors affect not only the public health dimension of HIV/AIDS but also individual physicians/health workers and patients, their decisions and relationships.

   Efforts to tackle the disease are also constrained by the lack of human and financial resources available in health care systems.

2. Discrimination against HIV / AIDS patients by physicians is unacceptable and must be eliminated completely from the practice of medicine.

   2.1 All persons with HIV/AIDS are entitled to adequate and timely support, treatment and care with compassion and respect for human dignity.

   2.2 It is unethical for a physician to refuse to treat a patient whose condition is within his or her current realm of competence, solely because the patient is seropositive.

   2.3 National Medical Associations should work with respective governments, patient groups and relevant national and international organizations to ensure that national health policies clearly and explicitly prohibit discrimination against people infected with or affected by HIV/AIDS, including vulnerable groups such as males having sex with males and transgender persons.

   2.4 Woman and man having sex with same sex partners are at a higher risk of discrimination at all levels. National Medical organizations shall work with Government, Non-Governmental Organizations, and Community based organizations to remove the discrimination for these under-privileged disadvantaged groups.

APPROPRIATE / COMPETENT MEDICAL CARE

3. Patients with HIV/AIDS must be provided with competent and appropriate medical care at all stages of the disease.

4. A physician who is not able to provide the care and services required by patients with HIV/AIDS must make an appropriate timely referral to those physicians or facilities that are equipped to provide such services. Unless or until the referral can be accomplished, the physician must take care for the patient.

5. All physicians should be able to timely suspect and identify common opportunistic infections such as tuberculosis, fungal infections in HIV-AIDs patients and also suspect HIV-AIDS in presence of these infections especially in high risk individuals like IV drug users.

   They must timely counsel these patient about the nexus of these infections with HIV infection.

6. Physicians and other appropriate professional bodies must ensure that patients have accurate information regarding transmission of HIV/AIDS and strategies to protect themselves against infection.

   Proactive measures should be taken to ensure that all members of the population, particularly at-risk groups, are educated to this effect.

   Public information and related strategies should recognise that everyone is at risk, and attempt to spell out methods of risk reduction.

7. Physicians must effectively counsel all seropositive patients regarding responsible behaviour to prevent the spread of the infection to their partners and prevention of opportunistic infections.

8. Physicians must recognize that many people still believe HIV/AIDS to be an automatic and immediate death sentence and therefore will not seek testing.

   Physicians must ensure that patients have accurate information regarding the treatment options available to them.

   Patients should understand the potential and need of starting early antiretroviral treatment (ART) to improve not only their medical condition but also the quality of their lives. The new strategy is test and treat strategy.

   Effective ART can greatly extend the period that patients are able to lead healthy productive lives, functioning socially and in the workplace and maintaining their independence.

   HIV/AIDS is now manageable chronic condition.

   For ART country – specific WHO evidence based practice guidelines should be

followed and promoted by all NMAs.

9. Physicians should be aware that misinformation regarding the negative aspects of ART has created resistance toward treatment by patients in some areas. Where misinformation is being spread about ART, physicians and medical associations must make it an immediate priority to publicly challenge the source of the misinformation and to work with the HIV/AIDS community to counteract the negative effects of the misinformation.

10. Physicians should encourage the involvement of support networks to assist patients in adhering to ART regimens. With the patient's consent, counselling and training should be available to family members to assist them in providing care.

11. Physicians must be aware of the discriminatory attitudes toward HIV/AIDS that are prevalent in society and local culture. Because physicians are the first, and sometimes the only, people who are informed of their patients' HIV status, physicians should be able to counsel them about their basic social and legal rights and responsibilities or should refer them to counsellors who specialize in the rights of persons living with HIV/AIDS.

12. Physicians should be aware of the current availability and prescribing guidelines for pre-exposure and post-exposure prophylaxis for any patient and health care providers who may have been exposed to HIV.

TESTING

13. Mandatory testing for HIV must be required of donated blood and blood fractions collected for donation or to be used in the manufacture of blood products; organs and other tissues intended for transplantation; and semen or ova collected for assisted reproduction procedures.

    Newer technologies which are more sensitive, specific, and reduce the window period of HIV detection, such as nuclear acid testing (NAT), should be encouraged for such screening.

14. Mandatory HIV testing of an individual against his or her will is a violation of medical ethics and human rights.

15. Physicians must clearly explain the purpose of an HIV test, the reasons it is recommended and the implications of a positive test result.

    Before a test is administered, the physician should have an action plan in place in case of a positive test result. Informed consent must be obtained from the patient prior to testing.

16. While certain groups are labeled "high risk", anyone who has had unprotected sex should be considered at risk.

    Physicians must become increasingly proactive about recommending testing to patients, based on a mutual understanding of the level of risk and the potential to benefit from testing. Pregnant women and her partner should routinely be offered

testing for HIV, and those pregnant women found to be HIV positive should be offered immediate counseling and offered timely ART (at diagnosis) in order to prevent transmission of the virus to the fetus and treatment of the fetus if seropositive.

17. Counselling and voluntary anonymous testing for HIV should be available to all persons who request it, along with adequate post-testing support mechanisms.

PROTECTION FROM HIV IN THE HEALTH CARE ENVIRONMENT

18. Physicians and all health care workers have the right to a safe work environment. Especially in developing countries, the problem of occupational exposure to HIV has contributed to high attrition rates of the health labour force. In some cases, employees become infected with HIV, and in other cases fear of infection causes health care workers to leave their jobs voluntarily. Fear of infection among health workers can also lead to refusal to treat HIV/AIDS patients. Likewise, patients have the right to be protected to the greatest degree possible from transmission of HIV from health professionals and in health care institutions.

    18.1 Proper infection control procedures and universal precautions consistent with the most current national or international standards, as appropriate, should be implemented in all health care facilities. This includes procedures for the use of preventive and timely ART for health professionals who have been exposed to HIV.

    18.2 If the appropriate safeguards for protecting physicians or patients against infection are not in place, physicians and National Medical Associations should take action to correct the situation.

    18.3 Physicians who are infected with HIV should not engage in any activity that creates a risk of transmission of the disease to others.

    In the context of possible exposure to HIV, the activity in which the physician wishes to engage will be the determining factor.

    There may be nationally agreed standards but if not a determination should be made by a suitable expert panel or committee of health workers.

    18.4 In the provision of medical care, if a risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease.

    18.5 If no risk exists, disclosure of the physician's medical condition to his or her patients will serve no rational purpose.

    18.6 Physicians should be aware of current professional guidelines for post-exposure prophylaxis of health care workers in case of any accidental

exposure to HIV.

PROTECTING PATIENT PRIVACY AND ISSUES RELATED TO NOTIFICATION

19. Fear of stigma and discrimination is a driving force behind the spread of HIV/AIDS. The social and economic repercussions of being identified as infected can be devastating and can include violence, rejection by family and community members, loss of housing and loss of employment.

    Normalizing the presence of HIV/AIDS in society through public education is the only way to reduce discriminatory attitudes and practices. Until that can be universally achieved, or a cure is developed, potentially infected individuals may refuse testing to avoid these consequences.

    The result of individuals not knowing their HIV status is not only disastrous on a personal level in terms of not receiving treatment, but may also lead to high rates of avoidable transmission of the disease. Fear of unauthorized disclosure of information also provides a disincentive to participate in HIV/AIDS research and generally thwarts the efficacy of prevention programs. Lack of confidence in protection of personal medical information regarding HIV status is a threat to public health globally and a core factor in the continued spread of HIV/AIDS. At the same time, in certain circumstances, the right to privacy must be balanced with the right of partners (sexual and injection drug) of persons with HIV/AIDS to be informed of their potential infection. Failure to inform partners not only violates their rights but also leads to the health problems of avoidable transmission and delay in treatment.

20. All standard ethical principles and duties related to confidentiality and protection of patients' health information, as articulated in the WMA Declaration of Lisbon on the Rights of the Patient, apply equally in the context of HIV/AIDS. In addition, National Medical Associations and physicians should take note of the special circumstances and obligations (outlined below) associated with the treatment of HIV/AIDS patients.

    20.1 National Medical Associations and physicians must, as a matter of priority, ensure that HIV/AIDS public education, prevention and counselling programs contain explicit information related to protection of patient information as a matter not only of medical ethics but of their human right to privacy.

    20.2 Special safeguards are required when HIV/AIDS care involves a physically dispersed care team that includes home-based service providers, family members, counsellors, case workers or others who require medical information to provide comprehensive care and assist in adherence to treatment regimens. In addition to implementing protection mechanisms regarding transfer of information, ethics training regarding patient privacy should be given to all team members.

    Many countries have specific legislation to protect the privacy of those who are HIV positive. Others may consider the same.

    20.3 Physicians must make all efforts to convince HIV/AIDS patients to take action to notify all partners (sexual and/or injection drug) about their exposure and potential infection. Physicians must be competent to counsel patients about the

options for notifying partners. These options should include:

20.3.1 Notification of the partner(s) by the patient. In this case, the patient should receive counselling regarding the information that must be provided to the partner and strategies for delivering it with sensitivity and in a manner that is easily understood. A timetable for notification should be established and the physician should follow-up with the patient to ensure that notification has occurred.

20.3.2 Notification of the partner(s) by a third party. In this case, the third party must make every effort to protect the identity of the patient.

20.4 When all strategies to convince the patient to take such action have been exhausted, and if the physician knows the identity of the patient's partner(s), the physician is compelled, either by law or by moral obligation, to take action to notify the partner(s) of their potential infection. Depending on the system in place, the physician will either notify directly the person at risk or report the information to a designated authority responsible for notification. Physicians must be aware of the laws and regulations in the jurisdiction in which they are practicing. In cases where a physician must disclose the information regarding exposure, the physician must:

20.4.1 inform the patient of his or her intentions,

20.4.2 to the extent possible, ensure that the identity of the patient is protected,

20.4.3 take the appropriate measures to protect the safety of the patient, especially in the case of a female patient vulnerable to domestic violence.

20.5 Regardless of whether it is the patient, the physician or a third party who undertakes notification, the person learning of his or her potential infection should be offered support and assistance in order to access testing and treatment.

20.6 National Medical Associations should develop guidelines to assist physicians in decision-making related to notification. These guidelines should help physicians understand the legal requirements and consequences of notification decisions as well as the medical, psychological, social and ethical considerations.

20.7 As per local and national laws and guidelines requiring the reporting of new HIV infections, sexually transmitted diseases, and opportunistic infections, physicians must protect the privacy and confidentiality of all patients and maintain the highest ethical standards.

20.8 National Medical Associations should work with governments to ensure that physicians who carry out their ethical obligation to notify individuals at risk, and who take precautions to protect the identity of their patient, are afforded adequate legal protection.

MEDICAL EDUCATION

21. National Medical Associations should assist in ensuring that there is training and

education of physicians in the most current prevention strategies and medical treatments available for all stages of HIV/AIDS and associated infections, including prevention and support.

22. National Medical Associations should, when appropriate, collaborate with NGOs and community based organizations, insist upon, and when possible assist with, the education of physicians in the relevant psychological, legal, cultural and social dimensions of HIV/AIDS.

23. National Medical Associations should fully support the efforts of physicians wishing to concentrate their expertise in HIV/AIDS care, even where HIV/AIDS is not recognized as an official specialty or sub-specialty within the medical education system.

24. The WMA encourages its national medical associations to promote the inclusion of designated, comprehensive courses on HIV/AIDS in undergraduate and postgraduate medical education programs, as well as continuing medical education.

INTEGRATION of HIV/AIDS SERVICES with other STDs MANAGEMENT ACTIVITES

25. The National Medical Associations should support governments to integrate HIV/AIDS preventive and curative services with other STD management activities in a comprehensive manner.

WMA STATEMENT ON MEDICAL EDUCATION

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and revised by the 68th WMA General Assembly, Chicago, United States, October 2017

PREAMBLE

1. Medical education consists of basic medical education, postgraduate medical education, and continuing professional development. Medical education is a dynamic process that commences at the start of basic medical education (medical school) and continues until a physician retires from active practice. Its goal is to prepare physicians to apply the latest scientific knowledge to promote health, prevent and cure human disease and mitigate symptoms. All physicians have a responsibility to themselves, the profession and their patients to maintain a high standard for medical education.

BASIC PRINCIPLES OF MEDICAL EDUCATION

2. Medical education consists of training aimed at ensuring physicians acquire the competencies, skills and aptitudes that that allow them to practice professionally and ethically at the highest level. All physicians, the profession as a whole, medical faculties, educational institutions, and governments share the responsibility for guaranteeing that medical education meets a high-quality standard throughout the medical education continuum.

I. BASIC MEDICAL EDUCATION

3. The goal of basic medical education is to ensure that medical students have acquired the knowledge, skills, and professional behaviors that prepare them for a spectrum of career choices, including, but not limited to, patient care, public health, clinical or basic research, leadership and management, or medical education. Each of these career choices will require additional education beyond the first professional degree.

4. At a medical school, the knowledge, skills and professional behavior that students should acquire should be based on the professional judgment of the faculty and accreditation councils, and be responsive to the healthcare needs of the region and/or the country. These decisions will inform the selection of students, the curriculum design and content, the student assessment system, and the evaluation of whether the school has achieved its goals. Such decisions should also be subject to relevant standards, the needs of fairness and accessibility, and diversity and inclusion in the medical workforce.

II. SELECTION OF STUDENTS

5. Prior to their entry to medical school, medical students should have acquired a broad education, ideally including background in the arts, humanities, and social sciences, as well as biological and physical sciences. Students should be chosen for the study of medicine based on their intellectual ability, motivation for medicine, previous relevant experiences, and character and integrity. The selection process for students must not be discriminatory and should reflect the importance of increasing diversity in the medical workforce. A medical school should also consider its mission when developing admission requirements.

6. Within a given country or region, there should be enough medical students to meet local and regional needs. National medical associations (NMAs) and national governments should collaborate to mitigate the economic barriers that prevent qualified individuals from entering and completing medical school.

7. Curriculum and Assessment

7.1 A medical school's educational program should be based on educational program objectives developed in response to the healthcare needs of the region and/or country. These educational program objectives must be used in the selection of curriculum content, the development of the system for student assessment, and the evaluations of whether the school has achieved its educational goals, subject to relevant regulatory and educational standards.

7.2 The medical curriculum should equip the student with a broad base of general medical knowledge. This includes the biological and behavioral sciences, as well as the socio-economics of health care, the social determinants of health, and population and public health. These disciplines, together with basic medical science, are central to an understanding and practice of clinical medicine. The WMA recommends that content related to medical ethics and human rights should be a core requirement in the medical curriculum.1 The student should also be introduced to the principles and methodology of medical research and how the results of research are used in clinical practice. Students should have opportunities, if desired or required by the medical school, to participate in research. The cognitive skills of self-directed learning, critical thinking, and medical problem solving should be introduced early in the medical curriculum to prepare students for clinical training.

7.3 Before beginning independent practice, every physician should complete a formal program of supervised clinical education. Within basic medical education, clinical experiences should range from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, clinics, physician practices, and other health care facilities. The clinical component of basic medical education should use an apprenticeship model of teaching using defined objectives and must involve direct experiences in the diagnosis and treatment of disease, with a gradual increase in the student's responsibility based on his/her demonstration of the relevant knowledge and skills. Experiences and training in interprofessional teams providing collaborative care to patients is important in preparing medical students for practice.

7.4 The medical school faculty have the responsibility to ensure that students who have graduated and received the first professional degree have acquired a basic understanding of clinical medicine, have the basic skills needed to evaluate clinical problems and take appropriate action, and exhibit the attitudes and character to be an ethical physician. The assessment system within a medical school should include appropriate and valid methods to ensure that all graduates have met each of these expectations. It would be useful for medical schools to have access to individuals with expertise in student assessment, either from within the medical school or from external sources.

8. Student Support

8.1 Medical students should receive academic and social support, such as counselling for personal problems and programs to support well-being, to assist them in meeting the demands of medical school. Academic support includes tutoring and advice for study and time management skills. Social support includes access to activities to promote their physical and mental well-being, as well as access to general and mental health services. Mentors and advisors to assist students in specialty choice and career planning also should be available.

9. Faculty and Institutional Resources

9.1 Basic medical education must be taught by appropriate staff including faculty who possess the appropriate qualifications that can only be achieved through formal training and experience. There should be a sufficient number of faculty to meet the educational, research, and other missions of the medical school. The selection process for faculty must be not be discriminatory. The faculty should have a formal commitment to the medical school, such as a faculty appointment, and be part of and subject to the medical school's governance and departmental structures.

9.2 The faculty of a medical school are accountable for developing the medical curriculum and the student assessment system. As such, the educational program objectives, curriculum content and format, and evaluation of the curriculum are the responsibility of the faculty. The faculty should review the curriculum frequently, ideally utilizing statistics on student achievement and input from students, graduates, and the practicing community. Furthermore, the faculty must regularly evaluate the quality of each component of the educational program and the program as a whole through the utilization of student and peer feedback. Medical schools should provide opportunities for faculty development to support the acquisition and maintenance of teaching and assessment, and curriculum development skills so that they can meet their responsibilities for the medical education program and curriculum design skills.

9.3 Medical schools must provide an academic environment which encourages learning and inquiry by faculty including an active institutional research program to advance the body of medical knowledge and the quality of care. Medical schools should

provide support for faculty to acquire research skills and to engage in independent or collaborative research.

9.4 In addition to sufficient numbers of well-prepared faculty, medical schools must ensure that there are adequate library and information technology resources, classrooms, research laboratories, clinical facilities, and study areas for students in sufficient quantity to meet the needs of all learners. There must be an administrative support structure for things such as academic records maintenance and registrar functions.

10. Financing Medical Education

10.1 National governments and medical schools should collaborate to develop financing mechanisms to support basic medical education. Support is needed for individual students and for the medical schools themselves. There should be sufficient financial resources for medical schools to educate the number of medical students required to meet national or regional health care system needs.

III. POSTGRADUATE MEDICAL EDUCATION

11. A graduate from a basic medical education institution must participate in a clinically-based advanced training program prior to being legally authorized to enter independent medical practice and, if required, obtaining a license to practice. Postgraduate medical education, the second phase of medical education continuum, prepares physicians for practice in a medical discipline or specialty and focuses on specific competencies needed for practice in that specialty area.

12. Postgraduate medical education programs, also termed residency programs, include educational experiences that support the resident's acquisition of the knowledge and skills characteristic of the specialty area. Depending on the specialty, postgraduate programs will use a variety of inpatient and ambulatory clinical settings, including community-based clinics, hospitals or other health care institutions. The education of residents should combine a structured didactic curriculum with clinical activity that includes the diagnosis and management of patients under appropriate and supportive levels of supervision. A residency program must ensure that each resident has opportunities to care for an adequate number of patients in order to gain experience in the range of conditions that characterize the specialty. These clinical experiences should occur in settings where high quality care is delivered, since educational quality and patient care quality are interdependent and must be pursued in a manner so that they enhance one another.

13. A proper balance must be maintained so that residents are not required to meet clinical service needs at the expense of their education. The residency program should further the resident's teaching and leadership skills and ability to contribute to continuous improvement. The program should also provide opportunities for scholarly activity aimed at enhancing scientific and critical thinking, clinical problem-solving, and life-long learning skills. These opportunities will have been introduced during basic

medical education and should be reinforced during residency to prepare and motivate the resident to exercise these skills during practice. Additionally, a proper balance must be maintained among clinical work, education, and personal life.

14. During the residency program, a resident takes on progressively greater responsibility for patient care based on his or her individual growth in clinical experience, knowledge, and skill. Allowing the resident to assume increased responsibility requires a system of assessment to monitor the resident's increase in knowledge and skills over time. There also needs to be a process in place to conclusively determine that the resident is prepared to undertake independent medical practice.

15. Postgraduate medical education should take place in institutions that are accredited or have been reviewed for quality.

IV. CONTINUING PROFESSIONAL DEVELOPMENT

16. Continuing professional development* (CPD) is defined as the activities that maintain, develop, or increase the knowledge, skills, and professional performance and relationships a physician uses on a daily basis to provide services for patients, the public, or the profession. CPD can include activities such as involvement in national or regional medical associations; committee work in hospitals or group practices; and teaching, mentoring and participating in education within his or her chosen specialty or more broadly within medicine.

17. One of the components of CPD is continuing medical education (CME), in which the physician participates in medically-related educational activities. Physicians should further their medical education throughout their careers, including acquiring new knowledge and skills in response to scientific discoveries and the introduction of new treatments. Such educational experiences are essential to for the physician to keep abreast of developments in clinical medicine and the health care delivery environment, and to continue to maintain the knowledge and skills necessary to provide high quality care. In many jurisdictions, CME is specialty-defined and may be required for maintaining a medical license.

18. The goal of continuing professional development is to broadly sustain and enhance the competent physician. Medical schools, hospitals and professional societies all share a responsibility for developing and making available to all physicians effective opportunities for continuing professional development, including continuing medical education.

RECOMMENDATIONS

19. The demand for physicians to provide medical care, prevent disease, and give advice in health matters to patients, the public, and policy-makers calls for the highest standards of basic, postgraduate, and continuing professional development. Recommendations are as follows:

19.1 That the WMA encourage NMAs, governments, and other relevant stakeholder groups to engage in planning for a high quality continuum of medical education within countries that is informed by and supports the health care needs of the population.

19.2 That the WMA encourage NMAs to work with medical schools to plan and deliver faculty development that enhances the skills of medical school faculty as teachers and researchers.

19.3 That the WMA encourage NMAs and governments to engage in dialogue related to medical school and postgraduate program funding so that adequate numbers of well-trained physicians are available to meet national health care needs.

19.4 That NMAs and national governments collaborate to mitigate the economic barriers that prevent qualified individuals from entering and completing medical school.

19.5 That the WMA encourage NMAs to individually or collaboratively provide opportunities for continuing physician professional development and continuing medical education.

---

* Note on terminology

There are different uses of the term 'Continuing Professional Development' (CPD). One way to describe it is all those activities that contribute to the professional development of a physician including involvement in organized medicine, committee work in hospitals or group practices, teaching, mentoring and reading, to name just a few. One of the components of CPD should be Continuing Medical Education, which in many jurisdictions is specially defined and possibly required for licensure.

WMA STATEMENT
ON
THE PHYSICIAN'S ROLE IN OBESITY

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

Obesity is one of the single most important health issues facing the world in the twenty-first century, affecting all countries and socio-economic groups and representing a serious drain on health care resources.

Obesity in children is of increasing concern and is emerging as a growing epidemic in itself.

Obesity has complex origins linked to economic and social changes in society including the obeso-genic environment within which much of the population lives.

Therefore the WMA urges physicians to use their roles as leaders to advocate for recognition by national health authorities that reduction in obesity should be a priority, with culturally and age appropriate policies involving physicians and other key stakeholders.

THE WMA RECOMMENDS THAT PHYSICIANS:

- Lead the development of societal changes that emphasize environments which support healthy food choices and regular exercise or physical activity for all people, with a specific focus on children;
- Individually and through medical associations, express concern that excessive television viewing and video game playing are impediments to physical activity among children and adolescents in many countries;
- Encourage individuals to make healthy choices and guide parents in helping their children to do so;
- Recognise the role of personal decision making and the adverse influences exerted by current environments;
- Recognise that collection and evaluation of data can contribute to evidence based

management, and should be part of routine medical screening and evaluation throughout life;

- Encourage the development of life skills that contribute to a healthy lifestyle in all persons and to better public knowledge of healthy diets, exercise and the dangers of smoking and excess alcohol consumption;
- Advocate for appropriately trained professionals to be placed in educational facilities, highlighting the importance of education on healthy lifestyles from an early age;
- Contribute to the development of better assessment tools and databases to enable better targeted and evaluated interventions;
- Ensure that obesity, its causes and management remain part of continuing professional development programmes for health care workers, including physicians;
- Use pharmacotherapy and bariatric surgery consistent with evidence-based guidelines and an assessment of the risks and benefits associated with such therapies.

WMA STATEMENT
ON
THE RESPONSIBILITIES OF PHYSICIANS IN PREVENTING AND TREATING OPIATE AND PSYCHOTROPIC DRUG ABUSE

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

Opiate and psychotropic drugs are valuable therapeutic tools when used as medically indicated for a variety of symptoms and conditions. Indeed, the WMA has called for the greater provision of pain management treatment in its Resolution on the Access to Adequate Pain Treatment (Montevideo, Uruguay, October 2011). Unfortunately, non-clinical misuse of these addictive substances is an enormous problem worldwide. Drug addiction is a complex social, economic and legal issue as well as a threat to public health and safety globally. It affects people from all demographic and social groups and economic spheres. In addition to exposing themselves to the direct health risks related to the inappropriate use of these substances, persons addicted to drugs may engage in high risk behaviour, such as needle-sharing and unprotected sex, and many resort to criminal activity to finance their expensive addiction. These factors increase transmission of viral infections, such as Hepatitis B and C and HIV/AIDS, among both users and non-users alike. Other results of addiction include failure to maintain employment or to function in social and family life.

The legal ramifications of non-medical drug use, which is illegal in most countries, generally do little to assist users in breaking free from their addiction. Despite the presence of drug programs in many correctional facilities, illegal substances are very often available to inmates and, in fact, some users begin their addiction in these institutions. Addressing addiction therefore falls largely to society and the health profession.

The World Medical Association, concerned by the widespread misuse of psychotropic and opiate drugs, urges physicians to prioritize this problem in the practice of medicine and to adhere to the following guidelines.

PRINCIPLES

Responsible prescribing practices

Physicians should be aware of the addictive properties of certain psychotropic and opiate drugs. Such drugs should be prescribed with the greatest restraint, observing the strictest possible generally accepted medical indications. Physicians must take all necessary measures to ensure that they are fully informed of the effects of these drugs. This includes reviewing up-to-date research regarding dosage, potential effectiveness for the specific

condition, potential side effects and pharmacological interactions and prevalence of misuse.

When such drugs are medically indicated, their use must be carefully monitored to ensure that the patient is following strict dosage instructions, timing and any other factors associated with the safe use of the particular drug. All appropriate measures must be taken to prevent the stockpiling, resale or other illicit usage of the drug.

Patients must be fully informed of all potential therapeutic and non-therapeutic effects of psychotropic and opiate drugs, including potential for addiction, and be fully involved in the decision to take them. No competent patient should be forced to take any psychotropic drug against his or her will.

Physicians should be aware of non-medical factors that may predispose patients to addiction. These may include, among others, family history, past addiction, emotional trauma, depression or other mental health conditions and peer pressure, especially among young persons.

Physicians should learn to recognize 'drug seekers', addicted patients who attempt to obtain psychotropic and opiate drugs under false medical pretenses. Drug seekers often consult more than one physician in an effort to obtain multiple prescriptions. In extreme cases, drug seekers may harm themselves to create symptoms to obtain a prescription. All patient conditions and symptoms should be clinically verified, to the extent possible, and meticulous records maintained regarding the patient's drug history. If databases containing patient drug records and prescribing histories are available, they should be consulted.

When prescribing any psychotropic or opiate substance to minors, physicians must ensure that the parents or guardians of the patient are fully informed of the potential misuse of the drug and encouraged to monitor the child carefully to ensure adherence to the physician's instructions. Parents or guardians should be informed that, in some countries, it is increasingly common for children to sell prescription drugs to their peers.

Non-drug therapy for addicts to opiate and psychotropic drugs

Physicians should be aware of all non-drug treatment options for addicts to opiate and psychotropic drugs, including inpatient and outpatient programs and therapeutic communities, in which recovering addicts live in a supportive, drug-free environment. Most treatment programs are focused on breaking the cycle of drug dependence through detoxification, counselling – including ongoing peer support – and permanent abstinence from the use of any addictive opiate or psychotropic substance, including alcohol. Some offer educational and/or vocational programs to facilitate successful reintegration into community life.

Physicians should encourage their patients to participate in drug treatment programs at the earliest possible stage of addiction.

All efforts should be made to respect the dignity and autonomy of addicted patients. Involuntary inpatient treatment of addicted persons should be a last resort, according to established guidelines and, where applicable, legal requirements.

Drug therapy for addicts to opiate drugs

In some cases, persons addicted to opiate drugs may be treated using medications that relieve withdrawal symptoms and cravings for the addictive substance without producing the 'high' associated with opiates. These medications also provide cross tolerance to other opioids. The objective of drug treatment is the immediate cessation of the use of opiate drugs.

Drug therapy can assist the opiate-dependent patient to function in his or her normal environment and activities while working to overcome the opiate addiction. However, it should always be part of a multi-disciplinary approach that includes proven non-drug treatment elements, such as counselling and peer support.

Drug therapy should be administered according to established evidence-based guidelines and supervised by specially trained physicians with an appropriate support team.

Awareness raising and policy development

National Medical Associations (NMAs) should engage in cross-sectoral national efforts to raise awareness of the risks associated with the abuse of opiate and psychotropic drugs and to ensure the availability of appropriate treatment options for addicted persons. NMAs should encourage their members to participate in similar programs at the community level.

NMAs should promote appropriate drug prevention programming at all levels of the educational system, recognizing that experimentation with drugs is increasingly prevalent among younger age groups.

NMAs and physicians should participate in the development of evidence-based guidelines that support a multi-disciplinary approach to the treatment of drug addiction, including harm reduction strategies such as needle exchange programmes.

NMAs should participate in the development of legal procedures relating to illegal drug use to ensure that addicted persons are recognized as entitled to receive appropriate medical and rehabilitative care, including in correctional institutions.

CONCLUSION

Physicians have an important role to play in the treatment of drug addiction, both as clinicians and as advocates for the treatment, rights and dignity of persons addicted to these harmful substances. Treatment of addiction, like treatment for any disease or condition, should be undertaken in the best interests of the patient and according to established principles of medical ethics.

WMA STATEMENT
ON
MEDICAL ASSISTANCE IN AIR TRAVEL

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
revised by the 68th WMA General Assembly, Chicago, United States, October 2017
and reaffirmed with minor revisions by the 221st WMA Council Session, Berlin, Germany, October 2022

PREAMBLE

Air travel is the preferred mode of long-distance transportation for people across the world. The growing convenience and affordability of air travel has led to an increase in the number of air passengers. In addition, long-duration flights are becoming increasingly common, increasing the risk of in-flight medical emergencies.

The environment in normal passenger planes is not conducive to delivering quality medical care, especially in medical emergencies. Noise and movement of the plane, the very confined space, the presence of other passengers who may be experiencing stress or fear as a result of the situation, the insufficiency or complete lack of diagnostic and therapeutic materials as well as other factors often create extremely difficult conditions for diagnosis and treatment. Even the most experienced medical professional is likely to be challenged by these circumstances.

Air travel can significantly affect people who suffer from mental health challenges and resources for in-flight mental health emergencies are often lacking.

Most airlines require flight personnel to be trained in basic first aid. In addition, many provide some degree of training beyond this minimum level and may also carry certain emergency medicines and equipment on board. Some carriers even have the capacity to provide remote ECG reading and medical counselling services. The ICAO (International Civil Aviation Organization) standard requires medical supplies to be carried on airplanes, but the detailed quantity and contents are in non-mandatory recommended practices. Requirements for individual airlines are determined by the national aviation regulatory authorities. Detailed requirements of the cabin crew training program are also determined by the respective national aviation regulatory authority as ICAO standards states that “An operator (airline) shall establish and maintain a training program approved by the State of the operator.”

Even well-trained flight personnel are often limited in their knowledge and experience and cannot offer the same assistance as a physician or other certified health professional. Currently, continuing medical education courses are available to physicians in some locales to train them specifically for in-flight emergencies.

Physicians are often concerned about providing assistance due to uncertainty regarding legal liability. While many airlines provide some liability insurance for medical professionals and lay persons who will provide voluntary assistance during a flight, this is not always the case and even where it does exist, the terms of the insurance cannot always be adequately explained and understood in an acute medical crisis. The financial and professional consequences of litigation against physicians who offer assistance can be very costly, though actual examples of this appear to be quite limited.

Some important steps have been taken to protect the life and health of airline passengers, yet this is far from ideal and still needs improvement. Many of the major problems could be mitigated by simple actions taken by both airlines and national legislatures, ideally in cooperation with one another and with the International Air Transport Association (IATA) to arrive at coordinated and consensus-based international policies and programs.

Constituent Members have an important leadership role to play in promoting measures to improve the availability and efficacy of in-flight medical care.

RECOMMENDATIONS

The World Medical Association calls on its Constituent Members to advocate for the delivering of quality medical care in air travel, in particular:

Airline companies

1. To encourage their national airlines companies, especially those providing medium and long-range passenger flights, to take the following specific actions:

    - Equip their airplanes with a sufficient and standardised set of medical emergency materials and drugs that are easily identifiable packaging with instruction in English as well as consideration of other languages, and include Automated External Defibrillators (AED), considered essential equipment in non-professional settings, while ensuring that at least one crew member is competent in the use of that particular AED.
    - Provide stand-by medical assistance, including a mental health component, that can be contacted by radio or telephone to help either the flight attendants or to support a volunteering health professional, if one is on board and willing to assist.
    - Develop medical emergency plans to guide airline personnel in responding to the medical needs of passengers.
    - Provide sufficient medical and organisational instruction to flight personnel, beyond basic first aid training, to enable them to better attend to passenger needs and to assist medical professionals who volunteer their services during emergencies.
    - Provide sufficiently comprehensive insurance for medical professionals and assisting lay personnel to protect them from damages and liabilities (material and non-material) resulting from in-flight diagnosis and treatment.

- Accept all legal and financial consequences of any assistance provided by a physician, in the absence of legal immunity for physicians.

National authorities

2. To encourage their national aviation authorities to provide yearly summarised reports of in-flight medical incidents based on mandatory standardised incident reports for every medical incident requiring the administration of first aid or other medical assistance and/or causing a change in flight plans.

3. To urge their legislators to enact Good Samaritan legislation to guarantee immunity from legal action to physicians who provide appropriate emergency assistance during in-flight medical incidents.

4. To advocate for the inclusion of potential challenges of in-flight medical emergencies in the ordinary emergency education courses for physicians.

Physicians

5. To inform physicians of training opportunities or promote the development of training programs where they do not exist;

6. To encourage physicians to consider whether they wish to identify themselves prior to departure as being willing to help in the event of a medical emergency;

7. To incite physicians to discuss potential problems with their own patients who are at high risk for requiring in-flight medical attention prior to their flight;

8. To encourage physicians to determine if their liability insurance includes cover for Samaritan deeds;

9. To inform and motivate physicians to attend appropriate training programs so they can make informed decisions when declaring their patients fit to travel by air.

International Civil Aviation Organization

The World Medical Association also calls on the ICAO to:

10. Further develop precise standards in the following areas and, where appropriate, work with governments to implement these standards as legal requirements:

    - Medical equipment and drugs on board medium and long-range flights;
    - Packaging and information materials standards, including multilingual descriptions and instructions in appropriate languages;
    - Medical, inclusive of mental health emergency procedures and training programs for medical personnel.

11. Define global guidelines guaranteeing physicians immunity from legal action when providing appropriate emergency assistance during in-flight medical incidents and ensure its implementation by its Member States.

WMA STATEMENT
ON
REDUCING DIETARY SODIUM INTAKE

Adopted by the 59th WMA General Assembly, Seoul, Korea, October 2008
and revised by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

PREAMBLE

Dietary table salt is an ionic compound comprising of sodium chloride, which is 40% sodium (Na+) and 60% chloride (Cl-). There is overwhelming evidence that excessive sodium intake is a risk factor for the development, or worsening of hypertension, which is one of the main cardiovascular risk factors. Hypertension may also be an independent risk factor for cardiovascular diseases as well as all-cause mortality. The effect of dietary sodium on blood pressure is influenced by various demographic factors such as age and ethnicity.

Salt intake is also a risk factor for gastric cancer [1].

The World Health Organization (WHO) recommends that average daily sodium consumption in adults (≥16 years of age) should be less than 2000 mg (5 g salt). For children (2–15 years of age), the adult intake limit of 2 g/day sodium should be adjusted downward based on the energy requirements of children relative to those of adults [2].

The majority of the world's population consumes too much sodium – 3.95 (3.89–4.01) g/day, equivalent to table salt level of 10.06 (9.88–10.21) g/day. These consumption levels are far above the recommended limit [3].

The main source of sodium is dietary consumption, 90% of it in the form of salt [4], as added salt during cooking or eating, or in processed foods such as canned soups, condiments, commercial meals, baking soda, processed meats (such as ham, bacon, bologna), cheese, snacks, and instant noodles, among others. In higher-income countries sodium added during food processing can be as high as 75%-80% of total salt intake [5].

The Global Action Plan for the Prevention and Control of Non-Communicable Disease (NCDs) 2013-2020 is made up of 9 global targets, including a 30 % relative reduction in mean population intake of sodium. The WHO has created the S.H.A.K.E technical package to assist Member States with the development, implementation and monitoring of salt reduction strategies.

The WHO recognises that while salt reduction is recommended globally, there is concern that iodine deficiency disorders (IDD) may re-emerge as iodized salt is the main vehicle for dietary iodine intake through fortification. Therefore the WHO, in recognition of the importance of both sodium reduction and iodine fortification, urges that efforts of the two programs be coordinated [6].

Substantial overall benefits can result from even small reductions in the population's blood pressure. Population-wide efforts to reduce dietary sodium intake are a cost-effective way to reduce overall hypertension levels and subsequent cardiovascular disease. Evidence shows that keeping sodium consumption within the reference level could prevent an estimated premature 2.5 million deaths each year globally [7].

RECOMMENDATIONS

1. WMA and its Constituent Members should:

a. Urge governments to recognise that salt consumption is a serious public health problem and prioritise prevention as an equitable, cost effective and lifesaving population-wide approach to address high sodium intake and the associated high burden of cardiovascular diseases.

b. Work in cooperation with national and international health organisations to educate consumers from childhood about the effects of excessive sodium intake on hypertension and cardiovascular disease, the benefits of long-term reductions in sodium intake, and about the dietary sources of salt/sodium and how these can be reduced.

c. Urge the governments and other stakeholders work together to achieve the targets set in the Global Action Plan for the Prevention and Control of NCDs 2013-2020.

d. Recognise the critical role of the food processing and food services industry in reducing dietary sodium, and support regulatory efforts involving mandatory targets in food processing, sodium content of foodstuffs, and clear labelling. Food reformulation efforts must target food products that are most commonly consumed in the population.

2. Constituent members of WMA should:

1. Encourage their governments strictly to enforce laws regulating the sodium content in processed foods.
2. Embrace a multi stakeholder approach in working towards reducing the consumption of excessive sodium by the population, including active promotion of physician awareness regarding the effects of excessive dietary sodium.
3. Recognise that sodium reduction and salt iodization programmes need to be compatible and support sodium reduction strategies that do not compromise dietary iodine content, or increase or worsen iodine deficiency disorders, especially in low income settings.
4. Contribute to making the public aware of the potential consequences of low iodine levels as a result of restricted iodized salt intake.
5. Encourage their members to contribute to scientific research on sodium reduction strategies.
6. Encourage the initiation of food labeling, media campaigns and population-wide policies such as mandatory reformulation to achieve larger reductions in population-wide salt consumption than individually focused interventions.

3. Individual physicians should:

Counsel patients about the major sources of sodium in their diets and how to reduce sodium intake, including reducing the amount of salt used in cooking at home, use of salt substitutes, and addressing any relevant local practices and beliefs that contribute to high sodium intake.

References:

[1] World Cancer Research Fund / American Institute for Cancer Research. Food, Nutrition, Physical Activity, and the Prevention of Cancer: a Global Perspective. Washington DC: AICR, 2007.

[2] Guideline: Sodium intake for adults and children. Geneva, World Health Organization (WHO), 2012.

[3] Mozaffarian, Dariush, Fahimi, Saman, Singh, Gitanjali M., Micha, Renata, Khatibzadeh, Shahab, Engell, Rebecca E., Lim, Stephen, Danaei, Goodarz, Ezzati, Majid and Powles, John (2014) Global sodium consumption and death from cardiovascular causes. New England Journal of Medicine, 371 7: 624-634. doi:10.1056/NEJMoa1304127.

[4] J. He, N.R.C. Campbell, G.A. MacGregor. Reducing salt intake to prevent hypertension and cardiovascular disease. Rev. Panam. Salud Publica, 32 (4) (2012), pp. 293-300.

[5] World Health Organization Regional Office for Europe Mapping salt reduction initiatives in the WHO European Region (Web. 10 May 2014.) http://www.euro.who.int/__data/assets/pdf_file/0009/186462/Mapping-salt-reduction-initiatives-in-the-WHO-European-Region.pdf (2013).

[6] Salt reduction and iodine fortification strategies in public health. 2014. http://www.who.int/nutrition/publications/publichealth_saltreduc_iodine_fortification/en/.

[7] McLaren L, Sumar N, Barberio AM, Trieu K, Lorenzetti DL, Tarasuk V, Webster J, Campbell NRC.Population-level interventions in government jurisdictions for dietary sodium reduction. Cochrane Database of Systematic Reviews 2016, Issue 9. Art. No.: CD010166. doi: 10.1002/14651858.CD010166.pub2.

WMA STATEMENT
ON
REDUCING THE GLOBAL BURDEN OF MERCURY

Adopted by the 59th WMA General Assembly, Seoul, Korea, October 2008
and reaffirmed with minor revision by the 210th WMA Council Session, Reykjavik, Iceland, October 2018

PREAMBLE

Mercury is a naturally occurring heavy metal that is a potent neurotoxin. The most likely routes of human exposure on a population basis are ingestion of methylmercury from contaminated fish. Less commonly, individuals are exposed via inhalation of inorganic mercury vapor after a spill or during a manufacturing process.

Mercury has been the ideal choice for use in medical devices that measure temperature and pressure. Therefore, a typical large hospital may have more than a hundred pounds of mercury onsite incorporated into various devices in separate locations.

Hospitals and clinics can avoid the occupational or environmental risk of mercury by using products that don't rely on mercury-based technology. Major healthcare institutions around the world have demonstrated that safe, effective alternative products exist, and can be safely used for most situations, such as electronic thermometers, recently calibrated aneroid devices and mercury-free batteries.

Although the rationale for instituting voluntary mercury replacement initiatives is compelling from both occupational and environmental perspectives, financial considerations may ultimately motivate hospitals to undertake a mercury replacement program. Hazardous waste clean-up costs, reporting requirements for spills, disruptions in services, and staff training are costly. The cost of cleaning up one significant contamination can be substantially higher than the cost of converting to mercury-free alternatives.

By implementing a "best practices" management method for mercury use, the need for increased government regulations in the future, may be avoided. Such regulations may create costly burdens that some facilities may not be able to meet.

The World Medical Association (WMA) recalls its statement on Environmental Degradation and Sound Management of Chemicals that provides recommendations for advocacy measures and capacity building in order to tackle this issue.

RECOMMENDATIONS

The following recommendations are based on the urgent need to reduce both the supply and demand of mercury in the health care sector:

Global

The World Medical Association and its member national medical associations should:

- Advocate for the United Nations and individual governments to voluntarily cooperate to implement key features of the United Nations Environment Programme (UNEP) Mercury Programme, which provides a framework for reducing the use, release, trade and risk related to mercury.
- Enhance the activity of existing partnerships.

Regional/National

National medical associations should advocate that their governments work to reduce risks related to mercury in the environment by:

- Reducing reliance on mercury mining in favor of environmentally-friendly sources of mercury, such as recycled mercury.
- Developing options and scientifically sound plans for the long term safe storage of excess mercury supplies.
- Urging Member States to ratify and implement the United Nations Minamata Convention on Mercury adopted in 2013 and designed to protect human health and the environment from anthropogenic emissions and releases of mercury and mercury compounds.
- Encouraging a phase-out of mercury use in the health care sector
- Designing and implementing regulations and/or requirements designed to significantly reduce mercury emissions from coal combustion and cement production by using specific mercury emission controls.

Local

Physicians should:

1. Explore eliminating mercury-containing products in their offices and clinical practices, including thermometers, sphygmomanometers, gastrointestinal tubes, batteries, lamps, electrical supplies, thermostats, pressure gauges, and other laboratory reagents and devices.
2. Ensure that local hospitals and medical facilities have a plan to identify sources of mercury in their workplace, a commitment to mercury reduction, and a mercury management policy regarding recycling, disposal and education.
3. Encourage local hospitals and medical facilities to phase out mercury-containing products and switch to non-mercury equivalents.
4. Counsel patients about local and national advisories related to fish consumption designed to limit exposure to mercury in children and women of childbearing age.

WMA STATEMENT ON CONFLICT OF INTEREST

Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009

PREAMBLE

This policy is intended to identify areas where a conflict of interest might occur during the day-to-day practice of medicine, and to assist physicians in resolving such conflicts in the best interests of their patients. A conflict of interest is understood to exist when professional judgement concerning direct patient care might be unduly influenced by a secondary interest.

In some cases, it may be enough to acknowledge that a potential or perceived conflict exists. In others, specific steps to resolve the conflict may be required. Some conflicts of interest are inevitable and there is nothing inherently unethical in the occurrence of conflicts of interest in medicine but it is the manner in which they are addressed that is crucial.

In addition to the clinical practice of medicine and direct patient care, physicians have traditionally served in several different roles and pursued various other interests, such as participation in research, the education of future physicians and physicians in training and the occupation of administrative or managerial positions. As private interests within medicine have expanded in many locales, physicians have occasionally provided their expertise to these endeavours as well, acting as consultants (and sometimes employees) for private enterprise.

Although the participation of physicians in many of these activities will ultimately serve the greater public good, the primary obligation of the individual physician continues to be the health and well-being of his or her patients. Other interests must not be allowed to influence clinical decision-making (or even have the potential to do so).

Each doctor has a moral duty to scrutinise his or her own behaviour for potential conflicts of interest, even if the conflicts fall outside the kinds of examples or situations addressed in this document. If unacknowledged, conflicts of interest can seriously undermine patient trust in the medical profession as well as in the individual practitioner.

Physicians may also wish to avail themselves of additional resources such as specialty societies, national medical associations or regulatory authorities, and should be aware of applicable national regulations and laws.

RECOMMENDATION

Research

The interests of the clinician and the researcher may not be the same. If the same individual is assuming both roles, as is often the case, the potential conflict should be addressed by ensuring that appropriate steps are put in place to protect the patient, including disclosure of the potential conflict to the patient.

As stated in the Declaration of Helsinki:

- The Declaration of Geneva of the World Medical Association states that, "The health of my patient will be my first consideration," and the International Code of Medical Ethics declares that, "A physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient."
- The Declaration of Helsinki states that "In medical research involving human subjects, the well-being of the individual research subject must take precedence over all other interests."

Research should be conducted primarily for the advancement of medical science. A physician should never place his or her financial interests above the welfare of his or her patient. Patient interests and scientific integrity must be paramount.

All relevant and material physician-researcher relationships and interests must be disclosed to potential research participants, research ethics boards, appropriate regulatory oversight bodies, medical journals, conference participants and the medical centre where the research is conducted.

All hypothesis-testing research trials should be registered with a publicly-accessible research registry.

A clear contract should be signed by all parties, including sponsors, investigators and program participants, clarifying terms relating to, at a minimum:

- financial compensation for the physician-researcher (which should approximate lost clinical earnings)
- ownership of research results (which should rest with the investigator)
- the right of the investigator to publish negative results
- the right of the investigator to release relevant information to trial participants at any point during the study.

Physician-researchers should retain control of and should have full access to all trial data, and should decline non-disclosure clauses.

Physician-researchers should ensure that, regardless of the trial results, the presentation or publication of the results of hypothesis-testing trials will not be unduly delayed or otherwise obstructed.

Referral fees should not be accepted for providing the names of potential trial participants, and patient information should not be released without the consent of the patient, except where required by legislation or regulatory authorities.

Any compensation received from trial sponsors should approximately replace lost clinical income and should be commensurate with the efforts and responsibilities of the physician performing the research. When enrolment is particularly challenging and time-consuming, reasonable additional payments may be made to compensate the clinical investigator or institution specifically for time and effort spent on extra recruiting efforts to enrol appropriate research participants. Escalating bonuses designed to increase trial enrolment should not be accepted.

Physician-researchers should decline requests to review grant applications or research paper submissions from colleagues or competitors where their relationship would have the potential to influence their judgment on the matter.

Payments or compensation of any sort should not be tied to the outcome of clinical trials. Physician-researchers should not have a financial interest in a company sponsoring a trial or a product being studied in a clinical trial if this financial interest could be affected positively or negatively by the results of the trial; they should have no direct financial stake in the results of the trial. They should not purchase, buy or sell stock (shares) in the company while the trial is ongoing and until the results have been made public. This might not apply for those physicians who have developed a medication but are not part of the enrolment process.

Physician-researchers should only participate in clinical trials when they relate to their area of medical expertise and they should have adequate training in the conduct of research and the principles of research ethics.

Authorship should be determined prior to the start of the trial and should be based on substantive scientific contribution.

Education

The educational needs of students and the quality of their training experience must be balanced with the best interests of patients. Where these are in conflict, the interests of patients will take precedence.

While recognizing that medical trainees require experience with real patients, physician-educators must ensure that these trainees receive supervision commensurate with their level of training.

Patients should be made aware that their medical care may be performed in part by students and physicians in training, including the performance of procedures and surgery, and where possible should give appropriate informed consent to this effect.

Patients should be made aware of the identity and qualifications of the individuals involved in their care.

Refusal by a patient to involve trainees in their care should not affect the amount or quality of care they subsequently receive.

Self-referrals and fee-splitting

All referrals and prescriptions (whether for specific goods or services) should be based on an objective assessment of the quality of the service or of the physician to whom the patient has been referred.

Referral by physicians to health care facilities (such as laboratories) where they do not engage in professional activities but in which they have a financial interest is called self-referral. This practice has the potential to significantly influence clinical decision-making and is not generally considered acceptable unless there is a need in that particular community for the facility and other ownership is not a possibility (for example, in small rural communities). The physician in this situation should receive no more financial interest than would an ordinary investor.

Kickbacks (or fee-splitting) occur when a physician receives financial consideration for referring a patient to a specific practitioner or for a specific service for which a fee is charged. This practice is not acceptable.

Physician offices

For reasons of patient convenience, many physician offices are located in close geographic proximity to other medical services such as laboratories, pharmacies and opticians. The physician should not receive any financial compensation or other consideration either for referring a patient to these services, or for being located in close geographical proximity to them. Physician-owned buildings should not charge above-market or below-market rates to tenants.

Non-medical products (those having nothing to do with patient health or the practice of medicine) and scientifically non-validated medical products should not be sold out of the physician's office. If scientifically validated medical products are sold out of the physician's office charges should be limited to the costs incurred in making them available and the products should be offered in such a way that the patient does not feel pressured to purchase them.

Organizational/institutional conflicts

Health care institutions in particular are increasingly subject to a number of pressures that threaten several of their roles, and many academic medical centres have begun to identify alternate sources of revenue. Policies should be in place to ensure that these new sources are not in conflict with the values and mission of the institution (for example, tobacco funding in medical schools).

Individual medical organizations and institutions (including, but not limited to, medical schools, hospitals, national medical associations, official/state regulators and research institutions) should develop and, where possible, enforce conflict of interest guidelines for their employees and members.

Physician-researchers and others will benefit from the development of institutional conflict of interest guidelines to assist them in making appropriate disclosure and clearly identifying situations where a conflict would preclude them from participating in a research study or other activity.

Academic health care institutions should have a clear demarcation between investment decision-making committees, technology transfer and the research arm of the institution.

Written policies should provide guidelines for disclosure requirements, or for discontinuing participation in the decision-making process, for those individuals who are conflicted due to sponsored research, consulting agreements, private holdings or licensing agreements.

WMA STATEMENT ON STEM CELL RESEARCH

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

PREAMBLE

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

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

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

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

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

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

Stem cells can be used to conduct research into basic developmental biology, human physiology and disease pathogenesis. There are many current research programs investigating the use of stem cells to treat human disease. Adult stem cell therapies, including using bone marrow, cord blood or blood-derived stem cells for transplantation, include several important and well-validated clinical advances. In contrast, clinical studies have not yet validated the use of embryonic stem cells in therapy.

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

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

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

RECOMMENDATION

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

WMA STATEMENT ON DIGITAL HEALTH

Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009
and revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

1. Digital health is a broad term that refers to "the use of information and communication technologies in medicine and other health professions to manage illnesses and health risks and to promote wellness." Digital health encompasses electronic health (eHealth) and developing areas such as the use of advanced computer sciences (including 'big data', bioinformatics and artificial intelligence). The term also includes telehealth, telemedicine, and mobile health (mHealth).

2. The term "digital health" may be used interchangeably with "eHealth." These terms also include within them: Telehealth" or "Telemedicine," which both utilize information and communications technology to deliver healthcare services and information at a distance (large or small). They are used for remote clinical services, including real-time patient monitoring such as in critical care settings. Also, they serve for patient-physician consultation where access is limited due to physicians'/patients' schedules or preferences, or patient limitations such as physical disability. Alternatively, they can be used for consultation between two or more physicians. The difference between the two terms is that "Telehealth" refers also to remote clinical and non-clinical services: preventive health support, research, training, and continuing medical education for health professionals.

3. Technological developments and the increasing availability and affordability of mobile devices have led to an exponential increase in the number and variety of digital health services in use in both developed and developing countries. Simultaneously, this relatively new and rapidly evolving sector remains largely unregulated, which could have potential patient safety and ethical

4. The driving force behind digital health should be improving quality of care, patient safety and equity of access to services otherwise unavailable.

5. Digital health differs from conventional health care in the medium used, its accessibility, and its effect on the patient-physician relationship, as well as on the traditional principles of patient care.

6. The development and application of digital health has expanded access to health care and health education in both regular and emergency situations. At the same time, its effect on the patient-physician relationship, accountability, patient safety, multistakeholder interactions, privacy and data confidentiality, fair access, and other social and ethical principles should be taken into consideration. However, the scope and application of digital health, telemedicine or telehealth are context-dependent. Factors such as human resources for health, size of service area and level of healthcare facilities should also be taken into consideration.

7. Physicians should be involved in the development and implementation of digital health solutions to be used in health care, in order to ensure they meet the needs of patients and health professionals.

8. Consistent with the mandate of the WMA, this statement is addressed primarily to physicians and their role in the health care setting. The WMA encourages others who are involved in healthcare to develop and adhere to similar principles, as appropriate to their role in the healthcare system.

Physician autonomy

9. Acceptable boundaries in the patient-physician relationship necessary for the provision of optimal care, should exist in digital as well as physical practice. The nearly continuous availability of digital health care has the potential to unduly interfere with a physician's work-life balance due to theoretical 24/7 availability. The physician should inform patients about his or her availability and recommend services when he or she is not available.

10. Physicians should exercise their professional autonomy in deciding whether digital health consultation is appropriate. This autonomy should consider the type of visit scheduled, the physician's comfort with the medium, and the physician's assessment, together with the patient, of the patient's comfort level with this type of care.

Patient-physician relationship

11. Face to face consultation should be the gold standard where a physical examination is required to establish a diagnosis, or where there is a wish on the part of the physician or patient to communicate in person as part of establishing a trusted physician-patient relationship. Face to face consultations may be preferable in some circumstances to take stock of non-verbal cues, and for consultations where there may be communication barriers or discussion of sensitive matters. Ideally, the patient-physician relationship in the context of digital health, should be based on a previously established relationship and sufficient knowledge of the patient's medical history.

12. However, in emergency and critical situations, or in settings where access to doctors is not available other than via telemedicine, delivery of care via telemedicine should be prioritized even when a prior patient-physician relationship was not established. Telemedicine can be

employed when a physician cannot be physically present within a safe and acceptable period. It can also be used to manage patients remotely including self-management and for chronic conditions or follow-up after initial treatment, where it has been proven to be safe and effective.

13. The physician providing telemedicine services should be familiar with the technology and/or should receive sufficient resources, training and orientation in effective digital communication. Additionally, the physician should strive to ensure that quality of communication during a digital health encounter is maximized. It is also important that the patient is comfortable using the technology employed. Any significant technical deficiencies should be noted in the documentation of the consultation and reported, if applicable.

14. The patient-physician relationship is based on mutual trust and respect. Therefore, the physician and the patient must identify each other reliably when telemedicine is employed. However, it must be recognized that sometimes third parties or 'surrogates' such as a family member should become involved in the case of minors, the frail, the elderly, or in an emergency situation.

15. The physician should give clear and explicit direction to the patient during the telemedicine encounter regarding who has ongoing responsibility for any required follow-up and ongoing health care.

16. In a digital consultation between two or more professionals, the primary physician remains responsible for the patient's care and coordination. The primary physician remains responsible for protocols, conferencing, and medical record review in all settings and circumstances. Physicians providing consultation should be able to contact other health professionals and technicians, as well as patients, in a timely manner.

Informed consent

17. Proper informed consent requires that the patient be informed of, have capacity for, and provide consent specific to the type of digital health being used. All necessary information regarding the distinctive features of digital health, in general, and telemedicine, in particular, must be explained fully to patients including, but not limited to: how telemedicine works, how to schedule appointments, privacy concerns, the possibility of technological failure, including confidentiality breaches; possible secondary use of data; protocols for contact during virtual visits, prescribing policies and coordinating care with other health professionals. This information should be provided clearly and understandably without coercion or undue influence of the patient's voluntary choices, while taking into account the patient's perceived level of health literacy and other resource limitations specific to the type of digital health being used.

Quality of care

18. The physician must ensure the standard of care delivered via digital health is at least equivalent to any other type of care given to the patient, considering the specific context, location and timing, and relative availability of face to face care. If the standard of care cannot be satisfied via digital technology, the physician should inform the patient and suggest an alternative form of healthcare delivery.

19. The physician should have clear and transparent protocols for delivering digital health care such as clinical practice guidelines, whenever possible, to guide the delivery of care in the digital setting, recognizing that certain modifications may need to be made to accommodate specific circumstances. Changes to clinical practice guidelines for the digital setting should be approved by the appropriate governing and/or regulatory body or association. If the digital health solution is equipped with automated clinical practice support, this support must be strictly professionally based and not influenced by economic interests in any way.

20. The physician providing digital services should follow all regulatory requirements and relevant protocols and procedures related to informed consent (verbal, written, and recorded); privacy and confidentiality; documentation; ownership of patient records; and appropriate video/telephone behaviors.

21. The physician providing care by means of telehealth should keep a clear and detailed record of the advice delivered, the information on which the advice was based and the patient's informed consent.

22. The physician should be aware of and respect the particular challenges and uncertainties that may arise when in contact with the patient through telecommunication. The physician must be prepared to recommend direct patient-physician contact whenever possible if he/she believes it is in the patient's best interests or will improve compliance.

23. The possibilities and weaknesses of digital health in emergencies must be duly identified. If it is necessary to use telemedicine in an emergency, the advice and treatment suggestions will be influenced by the severity of the patient's medical condition and the patient's technological and health literacy. To ensure patient safety, entities that deliver telemedicine services should establish protocols for referrals in emergency situations.

Clinical Outcomes

24. Entities providing digital health programs should monitor and continuously strive to improve the quality of services to achieve the best possible outcomes.

25. Entities providing digital health programs should have a systematic protocol for collecting, evaluating, monitoring and reporting meaningful health care outcomes, safety data and clinical effectiveness. Quality indicators should be identified and utilized. Like all health care interventions, digital technology must be tested for its effectiveness, efficiency, safety,

feasibility, and cost-effectiveness. Quality assurance and improvement data should be shared to improve its equitable use.

26. Entities implementing digital health are urged to report unintended consequences to help improve patient safety and further the overall development of the field. Countries are encouraged to implement these guiding principles in their own legislation and regulation.

Equity of care

27. Although digital health can provide greater access to distant and underserved populations, it may also exacerbate existing inequalities due to, among other things, age, race, socioeconomic status, cultural factors, or literacy issues. Physicians must be aware that certain digital technologies might be unavailable or unaffordable to patients, impeding access and further widening the health outcomes gaps.

28. Digital technologies should be implemented and monitored carefully to avoid inequity of access to these technologies. Where appropriate, social or healthcare services should facilitate access to technologies as part of basic benefit packages while taking all necessary precautions to guarantee data security and privacy. Access to vital technologies should not be denied to anyone based on financial status or a lack of technical expertise.

Confidentiality and data security

29. In order to ensure data confidentiality, officially recognized data protection measures must be used. Data obtained during a digital consultation must be secured to avoid unauthorized access and breaches of identifiable patient information through appropriate and up-to-date security and privacy measures. If data breaches do occur, the patient must be notified immediately in accordance with the law.

30. Digital health technologies generally involve the measurement or manual input of medical, physiological, lifestyle, activity, and environmental data to fulfill their primary purpose. The large amount of data generated also may be used for research or other purposes to improve healthcare and disease prevention. However, secondary uses of personal mHealth data can result in misuse and abuse.

31. Robust policies and safeguards to regulate and secure the collection, storage, protection, and processing of digital health users' data, especially personal health data, must be implemented to assure valid informed consent and guarantee patients' rights.

32. If patients believe that their privacy rights have been violated, they may file a complaint with the covered entity's Privacy Officer or data protection authorities, in accordance with local regulations.

Legal principles

33. A clear legal framework must be drawn up to address potential liability arising from the use of digital technologies. Physicians should only practice telemedicine in countries/jurisdictions where they are licensed to practice and should adhere to the legal framework and regulations as defined by the country/jurisdiction where the physician originates care and the countries in which they practice. Physicians should ensure that their medical indemnity includes telemedicine and digital health coverage.

34. Reimbursement models must be set up in consultation with national medical associations and healthcare providers to ensure that physicians receive appropriate reimbursement for providing digital health services.

Specific principles of mHealth technology

35. Mobile health (mHealth) is a form of electronic health (eHealth) for which there is no fixed definition. It has been described as medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other devices intended to be used in connection with mobile devices. It includes voice and short messaging services (SMS), applications (apps), and the use of the global positioning system (GPS).

36. A clear distinction must be made between mHealth technologies used for lifestyle purposes and those that require physicians' medical expertise and meet the definition of medical devices. The latter must be appropriately regulated, and users must be able to verify the source of medical information provided, as these applications could potentially recommend non-scientific or non-evidence-based treatments. The information provided must be comprehensive, clear, reliable, non-technical, and easily understood by laypeople.

37. Concerted work must improve the interoperability, reliability, functionality, and safety of mHealth technologies, e.g., through the development of standards and certification schemes.

38. Comprehensive and independent evaluations must be carried out regularly by competent authorities with appropriate medical expertise to assess the functionality, limitations, data integrity, security, and privacy of mHealth technologies. This information must be made publicly available.

39. mHealth can only positively contribute to improvements in care if services are based on sound medical rationale. As evidence of clinical usefulness is developed, findings should be published in peer-reviewed journals and be reproducible.

RECOMMENDATIONS

1. The WMA recognizes the value of digital health to supplement traditional ways of managing health and delivering healthcare. The driving force behind digital health should be improving quality of care and equity of access to services otherwise unavailable.

2. The WMA emphasizes that the principles of medical ethics, as outlined in The Declaration of Geneva: The Physician's Pledge and the International Code of Medical Ethics, must be respected in the practice of all forms of digital health.

3. The WMA recommends that the training of digital health literacy and skills be included in medical education and continuing professional development.

4. The WMA urges patients and physicians to be discerning in their use of digital health and to be mindful of potential risks and implications.

5. The WMA recommends further research in digital health to assess safety, efficacy, cost-effectiveness, feasibility of implementation, and patient outcomes.

6. The WMA recommends monitoring the risks of excessive or inappropriate use of digital health technologies and the potential psychological impact on patients and ensuring that the benefits of such technologies outweigh the risks.

7. The WMA recommends special attention be given to patients' disabilities (audio-visual or physical) and patients who are minors, when using digital healthcare.

8. Where appropriate, National Medical Associations should encourage the development and update of ethical norms, practice guidelines, national legislation, and international agreements on digital health.

9. The WMA recommends that other regulatory bodies, professional societies, organizations, institutions, and private industry, monitor the proper use of digital health technologies and share these findings widely.

WMA STATEMENT ON ENVIRONMENTAL DEGRADATION AND SOUND MANAGEMENT OF CHEMICALS

Adopted by the 61st WMA General Assembly, Vancouver, Canada, October 2010
and amended by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

PREAMBLE

1. This Statement focuses on one important aspect of environmental degradation, which is environmental contamination by domestic and industrial substances. It emphasizes the harmful chemical contribution to environmental degradation and physicians' role in promoting sound management of chemicals as part of sustainable development, especially in the healthcare environment.
2. Unsafe management of chemicals has potential adverse impacts on human health and human rights, with vulnerable populations being most at risk.
3. Most chemicals to which humans are exposed come from industrial sources and include, toxic gases, food additives, household consumer and cosmetic products, agrochemicals, and substances used for therapeutic purposes, such as drugs and dietary supplements. Recently, attention has been concentrated on the effects of human engineered (or synthetic) chemicals on the environment, including specific industrial or agrochemicals and on new patterns of distribution of natural substances due to human activity. As the number of such compounds has multiplied, governments and international organizations have begun to develop a more comprehensive approach to their safe regulation. The increasing amount of plastic waste in our environment is another serious concern, that needs to be addressed.
4. While governments have the primary responsibility for establishing a framework to protect the public's health from chemical hazards, the World Medical Association, on behalf of its members, emphasizes the need to highlight the human health risks and make recommendations for further action.

BACKGROUND

Chemicals of Concern

5. During the last half-century, the use of chemical pesticides and fertilizers dominated agricultural practice and manufacturing industries rapidly expanded their use of synthetic chemicals in the production of consumer and industrial goods.
6. The greatest concern relates to chemicals, which persist in the environment, have low rates of degradation, bio-accumulate in human and animal tissue (concentrating as they move up the food chain), and which have significant harmful impacts on human health and the environment (particularly at low concentrations). Some naturally occurring

metals including lead, mercury, and cadmium have industrial sources and are also of concern. Advances in environmental health research including environmental and human sampling and measuring techniques, and better information about the potential of low dose human health effects have helped to underscore emerging concerns.

7. Health effects from chemical emissions can be direct (occurring as an immediate effect of the emission) or indirect. Indirect health effects are caused by the emissions' effects on water, air and food quality as well as the alterations in regional and global systems, such as red tide in many oceans, and the ozone layer and the climate, to which the emissions may contribute.

National and International Actions

8. The model of regulation of chemicals varies widely both within and between countries, from voluntary controls to statutory legislation. It is important that all countries move to a coherent, standardized national legislated approach to regulatory control. Furthermore, international regulations must be coherent such that developing countries will not be forced by economic circumstances to accept elevated toxic exposure levels.
9. Synthetic chemicals include all substances that are produced by, or result from, human activities including industrial and household chemicals, fertilizers, pesticides, chemicals contained in products and in wastes, prescription and over-the-counter drug products and dietary supplements, and unintentionally produced byproducts of industrial processes or incineration, like dioxins. Furthermore, nanomaterials may need explicit regulation beyond existing frameworks.

Strategic approach to international chemicals management

10. Worldwide hazardous environmental contamination persists despite several international agreements on chemicals, making a more comprehensive approach to chemicals essential. Reasons for ongoing contamination include persistence of companies, absolute lack of controls in some countries, lack of awareness of the potential hazards, inability to apply the precautionary principle, non-adherence to the various conventions and treaties and lack of political will. The Strategic Approach to International Chemicals Management (SAICM) was adopted in Dubai, on February 6, 2006 by delegates from over 100 governments and representatives of civil society. This is a voluntary global plan of action designed to assure the sound management of chemicals throughout their life cycle so that, by 2020, chemicals are used and produced in ways that minimize significant adverse effects on human health and the environment. The SAICM addresses both agricultural and industrial chemicals, covers all stages of the chemical life cycle of manufacture, use and disposal, and includes chemicals in products and in wastes.

Plastic waste

11. Plastic has been part of life for more than 100 years and is regularly used in some form by nearly everyone. While some biodegradable varieties are being developed, most plastics break down very slowly with the decomposition process taking hundreds of years. This means that most plastics that have ever been manufactured are still on Earth, unless they have been burnt, thus polluting the atmosphere with poisonous

smoke.

12. Concerns about the use of plastic include accumulation of waste in landfills and in natural habitats, terrestrial and marine, physical problems for wildlife resulting from ingestion or entanglement in plastic, the leaching of chemicals from plastic products and the potential for plastics to transfer chemicals to wildlife and humans. Many plastics in use today are halogenated plastics or contain other additives used in production, that have potentially harmful effects on health (e.g. carcinogenic or promoting endocrine disruption).
13. Our current usage of plastic is not sustainable, accumulating waste and therefore contributing to environmental degradation and potentially harmful effects on health. Specific regulation is therefore needed to counter the harmful distribution of slowly degradable plastic waste into the environment and the incineration of such waste which often creates toxic byproducts.

WORLD MEDICAL ASSOCIATION (WMA) RECOMMENDATIONS

14. Despite national and international initiatives, chemical contamination of the environment due to inadequately controlled production and usage continues to exert harmful effects on global public health. Evidence linking some chemicals to some health issues is strong, but far from all chemicals have been tested for their health or environmental impacts. This is especially true for newer chemicals or nano materials, particularly at low doses over long periods of time. Plastic contamination of our natural environment, including in the sea where plastic decomposes to minute particles, is an additional area of serious concern. Physicians and the healthcare sector are frequently required to make decisions concerning individual patients and the public as a whole based on existing data. Physicians therefore recognize that they, too, have a significant role to play in closing the gap between policy formation and chemicals management and in reducing risks to human health.
15. The World Medical Association reaffirms its commitment to advocate for the environment in order to protect health and life, and recommends that:

ADVOCACY

16. National Medical Associations (NMAs) advocate for legislation that reduces chemical pollution, enhances the responsibilities of chemical manufacturers, reduces human exposure to chemicals, detects and monitors harmful chemicals in both humans and the environment, and mitigates the health effects of toxic exposures with special attention to fertility for women and men and vulnerability during pregnancy and early childhood.
17. NMAs urge their governments to support international efforts to restrict chemical pollution through safe management, or phase out and safer substitution when unmanageable (e.g. asbestos), with particular attention to developed countries aiding developing countries to achieve a safe environment and good health for all.
18. NMAs facilitate better inter-sectoral collaboration between government ministries/departments responsible for the environment and public health.
19. NMAs promote public awareness about hazards associated with chemicals (including plastics) and what can be done about it.

20. Modern medical diagnosis and treatment relies heavily on the single use of packaged clean or sterile materials with various plastic components, whether the device itself or its packaging. NMAs should encourage research and the dissemination of practices that can reduce or eliminate this component of environmental degradation.
21. Physicians and their medical associations advocate for environmental protection, disclosure of product constituents, sustainable development, green chemistry and green hospitals within their communities, countries and regions.
22. Physicians and their medical associations should support the phase out of mercury and persistent bioaccumulative and toxic chemicals in health care devices and products and avoid incineration of wastes from these products which may create further toxic pollution.
23. Physicians and their medical associations should support the Globally Harmonized System of Classification and Labelling of Chemicals (GHS) and legislation to require an environmental and health impact assessment prior to the introduction of a new chemical or a new industrial facility.
24. Physicians should encourage the publication of evidence of the effects of different chemicals and plastics, and dosages on human health and the environment. These publications should be accessible internationally and readily available to media, non-governmental organizations (NGOs) and concerned citizens locally.
25. Physicians and their medical associations should advocate for the development of effective and safe systems to collect and dispose of pharmaceuticals that are not consumed. They should also advocate for the introduction worldwide of efficient systems to collect and dispose of plastic waste.
26. Physicians and their medical associations should encourage efforts to curb the manufacture and use of plastic packaging and plastic bags, to halt the introduction of plastic waste into the environment, and to phase out and replace plastics with more biocompatible materials. These efforts may include measures to enhance recycling and specific regulations limiting the use of plastic packaging and plastic bags.
27. Physicians and their medical associations should support efforts to rehabilitate or clean areas of environmental degradation based on a “polluter pays” and precautionary principles and ensure that moving forward, such principles are built into legislation.
28. The WMA, NMAs and physicians should urge governments to collaborate within and between departments to ensure coherent regulations are developed.

LEADERSHIP

The WMA:

29. Supports the goals of the Strategic Approach to International Chemicals Management (SAICM), which promotes best practices in the handling of chemicals by utilizing safer substitution, waste reduction, sustainable non-toxic building, recycling, as well as safe and sustainable waste handling in the health care sector.
30. Cautions that these chemical practices must be coordinated with efforts to reduce greenhouse gas emissions from health care and other sources to mitigate its contribution to global warming.
31. Urges physicians, medical associations and countries to work collaboratively to

develop systems for event alerts to ensure that health care systems and physicians are aware of high-risk industrial accidents as they occur, and receive timely and accurate information regarding the management of these emergencies.

32. Urges local, national and international organizations to focus on sustainable production, safer substitution, green safe jobs, and consultation with the health care community to ensure that damaging health impacts of development are anticipated and minimized.
33. Emphasizes the importance of the safe disposal of pharmaceuticals as one aspect of health care's responsibility and the need for collaborative work in developing best practice models to reduce this part of the chemical waste problem.
34. Encourages environmental classification of pharmaceuticals in order to stimulate prescription of environmentally less harmful pharmaceuticals.
35. Encourages local, national and international efforts to reduce the use of plastic packaging and plastic bags.
36. Encourages ongoing outcomes research on the impact of regulations and monitoring of chemicals on human health and the environment.

The WMA recommends that Physicians:

37. Work to reduce toxic medical waste and exposures within their professional settings as part of the World Health Professional Alliance's campaign for Positive Practice Environments.
38. Work to provide information on the health impacts associated with exposure to toxic chemicals, how to reduce patient exposure to specific agents and encourage behaviors that improve overall health.
39. Inform patients about the importance of safe disposal of pharmaceuticals that are not consumed.
40. Work with others to help address the gaps in research regarding the environment and health (i.e., patterns and burden of disease attributed to environmental degradation; community and household impacts of industrial chemicals; the effects, including on health, of distribution of plastic and of plastic waste into our natural environment; the most vulnerable populations and protections for such populations).

PROFESSIONAL EDUCATION & CAPACITY BUILDING

The WMA recommends that:

41. Physicians and their professional associations assist in building professional and public awareness of the importance of the environment and global chemical pollutants on personal health.
42. NMAs develop tools for physicians to help assess their patients' risk from chemical exposures.
43. Physicians and their medical associations develop locally appropriate continuing medical education on the clinical signs, diagnosis, treatment and prevention of diseases that are introduced into communities as a result of chemical pollution and exacerbated by climate change.

44. Environmental health and occupational medicine should become a core theme in medical education. Medical schools should encourage the training of sufficient specialists in environmental health and occupational medicine.

WMA RESOLUTION
ON
VIOLENCE AGAINST WOMEN

Adopted by the 61st WMA General Assembly, Vancouver, Canada, October 2010
and amended by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

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

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

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

RECOMMENDATIONS

The WMA:

1. Calls for zero tolerance for all forms of violence against women.

2. Asserts that violence against women is not only about physical, psychological and sexual violence but includes neglect and abuses such as harmful cultural and traditional practices and is a major public health issue as well as a social determinant of health.

3. Recognizes the linkage between better education, other women's rights and societal health and wellbeing, and emphasizes that equality in civil liberties and human rights are health-related issue.

4. Calls on WHO, other United Nations agencies and relevant actors at national and international levels to accelerate actions towards ending discrimination and violence against women.

5. Urges the governments to implement WHO's Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in particular Against Women and Girls, and Against Children.

6. Encourages the development of free educational materials online to provide guidance to front line health care personnel on abuse and its effects, and on prevention strategies.

National Medical Associations are urged to:

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

8. Seek to ensure that physicians and other health care personnel are alerted on the phenomenon of violence, its consequences, and the evidence on preventative strategies that work, and place appropriate emphasis on this in undergraduate,

graduate and continuing education.

9. Recognise the importance of more complete reporting of violence and encourage the development of education emphasising violence awareness and prevention.

10. Advocate for legislation against specific harmful practices including female feticide, female genital mutilation, forced marriage, and corporal punishment.

11. Advocate for the criminalization of intimate partner violence as well as rape in all circumstances including within marriage.

12. Advocate for the development of research data on the impact of violence and neglect upon primary and secondary victims and upon society, and for increased funding for such research.

13. Encourage medical journals to publish more of the research on the complex interactions in this area, thus keeping it in the professions' awareness and contributing to the development of a solid research base and ongoing documentation of types and incidence of violence.

14. Advocate for the national implementation of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Physicians are encouraged to:

15. Use the material developed for their education to better inform themselves about the effects of violence and the successful strategies for prevention.

16. Treat and reverse, where possible, the complications and adverse effects of female genital mutilation and refer the patient to social support services.

17. Oppose the publication or broadcast of victims' names or addresses without the explicit permission of the victim.

18. Assess risk of family violence in the context of taking a routine social history of a patient.

19. Be alert to the association between alcohol or drug dependence among women and a history of abuse.

20. Where appropriate, report suspected violence or ill-treatment against women to relevant protection services and take the necessary measures to ensure that victims of violence are not at risk.

21. Support global and local action to better understand the health consequences both of violence and of the denial of rights, and advocate for increased services for victims.

WMA STATEMENT
ON
THE GLOBAL BURDEN OF CHRONIC NON-COMMUNICABLE DISEASE

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011
and revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

Chronic non-communicable diseases (NCDs), are the leading cause of mortality and disability in both the developed and developing world. The four main NCDs are cancers, cardiovascular diseases, chronic respiratory diseases, and diabetes (referred to as NCD4 hereafter) and they account for seven of every ten deaths worldwide. Eighty per cent of deaths due to NCDs occur in low- and middle-income countries (WHO).

NCD4 are not replacing existing causes of disease and disability, such as infectious disease and trauma, but are adding to the disease burden. While all countries face the triple burden of infectious diseases, traumas and chronic diseases, it is a much more difficult challenge for developing countries. This increased burden is straining the capacity of many countries to provide adequate healthcare services as well as increase life expectancy.

Chronic diseases are not equally distributed, which has a significant effect on health inequalities. For example, NCDs occur more frequently among socioeconomically underprivileged individuals with inferior chronic disease outcomes. Conversely, life expectancy and other health outcomes are markedly higher in more developed countries than in less developed countries, and in the higher socio-economic segments of society.

In addition, this burden is also undermining nations' efforts to spur economic growth. NCDs are a barrier to development. In low- and middle-income countries (LMICs), poverty exposes people to lifestyle-mediated risk factors for NCDs and in turn, resulting NCDs become an important driver for poverty. Chronic diseases and poverty are linked in a vicious circle, hindering economic development and worsening poverty.

Ongoing and anticipated global trends that will lead to more chronic disease problems in the future include an aging population, urbanization and inadequate community planning, increasingly sedentary lifestyles, increasing psychosocial stress, climate change and the rapidly increasing cost of medical technology to treat NCDs. Chronic disease prevalence is closely linked to global social and economic development, globalization and mass marketing of unhealthy foods and other products.

The prevalence and cost of addressing the chronic disease burden is expected to rise in coming years. In addition to the individual and public expenses, chronic diseases lead to a marked economic burden because of the mutual effects of healthcare costs and lost productivity from disability and death. The WHO considers the global burden of chronic diseases as one of the most important challenges facing the field of health for this century.

The rapid increase in chronic diseases represents a major health challenge for global development, for which immediate global action is needed.

Eighty percent of the global burden of chronic diseases affects LMICs, where most of the world's population lives. The impact of this devastating burden is constantly growing. Chronic diseases and poverty are linked in a vicious circle, hindering economic development and worsening poverty.

Solutions

The NCD4 merit global attention. The primary solution for these diseases is prevention. Tobacco use, poor diet, physical inactivity and alcohol abuse are the four most common modifiable risk factors for NCDs. Poor mental health has recently been included as an additional risk factor for NCD. National policies that help people achieve healthy lifestyles and behaviours are the foundation for all possible solutions.

Increased access to primary care combined with well-designed and affordable disease-control, disease prevention and health promotion programs can greatly improve healthcare. Partnerships of national ministries of health with institutions in developed countries may overcome many barriers in the poorest settings. In addition, having health insurance improves health outcomes. Conversely, in some countries the lack of health insurance hinders the practice of preventive and primary care and is linked with adverse health outcomes. Uninsured individuals may postpone pursuing assistance when ill or injured, and they are more likely to be hospitalized for chronic illnesses such as diabetes or hypertension. Furthermore, children without health insurance are less likely to receive immunizations, and regular primary care.

Medical education systems should become more socially accountable. The World Health Organization (WHO) defines social accountability of medical schools as the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public. There is an urgent need to adopt accreditation standards and norms that support social accountability and community engagement. Educating physicians and other health care professionals to deliver health care that is concordant with the needs of the population and the resources of the country must be a primary consideration. Led by primary care physicians, teams of physicians, nurses and community health workers will provide care that is driven by the principles of quality, equity, relevance and effectiveness.

Distributions of funds for health should be based on all individual nation needs. No nation can accomplish positive NCD4 outcomes by tackling a single cause of death.

Strengthening the healthcare infrastructure, including training the primary healthcare team, chronic disease surveillance, public health promotion campaigns, quality assurance and establishment of national and local standards of care, is important in caring for the increasing numbers of patients with NCD4. Most premature deaths due to NCDs are preventable; however, in most developing countries health systems are inadequate, or unprepared to appropriately act on NCDs.

One of the most important components of healthcare infrastructure is human resources; well-trained and motivated health care professionals led by primary care physicians are crucial to success. International aid and development programs need to move from "vertical focus" on single diseases or objectives to a more sustainable and effective primary care health infrastructure development.

RECOMMENDATIONS

Recalling its Statement on Hypertension and Cardiovascular Disease and its Declaration of Oslo on Social Determinants of Health, the WMA calls on:

National Governments to:

1. Recognize the importance of socio-economic development for health and reduce socioeconomic status disparities in income, education, and occupation;
2. Support global immunization strategies;
3. Support global tobacco and alcohol control strategies, as well as control strategies addressing other forms of addiction, particularly drug use;
4. Promote healthy living and implement comprehensive, collaborative policies and strategies at all relevant levels and divisions of government that support prevention and healthy lifestyle behaviours;
5. Set aside a fixed percentage of the national budget for healthcare infrastructure development and promotion of healthy lifestyles and invest in better management of NCDs4 including detection, care and treatment;
6. Advocate for trade / commercial agreements that protect rather than undermine public health;
7. Develop and execute global and national action strategies for mitigating the health effects of climate change;

8. Promote research for prevention and treatment of NCDs, including research on occupational health hazards leading to chronic diseases;
9. Promote access to good quality effective medicines to treat NCDs;
10. Develop monitoring and surveillance systems for NCDs and,
11. Reinforce primary health care, human resources and infrastructure.

Its Constituent Members to:

12. Increase physician, public and NGO awareness of optimal disease prevention behaviours;
13. Enhance skills and capacity to promote a team-based multidisciplinary approach to chronic disease management;
14. Advocate for integration of NCD prevention and control strategies in government-wide policies;
15. Promote high quality training and professional associations for more primary care physicians and advocate for their equitable distribution;
16. Advocate for high quality readily accessible resources for continuing medical education that is responsive to societal needs;
17. Support establishing evidence-based standards of care for NCDs;
18. Promote an environment of support for continuity of care for NCDs, including collaborative efforts to encourage patient education and self-management;
19. Support strong public health infrastructure and,
20. Recognize and support the concept that addressing and acting on social determinants are part of prevention and health care.

Medical Schools to:

21. Develop curriculum objectives that meet current societal needs;
22. Create primary care departments;
23. Provide community-oriented and community-based primary care training opportunities in primary care specialties that allow students to become acquainted with the basic elements of chronic care infrastructure and continuity of care;
24. Promote the use of interdisciplinary, interprofessional, intersectoral and other collaborative training methodologies within primary and continuing education programs and,

25. Include instruction in chronic disease prevention, including nutrition and lifestyle promotion counselling, in the general curriculum.

Individual Physicians to:

26. Work to create communities that promote healthy lifestyles and prevention behaviours;

27. Offer patients smoking cessation, weight control strategies, substance abuse counselling, early screening, self-management education and support, nutritional counselling, and ongoing coaching;

28. Inform patients about the dangers of illusory or insufficiently proven remedies or procedures, and charlatanism practices;

29. Promote a team-based multidisciplinary and value-based approach to chronic disease management;

30. Ensure continuity of care for patients with chronic disease;

31. Model healthy lifestyles by maintaining personal health;

32. Become community advocates for improved social determinants of health, equity in health care and for best prevention methods and,

33. Work with parents and the community at large to ensure that parents have the best advice on maintaining the health of their children.

WMA STATEMENT ON THE DEVELOPMENT OF A MONITORING AND REPORTING MECHANISM TO PERMIT AUDIT OF ADHERENCE OF STATES TO THE DECLARATION OF TOKYO

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011
and reaffirmed with minor revisions by the 218th Council session (online), London, United Kingdom, October 2021

The WMA reaffirms its Declaration of Tokyo establishing guidelines for physicians concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment, and recommends that a monitoring and reporting mechanism be established to permit audit of adherence of States to the terms of the said declaration, in particular:

1. Where physicians are working in situations of dual loyalties, support must be offered to ensure they are not put in positions that might lead to violations of fundamental professional ethics, whether by active breaches of medical ethics or omission of ethical conduct, and/or of human rights, as laid out in the Declaration of Tokyo.

2. Its constituent members should offer support for physicians in difficult situations, including, as feasible and without endangering either patients or doctors, helping individuals to report violations of patients' health rights and physicians' professional ethics in custodial settings. The support given must adhere to the principles put forward in the WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment.

3. The WMA should review the evidence available of the violation of human rights codes by states and/or the forcing of physicians to violate the Declaration of Tokyo and refer as appropriate such cases to the relevant national and international authorities.

4. The WMA should encourage its member associations to investigate accusations of physician involvement in torture and similar abuses of human rights reported to it from reputable sources, and to report back in particular on whether physicians are at risk and in need of support.

5. The WMA should provide support to its constituent members and their individual physicians members to resist such violations, and as far as realistically possible, stand firm in their ethical convictions. The medical profession and governments should also protect physicians endangered because they adhere to their professional and ethical obligations.

6. The WMA shall encourage and support its member associations in their calls for investigations by the relevant United Nations special rapporteur or any other standard and reliable accountability mechanism in place when valid concerns are raised.

WMA STATEMENT ON THE PROTECTION AND INTEGRITY OF MEDICAL PERSONNEL IN ARMED CONFLICTS AND OTHER SITUATIONS OF VIOLENCE

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011
and revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

The right to health and medical assistance is a basic human right that should be guaranteed at all times; ethical principles of healthcare remain the same in times of emergencies and in times of peace. Healthcare personnel must be duly protected.

Various international agreements, including the Geneva Conventions (1949), Additional Protocols to the Geneva Conventions (1977, 2005) and the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials of the United Nations, must guarantee safe access to medical assistance as well as the protection of healthcare personnel.

The United Nations Security Council Resolution 2286 (2016) condemns attacks and threats against health care personnel, demands an end to impunity for those responsible, and that all parties to armed conflict comply fully with their obligations under international law.

Despite recognized international standards and the mobilization of humanitarian and human rights stakeholders over the last years denouncing the surge of violence against healthcare worldwide, the WMA notes with great concerns persistent attacks and misuses of hospitals and other medical facilities, as well as threats, killings and other violence against patients and healthcare personnel in emergency contexts.

The WMA condemns in the strongest terms this scourge of violence against healthcare personnel and facilities, which has disastrous humanitarian implications with critical impacts on the capacity of the health system to provide the care needed, resulting in unjustifiable suffering and death. Violence against healthcare personnel constitutes an international emergency, requiring urgent actions.

Recalling its Statement on Armed Conflicts, the WMA reaffirms that armed conflicts should always be a last resort and that States and other authorities who enter into armed conflict must accept responsibility for the consequences of their actions.

The safety and personal security of physicians and other healthcare personnel are essential in enabling them to provide care and save lives in situations of conflicts. They must always be

respected as neutral and should never be prevented from fulfilling their duties. Healthcare personnel and facilities should never be instrumentalised as means of war.

Recalling its Regulations in Times of Armed Conflict and Other Situations of Violence, the WMA reaffirms that the primary obligation of physicians and other healthcare personnel is always to their patients; they have the same ethical responsibilities in situation of violence or armed conflicts as in peacetime, the same duty of preserving health and saving lives; they shall at all times act in accordance with the ethical principles of the profession, relevant international and national law, and their conscience.

RECOMMENDATIONS

The WMA calls upon all parties involved in situations of violence to:

1. Fully comply with their obligations under international law, including human rights law and international humanitarian law, in particular with their obligations under the Geneva Conventions of 1949 and the obligations applicable to them under the Additional Protocols of 1977 and 2005;

2. Ensure the safety, independence and personal security of healthcare personnel at all times, including during armed conflicts and other situations of violence, in accordance with the Geneva Conventions and their additional protocols;

3. Respect and promote the principles of international humanitarian and human rights law which safeguard medical neutrality in situations of conflict;

4. Protect medical facilities, medical transport and the people being treated in them, provide the safest possible working environment for healthcare personnel, and protect them from threats, interference and attack;

5. Never misuse hospitals and other health facilities for military purposes and dedicate them exclusively to health care;

6. Enable healthcare personnel to treat injured and sick patients, regardless of their role in a conflict, and to carry out their medical duties freely, independently and in accordance with the principles of their profession without fear of punishment or intimidation;

7. Ensure that safe access to adequate medical facilities for the injured and others in need of medical aid is not unduly impeded;

8. Ensure that the equipment, including personal protection equipment, necessary for the safety of healthcare workers, is available to them as needed, and that the staffing is adequate;

9. Support and strictly respect the ethical rules of the medical profession as defined, among other documents, in the Ethical Principles of Health Care in Times of Armed Conflict and

Other Emergencies and in the WMA Regulations in Times of Armed Conflict and Other Situations of Violence, and to never require from physicians or force them to breach or renounce these rules, in particular:

- privileges and facilities afforded to physicians and other health care professionals in times of armed conflict and other situations of violence must never be used for purposes other than health care;
- physicians must at all times show appropriate respect for medical confidentiality;
- physicians must never accept acts of torture or any other form of cruel, inhuman or degrading treatment under any circumstances; they must never be present at nor take part in such acts;
- physicians have a duty to recognize and support vulnerable populations, including women, children, refugees, the disabled and displaced persons;
- physicians and WMA constituent members should alert governments and non-state actors of the human consequences of warfare;
- where conflict appears to be imminent and inevitable, physicians should ensure that authorities are planning for the protection of the public health infrastructure and for any necessary repair in the immediate post-conflict period.

The WMA calls upon governments to:

10. Establish efficient, secure and unbiased reporting mechanisms with sufficient resources to collect and disseminate data regarding assaults on physicians, other healthcare personnel and medical facilities;

11. Provide to the WHO the necessary support to fulfil its leadership role in documenting attacks on healthcare personnel and facilities[i];

12. Foster the mechanisms of investigating and bringing to justice those responsible for reported violations of the international agreements pertaining to the protection of healthcare personnel in armed conflicts and other situations of violence, and of enforcing the sanctions when such have been decided;

13. Develop and implement more efficient legal protection for medical and other healthcare personnel, so that whoever attacks a nurse, physician or another healthcare personnel knows that such actions will be severely penalised.

The WMA calls upon governments, its member organisations and the appropriate international bodies to:

14. Raise awareness of international norms on the protection of healthcare personnel and cooperate with different actors to identify strategies to tackle threats to healthcare and strengthen the mechanism of investigating the reported violations;

15. Raise awareness at both national and local level of the fundamental importance of protecting the healthcare personnel and of upholding their neutrality in times of conflict;

16. Support the development of pregraduate, postgraduate and continuous education for the healthcare personnel to ensure their competencies and their security and to minimize the psychological toll when confronted with armed conflicts and other situations of violence.

[i] The WMA recognizes that in some circumstances, documenting and denouncing acts of torture or other violence may put the physician, and those close to him or her, at great risk. Doing so may have excessive personal consequences. Physicians must avoid putting individuals in danger while assessing, documenting or reporting signs of torture and cruel, inhuman and degrading treatment and punishments.

WMA STATEMENT
ON
THE PROFESSIONAL AND ETHICAL USE OF SOCIAL MEDIA

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011
and revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022

DEFINITION

Social media is a collective term for the different interactive platforms, websites and applications intended for digital networking, that allow individuals and organizations to create and share user-generated content digitally.

The objectives of this policy are to:

- Examine the professional and ethical challenges related to the increasing usage of social media by physicians, medical students, and patients.
- Establish a framework that protects their respective interests.
- Ensure trust and reputation by maintaining high professional and ethical standards.
- Promote the availability of quality information across social media.
- Stand against misinformation and disinformation on social media.

The use of social media has become a fact of life for billions of people worldwide including physicians, medical students, and patients.

Interactive, collaborative tools such as wikis, social networking platforms, chat applications and blogs have transformed passive Internet users into active participants. These tools are means for gathering, sharing and disseminating information, including healthcare and science information, socializing and connecting with friends, relatives, professionals etc. They can be used to seek medical advice, and patients share their health and healthcare experiences. They can also be used in research, public health, and education.

The positive aspects of social media should be recognized such as in promoting a healthy lifestyle, the dissemination of medical knowledge to society and in reducing patients' isolation.

Areas, which may require special attention include:

- Sensitive content, photographs, videos, other personal materials posted on online social forums often exist in the public domain and have the capacity to remain on the internet permanently. Individuals may not have control over the ultimate distribution of material they post on-line.

- Patient portal, blogs and tweets are not a substitute for one on one consultation with physicians but may widen engagement with health services amongst certain groups. Online "friendships" with patients may also alter the patient-physician relationship, and may result in unnecessary, possibly problematic physician and patient self-disclosure.
- Each party's privacy may be compromised in the absence of adequate and conservative privacy settings or by their inappropriate use. Privacy settings are not absolute; social media sites may change default privacy settings unilaterally, without the user's knowledge. Social media sites may also make communications available to third parties.
- Misinformation and disinformation often spread more rapidly through social media than fact-based accurate information. It may cause harm to the health of individuals as well as to public health and foster doubt and distrust towards professionals seeking to promote truth and science-based evidence.
- Appropriate disclaimers to include in biographical information (e.g., "my opinions are my own", "posts are not personalized medical advice", etc).

The dissemination of medical knowledge, best practices and treatment options on social media can increase and expedite access to new and valid information among medical professionals. However, individuals or companies can take advantage of these channels in misleading ways, including to market or promote their medical products or treatments.

RECOMMENDATIONS

The WMA urges National Medical Associations (NMA) to establish social media guidelines for their members addressing the following objectives:

1. To maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just as they would in any other context.

2. To ensure that no identifiable patient information is posted in any social media by their physician, by increasing the understanding of privacy provisions of social networking sites and their limitations while considering intended audience and the technical feasibility to restrict access to the content to predefined individuals or groups.

3. To exercise care when using applications that might compromise the security of the data, including when consulting with colleagues.

4. To promote and apply the principles in the WMA Guidelines on Promotional Mass Media Appearances by Physicians to all social media activities by physicians.

5. To encourage physicians to routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others is accurate and appropriate.

6. To prevent the use of technological devices from diverting our attention during direct consultation with the patient.

7. To provide factual, concise, understandable information, declare any conflicts of interest and adopt a sober tone when discussing professional matters.

8. To avoid inappropriate use of the networks, frivolous, insensitive attitudes or light-hearted opinions on medical matters.

9. To draw the attention of physicians to the fact that social media content posted by health professionals may contribute to the public perception of the profession and should be done in accordance with the principles in the WMA Declaration of Geneva and the International Code of Medical Ethics.

10. To include education on the use of social media in medical curricula and continuing medical education.

11. To behave in the media and on social networks with the same scientific rigor and the same approach as in a consultation and show the same respect to patients and colleagues.

12. To create mechanisms for accountability in professional settings when inappropriate behavior on social media is observed and reported.

13. To promote health literacy and knowledge among populations and with individual patients by using objective and evidence based messages in accordance with the principles in the WMA Declaration of Geneva, the WMA International Code of Medical Ethics, and the WMA Statement on Healthcare Information for All.

14. To combat misinformation, disinformation, and the promotion of pseudoscience and pseudotherapy on social media, all of which can result in negative health outcomes for patients and communities.

15. To counsel fellow physicians who engage in misinformation, disinformation, or violation of patient trust on social media and/or report to relevant authorities for ongoing deliberate acts of the same.

16. To raise awareness among physicians and medical students about the possibility that information shared on social media could be used in misleading ways by individuals or companies.

WMA STATEMENT ON ELECTRONIC CIGARETTES AND OTHER ELECTRONIC NICOTINE DELIVERY SYSTEMS

Adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012

INTRODUCTION

Electronic cigarettes (e-cigarettes) are products designed to deliver nicotine to a user in the form of a vapor. They are usually composed of a rechargeable battery-operated heating element, a replaceable cartridge that contains nicotine and/or other chemicals, and an atomizer that, when heated, turns the contents of the cartridge into a vapor (not smoke). This vapor is then inhaled by the user. These products are often made to look like other tobacco-derived products like cigarettes, cigars, and pipes. They can also be made to look like everyday items such as pens and USB memory sticks.

No standard definition of e-cigarettes exists and different manufacturers use different designs and different ingredients. Quality control processes used to manufacture these products are substandard or non-existent. Few studies have been done to analyze the level of nicotine delivered to the user and the composition of the vapor produced.

Manufacturers and marketers of e-cigarettes often claim that use of their products is a safe alternative to smoking, particularly since they do not produce carcinogenic smoke. However, no studies have been conducted to determine that the vapor is not carcinogenic, and there are other potential risks associated with these devices: Appeal to children, especially when flavors like strawberry or chocolate are added to the cartridges. E-cigarettes can increase nicotine addiction among young people and their use may lead to experimenting with other tobacco products.

Manufacturers and distributors mislead people into believing these devices are acceptable alternatives to scientifically proven cessation techniques, thus delaying actual smoking cessation. E-cigarettes are not comparable to scientifically-proven methods of smoking cessation. Their dosage, manufacture, and ingredients are not consistent or clearly labelled. Brand stretching by using known cigarette logos is to be deplored.

Unknown amounts of nicotine are delivered to the user, and the level of absorption is unclear, leading to potentially toxic levels of nicotine in the system. These products may also contain other ingredients toxic to humans.

High potential of toxic exposure to nicotine by children, either by ingestion or dermal absorption, because the nicotine cartridges and refill liquid are readily available over the Internet and are not sold in child resistant packaging.

Due to the lack of rigorous chemical and animal studies, as well as clinical trials on commercially available e-cigarettes, neither their value as therapeutic aids for smoking cessation nor their safety as cigarette replacements is established. Lack of product testing does not permit the conclusion that e-cigarettes do not produce any harmful products even if they produce fewer dangerous substances than conventional cigarettes.

Clinical testing, large population studies and full analyses of e-cigarette ingredients and manufacturing processes need to be conducted before their safety, viability and impacts can be determined as either clinical tools or as widely available effective alternatives to tobacco use.

RECOMMENDATIONS

That the manufacture and sale of e-cigarettes and other electronic nicotine delivery systems be subject to national regulatory bodies prior approval based on testing and research as either a new form of tobacco product or as a drug delivery device.

That the marketing of e-cigarettes and other electronic nicotine delivery systems as a valid method for smoking cessation must be based on evidence and must be approved by appropriate regulatory bodies based on safety and efficacy data.

That e-cigarettes and other electronic nicotine delivery systems be included in smoke free laws.

Physicians should inform their patients of the risks of using e-cigarettes even if regulatory authorities have not taken a position on the efficacy and safety of these products.

WMA STATEMENT
ON
THE ETHICAL IMPLICATIONS OF COLLECTIVE ACTION BY PHYSICIANS

Adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012
and reaffirmed with minor revisions by the 221st WMA Council Session, Berlin, Germany, October 2022

PREAMBLE

In recent years, in countries where physicians' satisfaction with their working conditions has decreased, collective action by physicians to advocate for better conditions has become increasingly common.

Physicians may carry out protests and sanctions, including collective resignations, in order to improve direct and indirect working conditions and to ensure safe and resilient health care systems. Physicians must consider not only their duty to individual patients, but also their responsibility to improve the system, such that it meets the requirements of accessibility and quality.

In addition to their professional obligations, physicians are often also employees. There may be tension between physicians' duty not to cause harm, and their rights as employees. Therefore, physicians' strikes or other forms of collective action often give rise to public debate on ethical and moral issues. This statement attempts to address these issues.

RECOMMENDATIONS

The World Medical Association recommends that Constituent Members adopt the following guidelines for physicians with regard to collective action:

1. Physicians who take part in collective action are not exempt from their ethical or professional obligations to patients.

2. Even when the action taken is not organized by or associated with the Constituent Member, the Constituent Member should ensure that the individual physician is aware of and abides by their ethical obligations.

3. Whenever possible, physicians should press for reforms through non-violent public demonstrations, lobbying and publicity or informational campaigns, and/or through negotiation or mediation.

4. If involved in collective action, Constituent Members should act to minimize the harm to the public and ensure that essential and emergency health services, and the continuity of care, are provided throughout a strike. Further, Constituents Members should advocate for measures to review exceptional cases. If involved in collective action, Constituent Members should provide continuous and up-to-date information to their patients and the general public with regard to the demands of the conflict and the actions being undertaken. The general public must be kept informed in a timely manner about any strike actions and the restrictions they may have on health care.

WMA STATEMENT
ON
FORCED AND COERCED STERILISATION

Adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012

The WMA recognises that no person, regardless of gender, ethnicity, socio-economic status, medical condition or disability, should be subjected to forced or coerced permanent sterilisation.

A full range of contraceptive services, including sterilisation, should be accessible and affordable to every individual. The state may have a role to play in ensuring that such services are available, along with private, charitable and third sector organisations. The decision to undergo contraception, including sterilisation, must be the sole decision of the individual concerned.

As with all other medical treatments, sterilisation should only be performed on a competent patient after an informed choice has been made and the free and valid consent of the individual has been obtained. Where a patient is incompetent, a valid decision about treatment must be made in accordance with relevant legal requirements and the ethical standards of the WMA before the procedure is carried out. Sterilization of those unable to give consent would be extremely rare and done only with the consent of the surrogate decision maker.

Such consent should be obtained when the patient is not facing a medical emergency, or other major stressor.

The WMA condemns practices where a state or any other actor attempts to bypass ethical requirements necessary for obtaining free and valid consent.

Consent to sterilisation should be free from material or social incentives which might distort freedom of choice and should not be a condition of other medical care (including safe abortion), social, insurance, institutional or other benefits.

The WMA calls on national medical associations to advocate against forced and coerced sterilisation in their own countries and globally.

WMA STATEMENT
ON
ORGAN AND TISSUE DONATION

Adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012
and revised by the 68th WMA General Assembly, Chicago, United States, October 2017

PREAMBLE

- Advances in medical sciences, especially surgical techniques, tissue typing and immuno-suppressive drugs, have made possible a significant increase in the rates of successful transplantation of human organs and tissue. Yet, in all countries, a shortage of organ donors results in potentially avoidable loss of life. National medical associations should support attempts to maximise the number of donor organs available in their countries and to ensure that the highest ethical standards are maintained. The World Medical Association has developed this policy to assist medical associations, physicians, other health care providers and policy makers to achieve this.

  This policy is based on a number of core ethical principles: altruism, autonomy, beneficence, equity and justice. These principles should guide those developing national policies and those operating within it, both in relation to organ procurement and to the distribution and transplantation of donor organs. All systems and processes should be transparent and open to scrutiny.

  This statement applies to organ and tissue donation from both deceased and living donors. It does not apply to blood donation.

RAISING PUBLIC AWARENESS

- It is important that individuals are aware of the option of donation and have the opportunity to choose whether or not to donate organs and/or tissue before and after their death. Awareness and choice should be facilitated in a coordinated multi-faceted approach by a variety of stakeholders and means, including media awareness and public campaigns. In designing such campaigns account needs to be taken of any religious or cultural sensitivities of the target audience.

- Through awareness raising campaigns, individuals should be informed of the benefits of transplantation, the impact on the lives of those who are waiting for a transplant and the shortage of donors available. They should be encouraged to think about their own wishes about donation, to discuss their wishes with their family and friends and to use established mechanisms to formally record them by opting into, or out of, donation.

- The WMA advocates informed donor choice. National medical associations in

countries that have adopted or are considering a policy of "presumed consent" (or opt-out), in which there is an assumption that the individual wishes to donate unless there is evidence to the contrary, or "mandated choice", in which all persons would be required to declare whether they wish to donate, should make every effort to ensure that these policies have been adequately publicised and do not diminish informed donor choice, including the patient's right not to donate.

- Consideration should be given to the establishment of national donor registries to collect and maintain a list of citizens who have chosen either to donate or not to donate their organs and/or tissue. Any such registry must protect individual privacy and the individual's ability to control the collection, use, disclosure of, and access to, his or her health information for other purposes. Provisions must be in place to ensure that the decision to sign up to a register is adequately informed and that registrants can withdraw from the registry easily and quickly and without prejudice.

- Living organ donation is becoming an increasingly important component of transplantation programmes in many countries. Most living donation is between related or emotionally close individuals and small but increasing numbers are donating to people they do not know. Given that there are health risks associated with living organ donation, proper controls and safeguards are essential. Information aimed at informing people about the possibility of donating organs as a living donor should be carefully designed so as not to put pressure on them to donate and to minimise the risk of financial or other coercion. Potential donors should know where to obtain detailed information about what is involved, should be informed of the inherent risks and should know that there are safeguards in place to protect those offering to donate.

PROTOCOLS FOR ORGAN AND TISSUE DONATION FROM DECEASED DONORS

- The WMA encourages its members to support the development of comprehensive, coordinated national protocols for deceased (also referred to as cadaveric) organ and tissue procurement in consultation and cooperation with all relevant stakeholders. Ethical, cultural and societal issues arising in connection with donation and transplantation should be resolved, wherever possible, in an open process involving public debate informed by sound evidence.

- National and local protocols should provide detailed information about the identification, referral and management of potential donors as well as communication with those close to people who have died. They should encourage the procurement of organs and tissues consistent with this statement. Protocols should uphold the following key principles:

    - Decisions to withhold or withdraw life-prolonging treatment should be based on an assessment of whether the treatment is able to benefit the patient. Such decisions must be, and must be seen to be, completely separate from any decisions about donation.

    - The diagnosis of death should be made according to national guidelines and as

outlined in the WMA's Declaration of Sydney on the Determination of Death and Recovery of Organs.

- There should be a clear separation between the treating team and the transplant team. In particular, the physician who declares or certifies the death of a potential donor should not be involved in the transplantation procedure. Nor should he/she be responsible for the care of the organ recipient.

- Countries that carry out donation following circulatory/cardiac death should have specific and detailed protocols for this practice.

- Where an individual has expressed a clear and voluntary wish to donate organs and/or tissue after death, steps should be taken to facilitate that wish wherever possible. This is part of the treating team's responsibility to the dying patient.

- The WMA considers that the potential donor's wishes are paramount. Relatives and those close to the patient should be strongly encouraged to support a deceased person's previously expressed wish to donate organs and/or tissues. Whenever possible, these conversations should occur prior to the death of the patient.

- Those charged with approaching the patient, family members or other designated decision maker about organ and tissue donation should possess the appropriate combination of knowledge, skill and sensitivity for engaging in such discussions. Medical students and practising physicians should seek the necessary training for this task, and the appropriate authorities should provide the resources necessary to secure that training.

- Donation must be unconditional. In exceptional cases, requests by potential donors, or their substitute decision makers, for the organ or tissue to be given to a particular recipient may be considered if permitted by national law. Donors seeking to apply conditions that could be seen as discriminatory against certain groups, however, should be declined.

- Hospitals and other institutions where donation occurs should ensure that donation protocols are publicised amongst those likely to use them and that adequate resources are available for their implementation. They should also foster a pro-donation culture within the institution in which consideration of donation is the norm, rather than the exception, when a patient dies.

- The role of transplant coordination is critical to organ donation. Those performing coordination act as the key point of contact between the bereaved family and the donation team and usually also undertake the complex logistical arrangements to make donation happen. Their role must be recognised and supported.

- Deceased organ donation must be based on the notion of a gift, freely and voluntarily given. It should involve the voluntary and unpressured consent of the individual provided before death (by opting in or opting out of donation depending upon the

jurisdiction) or the voluntary authorisation of those close to the deceased patient if that person's wishes are unknown. The WMA is strongly opposed to the commercialisation of donation and transplantation.

- Prospective donors or their substitute health care decision makers should have access to accurate and relevant information, including through their general practitioners. Normally, this will include information about:
  - the procedures and definitions involved in the determination of death,
  - the testing that is undertaken to determine the suitability of the organs and/or tissue for transplantation and that this may reveal previously unsuspected health risks in prospective donors and their families,
  - measures that may be required to preserve organ function until death is determined and transplantation can occur,
  - what will happen to the body once death has been declared,
  - what organs and tissues can be donated,
  - The protocol that will be followed in the event that the family objects to donation, and
  - the possibility of withdrawing consent.
- Prospective donors or their substitute health care decision makers should be given the opportunity to ask questions about donation and should have their questions answered sensitively and intelligibly.
- Where both organs and tissues are to be donated, information should be provided, and consent obtained, for both together in order to minimise distress and disruption to those close to the deceased.
- In some parts of the world a contribution towards funeral costs is given to the family of those who donate. This can be viewed either as appropriate recognition of their altruistic act or as a payment that compromises the voluntariness of the choice and the altruistic basis for donation. The interpretation may depend, in part, on the way it is set up and managed. When considering the introduction of such a system, care needs to be taken to ensure that the core principles of altruism, autonomy, beneficence, equity and justice are met.
- Free and informed decision making requires not only the provision of information but also the absence of coercion. Any concerns about pressure or coercion must be resolved before the decision to donate organs or tissue is made.
- Prisoners and other people who are effectively detained in institutions should be eligible to donate after death where checks have been made to ensure that donation is in line with the individual's prior, un-coerced wishes and, where the individual is

incapable of giving consent, authorisation has been provided by a family member or other authorized decision-maker. Such authorisation may not override advance withholding or refusal of consent.

- Their death is from natural causes and this is verifiable.

- In jurisdictions where the death penalty is practised, executed prisoners must not be considered as organ and/or tissue donors. While there may be individual cases where prisoners are acting voluntarily and free from pressure, it is impossible to put in place adequate safeguards to protect against coercion in all cases.

ALLOCATION OF ORGANS FROM DECEASED DONORS

- The WMA considers there should be explicit policies, open to public scrutiny, governing all aspects of organ and tissue donation and transplantation, including the management of waiting lists for organs to ensure fair and appropriate access.

- Policies governing the management of waiting lists should ensure efficiency and fairness. Criteria that should be considered in allocating organs or tissue include:

  - Severity and urgency of medical need,

  - Length of time on the waiting list,

  - Medical probability of success measured by such factors as age, type of disease, likely improvements in quality of life, other complications, and histocompatibility.

- There must be no discrimination based on social status, lifestyle or behaviour. Non-medical criteria must not be considered.

PROTOCOLS FOR ORGAN AND TISSUE DONATION FROM LIVING DONORS

- Living donation is becoming increasingly common as a way to overcome the shortage of organs from deceased donors. In most cases donors provide organs to relatives or people to whom they are emotionally close. A small number of individuals choose to donate an organ altruistically to a stranger. Another scenario is where one or more donor and recipient pairs are incompatible with each other but donate in the form of a cross-over or pooled donation system (for example, donor A donates to recipient B, donor B donates to recipient C and donor C donates to recipient A).

- All potential donors should be given accurate and up to date information about the procedure and the risks of donation and have the opportunity to discuss the issue privately with a member of the healthcare team or a counsellor. Normally this information will include:

  - The risks of becoming a living donor,

- The tests that are undertaken to assess suitability for donation and that this may reveal previously unsuspected health problems,

- What will happen before, during and after donation takes place, and

- In the case of solid organs, the long-term implications of living without the donated organ.

- Prospective donors should be given the opportunity to ask questions about donation and should have their questions answered sensitively and intelligibly.

- Procedures should be in place to ensure that living donors are acting voluntarily and free from pressure or coercion. In order to avoid donors being paid and then posing as a known donor, independent checks should also be undertaken to verify the claimed relationship and, where this cannot be proven, the donation should not proceed. Such checks should be independent of the transplant team and those who are caring for the potential recipient.

- Additional safeguards should be in place for vulnerable donors, including but not limited to, people who are dependent in some way (such as competent minors donating to a parent or sibling).

- Prisoners should be eligible to be living donors only in exceptional circumstances, to first or second degree family members; evidence should be provided of any claimed relationship before the donation may proceed. Where prisoners are to be considered as living donors, extra safeguards are required to ensure they are acting voluntarily and are not subject to coercion.

- Those who lack the capacity to consent should not be considered as living organ donors because of their inability to understand and decide voluntarily. Exceptions may be made in very limited circumstances, following legal and ethical review.

- Donors should not lose out financially as a result of their donation and so should be reimbursed for general and medical expenses and any loss of earnings incurred.

- In some parts of the world individuals are paid for donating a kidney, although in virtually all countries the sale of organs is unlawful. The WMA is strongly opposed to a market in organs.

PROTOCOLS FOR RECIPIENTS

- Protocols for free and informed decision making should be followed in the case of recipients of organs or tissue. Normally, this will include providing information about:

  The risks of the procedure,

  The likely short, medium and long-term survival, morbidity, and quality-of-life

prospects,

Alternatives to transplantation, and

How organs and tissues are obtained.

- In the case of a delayed diagnosis for infection, disease or malignancy in the donor, there should be a strong presumption that the recipient will be informed of any risk to which they may have been exposed. Individual decisions about disclosure need to take account of the particular circumstances, including the level and severity of risk. In most cases disclosure will be appropriate and should be managed carefully and sensitively.

COSTS AND ORIGIN OF ORGANS AND TISSUES

- Organs or tissue suspected to have been obtained through unlawful means must not be accepted for transplantation.
- Organs and tissues must not be sold for profit. In calculating the cost of transplantation, charges related to the organ or tissue itself should be restricted to those costs directly associated with its retrieval, storage, allocation and transplantation.
- Transplant surgeons should seek to ensure that the organs and tissues they transplant have been obtained in accordance with the provisions of this policy and should refrain from transplanting organs and tissues that they know, or suspect, have not been procured in a legal and ethical manner.

TRANSPARENCY AND ACCOUNTABILITY

- National Medical Associations should work with governments and relevant institutions to ensure that appropriate, effective structures and processes are in place to:

    1. support relevant traceability and follow-up of all transplant recipients and living donors including those who require ongoing medical management receive care and support;
    2. record information on donation and transplantation rates and outcomes;
    3. assess the short and long-term outcomes, quality, safety and efficacy of organ donation and transplantation activities;
    4. assess the adherence to ethical and clinical protocols of organ donation and transplantation activities;

- The data arising from these activities should be publicly accessible and open to scrutiny (notwithstanding appropriate protection of donor and recipient confidentiality).

FUTURE OPTIONS

- Public health measures to reduce the demand for donated organs should be seen as a priority, alongside initiatives to increase the effectiveness and success of organ

donation systems.

- New developments and possibilities, such as xenotransplantation and the use of stem cell technology to repair damaged organs, should be monitored. Before their introduction into clinical practice such technologies should be subject to scientific review and robust safety checks as well as ethical review. Where, as with xenotransplantation, there are potential risks that go beyond individual recipients, this process must also involve public debate.

WMA STATEMENT
ON
THE PRIORITISATION OF IMMUNISATION

Adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012
and reaffirmed by the 212th WMA Council Session, Santiago, Chile, April 2019

PREAMBLE

Vaccination use to prevent against disease was first done successfully by Jenner in 1796 when he used cowpox material for vaccination against smallpox. Since then, vaccination and immunisation have been acknowledged as an effective preventive strategy for several communicable diseases and are now being developed for the control of some non-communicable diseases.

Vaccine development and administration are some of the most significant interventions to influence global health in modern times. It is estimated that immunisation currently prevents approximately 2.5 million deaths every year, saving lives from diseases such as diphtheria, tetanus, whooping cough (pertussis) and measles. Approximately 109 million children under the age of one are fully vaccinated with the diphtheria-tetanus-pertussis (DTP3) vaccine alone.

Mostly the ultimate goal of immunisation is the total eradication of a communicable disease. This was achieved for smallpox in 1980 and there is a realistic goal for the eradication of polio within the next few years.

The Global Immunisation Vision Strategy (GIVS) 2006-2015 was developed by the WHO and UNICEF in the hope of reaching target populations who currently do not have immunisation services or who do not have an adequate level of coverage.

The four strategies promoted in this vision are:

- Protecting more people in a changing world
- Introducing new vaccines and technologies
- Integrating immunisation, other linked health interventions and
- Surveillance in the health systems context
- Immunizing in the context of global interdependence [1]

Vaccine research is constantly revealing new possibilities to protect populations from serious health threats. Additionally, new strains of diseases emerge requiring the adaptation of vaccines in order to offer protection.

The process of immunisation requires an environment that is resourced with appropriate

materials and health workers to ensure the safe and effective administration of vaccines. Administration of vaccines often requires injections, and safety procedures for injections must always be followed.

Immunisation schedules can vary according to the type of vaccine, with some requiring multiple administrations to be effective. It is vitally important that the full schedule is followed otherwise the effectiveness of the vaccine may be compromised.

The benefits of immunisation have had a profound effect on populations, not only in terms of preventing ill health but also in permitting resources previously required to treat the diseases to be redirected to other health priorities. Healthier populations are economically beneficial and can contribute more to society.

Reducing child mortality is the fourth of the United Nation's Millennium Development Goals, with immunisation of children having a significant impact on mortality rates on children aged under five. According to the WHO, there are still more than 19 million children who have not received the DTP3 vaccine. In addition, basic health care services for maternal health with qualified health care personnel must be established.

Immunisation of adults for diseases such as influenza and pneumococcal infections has been shown to be effective, not only in decreasing the number of cases amongst those that have received immunisation but also in decreasing the disease burden in society.

The medical profession denounce any claims that are unfounded and inaccurate with respect to the possible dangers of vaccine administration. Claims such as these have resulted in diminished immunisation rates in some countries. The result is that the incidences of the diseases to be prevented have increased with serious consequences for a number of persons.

Countries differ in immunisation priorities, with the prevalence and risk of diseases varying among populations. Not all countries have the same coverage rates, nor do they have the resources to acquire, coordinate, distribute or effectively administer vaccines to their populations, often relying on non-governmental organizations to support immunisation programmes. These organizations in turn often rely on external funding that may not be secure. In times of global financial crisis, funding for such programmes is under considerable pressure.

The risk of health complications from vaccine-preventable diseases is greatest in those who experience barriers in accessing immunisation services. These barriers could be cost, location, lack of awareness of immunisation services and their health benefits or other limiting factors.

Those with chronic diseases, underlying health issues or other risk factors such as age are at particular risk of major complications due to vaccine-preventable diseases and therefore should be targeted to ensure adequate immunisation.

Supply chains can be difficult to secure, particularly in countries that lack coordination or

support of their immunisation programmes. Securing the appropriate resources, such as qualified health professionals, equipment and administrative support can present significant challenges.

Data collection on vaccine administration rates, side effects of vaccines and disease surveillance can often be difficult to achieve, particularly in isolated and under-resourced areas. Nevertheless, reporting incidents and monitoring disease spread are vital tools in combating global health threats.

RECOMMENDATIONS

The WMA supports the recommendations of the Global Immunisation Vision Strategy (GIVS) 2006-2015, and calls on the international community to:

- Encourage governments to commit resources to immunisation programmes targeted to meet country specific needs.
- Recognise the importance of vaccination/immunisation through the continued support and adoption of measures to achieve global vaccination targets and to meet the Millennium Development Goals, especially four (reduce child mortality), five (improve maternal health) and six (combat HIV/AIDS, malaria and other diseases).
- Recognise the global responsibility of immunisation against preventable diseases and support work in countries that have difficulties in meeting the 2012 targets in the Global Polio Eradication Initiative [2].
- Support national governments with vulnerable populations at risk of vaccine-preventable diseases, and the local agencies that work to deliver immunisation services and to work with them to alleviate retrictions in accessing services.
- Support vaccine research and development and ensure commitment through the adequate funding of vital vaccine research.
- Promote vaccination and the benefits of immunisation, particularly targeting those at-risk and those who are difficult to reach. Comply with monitoring activities undertaken by WHO and other health authorities.Promote high standards in the research, development and administration of vaccines to ensure patient safety. Vaccines need to be thoroughly tested before implemented on a large scale and subsequently monitored in order to identify possible complications and untoward side effects. In order to be successful, immunisation programmes need public trust which depends on safety.

In delivering vaccination programmes, the WMA recommends that:

- The full immunisation schedule is delivered to provide optimum coverage. Where possible, the schedule should be managed and monitored by suitably trained individuals to ensure consistent delivery and prompt appropriate management of adverse reactions to vaccines.
- Strategies are employed to reach populations that may be isolated because of location, race, religion, economic status, social marginalization, gender and/or age.
- Ensure that qualified health professionals receive comprehensive training to safely

deliver vaccinations and immunisations, and that vaccination/immunisations are targeted to those whose need is greatest.
- Educate people on the benefits of immunisation and how to access immunisation services.
- Maintain accurate medical records to ensure that valid data on vaccine administration and coverage rates are available, enabling immunisation policies to be based upon sound and reliable evidence.
- Healthcare professionals should be seen as a priority population for the receipt of immunisation services due to their exposure to patients and to diseases.

The WMA calls upon its members to advocate the following:

- To increase awareness of national immunisation schedules and of their own (and their dependents) personal immunisation history.
- To work with national and local governments to ensure that immunisation programmes are resourced and implemented.
- To ensure that health personnel delivering vaccines and immunisation services receive proper education and training.
- To promote the evidence base and increase awareness about the benefits of immunisation amongst physicians and the public.

References

[1] World Health Organization and United Nations Children's Fund. Global Immunisation Vision and Strategy, 2006-2015. Geneva, Switzerland: World Health Organization and United Nations Children's Fund; 2005. Available at: http://www.who.int/immunisation/givs/related_docs/en/index.html

[2] World Health Organization. Global Polio Eradication Initiative: Strategic Plan 2010-2012. Geneva, Switzerland: World Health Organization; 2010. Available at: http://polioeradication.org/who-we-are/strategy/

WMA STATEMENT ON VIOLENCE IN THE HEALTH SECTOR BY PATIENTS AND THOSE CLOSE TO THEM

Adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012

PREAMBLE

All persons have the right to work in a safe environment without the threat of violence. Workplace violence includes both physical and non-physical (psychological) violence. Given that non-physical abuse, such as harassment and threats, can have severe psychological consequences, a broad definition of workplace violence should be used. For the purposes of this statement we will use the widely accepted definition of workplace violence, as used by the WHO: "The intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation".

Violence, apart from the numerous health effects it can have on its victims, also has potentially destructive social effects. Violence against health workers, including physicians, not only affects the individuals directly involved, but also impacts the entire healthcare system and its delivery. Such acts of violence affect the quality of the working environment, which has the potential to detrimentally impact the quality of patient care. Further, violence can affect the availability of care, particularly in impoverished areas.

While workplace violence is indisputably a global issue, various cultural differences among countries must be taken into consideration in order to accurately understand the concept of violence on a universal level. Significant differences exist in terms of what constitutes violence and what specific forms of workplace violence are most likely to occur. Threats and other forms of psychological violence are widely recognized to be more prevalent than physical violence. Reasons and causes of violence in the healthcare setting are extremely complex.

Several studies have identified common triggers for acts of violence in the health sector to be delays in receiving treatment and dissatisfaction with the treatment provided[1]. Moreover, patients may act aggressively as a result of their medical condition, the medication they take or the use of alcohol and other drugs. Another important example is that individuals may threaten or perpetrate physical violence against healthcare workers because they oppose, on the basis of their social, political or religious beliefs, a specific area of medical practice.

A multi-faceted approach encompassing the areas of legislation, security, data collection, training, environmental factors, public awareness and financial incentives is required in order to successfully address the issue of violence in the health sector.

In addition, collaboration among various stakeholders (including governments, National Medical Associations (NMAs), hospitals, general health services, management, insurance companies, trainers, preceptors, researchers, police and legal authorities) is more effective than the individual efforts of any one party. As the representatives of physicians, NMAs should take an active role in combating violence in the health sector and also encourage other key stakeholders to act, thus further protecting the quality of the working environment for healthcare employees and the quality of patient care.

This collaborative approach to addressing violence in the health sector must be promoted throughout the world.

RECOMMENDATIONS

The WMA encourages National Medical Associations (NMAs) to act in the following areas:

Strategy - NMAs should encourage healthcare institutions to develop and implement a protocol to deal with acts of violence. The protocol should include the following:

1. A zero-tolerance policy towards workplace violence.
2. A universal definition of workplace violence.
3. A predetermined plan for maintaining security in the workplace.
4. A designated plan of action for healthcare professionals to take when violence takes place.
5. A system for reporting and recording acts of violence, which may include reporting to legal and/or police authorities.
6. A means to ensure that employees who report violence do not face reprisals.

In order for this protocol to be effective, it is necessary for the management and administration of healthcare institutions to communicate and take the necessary steps to ensure that all staff are aware of the strategy.

Policymaking - In order to help increase patient satisfaction, national priorities and limitations on medical care should be clearly addressed by government institutions.

The state has obligations to ensure the safety and security of patients, physicians, and other healthcare workers. This includes providing an appropriate physical environment. Hence, healthcare systems should be designed to promote the safety of healthcare staff and patients. An institution which has experienced an act of violence by a patient may require the provision of extra security, as all healthcare workers have the right to be protected in their work place.

In some jurisdictions, physicians might have the right to refuse to treat a violent patient. In such cases, they must ensure that adequate alternative arrangements are made by the relevant authorities in order to safeguard the patient's health and treatment.

Patients with acute, chronic or illness-induced mental health disturbances may act violently toward caregivers; those offering care to these patients must be adequately protected.

Training - A well-trained and vigilant staff supported by management can be a key deterrent of violent acts. NMAs should work with undergraduate and postgraduate education providers to ensure that healthcare professionals are trained in the following: com-

munication skills and recognising and handling potentially violent persons and high risk situations in order to prevent incidents of violence. The cultivation of physician-patient relationships based on respect and mutual trust will not only improve the quality of patient care, but will also foster feelings of security resulting in a reduced risk of violence.

Communication - NMAs should work with other key stakeholders to increase awareness of violence in the health sector. When appropriate, they should inform healthcare workers and the public when acts of violence occur and encourage physicians to report acts of violence through the appropriate channels.

Further, once an act of violence has taken place, the victim should be informed about the procedures undertaken thereafter.

Support to victims - Medical, psychological and legal counselling and support should be provided to staff members who have been the victims of threats and/or acts of violence while at work.

Data Collection - NMAs should lobby their governments and/or hospital boards to establish appropriate reporting systems enabling all healthcare workers to report anonymously and without reprisal, any threats or incidents of violence. Such a system should assess in terms of number, type and severity, incidents of violence within an institution and resulting injuries. The system should be used to analyse the effectiveness of preventative strategies. Aggregated data and analyses should be made available to NMAs.

Investigation - In all cases of violence there should be some form of investigation to better understand the causes and to aid in prevention of future violence. In some cases, the investigation may lead to prosecution under civil or criminal codes. The procedure should be, as much as possible, authoritative-led and uncomplicated for the victim.

Security - NMAs should work to ensure that appropriate security measures are in place in all healthcare institutions and that acts of violence in the healthcare sector are given a high priority by law-enforcement institutions. A routine violence risk audit should be implemented in order to identify which jobs and locations are at highest risk for violence. Examples of high risk areas include general practice premises, mental health treatment facilities and high traffic areas of hospitals including the emergency department.

The risk of violence may be ameliorated by a variety of means which could include placing security guards in these high risk areas and at the entrance of buildings, by the installation of security cameras and alarm devices for use by health professionals, and by maintaining sufficient lighting in work areas, contributing to an environment conducive to vigilance and safety.

Financial - NMAs should encourage their governments to allocate appropriate funds in order to effectively tackle violence in the health sector.

---

[1] Carmi-Iluz T, Peleg R, Freud T, Shvartzman P. *Verbal and physical violence towards hospital- and community- based physicians in the Negev: an observational study* BMC Health Service Research 2005; 5: 54
Derazon H, Nissimian S, Yosefy C, Peled R, Hay E. *Violence in the emergency department* (Article in Hebrew) Harefuah. 1999 Aug; 137(3-4): 95-101, 175
Landua SF. *Violence against medical and non-medical personnel in hospital emergency wards in Israel* Research Report, Submitted to the Israel National Institute for Health Policyand Health Services Research, December 2004

WMA STATEMENT
ON
WORKPLACE VIOLENCE IN THE HEALTH SECTOR

Adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012
and revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

Violence in the health sector has increased substantially in the new millennium, especially in time of COVID-19 pandemic. All persons have the right to work in a safe environment without the threat of violence. Workplace violence includes both physical and non-physical, such as (psychological) violence, intimidation and cyber harassment, among others.

Cyber and social media harassment particularly includes online threats and intimidation towards physicians who take part in a public debate in order to give adequate information and fight disinformation. These physicians are increasingly confronted with, amongst others, malicious messages on social media, death threats and intimidating home visits.

For the purposes of this document, the broad WHO definition of workplace violence will be used: "The intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation".

In addition to the numerous consequences on victims' health, violence against health personnel has potentially destructive social effects. It affects the entire healthcare system and undermines the quality of the working environment, ultimately impacting the quality of patient care. Furthermore, violence can affect the availability of health care, particularly in impoverished areas.

While workplace violence is indisputably a global issue, various cultural differences among countries must be taken into consideration in order to accurately understand the concept of violence on a universal level. Significant differences exist in terms of what defines various levels of violence and what specific forms of workplace violence are most likely to occur. This may create tolerance for some levels of violence in those places. However, threats and other forms of psychological violence are widely recognized to be more prevalent than physical violence.

Causes of violence in the healthcare setting are extremely complex. Several studies have identified common triggers for acts of violence by patients and relatives to be delays in receiving treatment, dissatisfaction with the treatment provided, aggressive patient behavior

caused by the patient's medical condition, the medication they take or the use of alcohol and other drugs. Additionally, individuals may threaten or perpetrate violence against health personnel because they oppose a specific area of medical practice, based on their social, political or religious beliefs. Cases of violence from the bystanders are reported as well. Co-worker violence, such as bullying, including initiation ceremonies and practical jokes, or harassment, constitutes another important pattern of workplace violence in the health sector.

Collaboration among various stakeholders (including governments, medical associations, hospitals, general health services, management, insurance companies, trainers, preceptors, researchers, media, police and legal authorities) together with a multi-faceted approach encompassing the areas of legislation, security, data collection, training/education, environmental factors, public awareness and financial incentives is required in order to successfully address this issue. As the representatives of physicians, medical associations should take a proactive role in combating violence in the health sector and also encourage other key stakeholders to act, thus further protecting the quality of the working environment for health personnel and the quality of patient care.

RECOMMENDATIONS

The WMA condemns in the strongest terms any forms of violence against healthcare personnel and facilities, which may include coworker violence, aggressive behavior exhibited by patients or family members, as well as acts of malicious intent from individuals in the general public, and calls on its constituent members, the health authorities and other relevant stakeholders to act through a collaborative, coordinated and effective strategy approach:

Policy-making

1. The state has obligations to ensure the safety and security of patients, physicians, and other health personnel. This includes providing an appropriate physical environment.

2. Governments should provide the necessary framework so that the prevention and elimination of workplace violence in the health sector be an essential part of national/regional/local policies on occupational health and safety, human rights protection, healthcare-facility management standards and gender equality.

Financial

3. Governments should allocate appropriate and sustainable funds in order to effectively tackle violence in the health sector.

Protocols for situation of violence in healthcare facilities

4. Healthcare facilities should adopt a zero-tolerance policy towards workplace violence eliminating its "normalization" through the development and implementation of adequate protocols including the following:

- A predetermined plan for maintaining security in the workplace; including recognition of non-physical abuse as a risk factor for physical abuse.
- A designated plan of action for health personnel when violence takes place.
- A strengthened internal communication strategy, involving the staff in decisions concerning their security.
- A system for reporting and recording acts of violence, which may include reporting to legal and/or police authorities.
- A means to ensure that employees who report violence do not face reprisals.

5. In order for these protocols to be effective, the management and administration of healthcare facilities should communicate and take the necessary steps to ensure that all staff are aware of the protocols. Managers should be urged to verbalize a no-tolerance policy towards violence in healthcare settings.

6. Patients with acute, chronic or illness-induced mental health disturbances or other underlying medical conditions may act violently toward health personnel; those taking care of these patients must be adequately protected. Except in emergency cases, physicians might have the right to refuse to treat and, in such situations, they must ensure that adequate alternative arrangements are made by the relevant authorities in order to safeguard the patient's health and treatment.

Training/Education

7. A well-trained and vigilant staff supported by management can be a key deterrent of violent acts. Constituent members should work with undergraduate and postgraduate education providers to ensure that health personnel are trained in the following areas: communication skills, empathy as well as recognising and handling potentially violent persons and high-risk situations in order to prevent incidents of violence.

8. Continuous education should include ethical principles of healthcare and the cultivation of the patient-physician relationships based on respect and mutual trust. This not only improves the quality of patient care but also fosters feelings of security resulting in a reduced risk of violence.

Communication and Social Awareness

9. Medical associations, health authorities and other stakeholders should work together to increase awareness of violence in the health sector, creating networks of information and expertise in this area. When appropriate, health personnel and the public should be informed of acts of violence.

10. Broadcasting agencies, newspapers, and other news outlets are encouraged to thoroughly verify their sources in order to keep the information shared to the highest standard of professional reporting. Social media companies and associated stakeholders should also take active steps to create a cyber-violence-free environment for its users. This includes

strengthening policies to protect user data, making reporting and flagging such violence easy and accessible, and engaging law enforcement for proper legal action when warranted.

Security

11. Appropriate security measures should be in place in all healthcare facilities and acts of violence should be given a high priority by law-enforcement authorities. A routine violence risk audit, including a risk assessment, should be implemented in order to identify which jobs and locations are at highest risk for violence, especially in places where violence has already occurred, and to determine weaknesses in facilities' security. Examples of high-risk areas include general practice premises, mental health treatment facilities and high traffic areas of hospitals including the emergency department.

12. The risk of violence may be ameliorated by a variety of means which include placing security personnel in high-risk areas and at the entrance of buildings, the installation of security cameras and alarm devices for use by health personnel, the use distinguishable items to identify the staff and by maintaining sufficient lighting in work areas, contributing to an environment conducive to vigilance and safety. The implementation of a system to screen patients and visitors for weapons upon entering certain areas, especially the high-risk ones, should be considered.

Support to victims

13. Adequate medical, psychological and legal support should be provided to victims of violence. Such support should be free of access for all the health personnel.

Investigation

14. In all cases of violence there should be investigation to better understand the causes and to aid in prevention of future violence. The investigation may lead to prosecution of perpetrators under civil or criminal codes. The procedure should be led by relevant officials in law enforcement and should not expose the victim to further physical or psychological harm.

Data Collection

15. Appropriate reporting systems should be established to enable health personnel to report anonymously and without reprisal, any threats or incidents of violence. Such a system should assess in terms of number, type and severity, incidents of violence within an institution and resulting injuries. The system should be used to analyse the effectiveness of preventative strategies. Aggregated data and analyses should be made available to health professional organizations and other relevant stakeholders.

WMA STATEMENT ON FUNGAL DISEASE DIAGNOSIS AND MANAGEMENT

Adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013

Annual WHO Global Burden of Disease estimates recognize that fungal diseases account for a significant proportion of health problems worldwide. These include cutaneous fungal infections which affect up to a billion persons and vulvovaginal candidiasis which affects tens of millions of women, often multiple times annually.

Even more serious are invasive and chronic fungal diseases that lead to estimated annual morbidity rates that are similar to those caused by commonly recognized global health concerns such as malaria and tuberculosis. In addition to death, these fungal diseases commonly lead to chronic ill health, including blindness with keratitis, respiratory distress *with allergic bronchopulmonary aspergillosis (ABPA)*, severe asthma with fungal sensitisation (SAFS) and chronic pulmonary aspergillosis (CPA), weight loss and nutritional deficiency with oesophageal candidiasis and CPA, and inability to engage in healthy sexual activity with vulvovaginal candidiasis.

Serious fungal diseases are often opportunistic, occurring as a consequence of other conditions that suppress the immune system, such as asthma, AIDS, cancer, post-transplant immunosuppressive drugs and corticosteroid therapies. Some occur in critically ill patients.

Despite the fact that many fungal diseases can be treated relatively simply, in many cases, these diseases go untreated. Fungal infections alone are often not distinctive enough to allow a clinical diagnosis, and as cultures are frequently falsely negative, missed diagnosis is common. In addition, a relatively narrow diagnostic window to cure the patient is frequently missed, resulting in prolonged expensive hospital stays, often with a fatal outcome. Despite the existence of effective medicine to treat fungal infections, these are often not available when and where they are needed.

STATEMENT

The WMA stresses the need to support the diagnosis and management of fungal diseases and urges national governments to ensure that both diagnostic tests and antifungal therapies are available for their populations. Depending on the prevalence of fungal diseases and their underlying conditions, specific antigen testing or microscopy and culture are essential. These tests, and personnel trained to administer and interpret the tests, should be available in all countries where systemic fungal infections occur. This will likely include developing at least one diagnostic centre of excellence with a sufficient staff of trained diagnostic personnel. Monitoring for antifungal toxicities should be available.

Physicians will be the first point of contact for most patients with a fungal infection and should be sufficiently educated about the topic in order to ensure an effective diagnostic approach.

The WMA encourages its members to undertake and support epidemiologic studies on the burden of fungal disease in their country and to inform the national government of the results.

WMA STATEMENT
ON
HUMAN PAPILLOMAVIRUS VACCINATION

Adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013

PREAMBLE

Human papillomavirus (HPV) vaccination presents a unique and valuable opportunity for physicians to substantially prevent morbidity and mortality from certain cancers in all populations, and to improve maternal health. The HPV vaccine therefore merits consideration by the World Medical Association (WMA) separately from other vaccines.

HPV is a sexually transmitted virus and is so common that most sexually active adults become infected at some point in their lives. Most infections are asymptomatic and resolve without medical intervention. However, some of the 40 types of HPV can cause cervical cancer. HPV is the cause of nearly 100% of cervical cancer cases and may also cause cancer of the vagina, vulva, anus, penis and the head and neck. Cervical cancer accounts for more than 10% of all female cancers, and the majority of cervical cancer deaths are in developing countries.

Vaccines can protect against infection by the most common HPV types and afford protection against cancer. The U.S. Advisory Committee on Immunization Practices recommends HPV vaccination for both females and males starting at age 11 years up to age 26 years. Benefits of vaccinating young men include protection against genital warts and cancer in addition to preventing transmission of HPV to sexual partners. The additional protection afforded by the quadrivalent vaccine against genital warts as well as cervical and other cancers should be taken into consideration when developing HPV vaccination programmes. The HPV vaccines are effective; post-marketing studies have shown decreases in HPV prevalence and HPV related disorders such as genital warts and abnormal cervical cytology. Studies concerning the safety of HPV vaccines have been reassuring.

These vaccines should be made widely available and should be promoted by physicians as a matter of individual patient wellbeing and public health.

RECOMMANDATIONS

The WMA urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination and routine cervical cancer screening; and encourages the development and funding of programs to make HPV vaccine available and to provide cervical cancer screening in countries without organized cervical cancer screening programs.

National medical associations (NMAs) are encouraged to carry out intensive education of and advocacy efforts toward their members to:

- Improve awareness and understanding of HPV and associated diseases;
- Understand the availability and efficacy of HPV vaccines;
- Understand the desirability of including HPV vaccines in national immunization programs;
- Understand the need for routine cervical cancer screening; and
- Integrate HPV cancer prevention methods, early detection and screening, diagnosis, treatment and palliative care into existing continuing professional development programs and pre-service training. Such training will leverage existing support for HPV programs and help in capacity building and quality assurance efforts.

NMAs are also encouraged to:

- Integrate HPV vaccination for all adolescents and routine cervical cancer screening for young women into all appropriate health care settings and visits;
- Support the availability of the HPV vaccine and routine cervical cancer screening for appropriate populations that benefit most from preventive measures, including but not limited to at-risk patients such as low-income, disadvantaged and populations that are not yet sexually active;
- Recommend HPV vaccination for all appropriate populations;
- Promote member advocacy for HPV prevention, care and treatment; and
- Create a network of physicians and practitioners who are willing and able to mentor and support one another and establish linkages to existing HPV vaccine and cancer prevention networks.

WMA STATEMENT ON NATURAL VARIATIONS OF HUMAN SEXUALITY

Adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013

PREAMBLE

Healthcare professionals encounter many aspects of human diversity when providing care, including different variations of human sexuality.

A large body of scientific research indicates that homosexuality is a natural variation of human sexuality without any intrinsically harmful health effects.

As a consequence homosexuality was removed from the American Psychiatric Association's official diagnostic manual in 1973. The World Health Organization (WHO) removed it from the ICD in 1990 following a similar process of scientific review. The Pan American Health Organization (WHO) states: *"In none of its individual manifestations does homosexuality constitute a disorder or an illness, and therefore it requires no cure."*

Direct and indirect discrimination, stigmatisation, peer rejection, and bullying continue to have a serious impact upon the psychological and physical health of people with a homosexual or bisexual orientation. These negative experiences lead to higher prevalence rates of depression, anxiety disorders, substance misuse, and suicidal ideations and attempts. The suicide rate among adolescents and young adults with a homosexual or bisexual orientation is, consequently, three times higher than that of their peers.

This can be exacerbated by so-called "conversion" or "reparative" procedures, which claim to be able to convert homosexuality into asexual or heterosexual behaviour and give the impression that homosexuality is a disease. These methods have been rejected by many professional organisations due to a lack of evidence of their effectiveness. They have no medical indication and represent a serious threat to the health and human rights of those so treated.

RECOMMENDATIONS

The WMA strongly asserts that homosexuality does not represent a disease, but rather a natural variation within the range of human sexuality.

The WMA condemns all forms of stigmatisation, criminalisation and discrimination of people based on their sexual orientation.

The WMA calls upon all physicians to classify physical and psychological diseases on the basis of clinically relevant symptoms according to ICD-10 criteria regardless of sexual orientation, and to provide therapy in accordance with internationally recognised treatments and protocols.

The WMA asserts that psychiatric or psychotherapeutic approaches to treatment must not focus upon homosexuality itself, but rather upon conflicts, which arise between homosexuality, and religious, social and internalised norms and prejudices.

The WMA condemns so-called “conversion” or “reparative” methods. These constitute violations of human rights and are unjustifiable practices that should be denounced and subject to sanctions and penalties. It is unethical for physicians to participate during any step of such procedures.

WMA STATEMENT

ON
THE RIGHT OF REHABILITATION OF VICTIMS OF TORTURE

Adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013

PREAMBLE

The World Medical Association notes with grave concern the continued use of torture in many countries throughout the world.

The WMA reaffirms its total condemnation of all form of torture, and other cruel, inhuman or degrading treatment or punishment, as defined by the UN Convention Against Torture (CAT, 1984). Torture is one of the gravest violations of international human rights law and has devastating consequences for victims, their families and society as a whole. Torture causes severe physical and mental injuries and is a crime absolutely prohibited under international law.

The WMA reaffirms its policies adopted previously, namely:

- The Declaration of Tokyo laying down Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (1975)
- The 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 (1997)
- The Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment (2003).

The medical evaluation is an essential factor in pursuing the documentation of torture and the reparation of victims of torture. Physicians have a critical role to play in gathering information about torture, documenting evidence of torture for legal purposes, as well as supporting and rehabilitating victims.

The WMA recognizes the adoption, in December 2012, by the UN Committee Against Torture of the General Comment on the Implementation of article 14 of Convention against Torture relating to the right to reparation of victims of torture.

The General Comment outlines the right of rehabilitation as an obligation on States and specifies the scope of these services. The WMA welcomes in particular:

- The obligation of State parties to adopt a “long-term and integrated approach and

ensure that specialized services for the victim of torture or ill treatment are available, appropriate and promptly accessible" (paragraph 13), without making access to these services dependent on the victim pursuing judicial remedies.

- The recognition of the right of victims to choose a rehabilitation service provider, be it a State institution, or a non-State service provider, which is funded by the State.
- The recognition that State parties should provide torture victims with access to rehabilitation programs as soon as possible following an assessment by qualified independent healthcare professionals.
- The references in paragraph 18 to measures aimed at protecting health and legal professionals who assist torture victims, developing specific training on the Istanbul Protocol for health professionals, and promoting the observance of international standards and codes of conduct by public servants, including medical, psychological and social service personnel.

RECOMMENDATIONS

The WMA emphasizes the vital function of reparation for victims of torture and their families in rebuilding their lives and achieve redress and the important role of physicians in rehabilitation.

The WMA encourages its member associations to work with relevant agencies – governmental and non-governmental – acting for the reparation of victims of torture, in particular in the areas of documentation and rehabilitation, as well as prevention.

The WMA encourages its members to support agencies that are under threat of – or subjected to – reprisals from state parties due to their involvement in the documentation of torture, rehabilitation and reparation of torture victims.

The WMA calls on its members to use their medical experience to support torture victims in accordance with article 14 of the UN Convention against Torture.

The WMA calls on its member associations to support and facilitate data collection at the national level in order to monitor the implementation of the State's obligation to provide rehabilitation services.

WMA STATEMENT
ON
THE UNITED NATIONS RESOLUTION FOR A MORATORIUM ON THE USE OF THE DEATH PENALTY

Adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013

PREAMBLE

The WMA Resolution on Physician Participation in Capital Punishment states that it is unethical for physicians to take part in capital punishment, and the WMA Declaration of Geneva obliges physicians to maintain the utmost respect for human life.

The WMA acknowledges that the views prevalent in the countries of some of its members prevent all members unconditionally opposing the death penalty.

The WMA therefore supports the suspension of the use of the death penalty through a global moratorium.

The WMA has long recognized that it cannot hold its national medical association members responsible for the actions and policies of their respective governments.

RECOMMANDATIONS

The World Medical Association supports United Nations General Assembly Resolution 65/206 calling for a moratorium on the use of the death penalty.

WMA STATEMENT ON AESTHETIC TREATMENT

Adopted by the 65th WMA General Assembly, Durban, South Africa, October 2014

PREAMBLE

Aesthetic treatments have become increasingly common in recent years as society appears to have become more preoccupied with physical appearance. These treatments are performed by practitioners with widely differing clinical and educational backgrounds.

For the purpose of this statement, aesthetic treatment is defined as an intervention that is performed not to treat an injury, a disease or a deformity, but for non-therapeutic reasons, with the sole purpose of enhancing or changing the physical appearance of the individual concerned. In this statement, the individual undergoing treatment is referred to as the patient. The treatments available include a great variety of interventions, ranging from surgical procedures to injections and different kinds of skin treatments. This statement focuses on interventions that are methodologically similar to those performed in conventional health care. Tattooing, scarring and similar interventions are therefore not considered in this statement.

Body image affects a person's self-esteem and mental health and is an integral part of a person's overall health and well-being. However, media images of “perfect bodies” have become the norm, causing some people, to develop unrealistic and unhealthy body images.

Many aesthetic treatments involve risks and may potentially harm the health of the patient. Minors[1] are particularly vulnerable, as their bodies are often not fully developed. In order to protect persons considering or undergoing aesthetic treatment the WMA has developed the following basic principles regarding aesthetic treatments.

Reaffirming the medical ethics principles laid out in the WMA Declaration of Geneva, the WMA Declaration of Lisbon on the Rights of the Patient and the WMA International Code of Medical Ethics, and consistent with the mandate of the WMA, this statement is addressed primarily to physicians. However, the WMA encourages other practitioners performing aesthetic treatments to adopt these principles.

PRINCIPLES

1. The patient´s dignity, integrity and confidentiality must always be respected.

2. Physicians have a role in helping to identify unhealthy body images and to address and treat disorders when these exist.

3. Aesthetic treatments must only be performed by practitioners with sufficient knowledge, skills and experience of the interventions performed.

4. All practitioners providing aesthetic treatments must be registered with and/or licensed by the appropriate regulatory authority. Ideally, the practitioner should also be authorized by this authority to provide these specific aesthetic treatments.

5. All aesthetic treatments must be preceded by a thorough examination of the patient. The practitioner should consider all circumstances, physical and psychological, that may cause an increased risk of harm for the individual patient and should refuse to perform the treatment if the risk is unacceptable. This is especially true in the case of minors. Practitioners should always choose the most appropriate treatment option, rather than the most lucrative one.

6. Minors may need or benefit from plastic medical treatments but pure aesthetic procedures should not be performed on minors. If, in exceptional cases, aesthetic treatment is performed on a minors[1], it should only be done with special care and consideration and only if the aim of the treatment is to avoid negative attention rather than gain positive attention. All relevant medical factors, such as whether the minor is still growing or whether the treatment will need to be repeated at a later date, must be considered.

7. The patient must consent explicitly to any aesthetic treatment, preferably in writing. Before seeking consent the practitioner should inform the patient of all relevant aspects of the treatment, including how the procedure is performed, possible risks and the fact that many of these treatments may be irreversible. The patient should be given sufficient time to consider the information before the treatment starts. Where the patient requesting the treatment is a minor, the informed consent of his or her parents or legally authorized representative should be obtained.

8. All aesthetic treatments performed should be carefully documented by the practitioner. The documentation should include a detailed description of the treatment performed, information on medications used, if any, and all other relevant aspects of the treatment.

9. Aesthetic treatments must only be performed under strictly hygienic and medically safe conditions on premises that are adequately staffed and equipped. This must include equipment for treating life-threatening allergic reactions and other potential complications.

10. Advertising and marketing of aesthetic treatments should be responsible and should not foster unrealistic expectations of treatment results. Unrealistic or altered photographs showing patients before and after treatments must not be used in advertising.

11. Advertising and marketing of aesthetic treatments should never be targeted to minors.

12. Practitioners should never offer or promote financial loans as a means of paying for aesthetic treatment.

[1] For the purpose of this statement minor is defined as a person who, according to applicable national legislation, is not an adult.

WMA STATEMENT
ON
THE PREVENTION OF AIR POLLUTION DUE TO VEHICLE EMISSIONS

Adopted by the 65th WMA General Assembly, Durban, South Africa, October 2014

PREAMBLE

There are a number of ways in which the volume of harmful emissions can be reduced. These include encouraging fewer road traffic journeys, active transport for individuals undertaking relatively short journeys, the use of mass public transit in preference to individual vehicles, and alternative energy sources for vehicles, including electric and hybrid technologies. Where vehicle use is essential, means of reducing harmful emissions should be used.

Physicians around the world are aware of air pollution. It impacts the quality of life for hundreds of millions of people worldwide, causing both, a large burden of disease as well as economic losses and increased health care costs. According to WHO estimates, in 2012, urban outdoor air pollution was responsible for 3.7 million annual deaths, representing 6.7% of the total deaths (WHO, 2014).

Especially, diesel soot is acknowledged as a proven carcinogen (IARC, 07/2012). Furthermore, it has many other toxic effects, most prominently in the cardiovascular (Brook et al., 2010) and respiratory systems (ERS, 2010). Moreover, in the context of global warming, soot, along with methane, is identified as the second most important greenhouse driving force substance after CO2 (Kerr, 2013).

Despite the fact that new vehicles will have to comply with stricter emission standards which take into account most harmful ultra fine particles too, a high-polluting in-use fleet, including off-road vehicles such as construction engines and ships, will continue polluting for many more years.

BACKGROUND

In many densely populated cities around the world, fine dust concentrations measurable as aerosols exceed up to 50 times the maximum WHO recommendation. High volumes of transport, power generated from coal, and pollution caused by construction machinery are among the contributing factors. People living and working near major (high density volume traffic) streets are most affected by pollutants. For fighting the health risks mentioned above, there exist a variety of highly efficient and reliable filter systems on the market (Best Available Technology (BAT) filters[1]). They are applicable to all internal combustion engines and they reduce even most harmful ultra-fine particles by a factor of

over one hundred. As soon as 90% of heavy duty vehicles, both, new and upgraded ones, satisfy this standard, health problems attributable to emissions of heavy duty traffic will be greatly reduced, and no further tightening of emission standards will be possible or even needed at all because of an almost total elimination of the pollutant as such.

In a variety of countries on different continents and under varying conditions retrofit or upgrading programs have been successfully performed. The UN's Working Party on Pollution Prevention and Energy in Geneva has just proposed a technical standard for regulation in their member states, which will be applicable worldwide.

The WMA supports these efforts and calls on policy makers in all countries, especially in urban regions, to introduce regulatory restrictions of access for vehicles without filter, and/or to provide financial assistance to support the retrofitting of in-use vehicles.

RECOMMENDATIONS

The WMA therefore recommends that all NMAs should encourage their respective governments to:

1. Introduce BAT standards for all new diesel vehicles (on road and off-road)

2. Incentivise retrofitting with BAT filters for all in-use engines

3. Monitor and limit the concentration of nanosize soot particles in the urban breathing air

4. Conduct epidemiological studies detecting and differentiating the health effects of ultrafine particles

5. Build professional and public awareness of the importance of diesel soot and the existing methods of eliminating the particles

6. Contribute to developing strategies to protect people from soot particles in aircraft passenger cabins, trains, homes and in the general environment. These strategies should include plans to develop and increase use of public transportation systems.

ABBREVIATIONS:

EPA: Environmental Protection Agency (US)

ERS: European Respiratory Society

IARC: International Agency for Research of Cancer

BAT Standards: Emission standards for passenger cars, heavy-duty vehicles and off-road machinery, based on count of ultrafine particles rather than mass and aimed at the protection of human health from the most hazardous soot particles, the lung and even cell membrane penetrating ultra-fines.

REFERENCES:

- Brook, Robert D. et al. (2010): AHA Scientific Statement: Particulate Matter Air Pollution and Cardiovascular Disease. An Update to the Scientific Statement from the American Heart Association. Circulation 121: 2331-2378.

- ERS (2010): The ERS report on air pollution and public health. European Respiratory Society, Lausanne, Switzerland. ISBN: 978-1-84984-008-8

- IARC (2012): "IARC: Diesel Engine Exhaust Carcinogenic". Press Release No. 213.http://www.iarc.fr/en/media-centre/pr/2012/pdfs/pr213_E.pdf. (access: 14/02/14)

- Kerr, Richard R. (2013): "Soot is Warming the World Even More Than Thought". In: Science 339(6118), p. 382.

- WHO (2014): "Burden of disease from Ambient Air Pollution for 2012." http://www.who.int/phe/health_topics/outdoorair/databases/AAP_BoD_results_March2014.pdf?ua=1 (access: 26/08/14)

[1] Euro 6/VI, US/EPA/CARB, Chinese and equivalent standards.

WMA STATEMENT ON SOLITARY CONFINEMENT

Adopted by the 65th WMA General Assembly, Durban, South Africa, October 2014
and revised by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

PREAMBLE

In many countries, a substantial number of prisoners are held in solitary confinement. Solitary confinement is a form of confinement used in detention settings where individuals are separated from the general detained population and held alone in a separate cell or room for upwards of 22 hours a day. Jurisdictions may use a range of different terms to refer to the process (such as segregation, separation, isolation or removal from association) and the conditions and environment can vary from place to place. However, it may be defined or implemented, solitary confinement is characterised by complete social isolation; a lack of meaningful contact; and reduced activity and environmental stimuli. Some countries have strict provisions on how long and how often prisoners can be kept in solitary confinement, but many countries lack clear rules on this.

Solitary confinement can be distinguished from other brief interventions when individuals must be separated as an immediate response to violent or disruptive behaviour or where a person must be isolated to protect themselves or others. These interventions should take place in a non-solitary confinement environment.

The reasons for the use of solitary confinement vary in different jurisdictions and it can be used at various stages of the criminal justice process. It may be used as a disciplinary measure for the maintenance of order or security; as an administrative measure, for the purposes of investigation or questioning; as a preventive measure against future harm (either to the individual or to others); or it may be the consequence of a restrictive regime that limits contact with others. It can be imposed for hours to days or even years.

Medical impacts of solitary confinement

People react to isolation in different ways. For a significant number of prisoners, solitary confinement has been documented to cause serious psychological, psychiatric, and sometimes physiological effects. These include insomnia, confusion, hallucinations, psychosis, and aggravation of pre-existing health problems. Solitary confinement is also associated with a high rate of suicidal behaviour. Negative health effects can occur after only a few days and may in some cases persist when isolation ends.

Certain populations are particularly vulnerable to the negative health effects of solitary confinement. Persons with psychotic disorders, major depression, or post-traumatic stress

disorder or people with severe personality disorders may find isolation unbearable and suffer considerable health harms. Solitary confinement may complicate treating such individuals and their associated health problems successfully later in the prison environment or when they are released back into the community. Prisoners with physical disabilities or other medical conditions often have their conditions aggravated, not only as a result of the physical conditions of isolation, but also as the particular health requirements linked to their disability or condition are often not accommodated.

For children and young people, who are in the crucial stages of developing socially, psychologically, and neurologically, there are serious risks of solitary confinement causing long-term mental and physical harm. A growing international consensus about the harms of solitary confinement on children and young people has resulted in some jurisdictions abolishing the practice completely.

International norms on solitary confinement

The increasing documentation on the harmful impact of solitary confinement on the health of prisoners led to the development of a range of international norms and recommendations seeking to mitigate the use and the harmful effect of solitary confinement.

The United Nations Standard Minimum Rules for the Treatment of Prisoners (SMR) were first adopted in 1957, and revised in 2015 as the Nelson Mandela Rules unanimously adopted by the United Nations Assembly. The SMR constitute the key international framework for the treatment of prisoners.

Other international standards and recommendations, such as the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Sanctions for Women Offenders (the Bangkok Rules), the United Nations Rules for the Protection of Juveniles Deprived of their Liberty and the observations of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, support and complete the Nelson Mandela Rules.

The misuse of solitary confinement can include indefinite or prolonged solitary confinement (defined as a period of solitary confinement in excess of 15 days), but can also include corporal or collective punishment, the reduction of a prisoner's diet or drinking water, or the placement of a prisoner in a dark or constantly lit cell. Misuse of solitary confinement in these ways can constitute a form of torture or ill-treatment and as such must be prohibited in line with international human rights law and medical ethics.

The WMA and its members reiterate their firm and long-standing position condemning any forms of torture and other cruel, inhuman or degrading treatment or punishment and reaffirm the basic principle that doctors should never participate in or condone torture or other cruel, inhuman or degrading treatment.

RECOMMENDATIONS

1. Given the harmful impact of solitary confinement, which can on occasion result in a form of torture or ill-treatment, the WMA and its members call for the implementation of the Nelson Mandela Rules and other associated international standards and recommendations, with a view to protect the human rights and the dignity of the prisoners.

2. The WMA and its members emphasize in particular the respect of the following principles:

    - In light of the serious consequences solitary confinement can have on physical and mental health (including an increased risk of suicide or self-harm), it should be imposed only in exceptional cases as a last resort and subject to independent review, and for the shortest period of time possible. The authority imposing the solitary confinement must be acting in line with clear rules and regulations as to its use.
    - All decisions on solitary confinement must be transparent and regulated by law. The use of solitary confinement should be time-limited by law. The detainee should be informed of the duration of the isolation, and the period of duration should be determined before the measure takes place. Prisoners subject to solitary confinement should have a right of appeal.
    - Solitary confinement should not exceed a time period of 15 consecutive days. Releasing the prisoner from solitary confinement for a very limited period of time, with the intention that the individual will be placed in solitary confinement immediately again to get around the rules on length of stay must also be prohibited.

Prohibitions of the use of solitary confinement

The indefinite or prolonged solitary confinement should be prohibited as amounting to torture or other cruel, inhuman or degrading treatment or punishment [1].

Solitary confinement should be prohibited for children and young people (as defined by domestic law), pregnant women, women up to six months post-partum, women with infants and breastfeeding mothers as well as for prisoners with mental health problems given that isolation often results in severe exacerbation of pre-existing mental health conditions.

The use of solitary confinement should be prohibited in the case of prisoners with physical disabilities or other medical conditions where their conditions would be exacerbated by such measures.

Where children and young people must be separated, in order to ensure their safety or the safety of others, this should be carried out in a non-solitary confinement setting with adequate resources to meet their needs, including ensuring regular human contact and purposeful activity.

Conditions of solitary confinement

The human dignity of prisoners confined in isolation must always be respected.

Prisoners in isolation should be allowed a reasonable amount of meaningful regular human contact, activity, and environmental stimuli, including daily outside exercise. As with all prisoners, they must not be subjected to extreme physically and/or mentally taxing conditions.

Prisoners who have been in solitary confinement should have an adjustment period, including a medical examination, before they are released from prison. This must never extend their period of incarceration.

Role of physician

The physician's role is to protect, advocate for, and improve prisoners' physical and mental health, not to inflict punishment. Therefore, physicians should never participate in any part of the decision-making process resulting in solitary confinement, which includes declaring an individual as "fit" to withstand solitary confinement or participating in any way in its administration. This does not prevent physicians from carrying out regular visits to those in solitary confinement to assess health and provide care and treatment where necessary, or from raising concerns where they identify a deterioration in an individual's health.

The provision of medical care should take place upon medical need or the request of the prisoner. Physicians should be guaranteed daily access to prisoners in solitary confinement, upon their own initiative. More frequent access should be granted if physicians deem this to be necessary.

Physicians working in prisons must be able to practice with complete clinical independence from the prison administration. In order to maintain that independence, physicians working in prisons should be employed and managed by a body separate from the prison or criminal justice system.

Physicians should only provide drugs or treatment that are medically necessary and should never prescribe drugs or treatment with the intention of enabling a longer period of solitary confinement.

Healthcare should always be provided in a setting that respects the privacy and dignity of prisoners. Physicians working in the prison setting are bound by the sample codes and principles of medical ethics as they would be in any other setting.

Physicians should report any concerns about the impact solitary confinement is having on the health and wellbeing of an individual prisoner to those responsible for reviewing solitary confinement decisions. If necessary, they should make a clear recommendation that the person be removed from solitary confinement, and this recommendation should be respected and acted upon by the prison authorities.

Physicians have a duty to consider the conditions in solitary confinement and to raise concerns with the authorities if they believe that they are unacceptable or might amount to inhumane or degrading treatment. There should be clear mechanisms in place in each system to allow physicians to report such concerns.

Reference

[1] Rule 43 SMR

WMA STATEMENT ON PHYSICIANS WELL-BEING

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

PREAMBLE

Physician well-being refers to the optimization of all factors affecting biological, psychological and social health and preventing or treating acute or chronic diseases experienced by physicians including mental illness, disabilities and injuries resulting from work hazards, occupational stress and burnout.

Physician's well-being could have positive impact on patient care, but more research is needed. The profession should therefore encourage and support on-going research on physician's health. Evidence that already exists should be implemented in policy and practice. While physicians tend to have healthy habits, it is essential to enhance their health as a way to improve health for the whole population.

Physicians and medical students at all career stages are exposed to both positive experiences as well as a variety of stressors and work injuries The medical profession should seek to identify and revise policies and practices that contribute to these stressors and collaborate with NMA's in order to develop policies and practices that have protective effects. Like all human beings, physicians experience illness, and they also have family obligations and other commitments outside their professional lives that should be taken into account.

One reason physicians delay seeking help is their concern about confidentiality and feeling ill at ease in the patient role. They experience feelings of responsibility towards their patients and are sensitive to external expectations on their health. Therefore, physicians must be assured of the same right of confidentiality as any other patient when seeking and undergoing treatment. The health care system may need to provide special arrangements for the care of physician-patients in order to uphold its duty to provide privacy and confidentiality. Prevention, early assistance and intervention should be available separately from any disciplinary process.

THREATS, BARRIERS AND OPPORTUNITIES FOR PHYSICIAN WELL-BEING

Professional Roles and Expectations

The medical profession often attracts highly driven individuals with a strong sense of duty. Successfully completing the long and intense educational requirements often confers

upon physicians a high degree of respect and responsibility in their communities.

With these high levels of respect and responsibility, physicians are subject to high expectations from patients and the public. These expectations can contribute to prioritizing the care of others over care of self and feelings of guilt and selfishness for managing their own well-being.

There is a direct relationship between physicians' and patients' preventive health practices. This relationship should encourage healthcare systems to better support and evaluate the effects on patients of improving physician and medical student health.

Work Environment

Working conditions, including workload and working hours, affect physicians' motivation, job satisfaction, personal life and psychological health during their careers.

Physicians are often perceived as being immune to injury and diseases as they care for their patients, and workplace health and safety programs may be overlooked. Physician who are employed by small organizations or who are self-employed may be at even a higher risk for occupational diseases and may not have access to health and safety programs provided by large health care establishments.

As a consequence of their professional duties, physicians and physicians in postgraduate education often confront emotionally challenging and traumatic situations including patients' suffering, injury and death. Physicians may also be exposed to physical hazards like radiation, noise, poor ergonomics, and biological hazards like HIV, TB and hepatitis.

Some healthcare systems may exacerbate stress because of the hierarchies and competition inherent in them. Physicians in postgraduate education and medical students can be victims of harassment and discrimination during their medical education. Due to their position within the medical hierarchy, they may feel powerless to confront these behaviours.

Physician autonomy is one of the strongest predictors of physician satisfaction. Increasing external regulatory pressures such as undue emphasis on cost efficiencies and concerns about consequences of reporting medical errors may unduly influence medical decision-making and diminish a physician's autonomy.

Illness

Even though medical professionals recognize that it is preferable to identify and treat illness early, physicians are often adept at hiding their own illnesses and may continue to function without seeking help until they become incapable of carrying out their duties. There are many potential obstacles to an ill physician seeking care including: denial, confidentiality issues, aversion to the patient role, practice coverage, fear of disciplinary action, potential loss of practice privileges, loss of performance based payment and the efficiencies of self-care. Because of these obstacles doctors are often reluctant to refer themselves or their colleagues for treatment.

Illnesses can include mental and behavioural health problems, burnout, communication and interpersonal issues, physical and cognitive problems and substance use disorders. These illnesses and problems can overlap and can occur throughout the professional life cycle from basic medical education to retirement. It is important to acknowledge the continuum of physician well-being, ranging from optimal health, to minor illness, to debilitating illness.

Substance abuse may disrupt a physician's personal life and may also significantly affect his or her ability to care for patients. Easy access to medications may contribute to physicians' risk for abuse of recreational drugs and prescription medications. Assistance prior to impairment in the workplace is protective for physicians, their professional credentials and their patients.

Improved wellness promotion, prevention strategies and earlier intervention can help mitigate the severity of mental and physical illnesses and help reduce incidence of suicide in physicians, physicians in postgraduate education and medical students.

RECOMMENDATIONS

The World Medical Association recommends that National Medical Associations (NMAs) recognize and, where possible, actively address the following:

1. In partnership with medical schools and workplaces, NMAs recognize their obligation to provide education at all levels about physician well-being. NMAs should collaboratively promote research to establish best practices that promote physician health and to determine the impact of physician well-being on patient care.

2. Physician well-being should be supported and provided within and outside the workplace. Support may include but is not limited to referral to medical treatment, counselling, support networks, recognized physician health programs, occupational rehabilitation and primary prevention programs including resiliency training, healthy lifestyles and case management.

3. NMA's should recognize the strong and consistent link between physicians' and patients' personal health practices, providing yet another critically important reason for health systems to promote physician health.

4. Physician health programs can help all physicians to proactively help themselves via prevention strategies and can assist physicians who are ill via assessment, referral to treatment and follow-up. Programs and resources to help promote positive psychological health should be available to all physicians. Early identification, intervention and special arrangements for the care of physician-patients should be available to protect the health of physicians. Fostering a supportive and accepting culture is critical to successful early referral and intervention.

5. Physicians at risk for abuse of alcohol or drugs should have access to appropriate

confidential medical treatment and comprehensive professional support. NMAs should promote programs that help physicians re-enter medical practice with appropriate ongoing supervision at the completion of their treatment programs. More research should be conducted to determine best practices in preventing substance abuse among physicians and physicians in postgraduate education.

6. Physicians have the right to working conditions that help limit the risk of burnout and empower them to care for their personal health by balancing their professional medical commitments and their private lives and responsibilities. Optimal working conditions include a safe and reasonable maximum number of consecutive and total working hours, adequate rest between shifts and appropriate number of non-working days. Relevant organizations should constructively address professional autonomy and work-life balance problems and involve physicians in making decisions about their work lives. Working conditions must not put the safety of patients or physicians at risk, and ultimately physicians should be engaged in establishing optimal workplace conditions.

7. Workplaces should promote conditions conducive to healthy lifestyles, including access to healthy food choices, exercise, nutrition counselling and support for smoking cessation.

8. Physicians, physicians in postgraduate education and medical students have the right to work in a harassment and violence-free workplace. This includes freedom from verbal, sexual and physical abuse.

9. Physicians, physicians in postgraduate education and medical students have the right to a collaborative safe workplace. Workplaces should promote interdisciplinary teamwork, and communication between physicians and all other professionals in the workplace should be offered in a spirit of cooperation and respect. Education on communications skills, self-awareness and team-work should be considered.

10. Medical staff should undergo training in recognizing, handling and communicating with potentially violent persons. Health care facilities should safeguard against violence including routine violence risk audits, especially in mental health treatment facilities and emergency departments. Staff members who are victims of violence or who report violence should be supported by management and offered medical, psychological and legal counselling.

11. Medical schools and teaching hospitals should develop and maintain confidential services for physicians in postgraduate education and medical students and to raise awareness of and access to such programs. Workplaces should consider offering medical consultations to physicians in postgraduate education in order to identify any health issues at the outset of medical education.

12. Workplace support for all physicians should be easily accessible and confidential. Physicians evaluating and treating their medical colleagues should not be required to report any aspects of their physician-patients' care in any manner not required for their non-physician patients.

WMA STATEMENT
ON
SUPPORTING HEALTH SUPPORT TO STREET CHILDREN

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

PREAMBLE

The WMA recognises that having children in living on the streets is unacceptable in a society even though this phenomenon is difficult to avoid in many communities around the world.

The WMA intends to raise awareness within civil and medical society about the fundamental role played by medical contact in improving the situation of street children. In this regard, it is important that the initial contact with street children be based on trust. Therefore, together with other healthcare professionals and social workers, medical contact should be viewed as the first step towards resocialising street children by building trust between the physician and the street child. Once achieved, a more global multidisciplinary and multidimensional approach can follow to improve the well-being of street children.

Childhood and adolescence are the beginnings of a long physical, mental, cultural and social growth process;

The health of young people shapes the health of tomorrow's population;

Young people play a part in social cohesion and they are an asset to any country;

Addressing the social determinants of health is essential to achieving equity in healthcare. The social determinants leading to the appearance and growth of the phenomenon of "street children" are varied and complex;

The negative health impact of living on the streets for children, both in terms of the additional health risks to which these children are exposed and their lack of access to healthcare and prevention; street children are, in particular, more vulnerable to acute illnesses and traumatic injuries. In addition, preventive care and continuity of care are non-existent for street children due to frequent relocation;

The health of street children remains critical and has been exacerbated by the global financial and economic crisis, which has contributed to family break-ups, social upheaval and disruptions in healthcare and education;

Children may be victims of discrimination arising from their gender, ethnic origin,

language, religion, political opinion, handicap, social status or population migration; Street children are especially vulnerable to abuse, violence, exploitation and manipulation, including trafficking;

Child homelessness often goes unrecognised at a national and international level since it is difficult to quantify and assess.

RECOMMENDATIONS

- The WMA strongly condemns any violations of the rights of children living on the streets and any infringements of these rights, in particular discrimination and stigmatisation and their exposure to abuse, violence, exploitation and manipulation, including trafficking.

- The WMA calls upon governments to address the factors, which lead to children living on the streets and to take action to implement all applicable legislation and systems of protection to reduce the health implications for street children. National authorities have an obligation to provide care for all children and, where necessary, to support their return to a living environment appropriate for a child.

- Reducing health implications includes not only direct treatment of health issues but also protection of Street Children from health risks such as exposure to drugs, HIV infection, smoking and drinking.

- The WMA calls upon governments, national medical associations and healthcare professionals to acknowledge the scale of this phenomenon and to instigate prevention and awareness campaigns. These children must be able to access the full range of necessary health and social protection.

- The WMA urges all national medical associations to work with legal counterparts, governments, health care professionals and public authorities to ensure the fundamental rights of children, who are a particularly vulnerable population in need of protection, particularly access to healthcare and education. The right to food and housing should be guaranteed, and any form of discrimination or exploitation should be forbidden.

- The WMA condemns any improper age-assessment practices that make use of insufficiently reliable clinical or paraclinical investigations. Until they reach adulthood, adolescents must be able to enjoy their status as minors, as recognised by the UN International Convention on the Rights of the Child.

- The WMA urges physicians to remain vigilant in terms of delivering all the support required to provide suitable and comprehensive care for 'street children'. Physicians should be aware that homelessness is a pervasive problem. They should be knowledgeable about the existence of homelessness in their own communities and are encouraged to establish a relationship of trust between the physician and the street child to become involved in local relief and advocacy programs.

- The WMA maintains that every effort should be made to provide all children, and particularly those that are homeless, with access to a suitable and balanced psycho-social environment, in which their rights, including the right to health, are respected.

WMA STATEMENT ON RIOT CONTROL AGENTS

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

PREAMBLE

There has been a long-standing concern regarding the use of chemical weapons. Despite this concern, poison gas was used fairly extensively during World War I, leading to a call from the International Committee of the Red Cross (ICRC) in February 1918 for cessation of its use.

This led to the Geneva Protocol of 1925, the Biological and Toxin Weapons Convention of 1972 (BTWC) and the Chemical Weapons Convention of 1993 (CWC).

All but six countries in the world have signed and ratified the CWC; two more have signed but not yet ratified, making it a nearly universally accepted Convention.

The conventions prohibit the development, production and stockpiling of chemical weapons in addition to their usage in warfare and call for measures to decommission or destroy existing stores. However, the CWC allows the use of specific chemicals in domestic law enforcement including riot control situations, which means that governments might hold stockpiles of certain agents. Even so, riot control agents cannot be used in warfare; the exclusion has reached the status of customary law, which allows their use only in domestic or national jurisdictions.

Although there is academic and military interest in what is often called non-lethal weapons, the incidence of morbidity and mortality caused by weapons are not criteria used in prohibition. A tiered approach based upon degrees of lethality of specific weapons is contrary to the ethos of both conventions.

In situations of widespread public unrest and political or other uprisings governments unfortunately may choose to deploy riot control agents in a domestic setting. Although this is not in conflict with the principles of the CWC their use may still give rise to specific medical, legal and ethical challenges.

While riot control agents are designed to make remaining within the riot unpleasant and impractical, they are not expected to directly cause any injuries or deaths. As with all other agents, how they are used determines the concentration to which individuals are exposed. The ability to take evasive actions, such as leaving the area, to reduce exposure may also have an impact. It is recognised that individual determinants including general health and age will affect an individual's response to chemical agent.

Release of chemical agents such as tear gas in a small enclosed space exposes individuals to concentrations far higher than those expected in normal deployment in riot situations, causing higher levels of serious morbidity and potentially death.

Misuse of riot control agents, leading to serious harms or deaths of demonstrators, exposing individuals excessively or using them for oppressing non-violent peaceful demonstrations, may lead to a breach of the human rights of the individuals concerned, in particular the right to life (article 3), the right to freedom of expression (article 19) and of peaceful assembly (article 20) of the Universal Declaration of Human Rights.

Governments, who authorize the stockpiling and use of such agents by their police and security forces, are urged to consider that there might be fatal results of their usage. Governments are required to ensure that they are used in a manner, which minimise their likelihood of causing serious morbidity and mortality.

RECOMMENDATION

The WMA recognises that the inappropriate use of riot control agents risks the lives of those targeted and exposes people around, amounting to a potential breach of human rights standards, in particular the right to life, the right to freedom of expression and of peaceful assembly as stated in the Universal Declaration of Human Rights.

In case of use of riot control agents, the WMA urges States to do so in a manner designed to minimise the risk of serious harm to individuals, and to prohibit its use in the presence of vulnerable populations, such as children, older people or pregnant women;

The WMA insists that riot control agents should never be used in enclosed spaces where chemical concentrations may reach dangerous levels, and where people cannot move away from areas with high concentrations of the agent;

The WMA insists that governments train police and other security forces in the safe and legal use of riot control agents, in order to minimise the risk of harm when they are deployed. This must include the rapid evacuation of any individual who is apparently suffering from a high level of exposure, not aiming people, and not using the agent excessively;

The WMA insists that States penalise individuals who misuse riot control agents and who deliberately endanger human life and safety by using the agents. Such misuse leading to serious physical harms or death of individuals should be investigated by independent experts.

The WMA calls for unimpeded and protected access of healthcare personnel to allow them to fulfil their duty of attending to the injured as set forth in the “WMA Declaration on the protection of healthcare workers in situations of violence”.

The WMA recommends that, because of the significant difficulties and risks to health and life associated with the use of such riot control agents, States should refrain from using them in any circumstances.

WMA STATEMENT ON TRANSGENDER PEOPLE

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

PREAMBLE

In most cultures, an individual's sex is assigned at birth according to primary physical sex characteristics. Individuals are expected to identify with their assigned sex (gender identity) and behave according to specific cultural norms strongly associated with this (gender expression). Gender identity and gender expression make up the concept of "gender" itself.

There are individuals who experience different manifestations of gender that do not conform to those typically associated with their sex assigned at birth. The term "transgender" refers to people who experience gender incongruence, which is defined as a marked mismatch between one's gender and the sex assigned at birth.

While conceding that this is a complex ethical issue, the WMA would like to acknowledge the crucial role played by physicians in advising and consulting with transgender people and their families about desired treatments. The WMA intends this statement to serve as a guideline for patient-physician relations and to foster better training to enable physicians to increase their knowledge and sensitivity toward transgender people and the unique health issues they face.

Along the transgender spectrum, there are people who, despite having a distinct anatomically identifiable sex, seek to change their primary and secondary sex characteristics and gender role completely in order to live as a member of the opposite sex (transsexual). Others choose to identify their gender as falling outside the sex/gender binary of either male or female (genderqueer). The generic term "transgender" represents an attempt to describe these groups without stigmatisation or pathological characterisation. It is also used as a term of positive self-identification. This statement does not explicitly address individuals who solely dress in a style or manner traditionally associated with the opposite sex (e.g. transvestites) or individuals who are born with physical aspects of both sexes, with many variations (intersex). However, there are transvestites and intersex individuals who identify as transgender. Being transvestite or intersex does not exclude an individual from being transgender. Finally, it is important to point out that transgender relates to gender identity, and must be considered independently from an individual's sexual orientation.

Although being transgender does not in itself imply any mental impairment, transgender people may require counseling to help them understand their gender

and to address the complex social and relational issues that are affected by it. The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-5) uses the term "gender dysphoria" to classify people who experience clinically significant distress resulting from gender incongruence.

Evidence suggests that treatment with sex hormones or surgical interventions can be beneficial to people with pronounced and long-lasting gender dysphoria who seek gender transition. However, transgender people are often denied access to appropriate and affordable transgender healthcare (e.g. sex hormones, surgeries, mental healthcare) due to, among other things, the policies of health insurers and national social security benefit schemes, or to a lack of relevant clinical and cultural competence among healthcare providers. Transgender persons may be more likely to forego healthcare due to fear of discrimination.

Transgender people are often professionally and socially disadvantaged, and experience direct and indirect discrimination, as well as physical violence. In addition to being denied equal civil rights, anti-discrimination legislation, which protects other minority groups, may not extend to transgender people. Experiencing disadvantage and discrimination may have a negative impact upon physical and mental health.

RECOMMENDATION

- The WMA emphasises that everyone has the right to determine one's own gender and recognises the diversity of possibilities in this respect. The WMA calls for physicians to uphold each individual's right to self-identification with regards to gender.

- The WMA asserts that gender incongruence is not in itself a mental disorder; however it can lead to discomfort or distress, which is referred to as gender dysphoria (DSM-5).

- The WMA affirms that, in general, any health-related procedure or treatment related to an individual's transgender status, e.g. surgical interventions, hormone therapy or psychotherapy, requires the freely given informed and explicit consent of the patient.

- The WMA urges that every effort be made to make individualised, multi-professional, interdisciplinary and affordable transgender healthcare (including speech therapy, hormonal treatment, surgical interventions and mental healthcare) available to all people who experience gender incongruence in order to reduce or to prevent pronounced gender dysphoria.

- The WMA explicitly rejects any form of coercive treatment or forced behaviour modification. Transgender healthcare aims to enable transgender people to have the best possible quality of life. National Medical Associations should take action to identify and combat barriers to care.

- The WMA calls for the provision of appropriate expert training for physicians at

all stages of their career to enable them to recognise and avoid discriminatory practises, and to provide appropriate and sensitive transgender healthcare.

- The WMA condemns all forms of discrimination, stigmatisation and violence against transgender people and calls for appropriate legal measures to protect their equal civil rights. As role models, individual physicians should use their medical knowledge to combat prejudice in this respect.

- The WMA reaffirms its position that no person, regardless of gender, ethnicity, socio-economic status, medical condition or disability, should be subjected to forced or coerced permanent sterilisation (WMA Statement on Forced and Coerced Sterilisation). This also includes sterilisation as a condition for rectifying the recorded sex on official documents following gender reassignment.

- The WMA recommends that national governments maintain continued interest in the healthcare rights of transgender people by conducting health services research at the national level and using these results in the development of health and medical policies. The objective should be a responsive healthcare system that works with each transgender person to identify the best treatment options for that individual.

WMA STATEMENT
ON
VITAMIN D INSUFFICIENCY

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

PREAMBLE

Vitamin D has major role in calcium and bone metabolism. Normal values are 75-100 nmol/L (30-40 ng/ml). Vitamin D deficiency is defined if serum hydroxyvitamin D levels are less than 50nmol/L (20 ng/ml), insufficiency as 50-75 nmol/L (20-30 ng/ml).

Studies demonstrate that vitamin D is essential also for overall health and well-being. In the body vitamin D is produced during exposure to sunlight and in lesser degree by food intake.

Vitamin D exists in two forms: vitamin D3 (cholecalciferol in humans and other mammals) and vitamin D2(ergocalciferol in plants), but both are similarly metabolized. Vitamin D3 is more active than vitamin D2.

The serum concentration of the hepatic metabolite of vitamin D3, the 25-hydroxyvitamin D, is consideredas the best biomarker of vitamin D status.

Vitamin D deficiency is an important health issue globally. About one third of the population is estimated to have lower serum concentration of vitamin D.

Many studies have shown that vitamin D deficiency is linked to impaired growth and development. Because vitamin D receptors are broadly distributed in tissues, vitamin D deficiency is associated with musculoskeletal disorders (osteoporosis), falls, fractures, autoimmune disorders, chronic inflammatory diseases, type 2 diabetes mellitus, and cardiovascular, neurologic and psychiatric disorders. High risk groups are young children, the elderly and pregnant women. Primary factors, contributing to vitamin D deficiency, include reduced sunshine exposure, poor quality diet, availability of fortified foods and supplement use.

RECOMMANDATIONS

Because of widespread occurrence of vitamin D deficiency/insufficiency it is desirable to focus attention on adequate preventive actions in populations at risk. Determining vitamin D levels requires only a blood test, and oral supplementation is a simple treatment method. Sun exposure is not generally recommended because it can increase the risk of skin cancer.

The World Medical Association recommends that national medical associations:

- Support continued research in vitamin D and its metabolites
- Educate physicians about the evolving science of vitamin D and its impact on health (documents, brochures, posters)
- Encourage physicians to consider measuring the serum concentrations of 25-hydroxyvitamin D in the patients at risk of vitamin D deficiency
- Monitor development of dietary recommendations for vitamin D.

WMA GUIDELINES ON PROMOTIONAL MASS MEDIA APPEARANCES BY PHYSICIANS

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

PREAMBLE

Mass media can effectively play diverse roles in medical communication. Physicians, as professionals and experts can contribute to improved public health by providing the public with accurate health related information. Mass media provides a channel through which physicians may contribute to society by leveraging mass media appearances in positive ways.

However, the increase in instances of physicians' frequent appearances on mass media to recommend unproven treatments or products and to use such appearances for marketing purposes is posing a serious concern. The public may readily accept groundless recommendations by physicians and may develop unrealistic expectations. The subsequent confusion and disappointment can damage the patient-physician-relationship.

This issue is more serious in some countries where there are different systems of medicine, including alternative medicine.

RECOMMANDATIONS

The WMA recommends the following guidelines regarding mass media appearances by physicians to prevent them from being involved in commercial activities that may compromise professional ethics and to contribute to patient safety by ensuring physicians providing accurate, timely, and objective information.

Accurate and Objective Delivery of Scientifically Proven Medical Information

When appearing in media, physicians shall provide objective and evidence-based information and shall not recommend medical procedures or products that are not medically proven or justified.

A physician shall not use expressions that may promote unrealistic patient expectations or mislead viewers about the function and effect of medical procedures, drugs or other products.

Physicians shall include important information including possible adverse effects and risks when explaining medical procedures, drugs, or other products.

Not Abusing Mass Media as a Means of Advertisement

Physicians should not recommend specific products by either specifically introducing or intentionally highlighting the name or trademark of a product.

Physicians shall practice prudence regarding personal appearances on home shopping programs.. The physician should have no financial stake in the products being sold.

Physicians shall not be a part of mass media advertisement on any product, which is harmful to human, and/or environment.

Maintaining Professional Integrity

Physicians shall not require or receive economic benefits for mass media appearances other than a customary appearance fee.

Physicians shall not provide economic benefits to broadcasting personnel in order to secure mass media appearances.

Physicians shall not engage in the promotion, sale or advertising of commercial products and shall not introduce false or exaggerated statements regarding their qualifications such as academic background, professional experience, medical specialty and licensure as a specialist, for the benefit of the economic interests of any commercial entity.

WMA STATEMENT
ON
TRADE AGREEMENTS AND PUBLIC HEALTH

Adopted by the 200th WMA Council Session, Oslo, April 2015
and amended by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

PREAMBLE

Trade agreements are treaties between two or more countries which include provisions addressing trade in goods and/or services. Trade agreements are tools of globalization and typically seek to promote global wealth through trade liberalization. They can have significant implications for the social, commercial, political and ecological determinants of health as well as the delivery of health care.

International trade contributes significantly to increases in national wealth which is a key factor in building strong health care systems.

While trade agreements are designed to produce economic benefits and global wealth, it is fundamental to identify public health implications that may arise from these agreements.

Negotiations should take into account broad impact to ensure that the right to health and to a healthy natural and social environment are well-prioritized. Trade agreements should be directed at contributing to global health and equity.

Trade agreements may have the ability to promote the health and wellbeing of all people when they are well-designed to protect health and preserve the ability of governments to legislate, regulate and plan for health promotion, health care delivery and health equity.

Recent trade agreement negotiations have sought to establish a new global governance framework for trade and have been unprecedented in their size, scope and secrecy. A lack of transparency and the selective sharing of information with a limited set of stakeholders are anti-democratic.

There must be recognition of the importance of innovation sharing in public health. This is particularly important during health emergencies. Access to medicines and medical supplies is essential to address the major public health problems such as pandemics and trade agreements must not act as a barrier to that access.

Investor-state dispute settlement (ISDS) provides a mechanism for investors to bring claims against governments and seek compensation, operating outside existing systems of accountability and transparency. ISDS in existing trade agreements has been used to challenge evidence-based public health measures including tobacco plain packaging. Inclusion of a broad ISDS mechanism could threaten public health actions designed to support evidence-based tobacco control, alcohol control, healthy and safe food consumption including regulation of obesogenic foods and beverages, access to medicines, health care services, environmental protection/climate change and occupational / environmental health protections. Efforts by industry to challenge domestic public health laws and regulation have targeted nations with limited access to legal resources and some of the world's most vulnerable populations.

Access to affordable medicines is critical to controlling the global burdens of communicable and non-communicable diseases. The World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) established a set of common international rules governing the protection of intellectual property including the patenting of pharmaceuticals. TRIPS safeguards and flexibilities including compulsory licensing seek to ensure that patent protection does not supersede public health.

The WMA Statement on Patenting Medical Procedures states that patenting of diagnostic, therapeutic and surgical techniques is unethical and "poses serious risks to the effective practice of medicine by potentially limiting the availability of new procedures to patients."

Trade agreements should not pose a new difficulty in accessing medicines, especially for developing countries and for the most vulnerable populations.

There must be a fair balance established between the prices of medicines and the protection of intellectual property through patents.

The WMA considers that patenting on medicines/vaccines must be regulated in accordance with the ethical principles and values of the medical profession in order to ensure effective and global action for public health and therefore recognizes that it may be necessary to temporarily waive patents in times of public health emergencies. Moreover, to produce fast and comprehensive results, sustainable solutions for patent issues must be supplemented by the transfer of technology, knowledge, and manufacturing expertise, global investment in manufacturing sites, training of personnel, and quality control.

The WMA Resolution on Medical Workforce states that the WMA has recognized the need for investment in medical education and has called on governments to "…allocate sufficient financial resources for the education, training, development, recruitment and retention of physicians to meet the medical needs of the entire population…"

The WMA Declaration of Delhi on Health and Climate Change states that global climate change has had and will continue to have serious consequences for health and demands comprehensive action.

The WMA Declaration on Fair Trade in Medical Products and Devices states that purchasing policies for medical goods should be fair and ethical, working conditions should be safe and modern slavery should be eradicated throughout supply chains. Health product manufacturers should establish a plan for continuity of supply of vital and life-sustaining products to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies.

RECOMMENDATIONS

Therefore, the WMA calls on national governments and constituent member associations to:

1. Call for transparency and openness in all trade agreement negotiations including public access to negotiating texts and meaningful opportunities for stakeholder engagement.

2. Call for a proactive assessment of anticipated effects on health, human rights, and the environment for all trade agreements.

3. Advocate for trade agreements that protect, promote and prioritize public health over commercial or political interests, and secure services in the public interest, especially those affecting individual and public health. This should include new modalities of health care provision including eHealth.

4. Ensure that trade agreements do not have negative impacts on health systems, human resources for health and universal health coverage (UHC). Ensure trade agreements do not interfere with governments' ability to protect and regulate health and health care, or to guarantee a right to health for all. Government action to protect and promote health should not be subject to challenge through an investor-state dispute settlement (ISDS) or similar mechanism.

5. Work to ensure that patents on medicines and vaccines are regulated in accordance with the principles of medical ethics, in order to protect public health in global emergency situations.

6. Therefore, urge NMAs to promote the possibility of temporarily waiving patents on medicines and vaccines to protect public health in global emergency situations while ensuring fair compensation for the intellectual property of the patent holders, global investment in manufacturing sites, and knowledge transfer. Promote public health, equity, solidarity and social justice and protect countries and people who are weaker economically and health-wise, and therefore most vulnerable.

7. Oppose any trade agreement provisions which would compromise access to health care services or medicines including but not limited to:
    - Patenting (or patent enforcement) of diagnostic, therapeutic and surgical techniques;
    - "Evergreening", or patent protection for minor modifications of existing drugs;
    - Patent linkage or other patent term adjustments that serve as a barrier to generic entry into the market;
    - Data exclusivity for biologics;
    - Any effort to undermine TRIPS safeguards or restrict TRIPS flexibilities including compulsory licensing;
    - Limits on clinical trial data transparency.
8. Oppose any trade agreement provision which would reduce public support for or facilitate commercialization of medical education.
9. Oppose any trade agreement which would facilitate the inappropriate privatization of public services in areas such as conservation of natural environment, education, healthcare, and daily necessities such as energy and water.
10. Ensure that trade agreements promote environmental protection and support efforts to reduce activities that cause climate change.
11. Ensure that trade agreements promote equity and human rights and include mechanisms for accountability following implementation.

WMA STATEMENT ON AGEING

Adopted by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

The world is undergoing a longevity extension at an unprecedentedly rapid pace. Over the last century, some 30 years have been added to global average Life Expectancy at Birth (LEB) – with more gains expected in the future. By 2050, LEB is projected to reach 74 years with an ever-increasing number of countries reaching 80 years and beyond. In 1950 the total number of people aged 80+ was 14 million – by 2050 the estimated number is 384 million, a 26-fold increase. The proportion of elderly will more than double from 10% in 2015 to 22% of the total population in 2050. These improvements are very variable; many of the poorest communities in all countries and a larger percentage of the population in the poorest countries have gained little in terms of life expectancy over this period of time.

The increase in longevity has been paired with a decreasing number of children, adolescents and younger adults as more and more countries experience Total Fertility Rates below replacement level, raising the average age in these countries.

The challenges of aging in developing countries are complicated by the fact that basic infrastructure is not always in place. In some cases, populations in developing countries are aging more quickly than infrastructure is being developed.

Longevity is arguably the greatest societal achievement of the 20th century but it could turn into a major problem during the 21st century. The World Health Organization (WHO) defines Active Ageing as "the process of optimizing opportunities for Health, Lifelong learning, Participation and Security in order of enhancing quality of life as individuals age". This definition presupposes a life course perspective as the determinants that influence active ageing operates throughout the life course of an individual. These are social determinants of health and include behavioral determinants (life-styles), personal determinants (not only hereditary factors which are, overall, responsible for no more than 25% of the chances of ageing well but also psychological characteristics), the physical environment where one lives as well as broad social and economic determinants. All of these act individually on the prospects of active ageing but also interact among themselves: the more they interact and overlap, the higher the chance of an individual ageing actively. Gender and culture are crosscutting determinants, influencing all the others.

GENERAL PRINCIPLES

Medical Expenses

There is strong evidence that chronic diseases increase the use (and costs) of health services rather than age per se.

However, chronic conditions and disabilities become more prevalent with advancing age – therefore health care use and spending rise in tandem with age.

In many countries health care spending for older persons has increased over the years as more interventions and new technologies have become available for problems common in older age.

Effect of Ageing on Health Systems

Health care systems face two major challenges in the longevity revolution: preventing chronic disease and disability and delivering high quality and cost-effective care that is appropriate for individuals regardless of age.

In less developed regions the disease burden in old age is higher than in more developed regions.

Special Health Care Considerations

The leading diseases contributing to disability in all regions are cardiovascular diseases, cancers, chronic respiratory diseases, musculoskeletal disorders, and neurological and mental diseases, including the dementias. Some common conditions in older age are especially disabling and require early detection and management.

Chronic diseases common among older people include diseases preventable through healthy behaviors and/or lifestyle interventions and effective preventive health services – typically cardiovascular disease, diabetes, chronic obstructive pulmonary disease and many types of cancer. Other diseases are more closely linked to ageing processes and are not understood well enough to prevent them – such as dementia, depression and some musculoskeletal and neurological disorders.

While research may eventually lead to effective disability prevention or treatment, early management is key to controlling disability and/or maintaining quality of life.

Older persons may be more vulnerable to the effects of accidents within and outside the home. This will include risks when operating machinery such as road vehicles, but also risks from handling other potentially dangerous equipment. As older people continue to work these risks must be assessed and managed. Those who suffer injuries may have their recovery complicated by other medical vulnerabilities and comorbidities.

Considerations for Health Care Professionals

Health care for elderly people usually requires a variety of professionals working as an articulated team.

Education and training of health professionals to treat and manage the conditions common in the elderly are generally not sufficiently emphasized in undergraduate curricula.

Reducing Impact on Health Care

A comprehensive continuum of health services needs to be adopted urgently as population age. It should include health promotion, disease prevention, curative treatments, rehabilitation, management and prevention of decline, and palliative care.

Different types of health care providers offer these services, from self and family/informal care – sometimes in a voluntary capacity – to community-based providers and institutions.

Establishing Optimal Health Care Systems

Universal Health Care coverage ideally should be provided to all, including elderly people.

The vast majority of health problems can and should be dealt with at the community level. In order to provide optimal community care and ensure care coordination over time it is critical to strengthen Primary Health Care (PHC) services.

In order to strengthen PHC to promote active ageing, WHO advanced evidence-based principles for age-friendly PHC in three areas which should be considered: information/education/communication/ training, health management systems and the physical environment.

The health sector should encourage health systems to support all such dimensions of care provided to individuals as they age given the importance of health to ensure quality of life.

Specificities of Health Care

Many formal systems of health care have been developed with an emphasis on “acute or catastrophic care” of a much younger population, often focused on communicable diseases and/or injuries. Health systems should emphasize other needs, especially chronic diseases management and cognitive decline, when treating the elderly.

While acute care services are essential for people of all ages, but they are not focused on keeping people healthy or providing the ongoing support and care required to manage chronic conditions. A paradigm shift is needed to avoid treating chronic diseases as if they were acute conditions.

Medical conditions in older age often occur simultaneously with social problems and both

need to be considered by health professionals when providing health care. Doctors, particularly specialists, should bear in mind that elderly patients may have other concurrent chronic diseases or comorbidities that interact with each other and that their treatment should not lead to inadvertent and preventable induction of complications.

When initiating a pharmacologic treatment for chronic disease in an elderly patient, prescribers should generally start low (doses) and go slow (increasing the doses) to accommodate the specific needs of the patient.

If the patient cannot decide for him/herself, due to the high prevalence of memory and cognitive problems in old age, physicians treating elderly patients should actively communicate with the family, and frequently with the formal caretaker, to better educate them about the patient's health condition and about medication administration, in order to avoid complications.

When considering different therapeutic options, physicians should always seek to find out the wishes of the patient and recognize that for some patients quality of life will be more important than the potential results of more aggressive treatment options.

Education and Training for Physicians

All physicians should be appropriately trained to diagnose and treat the health problems of older people, which means mainstreaming ageing in the medical curriculum.

Secondary health care for the elderly should be provided as necessary. It should be holistic, including taking into consideration psychosocial as well as environmental aspects. Physicians should also be aware of the risks of elder abuse and measures to be taken when abuse is identified or suspected. (See the WMA Declaration of Hong Kong on the Abuse of the Elderly.)

Every doctor, particularly general practitioners, should have access to information and undergo training to identify and prevent polypharmacy and adverse drugs interactions that may be more common in elderly patients.

Continuing medical education on topics relevant to the ageing patient should be emphasized in order to help physicians adequately diagnose, treat, and manage the complexities of caring for an ageing population.

WMA STATEMENT
ON
CYBER-ATTACKS ON HEALTH AND OTHER CRITICAL INFRASTRUCTURE

Adopted by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

1. Advancements in modern information technology (IT) pave the way for improvements in healthcare delivery and help streamline physician workflow, from medical record keeping to patient care. At the same time, implementing new and more sophisticated IT infrastructure is not without its challenges and risks, including cyber-attacks and data breaches.

2. Cyber security threats are an unfortunate reality in an age of digital information and communication. Attacks on critical infrastructure and vital assets of public interest, including those used in the fields of energy, food and water supply, telecommunications, transportation and healthcare, are on the rise and pose a serious threat to the health and well-being of the general public.

3. With the proliferation of electronic medical records and billing systems, the healthcare sector is especially susceptible to cyber intrusions and has become a prime soft target for cyber criminals. Healthcare institutions and business partners, from the smallest of private practices to the largest of hospitals, are vulnerable not only to the theft, alteration and manipulation of patients' electronic medical and financial records, but also to increasingly sophisticated system breaches that could jeopardise their ability to provide care for patients and respond to health emergencies. Especially disconcerting is the threat posed to a patient's fundamental right to data privacy and safety. In addition, repairing the damage caused by successful cyber-attacks can entail significant costs.

4. Patient data also demands protection because it often contains sensitive personal information that can be used by criminals to access bank accounts, steal identities, or obtain prescriptions illegally. For this reason, it is worth far more on the black market than credit card information alone. Alterations to or abuse of patient data in the case of a breach can be detrimental to the health, safety and material situation of patients. In some cases, breaches can even have life-threatening consequences.

5. Current security procedures and strategies in the healthcare sector have generally not kept pace with the volume and magnitude of cyber-attacks. If not adequately protected, hospital information systems, practice management systems or control systems for medical devices can become gateways for cybercriminals. Radiology imaging software, video conferencing systems, surveillance cameras, mobile

devices, printers, routers and digital video systems used for online health monitoring and remote procedures are just some of the many IT structures at risk of being compromised.

6. Despite this danger, many healthcare organisations and institutions lack the financial resources (or the will to provide them) and the administrative or technical skills and personnel required to detect and prevent cyber-attacks. They may also fail to adequately communicate the seriousness of cyber threats both internally and to patients and external business partners.

RECOMMENDATIONS

- The WMA recognises that cyber-attacks on healthcare systems and other critical infrastructure represent a cross-border issue and a threat to public health. It therefore calls upon governments, policy makers and operators of health and other vital infrastructure throughout the world to work with the competent authorities for cyber security in their respective countries and to collaborate internationally in order to anticipate and defend against such attacks.

- The WMA urges national medical associations to raise awareness among their members, health care institutions and other industry stakeholders about the threat of cyber-attacks and to support an effective, consistent healthcare IT strategy to protect sensitive medical data and to assure patient privacy and safety.

- The WMA underscores the heightened risk of cyber intrusions and other data breaches faced by the healthcare sector and urges medical institutions to implement and maintain comprehensive systems for preventing security breaches, including but not limited to providing training to ensure employee compliance with optimal data handling practices and to maintain security of computing devices.

- In the event of a data security breach, healthcare institutions should have proven response systems in place, including but not limited to notifying and offering protection services to victims and implementing processes to correct errors in medical records that result from malicious use of stolen data. Data breach insurance policies could be considered as a precautionary measure for defraying the costs associated with a potential cyber intrusion.

- The WMA calls upon physicians, as guardians of patient safety and data confidentiality, to remain aware of the unique challenge cyber-attacks could pose to their ability to practice their profession and to take all necessary measures that have been shown to safeguard patient data, patient safety and other vital information.

- The WMA recommends that undergraduate and postgraduate medical education curricula include comprehensive information on how physicians can use modern IT and electronic communications systems to full advantage, while still ensuring data protection and maintaining the highest standards of professional conduct.

- The WMA acknowledges that physicians and healthcare providers may not always

have access to the resources (including financial), infrastructure and expertise required to establish fail-safe defence systems and stresses the need for the appropriate public as well as private bodies to support them in overcoming these limitations.

WMA STATEMENT
ON
DIVESTMENT FROM FOSSIL FUELS

Adopted by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

- As noted by the 65th World Medical Assembly in Durban in 2014, physicians around the world are aware that fossil fuel air pollution reduces quality of life for millions of people worldwide, causing a substantial burden of disease, economic loss, and costs to health care systems.
- According to World Health Organization data, in 2012, approximately "7 million people died, one in eight of total global deaths, as a result of air pollution" (WHO, 2014).
- The United Nations' Intergovernmental Panel on Climate Change (IPCC) notes that global economic and population growth, relying on an increased use of coal, continues to be the most important driver of increases in Carbon Dioxide emissions. These emissions are the major component of an accelerating the amount of human fossil fuel Greenhouse Gas (GHG) emissions despite the adoption of climate change mitigation policies (IPCC, 2014).
- The burden of disease arising from Climate Change will be differentially distributed across the globe and, while it will affect everyone, the most marginal populations will be the most vulnerable to the impacts of climate change and have the least capacity for adaptation.

BACKGROUND

- In many densely settled populated cities around the world, the fine dust measurable in the air is up to 50 times higher than the WHO recommendations. A high volume of transport, power generated from coal, and pollution caused by construction equipment are among the contributing factors (WMA, SMAC 197, Air Pollution WMA Statement on the Prevention of Air pollution due to Vehicle Emissions 2014).
- Evidence from around the world shows that the effects of climate change and its extreme weather are having significant and sometimes devastating impacts on human health. Fourteen of the 15 warmest years on record have occurred in the first 15 years of this century (World Meteorological Organization 2014). The

vulnerable among us including children, older adults, people with heart or lung disease, and people living in poverty are most at risk from these changes.

- The WMA notes the Lancet Commission's description of Climate Change as "the greatest threat to human health of the 21st century", and that the Paris agreement at COP21 on Climate calls upon governments "when taking action on climate change" to "respect, promote and consider their respective obligations on human rights (and) the right to health".

- As the WMA states in its Delhi Declaration on Health and Climate Change, "Although governments and international organizations have the main responsibility for creating regulations and legislation to mitigate the effects of climate change and to help their populations adapt to it, the World Medical Association, on behalf of (…) its physician members, feels an obligation to highlight the health consequences of climate change and to suggest solutions. (…) The WMA and NMAs should develop concrete actionable plans/practical steps" to both mitigate and adapt to climate change (WMA 2009).

RECOMMENDATIONS

The WMA recommends that its national medical associations and all health organizations:

1. Continue to educate health scientists, businesses, civil society, and governments concerning the benefits to health of reducing greenhouse gas emissions and advocate for the incorporation of health impact assessments into economic policy.

2. Encourage governments to adopt strategies that emphasize strict environmental regulations and standards that encourage energy companies to move toward renewable fuel sources.

3. Begin a process of transferring their investments, when feasible without damage, from energy companies whose primary business relies upon extraction of, or energy generation from, fossil fuels to those generating energy from renewable energy sources.

4. Strive to invest in companies upholding the environmental principles consistent with the United Nations Global Compact (www.unglobalcompact.org), and refrain from investing in companies that do not adhere to applicable legislation and conventions regarding environmental responsibility.

WMA STATEMENT
ON
ETHICAL CONSIDERATIONS IN GLOBAL MEDICAL ELECTIVES

Adopted by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

1. Medical trainees are increasingly participating in global educational and service experiences, commonly referred to as 'international medical electives' (IMEs). These experiences are normally short term, i.e., less than 12 months, and are often undertaken in resource-limited settings in low-and middle-income countries.

2. Although IMEs can provide valuable learning experience, this must be weighed against the potential risks to the host community, the sponsor organization and the visiting trainee. Successful placements help to ensure that there are mutual benefits for all parties and are built upon an agreed understanding of concepts including non-maleficence and justice.

3. Published ethical guidelines, such as the Ethics and Best Practice Guidelines for Training Experiences in Global Health by the Working Group on Ethics Guidelines for Global Health Training (WEIGHT), call on sponsor institutions (i.e., universities and organizations facilitating electives) to commit to sustainable partnerships with host institutions and local communities. All parties are also called upon to work collaboratively in creating professional guidelines and standards for medical electives.

4. In turn, trainees undertaking IMEs must adhere to relevant ethical principles outlined in WMA ethical documents, including the WMA's Declaration of Geneva, the WMA International Code of Medical Ethics and the WMA Statement on the Professional and Ethical Use of Social Media.

RECOMMENDATIONS

Therefore the WMA recommends that:

- Sponsor institutions work closely with host institutions and local communities to create professional and ethical guidelines on best practices for international medical electives. Both institutions should be actively engaged in guideline development. The sponsor organization should evaluate the proposed elective using such standards prior to approval.

- Guidelines should be appropriate to local context and endorse the development of

sustainable, mutually-beneficial and just partnerships between institutions and the patients and the local community, with their health as the first consideration. These must take account of best practice guidelines, already available in many countries.

- Guidelines must hold patient and community safety as paramount, and outline processes to ensure informed consent, patient confidentiality, privacy, and continuity of care as outlined in the WMA International Code of Medical Ethics.
- Guidelines should also outline processes to protect the safety and health of the trainee, and highlight the obligations of the sponsor and host institutions to ensure adequate supervision of the trainee at all times. Institutions should consider means of addressing possible natural disasters, political instability, and exposure to disease. Emergency care should be available.
- Sponsor and host institutions have a responsibility to ensure that IMEs are well planned, including, at a minimum, appropriate pre-departure briefings, which should include training in culture and language competency and explicit avoidance of any activity which could be exploitative, provision of language services as required, and sufficient introduction and guidance at the host institution. Post-departure debriefing should be planned on return of the trainee, including reviewing ethical situations encountered and providing appropriate emotional and medical support needed.
- It is expected that the trainee will receive feedback and assessment for the experience so that he/she can receive academic credit. The trainee should have the opportunity to evaluate the quality and utility of the experience.
- Trainees must be fully informed of their responsibility to follow instructions given by local supervisors, and to treat local host staff and patients with respect.
- These guidelines and processes should be reviewed and updated on a regular basis as sponsor and host institutions develop more experience with one another.
- National Medical Associations should develop best practices for international medical electives, and encourage their adoption as standards by national or regional accrediting bodies, as feasible, and their implementation by sponsor and host institutions.

WMA STATEMENT ON OBESITY IN CHILDREN

Adopted by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

Childhood obesity is a serious medical condition and a major public health concern affecting many children. Childhood obesity is emerging as a growing epidemic and is a challenge in both developed and developing countries. Due to its increasing prevalence and its immediate and long-term impact on health, including predisposition to diabetes and cardiovascular abnormalities, childhood obesity should be viewed as a serious concern for public health. The increase in childhood obesity may be attributed to many factors:

1. Recent studies show that marketing targeted at children has a wide influence on the shopping trends and food preferences of households all over the world. Special offers, short-term price reductions and other price promotions and advertising on social as well as traditional media all play a role in increasing product demand.

2. Many advertisements are in conflict with nutritional recommendations of medical and scientific bodies. TV advertisements for food and drink products with little or no nutritional value are often scheduled for broadcast hours with a large concentration of child viewers and are intended to promote the desire to consume these products regardless of hunger. Advertisements increase children's emotional response to food and exploit their trust. These methods and techniques are also used in non-traditional media, such as social networks, video games and websites aimed at children.

3. Unhealthy dietary patterns, together with a sedentary lifestyle and lack of exercise, contribute to childhood obesity. The sedentary lifestyle is the most predominant one in the developed world today. Many children typically spend more time than ever in front of screens, rarely engaging in physical activities.

4. International corporations and conglomerates that manufacture foods and beverages are not always subject to regional regulations that govern food labeling. Concern for profits may come at the expense of corporate responsibility for environmental and public health issues.

5. Products containing large amounts of added sugar, fat, and salt can be addictive, especially when combined with flavor enhancers. In some countries, not all ingredients are required to be listed on food labels and manufacturers often refuse to release data on methods employed to maximize consumption of their products.

Governments should require that all ingredients in food and beverages be clearly labeled, including those proprietary ingredients intended to increase consumption of the product.

6. Socioeconomic disparities also correlate with increasing rates of childhood obesity. The link between living in poverty and early childhood obesity continues to negatively affect health in adult life.[1] Exposure to environmental contaminants, sporadic medical checkups, insufficient access to nutritious foods and limited physical activity lead to obesity and other chronic illnesses that are all more prevalent among children living in poverty.

RECOMMENDATIONS

1. A comprehensive program is needed to prevent and address obesity in all segments of the population, with a specific focus on children. The approach must include initiatives on price and availability of nutritious foods, access to education, advertising and marketing, information, labeling and other areas specific to regions and countries. An approach similar to that on tobacco in the WHO Framework Convention on Tobacco Control is advocated.

2. International studies stress the importance of adopting an integrated approach to education and health promotion. Investment in education is key to minimizing poverty, improving health and providing economic benefits.

3. Quality education offered in formal settings to children aged 2 to 3 years, combined with enrichment activities for parents, and sufficient supply of nutritious food and beverages may help to reduce the rate of adolescent obesity and reduce its health implications throughout the life course. Developing early healthy eating practices and experiencing flavors of healthy food when very young appear to be positive factors in prevention of childhood obesity.

4. Governments should invest in education related to menu design, food shopping including budget setting, storage and preparation so that people are better equipped to plan their food intake.

5. Governments should seek to regulate the availability of food and beverages of poor nutritional value, by a range of methods including price. Attention should be paid to the availability close to schools of establishments selling products of poor nutritional quality. Governments should seek to persuade manufacturers to reformulate products to reduce their obesogenic effects. Where possible government and local authorities should seek to manage the density of such establishments in the area.

6. Governments should consider imposing a tax on non-nutritious foods and sugary drinks and use the additional revenue to fund research and epidemiological studies aimed at preventing childhood obesity and reducing the resulting disease risk.

7. Ministries of health and education should regulate food and beverages that are sold and served at educational and healthcare facilities.

8. Given the scientifically proven link between the extent of media consumption and adverse effects on body weight in children, the WMA recommends that the advertising of non-nutritious products be restricted during television programming and other forms of media that appeal to children. Regulators should be aware that children access television programs designed for adults and ensure that legislation and regulation also limits marketing associated with such programs.

9. Governments should work with independent health experts to produce sound guidance on food and nutrition, with no involvement of the food and drink industry.

10. Governments and local authorities should subsidize and encourage activities that promote good health among their residents, including providing safe spaces for walking, bike riding and other forms of physical activity.

11. Parents have a crucial role in fostering physical activity in their children. Schools should incorporate daily physical activity into their daily routine. Participation in sport activities should be possible for everyone regardless of their economic situation.

12. National Medical Associations should support or develop guidelines and recommendations to ensure that they reflect current knowledge of prevention and treatment of childhood obesity.

13. National Medical Associations should work to raise public awareness on the issue of childhood obesity and highlight the need to tackle the rising prevalence of obesity and its health and economic burden.

14. Clinics and Health Maintenance Organizations should employ appropriately trained professionals to offer classes and consultation in selecting appropriate amounts of nutritious foods and beverages and attaining optimal levels of physical activity for children. They should also ensure that their premises are exemplars in the provision of healthy food options.

15. Educational facilities should employ appropriately trained professionals who educate for healthy lifestyles from an early age and allow all children, whatever their social environment, to practice regular physical activities.

16. Physicians should guide parents and children in how to live healthy lives and emphasize the importance of doing so, and must identify as soon as possible obesity in their patients, particularly children. They should direct patients suffering from obesity to the appropriate services at the earliest possible stage, and conduct regular follow-ups.

17. Physicians and health professionals should be educated in nutrition assessment, obesity prevention and treatment. This could be accomplished by strengthening CME activities focused on nutritional medicine.

[1] WHO Commission on Social Determinants of Health (Closing the Gap in a Generation) 2008.

WMA STATEMENT
ON
OCCUPATIONAL AND ENVIRONMENTAL HEALTH AND SAFETY

Adopted by the 67th WMA General Assembly, Taipei, Taiwan, October 2016
and revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

Occupational and environmental health and safety (OEHS) is an integral part of public health, and the primary health care (PHC) system in particular, since it is often the first level of contact of individuals, the family and the community with a health system, bringing health care as close as possible to where people live and work.

Workers represent at least half of the world's population and are the backbone of many economies, but many may have inadequate access to occupational and environmental health services and do not operate in a safe working environment.

The International Labour Organization (ILO) defines decent work as opportunities for work that are productive and deliver fair income with dignity, equality, and within safe working conditions. Despite the fact that the right to decent work is recognized in the Universal Declaration of Human Rights, every 15 seconds, a worker dies from a work-related accident or disease , resulting in an annual 4% loss in global GDP.

Despite this, the proportion of work accidents and occupational diseases that are recorded and reported worldwide is incredibly small. It is estimated that less than 1% of occupational diseases are recorded.

Additionally, as many workers face greater pressures to meet the demands of working life, many of them are at risk to develop work-related stress which may occur when the demands of the job do not match or exceed the capabilities, resources or needs of the worker or when the knowledge or abilities of an individual worker or group to cope are not matched with the expectations of the organizational culture of an enterprise. High-level of stress can result in health impairments such as burnout, depression, anxiety, cardiovascular disease or even suicide.

Recently and even more due to the COVID-19 pandemic, the world has witnessed an increased number of employees working outside the employer's premises using digital information and communication technologies either full-time or part-time. Despite some positive aspects, there are risks associated with this work arrangement as it isolates employees, particularly individuals living alone and can result in increased levels of stress and anxiety. Extended

working hours and employee availability in addition to diminished boundaries between personal and professional life may impact work-life balance. A healthy digital working environment needs to be in place to ensure employee health and safety.

The United Nations Development Programme's Sustainable Development Goals 3, 5, 8 and 13 call for action in health promotion for all people of all ages, gender equality, decent work and management of the impact of climate change; OEHS is well positioned to maintain physical, mental and social well-being for all workers, that will result in poverty reduction, sustainable development and saving millions of lives every year.

Physicians have a critical role in preventing, diagnosing, monitoring, treating and reporting work accidents and occupational diseases. In addition, physicians should promote equal, decent and inclusive work environments for all regardless of age, gender, ethnic origin, nationality, religion, political affiliation, race, sexual orientation, or the presence of a disability.

Despite many governments and employers' and workers' organizations placing greater emphasis on the prevention of occupational diseases. prevention is not receiving the priority warranted by the scale and severity of the occupational disease epidemic.

Physicians and medical associations can contribute to the identification of problems, development of national reporting systems, and formulation of relevant policies in the field of OEHS.

Unsatisfactory and unsafe working conditions play a significant role in the development of occupational diseases and injuries, which are subsequently causes of mortality in the working population.

RECOMMENDATIONS

1. Physicians should play a pivotal role in the development of a workforce that is educated in and raise workplace awareness about the social determinants of health.

2. The field of occupational and environmental health and safety (OEHS) should be accorded the necessary importance in both graduate and post-graduate medical studies

3. Physicians must cooperate with the healthcare and occupational authorities to promote health and safety in the workplace.

4. All workers should have access to risk based OEHS services from the first day of work and extending beyond the last day at work in order to account for occupational diseases with a long latency period. Service content should be standardized and the role of physicians in the planning and implementation of OEHS systems that are essentially preventive/protective must be recognized.

5. WMA Constituent members should act proactively and encourage the expansion of the scope of OEHS services, in order to prevent and reduce occupational diseases, and injuries,

reproductive health issues and protect the environment. They should also promote workplace gender equality and encourage improvement of recording and reporting systems for OEHS-related metrics. They should also focus on workforce capacity building, teaching and training, and collaborative research.

6. WMA Constituent members, together with governments, should take an active role, where appropriate, in the formulation and development of national systems that facilitate OEHS prevention, and the recording and reporting of occupational diseases and incidents in their respective countries.

7. Physicians who are evaluating workers' compensation patients should be experienced in occupational and environmental medicine. When a relationship between the diagnosis and occupational and environmental exposures is established, the physician should report it through the appropriate reporting system.

8. Occupational diseases and injuries are often addressed in the context of insurance and compensation. Where these mechanisms are not in place, WMA Constituent members should advocate for the protection of workers by means of insurance or social security.

9. When rendering services for an employer, physicians should advocate that employers fulfil the minimum requirements set in the International Labour Organization's (ILO) occupational standards, especially when such requirements are not set by national legislation.

10. Employers should provide a safe working environment, recognising and addressing the impact of adverse working conditions on individuals and society.

11. Employers should consider promoting and offering essential vaccines to employees.

12. WMA Constituent members should consider forming an internal body for addressing the problems of physicians working in OEHS and encourage them to contribute to research and related scientific studies.

13. Governments should collaborate in setting up an international system to assess occupational hazards and develop strategies to protect the health of workers.

14. Governments should establish legislative frameworks that protect the rights and health of workers, including reproductive health and health effects of work at home.

15. Governments and NMAs must promote the development of training, information and research programs in occupational health to their members.

WMA STATEMENT
ON
BULLYING AND HARASSMENT WITHIN THE PROFESSION

Adopted by the 68th General Assembly, Chicago, October 2017

PREAMBLE

1. Workplace bullying has been recognised as a major occupational stressor since the early 1980s.

2. Workplace bullying is unreasonable and inappropriate behaviour directed towards a worker or a group of workers that creates a risk to health and safety. By definition, bullying is behaviour that is repeated over time or occurs as part of a pattern of behaviour, rather than a single episode. Unreasonable behaviour is what a reasonable person in the same circumstances would see as unreasonable. It includes behaviour that intimidates, offends, victimises, threatens, degrades, insults or humiliates. Bullying can take psychological, social and physical forms. It is not the perpetrator's intention, but the victim's perception, that is key to determining whether bullying has occurred.

3. Harassment is unwanted, unwelcome or uninvited behaviour that makes a person feel humiliated, intimidated or offended. Harassment can be related to a person's ethnicity, gender, sexual orientation, disability or other factors such as whether a person has made a complaint.

4. Employers generally have a legal duty to ensure the health, safety and welfare of their employees. This includes identifying bullying and harassment and taking steps to eliminate and prevent it. Employees are generally required to take reasonable care for their own health and safety as well as for the health and safety of others who may be affected by their acts in the workplace.

5. In recent years, bullying and harassment have become more recognised in the medical profession; there is good evidence that disruptive behaviour, inappropriate behaviour and harassment occurs in the medical workplace. International research has shown that bullying in the healthcare profession is not associated with specialty or sex. It appears that bullying is widespread and occurs across all specialties and at all levels of seniority, although it is fair to say that where bullying occurs it is more common to be inflicted by a more senior employee upon a more junior one. The hierarchical nature of medicine and the inherent power imbalance associated with this can however create a culture of bullying and harassment which, in some cases, becomes pervasive and institutionalized.

6. Workplace bullying can have detrimental effects such as decreased job satisfaction, depression, anxiety, and absenteeism, all of which impact adversely on staff retention and quality of patient care.

RECOMMENDATIONS

7. The WMA condemns bullying or harassment under any circumstances. It further believes that raising awareness of inappropriate behaviour, disruptive behaviour and harassment in the medical profession is an important step in the process of eliminating the problem. The WMA is of the view that this is an issue of professionalism and it encourages National Medical Associations (NMAs), medical schools, employers, and medical colleges to establish and implement anti-bullying and harassment policies.

8. The WMA recommends that NMAs recognise and, where possible, actively address the following:

    8.1 Bullying in the health workplace is an entirely unprofessional and destructive behaviour and should not be tolerated.

    8.2 Steps should be taken to prevent, confront, report and eliminate bullying at any level.

    8.3 Bystanders also have a responsibility to take action.

    8.4 There can be significant barriers for junior doctors to speak out about bullying by senior colleagues, for example fear of career retribution.

    8.5 Professionalism is not just how we treat our patients, but how we treat each other as professional colleagues. Acting professionally means also being vigilant and stepping in to intervene, for the good of all.

    8.6 Bullying is unprofessional, contradicts the fundamentals of the profession and raises fitness to medical practise concerns.

    8.7 Healthcare needs good teams. Eliminating bullying ensures a safer team environment and a safer healthcare environment for patients.

    8.8 It is the responsibility of the management to maintain a good working environment and address all signs of harassment and bullying. There should be zero tolerance of bullying and harassment

WMA STATEMENT ON ARMED CONFLICTS

Adopted by the 68th General Assembly, Chicago, October 2017

PREAMBLE

1. The duties of physicians in times of armed conflict are set out in the WMA Statement on Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies and WMA Regulations in Times of Armed Conflict and Other Situations of Violence.

2. Physicians should encourage politicians, governments, and others in positions of power to be more aware of the consequences, including the impact on health, of their decisions on the commencement or continuation of armed conflict.

3. Armed conflict damages the health of individuals and of populations as well as critical infrastructure including health care facilities, housing, potable-water supplies and sewerage. It also leads to environmental degradation. Such destruction of critical infrastructure may lead to adverse health consequences including malnutrition, and infectious or waterborne diseases, such as cholera and typhoid. Warfare also destroys work-related infrastructure, including factories and manufacturing centres as well as agriculture. Repair to damaged infrastructure cannot proceed until cessation of the conflict.

4. Wars start for many different reasons. Efforts to avoid conflicts are often insufficient and inadequate and country leaders may not seek all alternatives. Avoiding war and seeking constructive alternatives is always desirable.

5. It is essential that those claiming that a war us a "just war" understand that this is a rare and extreme circumstance, which must not be overcited. The concept of a "just" war must not be used to legitimize violence.

6. Warfare and other forms of armed conflict are likely to worsen the suffering of the poorest and to contribute to the development of large numbers of Internally Displaced Persons and refugees.

7. Physicians should seek, during conflicts, to influence parties in order to alleviate the suffering of populations.

RECOMMENDATIONS

8. The WMA believes that armed conflict should always be a last resort. Physicians and NMAs should alert governments and non-state actors of the human consequence of

warfare.

9. Physicians should encourage politicians, governments, and others in positions of power to be more aware of the consequence of their decisions related to armed conflict.

10. The WMA recognizes that armed conflict always produces enormous human suffering. States and other authorities, including non-state actors, who enter into armed conflict must accept responsibility for the consequences of their actions, and be prepared to answer for their consequences including to international courts and tribunals and recommends that authorities recognize and cooperate to ensure this occurs.

11. The WMA recognizes that the impact of armed conflict will be most significant upon women and vulnerable populations, including children, the young, the elderly and the poorest members of society. Physicians should seek to ensure that allocation of medical care resources does not have a discriminatory impact.

12. Physicians must continually remind those in power of the need to provide essential services to those within areas damaged and disrupted by conflict.

13. After a conflict ends, priority must be given to rebuilding the essential infrastructure necessary for a healthy life, including shelter, sewerage, fresh water supplies, and food provision, followed by the restoration of educational and occupational opportunities.

14. The WMA demands that parties to a conflict respect relevant Humanitarian Law and do not use health facilities as military quarters, nor target health institutions, workers and vehicles, and respect established International Humanitarian Law (IHL) and do not use health facilities as military quarters, nor initiate attacks against health institutions, workers and vehicles, or restrict the access of wounded persons and patients to healthcare, as set out in the WMA Declaration on the Protection of Health Workers in Situations of Violence.

15. Physicians should work with aid and other agencies to seek to ensure that parties protect family integrity and, wherever possible, remove people from direct and immediate danger.

16. Physicians should be aware of the likely prevalence of Post-Traumatic Stress Disorder (PTSD) and other post-conflict psychosocial and psychosomatic problems and provide appropriate care and treatment to combatants and civilians.

17. Physicians, including forensic medicine specialists, should help families ensure that efforts to identify the missing and the dead are not subverted by security forces.

WMA STATEMENT ON MEDICAL CANNABIS

Adopted by the 68th General Assembly, Chicago, October 2017

PREAMBLE

1. Cannabis is the generic term used to denote psychoactive preparations of the plant Cannabis sativa, which grows wild in many parts of the world and is known by numerous other names, such as: “marijuana”, “dagga”, “weed”, “pot”, “hashish”, or “hemp”.

2. Cannabis for medical use refers to the use of cannabis and its constituents, natural or synthetic, to treat disease or alleviate symptoms under professional supervision; however, there is no single agreed upon definition.

3. Recreational cannabis refers to the use of cannabis to alter one’s mental state in a way that modifies emotions, perceptions, and feelings regardless of medical need.

4. This WMA statement is intended to provide a position on legalisation of cannabis for medical use and highlight the adverse effects associated with recreational use.

5. Recreational cannabis use is an important health and social issue across the world. Cannabis is the most commonly used illicit drug in the world. The World Health Organisation estimates that about 147 million people, 2.5% of the world population, use cannabis compared with 0.2% using cocaine and 0.2% using opiates.

6. The WMA opposes recreational cannabis use due to serious adverse health effects such as increased risk of psychosis, fatal motor vehicle accidents, dependency, as well as deficits in verbal learning, memory and attention. Use of cannabis before the age of 18 doubles the risk of psychotic disorder. The ominously growing availability of cannabis or its forms in foodstuffs such as sweets and “concentrates”, which have enormous appeal to children and adolescent, requires intensive vigilance and policing.

7. National Medical Associations should support strategies to prevent and reduce recreational cannabis use.

8. Evidence for use of cannabis for medical use

   8.1 Cannabinoids are chemical constituents of Cannabis sativa that contain similar structural features; some of the chemical constituents act on human cannabinoid receptor cells. Conceptually, cannabinoids that activate these receptors (1) occur naturally in the human body like other endogenous neurotransmitters (endocannabinoids); (2) occur naturally in the cannabis plant

(phytocannabinoids); or (3) are pharmaceutical preparations containing either synthetic cannabinoids, (e.g. delta9-tetrahydrocannabinol [dronabinol, Marinol™], or a related compound, nabilone [Cesamet™], or extracts of phytocannabinoids (nabiximols [Sativex™]).

8.2 Amongst phytocannabinoids is naturally occurring Cannabis sativa, delta-9-tetrahydrocannabinol (THC), the main bioactive cannabinoid and the principal psychoactive constituent, while cannabidiol (CBD) is the second most abundant. CBD lacks significant psychoactive properties but may possess analgesic and antiseizure properties.

8.3 The human endocannabinoid system is believed to mediate the psychoactive effects of cannabis and is involved in a variety of physiologic processes including appetite, pain-sensation, mood, and memory. The significant medical and pharmacological therapeutic potential of influencing the endocannabinoid system has been widely recognized.

8.4 The medical benefits of cannabis reported in scientific literature are widely debated globally. Cannabis has been used for the treatment of severe spasticity in multiple sclerosis, chronic pain, nausea and vomiting due to cytotoxics, and loss of appetite and cachexia associated with AIDS. Evidence suggest that certain cannabinoids are effective in the treatment of chronic pain, particularly as an alternative or adjunct to the use of opiates when the development of opiate tolerance and withdrawal can be avoided. Evidence supporting use of cannabis for medicinal purposes is of low to moderate quality, and inconsistent. The inconsistency can be partially attributable to the prohibition of cannabis. Its classification as an illegal substance in some countries has constrained safe and high-quality clinical research.

8.5 The short-term adverse effects of cannabis use are well documented. However, the long-term adverse effects are less well understood, particularly the risk of dependence and cardiovascular disease. There are also significant public health concerns for vulnerable populations such as adolescents, and pregnant or breastfeeding women.

8.6 Despite weak evidence of its medical benefits, cannabis for medical use has been legalised in some countries. In other countries medical cannabis is forbidden or under debate.

9. Medical professionals may find themselves in a medico-legal dilemma as they try to balance their ethical responsibility to patients for whom cannabis may be an effective therapy and compliance with applicable legislation. This dilemma can manifest itself both with patients who may medically benefit from the use of cannabis, and those who are not likely to do so, but pressure the medical professionals to prescribe it.

RECOMMENDATIONS

10. Cannabis Research

10.1 In the light of the low-quality scientific evidence on the health effects and therapeutic effectiveness of cannabis, more rigorous research involving larger samples is necessary before governments decide whether or not to legalise medical cannabis for medical purposes. Comparators must include the existing standards of treatment. Expansion of such research should be supported. Research should also examine the public health, social and economic consequences of cannabis use.

10.2 Governments may consider reviewing laws governing access to and possession of research-grade cannabis for the purpose of allowing well-designed scientific research studies to broaden the evidence base on the health effects and therapeutic benefits of cannabis.

11. In countries where cannabis is legalised for medicinal purposes, the following requirements should apply:

11.1 Requirements for producers and products:

11.1.1 Provision of cannabis plant products for treatment must be in accordance with the UN Single Convention on Narcotic Drugs from 30 March 1961, including the Convention's rules on production, trade, and distribution. Thus, it is essential that the cannabis included in the products delivered for medical treatment must be provided and handled in accordance with the requirements of the Convention.

11.1.2 Requirements must include that the cannabis plants meet appropriate quality demands for growing and standardization. The produced cannabis plant products must have a specific indication (interval) of ingredients, including the content of delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) and strength indication of these.

11.2 Requirements for prescription and dispensing of cannabis for medical purposes:

11.2.1 Cannabis must be prescribed by an authorised physician/prescriber in accordance with the best level of evidence and the country's regulatory frameworks.

11.2.2 It is recommended that treatment with approved conventional drugs is undertaken before cannabis products are used for treatment.

11.2.3 Each individual physician must take responsibility for and make a decision regarding treatment with cannabis products, in accordance with the best available evidence and country specific registered indications.

11.2.4 Cannabis for medical purposes must only be dispensed at pharmacies or by authorised dispensers in accordance with the country´s regulatory frameworks.

11.2.5 Effective control measures must be put in place to impede illicit use of medical cannabis.

11.2.6 Public health surveillance systems to monitor prevalence of cannabis use and trends in utilisation patterns are necessary.

12. In considering policy and legislation on cannabis, governments, NMAs, policymakers, and other health stakeholders, should emphasize and examine the health effects and therapeutic benefits based on the available evidence, while also recognizing various contextual factors such as regulatory capacity, cost-effectiveness, societal values, social circumstances of the country, and the public health and safety impact on the wider population.

WMA STATEMENT
ON
THE COOPERATION OF NATIONAL MEDICAL ASSOCIATIONS DURING OR IN THE AFTERMATH OF CONFLICTS

Adopted by the 68th General Assembly, Chicago, October 2017

PREAMBLE

1. Throughout history, there have been cases of political conflict in which physicians and the professional bodies that represent them have adopted and reinforced the policies of their respective governments in violation of medical ethical standards. There have also been cases of physicians themselves deliberately engaging in criminal activities and embracing unethical ideologies. Even today, on-going moral and political conflicts can lead physicians and their representative organisations to overstep ethical boundaries.

2. To prevent such breaches of ethical conduct from occurring, physicians and their representative organisations have a responsibility to rise above national conflicts, to foster mutual professional support and to base their actions on the highest medical ethical standards, including the physician's primary obligation to the health of individual patients.

3. All national medical associations and their members have an obligation to uphold the ethos of medicine, to demonstrate absolute forthrightness and honesty in confronting historical and ongoing national conflicts, as well as to preserve the lessons gleaned from all forms of unethical behaviour. This includes maintaining a clear commitment to human rights, explicitly rejecting racial, religious, gender, sexual orientation and any other forms of discrimination and actively confronting moral failures of the medical profession.

4. Physicians have professional and ethical obligations that go beyond ethnic and national interests. Medical associations have a role to play in bridging the gap between different groups based on their common medical ethical codes, regardless of political, religious, ethnic and social background. Medical expertise as represented in the medical associations could be a powerful agent for re-establishing respect for human rights in general at times of war and other conflicts.

RECOMMENDATIONS

5. The World Medical Association urges National Medical Associations to:

   5.1 Meet regularly in the spirit of enduring friendship and cooperation;

5.2 Take initiative to invite colleagues from medical associations from nations in conflict to meetings with the intention of re-establishing the contact and cooperation between the associations;

5.3 Engage in a meaningful exchange of experience and knowledge with the regional and global medical community in order to maintain the highest levels of ethical standards and care;

5.4 Ensure that all generations of physicians, including those who have not been involved in any wrongdoing, are made aware of the vital importance of medical ethics and the dire consequences of any departure therefrom. This can be accomplished by including these principles as part of basic medical training (see WMA Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools Worldwide) and continuing throughout physicians' careers;

5.5 Recognise their obligation to work with each other and with other competent authorities to keep the memory of any deviations from medical ethics or violations of human rights alive, in order to prevent them from happening again;

5.6 Promote the preservation and growth of constructive relations in the medical profession, even in the aftermath of regretful pasts or on-going conflicts. To achieve this, it is particularly important to engage in continuous communication in an atmosphere of professional collegiality.

WMA STATEMENT ON EPIDEMICS AND PANDEMICS

Adopted by the 68th General Assembly, Chicago, October 2017

PREAMBLE

1. History demonstrates that new diseases may emerge and old diseases re-emerge, unpredictably. The rapid global movement of people and goods now means that infections spread globally at unprecedented rates, challenging health systems to respond in a timely manner. Therefore, quickly recognizing and reacting appropriately to such epidemics or pandemics must be an international concern, with effective communication and collaboration between nations.

2. Epidemics may be caused by a variety of infectious agents with different methods of transmission. These diseases may be self-limiting, may lead to few obvious symptoms or may cause short or long term, sometimes serious, effects. Relatively minor illnesses may become life threatening in some vulnerable individuals. This may include the elderly and the very young as well as those with some degree of compromised immunity.

3. Investment in public health systems will enhance capacity to effectively detect and to contain rare or unusual disease outbreaks. Core public health functions are needed as a foundation for detection, investigation and response to all epidemics. A more effective global surveillance program will improve response to infectious diseases and will allow earlier detection and identification of new or emerging diseases. Epidemics and pandemics have the potential to spread more rapidly in countries with systematically underfunded and underdeveloped public health systems.

RECOMMENDATIONS

WHO and National Governments

4. The World Health Organization (WHO) has the responsibility for coordinating the international response to epidemics and pandemics. It has defined phases that allow an escalating approach to preparedness planning and response as an epidemic evolves. The WMA recommends:

   4.1 WHO should ensure that all relevant data on the development of infectious diseases and their spread is collected, including working with voluntary bodies or non-state actors as well as national and local governments who observe developments in areas where documentation may be limited. A global system of

data capture and surveillance is essential for tracking infectious diseases and their consequences.

4.2 WHO should work closely with the Centers for Disease Control in Atlanta and Europe (CDC and ECDC), National Centres for Disease Control and other applicable regional public health agencies to examine reports of disease pattern changes and to declare epidemics and pandemics as soon as they are identified. Emergence and identification may be on different time scales.

4.3 WHO and others should work with national governments and international government groups to coordinate responses to emerging and reemerging infectious diseases.

4.4 WHO should collaborate with national medical associations and other health authorities to ensure that accurate and timely clinical care guidelines are made available to physicians and health care providers.

4.5 As infections emerge or reemerge WHO and other UN agencies must ensure that easy-to-understand information is made available to all people in the affected zone in local languages, working with governments and other partners. This should include information on disease prevention, including appropriate information on optimal hygiene and infection control practices.

4.6 Where diseases lead to the development of birth defects, governments must provide support to families that are affected.

4.7 A cadre of public health specialists who can offer support during a developing health emergency should be developed and supported by all national governments.

They and other physicians should be prepared to make themselves available to assist in epidemic control, according to their relevant skill set.

National Medical Associations (NMAs)

5.1 NMAs should clearly identify their responsibilities during an epidemic including the extent of their participation in the national epidemic planning process. These responsibilities should include communicating vital information to the public and especially to health care professionals.

5.2 Where applicable, NMAs should offer training, information and clinical support tools to physicians and regional medical associations, working with public health and educational institutions.

5.3 NMAs should be prepared to advocate for adequate government funding for supporting the health care workforce and preparing for an epidemic.

Physicians

6.1 Physicians should be sufficiently educated about transmission risks, infection control, and concurrent chronic illness management during an epidemic.

6.2 Since physicians will be the first responders, they must remain involved in planning for epidemics and all stages of epidemic response at the local level.

6.3 Physicians should take all measures necessary to protect their own health and the health of their staff and co-workers.

6.4 Physicians should assist in primary data collection to monitor epidemics with due regard to confidentiality and protecting the vulnerable.

WMA STATEMENT
ON
THE ROLE OF PHYSICIANS IN PREVENTING EXPLOITATION IN ADOPTION PRACTICES

Adopted by the 68th General Assembly, Chicago, October 2017

PREAMBLE

- UNICEF's Convention on the Rights of the Child calls in article 21 for a transparent and proper adoption process in which the best interests of the child are the principal concern.
- The Hague Convention on the Protection of Children and Co-operation in Respect of Inter-Country Adoption (Hague Adoption Convention) establishes safeguards to ensure that intercountry adoptions take place in the best interests of the child. Its principles should form the basis for global intercountry adoption practices.
- Physicians may be in touch with children who are going to be adopted, with parents and/or legal guardians of those children, and with parents who are going to adopt a child. Because physicians may confront the consequences of exploitation in adoptive practices, their role is crucial in seeking to ensure adherence to children's' rights, and in particular to article 21 of UNICEF´s Convention on the Rights of the Child. Professional awareness of the legal adoption process is necessary to protect the rights and health of the child.

RECOMMENDATIONS

- The WMA condemns all forms of exploitation in child adoption practices. Unacceptable practices may include criminal acts, including trafficking and sexual crimes.
- WMA calls on National Medical Associations and physicians to actively participate in preventing exploitation in adoption practices.
- Physicians should be educated about the nature and importance of their role during the adoption process. Physicians should become knowledgeable about exploitative adoption practices and should be aware of resources to help them identify and address the needs of victims.
- Physicians having contact with families who are adopting minors, should strongly

encourage them to verify that the adoption practices meet all legal and regulatory requirements in their jurisdiction.

- The WMA supports providing information to families who are considering adoption about the existence of networks that may engage in exploitation in adoption practices, especially when adoption will take place across legal jurisdictions.
- Physicians who have justifiable reason to suspect that a child or adult patient may be involved in exploitative adoption practices should, according to national regulations, notify appropriate authorities.
- Physicians should be educated about the existence of tools that may help identify family members of adopted children, including DNA identification testing.
- The WMA encourages scientific and professional activities that could support local authorities' efforts to deter exploitation in adoption practices.

WMA STATEMENT
ON
BIOSIMILAR MEDICINAL PRODUCTS

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

PREAMBLE

1. he expiry of patents for original biotherapeutics has led to the development and approval of copies, called 'similar biological medicinal products' or 'biosimilars' that are highly similar to a previously approved biological product, known as the originator or reference product.

2. In light of the fact that biosimilars are made in living organisms, there may be some minor differences from the reference medicine, as minor variability is a characteristic attribute of all biological medicines. The manufacture of biosimilars is generally more complex than the manufacture of chemically derived molecules. Therefore, the active substance in the final biosimilar can have an inherent degree of minor variability. Innovator biologics also have inherent batch-to-batch variability, and for that reason biosimilars are not always interchangeable with the reference products, even after regulatory approval.

3. Biosimilars are not the same as generics. A generic drug is an identical copy of a currently licenced pharmaceutical product that has an expired patent protection and must contain the 'same active ingredients as the original formulation'. A biosimilar is a different product with a similar, but not identical, structure that elicits a similar clinical response. As a result, biosimilar medicines have the potential to cause an unwanted immune response. Whereas generics are interchangeable, biosimilars are not always interchangeable.

4. Biosimilars have been available in Europe for almost a decade following their approval by the European Medicines Agency (EMA) in 2005. The first biosimilar was approved by the Food and Drug Administration (FDA) for use in the United States in 2015.

5. Biosimilar medicines have transformed the outlook for patients with chronic and debilitating conditions, as it is possible to obtain similar efficacy as that of the reference product at a lower cost.

6. Biosimilars will also increase availability for patients without access to the bio-originator. Greater global access to effective biopharmaceuticals can reduce disability, morbidity, and mortality associated with various chronic diseases.

7. Nonetheless, the potentially lower cost of biosimilars raises the risk that insurers and health care providers may favor them over the originator product, even when

they may not be appropriate for an individual patient or in situations when they have not demonstrated adequate clinical equivalence to an original biological product. The decision to prescribe biosimilars or to switch patients from reference medicine to a biosimilar must be made by the attending physicians, not by health insurance companies.

RECOMMENDATIONS

1. National medical associations should work with their governments to develop national guidance on safety of biosimilars.
2. National medical associations should advocate for delivering biosimilar therapies that are as safe and effective as their reference products.
3. National medical associations should strive to ensure that physician autonomy is preserved in directing which biologic product is dispensed.
4. Where appropriate, national medical associations should lobby against allowing insurers and health funds to require biosimilar and originator product's interchangeability, and for safe regulations of interchanging biosimilar medicines where this is allowed.
5. Physicians must ensure that patient medical records accurately reflect the biosimilar medicine that is being prescribed and taken.
6. Physicians shouldn't prescribe a biosimilar to patients already showing success with the originator product, unless clinical equivalence has been clearly demonstrated and established and patients are adequately informed and have given consent. There should be no substitution between biosimilars and other drugs without the attending physcian's permission.
7. Physicians should seek to improve their understanding of the distinctions between biosimilar products that are highly similar to or are interchangeable with an originator product; raise awareness of the issues surrounding biosimilars and interchangeability; and promote clearly delineated labelling of biosimilar products.
8. Physicians should remain vigilant and report to the manufacturer, as well as through the designated regulatory pathways, any adverse events suffered by patients using originator biological products or biosimilars.

WMA STATEMENT
ON
THE DEVELOPMENT AND PROMOTION OF A MATERNAL AND CHILD HEALTH HANDBOOK

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

PREAMBLE

The WMA believes that both a continuum of care and family empowerment is necessary to improve the health and wellbeing of the mother and child. The reduction of maternal mortality ratio and infant deaths was an important objective of the Millennium Development Goals (MDGs). The reductions of the maternal mortality ratio, neonatal mortality rate and the under-five mortality rate are important targets to be achieved under the Sustainable Development Goals (SDGs).

The maternal and child health (MCH) handbook is a comprehensive home-based booklet designed to provide relevant health information and include integrated mother and child health records. The MCH handbook covers health records and information on pregnancy, delivery, neonatal and childhood periods, and child growth and immunizations. The MCH handbook supports the integration of maternal, neonatal and child health services. The MCH handbook is not only about health education, but about creating ownership with women and families.

In 1948, Japan became the first country in the world to create and distribute a maternal and child health (MCH) handbook, in order to protect and improve the health and wellbeing of the mother and child.

There are now approximately 40-country versions of the MCH handbook, all adapted to the local culture and socio-economic context. There are a variety of handbooks and educational materials concerned to MCH in many countries. The use of MCH handbooks has helped improve the knowledge of mothers on maternal and child health issues, and has contributed to changing behaviors during pregnancy, delivery and post-delivery period.

The MCH handbook can promote the health of pregnant women, neonates and children by using it as a tool for strengthening a continuum of care. Physicians can make better care decisions, by referring to the patient's medical history and health-check data recorded in the MCH handbook. The MCH handbook alone has not been shown to improve health indicators. The benefits are maximized when women and children have access to relevant healthcare services based on information recorded in the handbook. Such benefits of the handbook could be shared globally.

In Japan, a digital handbook is spreading progressively. The digital handbook is expected to be utilized in a way that protects confidentiality of the patient's health information.

Some private kindergarten and primary schools request access to the MCH as part of their admission process, placing pressure on parents and physicians to modify the answers to questions in the handbook.

RECOMMENDATIONS

1. The WMA recommends that the constituent member associations encourage their health authorities and health institutions to provide accessible and easy to understand information regarding maternal and child health. The MCH handbook, or equivalents, can be an important tool to improve continuity of care and benefit health promotion for mothers, neonates and children.

2. The WMA recommends that the constituent member associations and medical professionals promote the adaptation to local setting and the utilization of MCH handbooks, or equivalents, in order to leave no one behind with respect to SDGs, especially for non-literate people, migrant families, refugees, minorities, people in underserved and remote areas.

3. When using a MCH handbook or similar documentation, in either digital or print form, the confidentiality of the individual health information and the privacy of mothers and children should be strictly protected. It should be used exclusively to improve health and wellbeing of mothers, neonates, and children. It should not be used in the admission procedures of schools.

4. The constituent member associations should promote local research to evaluate the utilization of the MCH handbooks, or equivalents, and make recommendations to improve the quality of care in the local setting.

WMA STATEMENT
ON
GENDER EQUALITY IN MEDICINE

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

PREAMBLE

- The WMA notes the increasing trend around the world for women to enter medical schools and the medical profession, and believes that the study and the practice of medicine must be transformed to a greater or lesser extent in order to support all people who study to become or practice as physicians, of whatever gender. This is an essential process of modernization by which inclusiveness is promoted by gender equality. This statement proposes mechanisms to identify and address barriers causing discrimination between genders.
- In many countries around the world, the number of women studying and practicing medicine has steadily risen over the past decades, surpassing 50% in many places.
- This development offers opportunities for action, including in the following areas:
    - Greater emphasis on a proper balance of work and family life, while supporting the professional development of individual physicians.
    - Encouragement and actualization of women in academia, leadership and managerial roles.
    - Equalization of pay and employment opportunities for men and women, the elimination of gender pay gaps in medicine, and the removal of barriers negatively affecting the advancement of female physicians.
- The issue of women in medicine was previously recognized in the WMA Resolution on Access of Women and Children to Health Care and the Role of Women in the Medical Profession which, among other things, called for increased representation and participation in the medical profession, especially in light of the growing enrolment of women in medical schools. It also called for a higher growth rate of membership of women in National Medical Associations (NMAs) through empowerment, career development, training and other strategic initiatives.

RECOMMENDATIONS

Increased presence of women in academia, leadership and management roles.

- National Medical Associations/Medical Schools/Employers are urged to facilitate the

establishment of mentoring programs, sponsorship, and active recruitment to provide medical students and physicians with the necessary guidance and encouragement necessary to undertake leadership and management roles.

- NMAs should explore opportunities and incentives to encourage both men and women to pursue diverse careers in medicine and apply for fellowships, academic, senior leadership and management positions.
- NMAs should lobby for gender equal medical education and work policies.
- NMAs should encourage the engagement of both men and women in health policy organizations and professional medical organizations.

Work-Life Balance

- Physicians should recognize that an appropriate work-life balance is beneficial to all physicians, but that women may face unique challenges to work-life balance imposed by societal expectations concerning gender roles that must be addressed to solve the issue. Healthcare employers can show leadership and help tackle this imbalance by:

  1. Ensuring women who go on maternity leave are able to access all their rights and entitlements;

  2. Introducing programmes which encourage men as well as women to take parental leave, so that women are able to pursue their careers and men are able to spend important time with their families.

- Hospitals and other places of employment should strive to provide and promote access to high quality, affordable, flexible childcare for working parents, including the provision of onsite housing and childcare where appropriate. These services should be available to both male and female physicians, recognizing the need for a better work-life balance. Employers should provide information on available services which support the compatibility of work and family.
- Hospitals and other places of employment should be receptive to the possibility of flexible and family-friendly working hours, including part-time residencies, posts, and professional appointments.
- There is a need for increased research on alternative work schedules and telecommunication opportunities that will allow flexibility in balancing work-life demands.
- NMAs should advocate for the enforcement and, where necessary, the introduction of policy mandating appropriate paid parental leave and rights in their respective countries.
- Medical workplaces and professional organisations should have fair, impartial and transparent policies and practices to give all physicians and medical students equal access to employment, education and training opportunities in medicine.

Pregnancy and Parenthood

- It should be illegal for employers to ask applicants about pregnancy and/or family planning in relation to work.
- Employers should assess the risks to pregnant physicians and their unborn children, when a physician has recently given birth and when she is breastfeeding. Where it is found, or a medical practitioner considers, that an employee or her child would be at risk were she to continue with her normal duties, the employer should provide suitable alternative work for which the physician should receive her normal rate of pay. Physician should have the right to not work night shifts or on-call shifts during the later part of pregnancy, without negative consequences on salary, employment or progression in residency.
- Pregnant physicians should have equal training opportunities in post-graduate training.
- Parents should have the right to take adequate parental leave without negative consequences on their employment, training or career opportunities.
- Parents should have the right to return to the same position after parental leave, without the fear of termination.
- Employers and training bodies should provide necessary support to any physician returning after a prolonged period of absence including parental, maternity and elder-care leave.
- Mothers should be able to breastfeed (or be given protected time for breast pumping) during work hours, within the current guidelines from the WHO.
- Workplaces should provide adequate accommodation for women who are breastfeeding including designated areas for breastfeeding, breast pumping, and milk storage, which are quiet, hygienic, and private.

Changes in organisational culture

- The medical profession and employers should work to eliminate discrimination and harassment on the basis of gender and create a supportive environment that allows equal opportunities for training, employment and advancement.
- Family friendliness should be part of the organizational culture of hospitals and other places of employment.

Workforce planning and research

- NMAs should encourage governments to take the increasing number of women entering medicine into consideration in the context of long-term workforce planning. A diverse workforce is beneficial to the health care system and to patients. Organizations delivering healthcare should focus on ensuring systems are

appropriately resourced to ensure that all those working within them are able to deliver safe care to patients and are appropriately and equitably rewarded. Governments should also work to counteract negative attitudes and behaviour, bias, and/or outdated norms and values from organizations and individuals.

- NMAs should encourage governments to invest in research to identify those factors that drive women and men to choose certain fields of specialization early on in their medical education and training and strive to address any identified barriers in order to achieve equal representation of men and women in all fields of medicine.
- NMAs should encourage governments and employers to ensure that men and women receive equal compensation for commensurate work and strive to eliminate the gender pay gap in medicine.

WMA STATEMENT ON MEDICAL TOURISM

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

PREAMBLE

1. Medical tourism is an expanding phenomenon, although to date it has no agreed upon definition and, as a result, practices and protocols in different countries can vary substantially. For purposes of this statement, medical tourism is defined as a situation where patients travel voluntarily across international borders to receive medical treatment, most often at their own cost. Treatments span a range of medical services, and commonly include: dental care, cosmetic surgery, elective surgery, and fertility treatment (OECD, 2011).

2. This statement does not cover cases where a national health care system or treating hospital sends a patient abroad to receive treatment at its own cost or where, as in the European Union, patients are allowed to seek care in another EU Member State according to legally defined criteria, and their home health system bears the costs. Also not covered is a situation in which people are in a foreign country when they become ill and need medical care.

3. If not regulated appropriately, medical tourism may have medico-legal and ethical ramifications and negative implications, including but not limited to: internal brain drain, establishment of a two-tiered health system, and the spread of antimicrobial resistance. Therefore, it is imperative that there are clear rules and regulation to govern this growing phenomenon.

4. Medical tourism is an emerging global industry, with health service providers in many countries competing for foreign patients, whose treatment represents a significant potential source of income. The awareness of health as a potential economic benefit and the willingness to invest in it rise with the economic welfare of countries, and billions of dollars are invested each year in medical tourism all over the world. The key stakeholders within this industry include patients, brokers, governments, health care providers, insurance providers, and travel agencies. The proliferation of medical tourism websites and related content raise concerns about unregulated and inaccurate on-line health information.

5. A medical tourist is in a more fragile and vulnerable situation than that of a patient in his or her home country. Therefore, extra sensitivity on the part of caretakers is needed at every stage of treatment and throughout the patient's care, including linguistic and cultural accommodation wherever possible. When medical treatment is sought abroad, the normal continuum of care may be interrupted and additional precautions should

therefore be taken.

6. Medical tourism bears many ethical implications that should be considered by all stakeholders. Medical tourists receive care in both state-funded and private medical institutions and regulations must be in place in both scenarios. These recommendations are addressed primarily to physicians. The WMA encourages others who are involved in medical tourism to adopt these principles.

RECOMMENDATIONS

General

7. The WMA emphasises the importance of developing health care systems in each country in order to prevent excessive medical tourism resulting from limited treatment options in a patient´s home country. Financial incentives to travel outside a patient's home country for medical care should not inappropriately limit diagnostic and therapeutic alternatives in the patient's home country, or restrict treatment or referral options.

8. The WMA calls on governments to carefully consider all the implications of medical tourism to the healthcare system of a country by developing comprehensive, coordinated national protocols and legislation for medical tourism in consultation and cooperation with all relevant stakeholders. These protocols should assess the possibilities of each country to receive medical tourists, to agree on necessary procedures, and to prevent negative impacts to the country´s health care system.

9. The WMA calls on governments and service providers to ensure that medical tourism does not negatively affect the proper use of limited health care resources or the availability of appropriate care for local residents in hosting countries. Special attention should be paid to treatments with long waiting times or involving scarce medical resources. Medical tourism must not promote unethical or illegal practices, such as organ trafficking. Authorities, including government, should be able to stop elective medical tourism where it is endangering the ability to treat the local population.

10. The acceptance of medical tourists should never be allowed to distort the normal assessment of clinical need and, where appropriate, the development of waiting lists, or priority lists for treatment. Once accepted to treatment by a health care provider, medical tourists should be treated in accordance with the urgency of their medical condition. Whenever possible patients should be referred to institutions that have been approved by national authorities or accredited by appropriately recognised accreditation bodies.

Prior to travel

11. Patients should be made aware that treatment practices and health care laws may be different than in their home country and that treatment is provided according to the

laws and practices of the host country. Patients should be informed by the physician/service provider of their rights and legal recourse prior to travelling outside their home country for medical care, including information regarding legal recourse in case of patient injury and possible compensation mechanisms.

12. The physician in the host country should establish a treatment plan, including a cost estimate and payment plan, prior to the medical tourist's travel to the host country. In addition, the physician and the medical tourism company (if any) should collaborate in order to ensure that all arrangements are made in accordance with the patient´s medical needs. Patients should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities.

13. Medical tourists should be informed that privacy laws are not the same in all countries and, in the context of the supplementary services they receive, it is possible that their medical information will be exposed to individuals who are not medical professionals (such as interpreters). If a medical tourist nonetheless decides to avail him or herself of these services, he or she should be provided with documentation specifying the services provided by non-medical practitioners (including interpreters) and an explanation as to who will have access to his or her medical information, and the medical tourist should be asked to consent to the necessary disclosure.

14. All stakeholders (clinical and administrative) involved in the care of medical tourists must be made aware of their ethical obligations to protect confidentiality. Interpreters, and other administrative staff with access to health information of the medical tourist should sign confidentiality agreements.

15. The medical tourist should be informed that a change in his or her clinical condition might result in a change in the cost estimate and in associated travel plans and visa requirements.

16. If the treatment plan is altered because of a medical need that becomes clear after the initial plan has been established, the medical tourist should be notified of the change and why it was necessary. Consent should be obtained from the patient for any changes to the treatment plan.

17. When a patient is suffering from an incurable condition, the physician in the host country shall provide the patient with accurate information about his or her medical treatment options, including the limitations of the treatment, the ability of the treatment to alter the course of the disease in an appreciable manner, to increase life expectancy and to improve the quality of life. If, after examining all the data, the physician concludes that it is not possible to improve the patient's medical condition, the physician should advise the patient of this and discourage the patient from travelling.

Treatment

18. Physicians are obligated to treat every individual accepted for treatment, both local and foreigner, without discrimination. All the obligations detailed in law and international medical ethical codes apply equally to the physician in his or her

encounter with medical tourists.

19. Medical decisions concerning the medical tourist should be made by physicians, in cooperation with the patient, and not by non-medical personnel.

20. At the discretion of the treating physicians, and where information is available and of good quality, the patient should not be required to undergo tests previously performed, unless there is a clinical need to repeat tests.

21. The patient should receive information about his or her treatment in a language he or she understands. This includes the right to receive a summary of the treatment progress and termination by the treating physician and a translation of the documents, as needed.

22. Agreement should be reached before treatment begins, on the transfer of test results and diagnostic images, back to the home country of the patient.

23. Where possible, communication between the physicians in the host and home country should be established in order to ensure appropriate aftercare and clinical follow-up of the medical problems for which the patient was treated.

24. The physician who prepares the treatment plan for the patient should confirm the diagnosis, the prognosis and the treatments that the medical tourist has received.

25. The patient should receive a copy of his or her medical documents for the purpose of continuity of care and follow-up in his or her home country. Where necessary, the patient should be given a detailed list of medical instructions and recommendations for the period following his or her departure. This information should include a description of the expected recovery time and the time required before travelling back to his or her home is possible.

Advertising

26. Advertising for medical tourism services, whether via the internet or in any other manner, should comply with accepted principles of medical ethics and include detailed information regarding the services provided. Information should address the service provider's areas of specialty, the physicians to whom it refers the benefits of its services, and the risks that may accompany medical tourism. Access to licensing/accreditation status of physicians and facilities and the facility's outcomes data should be made readily available. Advertising material should note that all medical treatment carries risks and specific additional risks may apply in the context of medical tourism.

27. National Medical Associations should do everything in their power to prevent improper advertising or advertising that is in violation of medical ethical principles, including advertising that contains incorrect or partial information and/or any information that is liable to mislead patients, such as overstatement of potential benefits.

28. Advertising that notes the positive attributes of a specific medical treatment should also present the risks inherent in such treatment and should not guarantee treatment results or foster unrealistic expectations of benefits or treatment results.

Transparency and the prevention of conflicts of interest

29. Possible conflicts of interest may be inevitable for physicians treating medical tourists, including at the behest of their employing institution. It is essential that all clinical circumstances and relationships are managed in an open and transparent manner.

30. A physician shall exercise transparency and shall disclose to the medical tourist any personal, financial, professional or other conflict of interest, whether real or perceived, that may be connected to his or her treatment.

31. A physician should not accept any benefit, other than remuneration for the treatment, in the context of the medical treatment, and should not offer the medical tourist nor accept from him or her any business or personal offer, as long as the physician-patient relationship exists. Where the physician is treating the medical tourist as another fee paying patient, the same rules should apply as with his/her other fee paying patients.

32. A physician should ensure that any contract with a medical tourism company or medical tourist does not constitute a conflict of interest with his or her current employment, or with his or her ethical and professional obligations towards other patients.

Transparency in payment and in the physician's fees

33. A treatment plan and estimate should include a detailed report of all costs, including a breakdown of physician's fees, such as: consultancy and surgery and additional fees the patient might incur, such as: hospital costs, surgical assistance, prosthesis (if separate), and costs for post-operative care.

34. The cost estimate may be changed after the treatment plan has been given only in the event that the clinical condition of the patient has changed, or where circumstances have changed in a way that it was impossible to anticipate or prevent. If the pricing was thus changed, the patient must be informed as to the reason for the change in costs in as timely a fashion as possible.

WMA STATEMENT
ON
SUSTAINABLE DEVELOPMENT

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

PREAMBLE

- The WMA believes that health and well-being are dependent upon social determinants of health (SDHs), the conditions in which people are born, grow, live, work and age. These social determinants will directly influence the achievement of the United Nations Sustainable Development Goals (SDGs). Many of the SDG goals, targets and indicators that have been developed to measure progress towards them, will also be useful measures of the impact of action is having on improving the SDH and, in particular, on reducing health inequities.

- This statement builds upon WMA policy on Social Determinants of Health as set out in the Declaration of Oslo, and upon the basic principles of medical ethics set out in the Declaration of Geneva.

- The WMA recognizes the important efforts undertaken by the United Nations with the adoption on 25 September 2015 of the resolution "Transforming our world: the 2030 Agenda for Sustainable Development". The Sustainable Development Agenda is based upon five key themes: people, planet, prosperity, peace and partnership and the principle of leaving no one behind. The WMA affirms the importance of global efforts on sustainable development and the impact that they can bring to humanity.

- SDGs are built on the lessons learned from successes and failures in achieving the Millennium Development Goals (MDGs), including inequity in many areas of life. While there is no overarching concept unifying the SDGs, the WMA believes that inequity in health and wellbeing encapsulates much of the 2030 Agenda. The WMA notes that while only SDG 3 is overtly about health, many of the goals have major health components.

- The WMA recognizes all governments must commit and invest to fully implement the goals by 2030, in alignment with the Addis Ababa Action Agenda. The WMA also recognizes the risk that the SDGs might be considered unaffordable due to their estimated potential cost of between US$ 3.3 and US$ 4.5 trillion a year.

- The WMA emphasises the need for cross and inter-sectoral work to achieve the goals and believes that health must be addressed in all SDGs and not only under health specific SDG 3.

Policy priorities:

- Recognition of Health in All Policies and the Social Determinants of Health / Whole of Society approach.
- Policy areas that are essential to achieving the SDG 3:
    - Patient Empowerment and Patient Safety
    - Continuous Quality Improvement in Health Care
    - Overcoming the Impact of Aging on Health Care
    - Addressing Antimicrobial Resistance
    - The safety and welfare of Health care staff
- Ensuring policy alignment among all the UN Agencies and the work of regional governmental organizations such as EU, African Union, Arab League, ASEAN, and Organization of American States.
- The WMA commits to support implementation of the other three global agreements regarding the sustainable development process:

    1. The Addis Ababa Action Agenda as the mechanism that will provide the financial support for the 2030 Agenda.
    2. The Paris Agreement is the binding mechanism of the sustainable development process that sets out a global action plan to put the world on track to avoid dangerous climate change by limiting global warming to well below 2°C above pre-industrial levels.
    3. The Sendai Framework for Disaster Risk Reduction as the agreement which recognizes that the State has the primary role to reduce disaster risk but that responsibility should be shared with local government, the private sector and other stakeholders.

Recommendations and Commitments

- The WMA commits to work with other intergovernmental organizations, including the UN, the WHO, healthcare professionals' organizations and other stakeholders, for the implementation and follow-up of this Agenda and related international agreements, and for policy and advocacy alignment.
- The WMA commits to collaborate with its constituent member Associations to support their work at regional and national levels, and with their governments on the 2030 Agenda implementation.
- The WMA recommends that NMAs create strategies regarding data collection, implementation, capacity building and advocacy, to enhance policy coherence and to maximise the 2030 Agenda implementation at national and global levels.

- The WMA also recommends that NMAs collaborate with development banks, NGOs, intergovernmental organisations and other stakeholders who are also working to implement of the 2030 Agenda, especially in their own countries.
- The WMA encourages the UN and the WHO to develop guidelines on how financing for health will be implemented to reach the targets established by the 2030 Agenda and the economic implications of NCDs, aging and antimicrobial resistance.

WMA STATEMENT
ON
AUGMENTED INTELLIGENCE IN MEDICAL CARE

Adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

PREAMBLE

Artificial Intelligence (AI) is the ability of a machine to simulate intelligent behavior, a quality that enables an entity to function appropriately and with foresight in its environment. The term AI covers a range of methods, techniques and systems. Common examples of AI systems include, but are not limited to, natural language processing (NLP), computer vision and machine learning. In health care, as in other sectors, AI solutions may include a combination of these systems and methods.

(Note: A glossary of terms appears as an appendix to this statement.)

In health care, a more appropriate term is "augmented intelligence", an alternative conceptualization that more accurately reflects the purpose of such systems because they are intended to coexist with human decision-making [1]. Therefore, in the remainder of this statement, AI refers to augmented intelligence.

An AI system utilizing machine learning employs an algorithm programmed to learn ("learner algorithm") from data referred to as "training data." The learner algorithm will then automatically adjust the machine learning model based on the training data. A "continuous learning system" updates the model without human oversight as new data is presented, whereas "locked learners" will not automatically update the model with new data. In health care, it is important to know whether the learner algorithm is eventually locked or whether the learner algorithm continues to learn once deployed into clinical practice in order to assess the systems for quality, safety, and bias. Being able to trace the source of training data is critical to understanding the risk associated with applying a health care AI system to individuals whose personal characteristics are significantly different than those in the training data set.

Health care AI generally describes methods, tools and solutions whose applications are focused on health care settings and patient care. In addition to clinical applications, there are many other applications of AI systems in health care including business operations, research, health care administration, and population health.

The concepts of AI and machine learning have quickly become attractive to health care organizations, but there is often no clear definition of terminology used. Many see AI as a technological panacea; however, realizing the promise of AI may have its challenges, since it might be hampered by evolving regulatory oversight to ensure safety and clinical efficacy, lack of widely accepted standards, liability issues, need for clear laws and

regulations governing data uses, and a lack of shared understanding of terminology and definitions.

Some of the most promising uses for health care AI systems include predictive analytics, precision medicine, diagnostic imaging of diseases, and clinical decision support. Development in these areas is underway, and investments in AI have grown over the past several years [2]. Currently, health care AI systems have started to provide value in the realm of pattern recognition, NLP, and deep learning. Machine learning systems are designed to identify data errors without perpetuating them. However, health care AI systems do not replace the need for the patient-physician relationship. Such systems augment physician-provided medical care and do not replace it.

Health care AI systems must be, transparent, reproducible, and be trusted by both health care providers and patients. Systems must focus on users' needs. Usability should be tested by participants who reflect similar needs and practice patterns of the end user, and systems must work effectively with people. Physicians will be more likely to accept AI systems that can be integrated into or improve their existing practice patterns, and also improve patient care.

Opportunities

Health care AI can offer a transformative set of tools to physicians and patients and has the potential to make health care safer and more efficient. By automating hospital and office processes, physician productivity would improve. The use of data mining to produce accurate useful data at the right time may improve electronic health records. and access to relevant patient information. Results of data mining may also provide evidence for trends that may serve to inform resource allocation and utilization decisions. New insights into diagnosis and best practices for treatment may be produced because of analyzing all known data about a patient. The potential also exists to improve the patient experience, patient safety, and treatment adherence.

Applications of health care AI to medical education include continuing medical education, training simulations, learning assistance, coaching for medical students and residents, and may provide objective assessment tools to evaluate competencies. These applications would help customize the medical education experience and facilitate independent individual or group learning.

There are a number of stakeholders and policy makers involved in shaping the evolution of AI in health care besides physicians. These include medical associations, businesses, governments, and those in the technology industry. Physicians have an unprecedented opportunity to positively inform and influence the discussions and debates currently taking place around AI. Physicians should proactively engage in these conversations in order to ensure that their perspectives are heard and incorporated into this rapidly developing technology.

Challenges

Developers and regulators of health care AI systems must ensure proper disclosure and note the benefits, limitations, and scope of appropriate use of such systems. In turn, physicians will need to understand AI methods and systems in order to rely upon clinical

recommendations. Instruction in the opportunities and limitations of health care AI systems must take place both with medical students and practicing physicians, as physician involvement is critical to successful evolution of the field. AI systems must always adhere to professional values and ethics of the medical profession.

Protecting confidentiality, control and ownership of patient data is a central tenet of the patient-physician relationship. Anonymization of data does not provide enough protection to a patient's information when machine-learning algorithms can identify an individual from among large complex data sets when provided with as few as three data points, which could put patient data privacy at risk. Current expectations patients have for confidentiality of their personal information must be addressed, and new models that include consent and data stewardship developed. Viable technical solutions to mitigate these risks are being explored and will be critical to widespread adoption of health care AI systems.

Data structure, and integrity are major challenges that need to be addressed when designing health care AI systems. The data sets on which machine learning systems are trained are created by humans and may reflect bias and contain errors. Because of this, these data sets will normalize errors and the biases inherent in their data sets. Minorities may be disadvantaged because there is less data available about minority populations. Another design consideration is how a model will be evaluated for accuracy and involves very careful analysis of the training data set and its relationship to the data set used to evaluate the algorithms.

Liability concerns present significant challenges to adoption. As existing and new oversight models develop health care AI systems, the developers of such systems will typically have the most knowledge of risks and be best positioned to mitigate the risk. As a result, developers of health care AI systems and those who mandate use of such systems must be accountable and liable for adverse events resulting from malfunction(s) or inaccuracy in output. Physicians are often frustrated with the usability of electronic health records. Systems designed to support team-based care and other workflow patterns but often fall short. In addition to human factors in the design and development of health care AI systems, significant consideration must be given to appropriate system deployment. Not every system can be deployed to every setting due to data source variations.

Work is already underway to advance governance and oversight of health care AI, including standards for medical care, intellectual property rights, certification procedures or government regulation, and ethical and legal considerations.

RECOMMENDATIONS

That the WMA:

- Recognize the potential for improving patient outcomes and physicians' professional satisfaction through the use of health care AI, provided they conform to the principles of medical ethics, confidentiality of patient data, and non-discrimination.
- Support the process of setting priorities for health care AI.

- Encourage the review of medical curricula and educational opportunities for patients, physicians, medical students, health administrators and other health care professionals to promote greater understanding of the many aspects, both positive and negative, of health care AI.

The WMA urges its member organizations to:

- Find opportunities to bring the practicing physician's perspective to the development, design, validation and implementation of health care AI.
- Advocate for direct physician involvement in the development and management of health care AI and appropriate government and professional oversight for safe, effective, equitable, ethical, and accessible AI products and services.
- Advocate that all healthcare AI systems be transparent, reproducible, and be trusted by both health care providers and patients.
- Advocate for the primacy of the patient-physician relationship when developing and implementing health care AI systems.

APPENDIX: GLOSSARY OF TERMS USED IN HEALTH CARE AUGMENTED INTELLIGENCE

Algorithm is a set of detailed, ordered instructions that are followed by a computer to solve a mathematical problem or to complete a computer process.

Artificial intelligence consists of a host of computational methods used to produce systems that perform tasks which exhibit intelligent behavior that is indistinguishable from human behavior.

Augmented intelligence (AI) is a conceptualization of artificial intelligence that focuses on artificial intelligence's assistive role, emphasizing that its design enhances human intelligence rather than replaces it.

Computer vision is an interdisciplinary scientific field that deals with how computers can be made to gain high-level understanding from digital images or videos and seeks to automate tasks that the human visual system can do.

Data mining is an interdisciplinary subfield of computer science and statistics whose overall goal is to extract information (with intelligent methods) from a data set and transform the information into a comprehensible structure for further use.

Machine learning (ML) is the scientific study of algorithms and statistical models that computer systems use to effectively perform specific tasks with minimal human interaction and without using explicit instructions, by learning from data and identification of patterns.

Natural language processing (NLP) is a subfield of computer science, information engineering, and artificial intelligence concerned with the interactions between computers and human (natural) languages, in particular how to program computers to process and analyze large amounts of natural language data.

Training data is used to train an algorithm; it generally consists of a certain percentage of

an overall dataset along with a testing set. As a rule, the better the training data, the better the algorithm performs. Once an algorithm is trained on a training set, it's usually evaluated on a test set. The training set should be labelled or enriched to increase an algorithm's confidence and accuracy.

Reference

[1] For purposes of this statement, the term "health care AI" will be used to refer to systems that augment, not replace, the work of clinicians.

[2] CB Insights. The Race for AI: Google, Baidu, Intel, Apple in a Rush to Grab Artificial Intelligence Startups. https://www.cbinsights.com/research/top-acquirers-ai-startups-ma-timeline/.

WMA STATEMENT ON FREE SUGAR CONSUMPTION AND SUGAR-SWEETENED BEVERAGES

Adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

PREAMBLE

Non-communicable diseases (NCDs) are the leading causes of death worldwide. Every year 40 million people die from NCDs [1]. The most common causes of these diseases are poorly balanced diet and physical inactivity. A high level of free sugar consumption has been associated with NCDs because of its association with obesity and poor dietary quality.

According to the World Health Organization (WHO), free sugar is sugar that is added to foods and beverages by the manufacturer, cook or consumer that results in excess energy intake which in turn may lead to parallel changes in body weight.

WHO defines free sugar as 'all sugars that are added during food manufacturing and preparation as well as sugars that are naturally present in honey, syrups, fruit juices, and fruit concentrates.'

Sugar has become widely available and its global consumption has grown from about 130 to 178 million tonnes over the last decade4.

Excess free sugar intake, particularly in the form of sugar-sweetened beverages, threatens the nutrient quality of the diet by contributing to the overall energy density but without adding specific nutrients. This can lead to unhealthy weight gain and increases the risk of dental disease, obesity and NCDs. Sugar-sweetened beverages are defined as all types of beverages containing free sugars (include monosaccharides and disaccharide) including soft drinks, fruit/vegetables juices and drinks, liquid and powder concentrates, flavored water, energy and sports drinks, ready-to-drink tea, ready-to-drink coffee and flavored milk drinks.

The World Health Organization recommends reducing sugar intake to a level that comprises 5% of total energy intake (that is around 6 teaspoons per day) and not to exceed 10% of total energy intake [2].

The price elasticity of sugar-sweetened beverages according to a meta-analysis published in USA, is -1.21. This means that for each 10% increase in the price of sugar-sweetened beverages, there is a -12.1% decrease in consumption. Successful examples of price elasticity were seen in Mexico as the consumption of sugar-sweetened beverages decreased after imposing the sugar tax.

Data and experience from across the world demonstrate that a tax on sugar works best as part of a comprehensive set of interventions to address obesity and related chronic diseases. Such interventions include food advertising regulations, food labelling, educational campaigns, and subsidy on healthy foods.

RECOMMENDATIONS

The World Medical Association (WMA) and its constituent members should:

- call upon the national governments to reduce the affordability of free sugar and sugar-sweetened beverages through sugar taxation. The tax revenue collected should be used for health promotion and public health preventive programs aimed at reducing obesity and NCDs in their countries;
- encourage food manufacturers to clearly label sugar, if present, in their products and urge governments to mandate such labeling;
- urge governments to strictly regulate the advertising of sugar containing food and beverages targeted especially at children;
- urge national governments to restrict availability of sugar-sweetened beverages and products that are highly concentrated with free sugar from educational and healthcare institutions and replace with healthier alternatives.

Constituent members of the WMA and their physician members should work with national stakeholders to:

- advocate for healthy sustainable food with limited free sugar intake that is less than 5% of total energy intake;
- encourage nutrition education and skills programs toward preparing healthy meals from foods without added sugar;
- initiate and/or support campaigns focused on healthy diets to reduce sugars intake;
- advocate for an inter-sectoral, multidisciplinary and comprehensive approach to reducing free sugar intake.

References

[1] http://www.who.int/fr/news-room/fact-sheets/detail/noncommunicable-diseases

[2] WHO Guideline: Sugars Intake for Adults and Children 2015

WMA STATEMENT
ON
HEALTHCARE INFORMATION FOR ALL

Adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

PREAMBLE

The WHO constitution states that "the extension to all people of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health". Access to relevant, reliable, unbiased, up-to-date and evidence-based healthcare information is crucial for the public, patients and health personnel for every aspect of health, including (but not limited to) health education, informed choice, professional development, safety and efficacy of health services, and public health policy.

Lack of access to healthcare information is a major contributor to morbidity and mortality, especially in low- and middle-income countries, and among vulnerable groups in all countries.

Healthcare information is only useful if it is relevant, appropriate, timely, updated, understandable and accurate. It covers a broad spectrum of issues and refers to diseases, treatments, services, as well as the promotion and preservation of health.

Health literacy is a key factor in understanding how health services work and how to use them. Health professionals need access to adequate training and support to communicate with patients with low health literacy or with those who have difficulty understanding healthcare information, for example because of a disability.

Globally, thousands of children and adults die needlessly because they do not receive basic life-saving interventions. Some interventions may be available locally but are simply not provided due to indecision, delays, misdiagnosis and incorrect treatment. Failure to provide basic life-saving interventions more commonly affects those who are socioeconomically disadvantaged.

In the case of children with acute diarrhea, for example, the widespread misconception among parents that they should withhold fluids, and among health workers that they should give antibiotics rather than oral rehydration, contributes to thousands of unnecessary deaths every day worldwide.

Governments have a moral obligation to ensure that the public, patients and health workers have access to the healthcare information they need to protect their own health and the health of those for whom they are responsible. This obligation includes providing adequate education, in form and content, to identify and use such information effectively.

The public, patients and healthcare workers need easy, reliable access to evidence-based, relevant healthcare information as part of a learning process throughout the life-course to enhance understanding, and to make informed and conscious decisions about their health, healthcare options and the health care they receive. These groups need information in the right language, and in a format and technical level that is understandable to them, with relevant services signposted as appropriate. This should take into account the characteristics, customs and beliefs of the population to which it is directed, and a feedback process should be established. The public, patients and families need information that is appropriate to their specific context and situation, which may change over time. They need guidance on when and how to make important health decisions, which are usually best made when there is time to consider, understand and discuss the issue at hand.

Meeting the information needs of the public, patients and healthcare providers is a prerequisite for the realisation of quality universal health coverage and the UN Sustainable Development Goals (SDGs).” UN SDG Target 3.8 on universal health coverage specifically aims to deliver ‘quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all’. Achieving this requires empowerment of the public and patients, as well as health workers, with the healthcare information they need to recognize and assume their rights and responsibilities to access, use and provide appropriate services and to prevent, diagnose and manage disease.

The development and availability of evidence-based, relevant healthcare information depends on the integrity of the global healthcare information system. This system comprises researchers, publishers, systematic reviewers, producers of end-user content (including academic publishers, health education, journalists and others), information professionals, policymakers, frontline health professionals and patient representatives, among others.

RECOMMENDATIONS

Recognizing this, the World Medical Association and its constituent members on behalf of their physician members, will support and commit to the following actions:

1. Promote initiatives to improve access to timely, current, evidence-based healthcare information for health professionals, patients and the public to support appropriate decision-making, lifestyle changes, care-seeking behaviour and improved quality of care – thereby upholding the right to health.

2. Promote standards of good practice and ethics to be met by information providers, guaranteeing reliable and quality information that is produced with the participation of physicians, other health professionals, and patient representatives.

3. Support research to identify enablers and barriers to the availability of healthcare information, including how to improve the production and dissemination of evidence-based information for the public, patients and health professionals, and measures to increase health literacy and the ability to find and interpret such information.

4. Ensure that health professionals have access to evidence-based information on diagnosis and treatment of diseases, including unbiased information on medicines. Particular attention should be paid to those working in primary care in low- and middle-income countries.

5. Combat myths and misinformation around healthcare through validated scientific and clinical evidence, and by urging the media to report responsibly on health issues. This includes the study of health-related beliefs stemming from cultural or sociological differences. This will improve the effectiveness of health promotion activities and allow the dissemination of healthcare information to be adequately targeted to different segments of the population.

    - Urge governments to recognize their moral obligation to take measures to improve the availability and use of evidence-based healthcare information. This includes:
    - resources to select, compile, integrate and channel scientifically validated information and knowledge. This should be adapted to target various different recipients;
    - measures to increase availability of healthcare information for healthcare workers and patients at health centres;
    - leveraging modern communication technology and social media;
    - policies that support efforts to increase the availability and use of reliable healthcare information.

6. Urge governments to provide the political and financial support needed for 'WHO's function to ensure access to authoritative and strategic information on matters that affect peoples' health', based on the WHO General Programme of Work 2019-23.

WMA STATEMENT
ON
MEDICAL AGE ASSESSMENT OF UNACCOMPANIED MINOR ASYLUM SEEKERS

Adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

PREAMBLE

Population displacement resulting from war, violence or persecution has wide-ranging implications for the entire global community. Refugees – that is, individuals who have been forced to flee their respective countries of origin for these reasons – generally must undergo rigorous procedures for determining their legal status according to the national legislation of the country in which they are seeking asylum.

An increasing number of refugees fall under the category of unaccompanied minors, which are defined as people under the age of 18 who have been separated from or who have fled their countries of origin without their families. In light of their unique vulnerability, unaccompanied minor refugees are eligible for special protections, as outlined in the United Nations' Convention on the Rights of the Child, which states that the best interests of the child must be the primary consideration in all stages of the displacement cycle.

Given the differences in how adults and unaccompanied minors are processed and protected when seeking asylum, recipient countries have an interest in verifying the age of applicants outside the context of criminal proceedings. However, some asylum seekers either do not have access to documentation confirming their age or originate from countries in which there is no central birth registry. In cases where there is doubt as to whether an asylum seeker is a child or an adult, e.g. if the authenticity of available documentation is called into question or if there is reason to believe the applicant's physical appearance suggests a discrepancy between the reported age and the actual age, the competent authorities may resort to medical and/or non-medical methods for assessing the applicant's age.

Medical age assessments carried out by medical professionals may take the form of X-ray scans of the jaw, hand or wrist; CT scans of the collarbone; MRI scans of the knee; or the examination of secondary sex characteristics to determine the applicant's stage of puberty. However, ethical concerns have been raised about these and other forms of examination, as they can potentially endanger the health of those being examined and violate the privacy and dignity of young people who may already be severely traumatized [1]. Furthermore, there is conflicting evidence about the accuracy and reliability of the available methods of medical age assessment, which may generate significant margins of error [2]. For example, some available studies do not appear to take into account potential

delays in skeletal maturation caused by malnutrition, which is just one factor that could translate into a risk of age misclassification among asylum seekers [3]. Comparative assessments are further impeded by a lack of standard images from certain world regions and limited representation in age assessment reference data, much of which was compiled on the basis of European and North American populations [4]. An imprecise assessment of an individual's age can have far-reaching administrative, ethical, psychological and other significant consequences, including potential breaches of children's rights.

The following recommendations apply explicitly and exclusively to cases outside the context of the criminal justice system.

RECOMMENDATIONS

1. The WMA recognizes that there is sometimes a need to assess the age of asylum seekers to ensure that all unaccompanied minors receive the protections afforded them under international and national law.

2. The WMA recommends that medical age assessments only be carried out in exceptional cases and only after all non-medical methods have been exhausted. The WMA recognizes that non-medical methods, e.g. questioning children about traumatic events, may also have a negative impact and must therefore be carried out with great care. Each case must be evaluated carefully based on the totality of circumstances and the preponderance of available evidence.

3. The WMA asserts that, in cases where medical age assessment is unavoidable, the health and safety and dignity of the young asylum seeker must be the highest priority. Physical examinations must be carried out by a qualified physician with appropriate pediatric examination experience in accordance with the highest medical and ethical standards, in observance of the principles of proportionality, in adherence to the standards of prior informed consent and with consideration of cultural and religious sensitivities and potential language barriers. The asylum seeker must always be made aware that the examination is carried out as part of the age assessment procedure and not to provide healthcare.

4. The WMA underscores that any medical methods that could involve a health risk for the applicant, e.g. radiological examinations without medical indication, or that infringe upon the dignity or privacy of an already potentially traumatized asylum seeker, e.g. genital examinations, must be avoided.

5. The WMA stresses that medical certificates indicating the results of medical age assessment examinations should include information concerning the accuracy and reliability of the methods used and the relevant margins of error.

6. The WMA urges constituent members to develop or promote the development of internationally accepted interdisciplinary guidelines which outline the scientific basis, as well as ethical and legal or regulatory principles of medical age assessment of asylum seekers, including the potential health risks and psychological impact of specific procedures.

7. The WMA emphasizes that, in cases where doubts regarding the age of an asylum seeker cannot be resolved or confirmed with absolute certainty, any remaining uncertainty should be interpreted in favor of the asylum seeker.

References:

[1] Zentrale Ethikkommission der Bundesärztekammer (2016): Stellungnahme "Medizinische Altersschätzung bei unbegleiteten jungen Flüchtlingen. Deutsches Ärzteblatt 2016; A1-A6. / German Medical Association's Central Ethics Committee: Statement on Medical Age Assessment of Unaccompanied Minor Refugees.

[2] Separated Children in Europe Programme (2012): Position Paper on Age Assessment in the Context of Separated Children in Europe. Online http://www.separated-children-europe-programme.org/separated_children/good_practice/index.html. Last accessed 03.07.2018.

[3] Sauer PJJ, Nicholson A, Neubauer D, On behalf of the Advocacy and Ethics Group of the European Academy of Paediatrics (2016): Age determination in asylum seekers: physicians should not be implicated. European Journal of Pediatrics 175, (3): 299-303.

[4] Aynsley-Green et al. (2012): Medical, statistical, ethical and human rights considerations in the assessment of age in children and young people subject to immigration control. British Medical Bulletin 2012; 102: 39.

WMA STATEMENT
ON
HUMAN GENOME EDITING

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

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

WMA STATEMENT
ON
HYPERTENSION AND CARDIOVASCULAR DISEASE

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

Prevalence

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

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

Risk Factors

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

- Lifestyle/Diet: Unavailability of healthy food choices, lack of access to safe neighborhoods for exercising, and unhealthy lifestyle habits can raise the risk of hypertension. Unhealthy lifestyle habits include unhealthy eating patterns such as eating too much sodium and highly processed food, drinking too much alcohol, smoking, and being physically inactive.

- Age: Blood pressure (BP) tends to increase with age. However, the risk of hypertension is increasing for children and teens, possibly due to the rise in the number of children and teens who are overweight or obese.
- Socioeconomic Status: In high-income countries, the greatest absolute burden of hypertension disease is in age groups 60 years and older, whereas in low/middle-income countries, the greatest absolute burden is in the middle-aged groups, such as 40 to 59 years. The age-standardized prevalence of hypertension is higher in low/middle-income countries than in high-income countries.
- Sex: Before age 55, men are more likely than women to develop hypertension. After age 55, women are more likely than men to develop it.
- Genetics/Family History: Research has identified many gene variations associated with small increases in the risk of developing hypertension. Some people are genetically predisposed to dietary sodium sensitivity.

Accurate blood pressure measurement

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

Policy implications

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

RECOMMENDATIONS

1. The World Medical Association recommends that national governments:
   - Recognize hypertension as the single most important risk factor for cardiovascular disease and death.
   - Declare hypertension control a national health priority.
   - Support campaigns to raise public awareness of hypertension, including recognition of its widespread and asymptomatic nature, and its risk of contributing to development of other serious diseases.
   - Deploy adequate resources to improve hypertension awareness, diagnosis, measurement, and management.

- Develop country-specific strategies which address the risk factors for hypertension and advocate for improvements in awareness, diagnosis, measurement and management.
- Promote the recommendations adopted by the WMA as stated in the Statement on Reducing Dietary Sodium Intake.

2. The World Medical Association recommends that its constituent members:

- Advocate at the international, national, and local levels to promote hypertension awareness, healthy lifestyles, and patient access to hypertension diagnosis and treatment including medications. This includes supporting the concept that social determinants of health are part of hypertension disease prevention.
- Recognize and support national guidelines and strategies for measuring BP accurately.
- Support the exchange of hypertension research, information, tools, and other resources amongst healthcare teams and patients.
- Support the development of medical curricula that respond to societal hypertension needs with a focus on community-based primary care training and BP measurement and management skills.
- Promote research on the causes, mechanisms and effective treatments of hypertension.
- Advocate for sustained availability antihypertensive medications.

3. The World Medical Association recommends that physicians:

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

WMA STATEMENT
ON
MEASURES FOR THE PREVENTION AND FIGHT AGAINST TRANSPLANT-RELATED CRIMES

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

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

The distinctive feature of transplant-related crimes is the necessary involvement of health professionals. It is precisely this feature that provides a unique opportunity to prevent and combat these crimes. Health professionals are key in evaluating prospective living donor and recipient pairs. They also care for desperate patients who are vulnerable and at risk of engaging in illicit transplant activities. In addition, since patients who receive a transplant

require long-term specialised care, physicians must deal with the many challenges of providing care to patients who have received an organ through illicit means, while unveiling trafficking rings.

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

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

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

The WMA reaffirms its Statement on organ and tissue donation and its Declaration of Sydney on the determination of death and the recovery of organs. Condemning all forms of trafficking in persons for the purpose of the removal of organs and trafficking in human organs, the WMA calls for the implementation of the following recommendations.

RECOMMENDATIONS

Policy makers and health actors:

1. Governments should develop, implement and vigorously enforce legislative frameworks that prohibit and criminalise trafficking in persons for the purpose of the removal of organs and trafficking in human organs, these should include provisions to prevent these crimes and protect their victims.

2. Governments should consider ratifying or acceding to the United Nations Convention against Transnational Organised Crime and the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organised Crime, as well as the Council of Europe Convention against Trafficking in Human Organs. They should also consider cooperating with existing international organisations for a more effective fight against transplant-related crimes. The WMA should play a leading role in influencing ethical practices in donation and transplantation.

3. Health authorities should develop and maintain registries to record information regarding each organ recovery and transplantation procedure, as well as information on the outcomes of living donors and organ recipients, to ensure the traceability of organs, with due regard to professional confidentiality and personal data protection. Registries should be designed to record information on procedures that take place within a country and on transplant and living donation procedures on residents of that country carried out in other destinations.

4. Countries are encouraged to periodically contribute this information to the Global Observatory on Donation and Transplantation developed in collaboration with the World Health Organization.

5. Health authorities and medical associations should ensure that all health professionals are trained in the nature, extent and consequences of transplant-related crimes, as well as in their responsibilities and duties in preventing and fighting these criminal activities and in the means to do so.

6. As self-sufficiency is the best long-term strategy to prevent transplant-related crimes, health authorities and policy makers should develop preventive strategies to decrease the burden of diseases treatable with transplantation and increase the availability of organs.

7. Increasing organ availability should be based on the development and optimisation of ethically sound deceased donation programs following the determination of death by neurological and by circulatory criteria. Of note is that donation after the determination of death by circulatory criteria is accepted in a limited number of countries. Governments should explore whether donation after the circulatory determination of death is a practice acceptable within their community and, should this be the case, consider introducing it within their jurisdiction.

8. In addition, governments should develop and optimise living donation programs based on recognised ethical and professional standards and ensure due protection and follow-up of living donors.

9. Health authorities and/or insurance providers should not reimburse the costs of transplant procedures that have occurred in the context of transplant-related crimes. However, the costs of medications and post-transplant care should be covered, as for any other transplant patient.

10. Authorities should also ensure that medical and psychosocial care is provided to victims of trafficking in persons for the purpose of organ removal and of trafficking in human organs. Consideration should be given to effective compensation of these persons for the damage suffered.

11. National Medical Associations should advocate for and cooperate with authorities in developing frameworks for health professionals to report any confirmed or suspected case of trafficking of persons for the purpose of the removal of organs and of trafficking in human organs to the relevant authorities. National Medical Associations should advocate for the ability of health professionals to report suspected trafficking of individual persons, on an anonymous basis if necessary, to protect the safety of the reporter. Where applicable, the reporting of trafficking cases should be a permitted exception to the physician's obligation to maintain patient confidentiality

Physicians and other health professionals:

12. Physicians should never perform a transplant using an organ that has been illicitly obtained. If there are reasonable concerns about the origin of an organ, the organ must not be used. If a physician or a surgeon is asked to perform a transplant with an organ that has been obtained through a financial transaction, without the valid consent of the

donor or without the authorisation required in a given jurisdiction, they must refrain from performing the transplant and should explain the reasons to the potential recipient.

13. Physicians who participate in the preoperative evaluation of potential living donors should not only assess the medical suitability of the individual, but also attempt to ensure that the person has not been subject to coercion of any kind or is participating in the procedure for financial gain or any other comparable advantage. The legitimacy of the donor-recipient relationship and the altruistic motivations for donation should be scrutinised. Physicians should be particularly vigilant of "red flags" suggestive of a transplant-related crime. Non-resident living donors may be particularly vulnerable and should be given special consideration. For linguistic, cultural and other reasons, assessing the validity of their consent to donation can be especially challenging, as can ensuring that appropriate follow-up is offered to them. A referring physician should be identified in the country of origin of the living donor – and in that of their intended recipient, where appropriate.

14. Physicians should never promote or facilitate the engagement of patients in transplant-related crimes. Moreover, they should inform patients of the risks these activities pose for their own health, that of their loved ones and, more generally, for public health. Patients should also understand that these activities entail an exploitation of vulnerable individuals who may themselves suffer from severe medical and psychosocial complications. By counselling patients, professionals may dissuade them from engaging in illicit transplant activities.

15. Physicians have a duty to care for transplant patients, even if their organ was illicitly Should a physician have ethical or moral objections about caring for a patient who has received an illicit organ, they should make the necessary arrangements to transfer the care of the patient to another physician.

16. Physicians should contribute to guaranteeing transparency of practices and traceability of organs. When patients who have undergone a donation or a transplantation procedure abroad seek follow-up care in their country of residence, all relevant information should be recorded in national transplant-registries and reported to health authorities, as should happen for all donation and transplantation procedures performed within the national transplant system.

17. Physicians have a responsibility to increase the deceased donor pool in order to satisfy the transplantation needs of patients. Physicians also have a duty towards possible organ donors in considering and facilitating organ donation if this is consistent with patients' values and principles. Donation should be routinely offered as an option at the end of life, always in a respectful manner, taking into account the culture and religion of the potential donor and their surrogates. Conversations about donation opportunities should be led by experienced and trained professionals.

18. Physicians should promote research in the field of donation and transplantation, in particular research targeted at increasing the availability of organs for transplantation, improving the outcomes of transplanted organs, and identifying alternative organ replacement strategies, as in the case of bioartificial organs.

WMA STATEMENT IN SUPPORT OF ENSURING THE AVAILABILITY, THE QUALITY AND THE SAFETY OF MEDICINES WORLDWIDE

Adopted by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

INTRODUCTION

Over the past decade, pressure on supply has led to shortages of certain medical products, including vaccines. In many situations, these shortages result from putting economic objectives before public health. These shortages are detrimental to patient care, to maintaining public health and to the organization of healthcare systems.

The world is going through rapid change; technological progress, radical progress in matters of communication and access to information as well as the increasing power of multi-nationals are transforming the global landscape, including the pharmaceutical industry. Unfortunately, some of these developments have encouraged the production and sale of medical products which do not meet the required safety standards, whether due to the manufacturing process or inappropriate storage, or due to the criminal manufacture and fraudulent distribution of sub-standard or falsified medicines.

According to the WHO's Global Surveillance and Monitoring System (GSMS) for sub-standard and falsified medical products, around one out of ten medicines is either of a sub-standard quality or falsified in countries with low or medium income. This observation is not limited to the most expensive medicines or the most well-known brands, but also concerns patented and generic products. The medicines most often flagged are the antimicrobials and antimalarials.

The WMA reiterates its position on biosimilar medicines, its resolution on prescribing medicines, its position on the substitution of medicines and resistance to antimicrobials.

The rational use of medicines implies ensuring that research, regulation, production, distribution, prescription, financing, delivery and proper administration of these medicines comply with coherent and rational scientific, professional, economic and social criteria.

From a healthcare point of view, a shortage of medicines is unacceptable, as it has a negative impact on confidence for patients, doctors, pharmacists and the healthcare system, it leads to insecurity and uncertainty and compromises treatment continuity; with all the risks that this implies.

With the objective of combatting the intolerable missed opportunities that such shortages represent for patients, undermining public trust in the healthcare system, the WMA is calling for the implementation of the following recommendations:

RECOMMENDATIONS

Availability of medicines

1. As a public health issue and out of concerns for safety, the WMA urges national governments to improve the availability of medicines.

2. National governments and regulatory authorities should:

    - Create a national entity responsible for gathering and communicating information relative to demand and offer for medicines under their jurisdiction. Establish standards and mechanisms guaranteeing the continuity and the supply of medicines and thus avoid shortages.
    - Improve the monitoring of medical product supply chains, as the weakness of regulatory structures make the application of good medical product distribution particularly difficult.
    - Design contingency strategies to counter the dependence of States on foreign medicine production due to the delocalization and centralization of the majority of structures which produce the main pharmaceutical components used in the composition of major medicines.
    - Encourage national healthcare authorities to maintain stocks of essential medicines in order to minimize the risk of shortages. Indeed, the Covid-19 health crisis has demonstrated the limits of stocks held by States and has constrained them to reorganize and restrict access to certain medicines.
    - In the case of global epidemic, to pool scientific research and clinical trials with the objective of accelerating the development of vaccines and/or treatments to eradicate the pandemic.
    - Support legislative and regulatory initiatives which guarantee an appropriate national capacity to produce pharmaceutical products, in the interests of the well-being of the populace and national security.
    - Identify and create sustainable mechanisms which will guarantee sufficient stocks and sufficient access to necessary medicines.
    - Promote co-operation between governments in the prevention and the management of medicine and vaccine shortages.

- Encourage governments to be more directive in their dealings with the pharmaceutical industry, notably in terms of adjusting quotas, of accelerating approvals and of importing substitute medicines when pharmaceutical companies are not able to ensure a continuous and adequate supply of medicines.
- Consider demanding that medicine producers establish a continuity plan for the supply of vital and necessary medicines and vaccines in order to avoid production shortages wherever possible.
- Ensure the transparency, sharing and availability of quality information coming from reliable sources in order to establish a trustworthy flow of communications between all stake-holders and healthcare professionals and to the patients. In the case of shortages, governments should divulge and detail the causes to all stake-holders.
- Enable WMA member states to acquire, via common supply contracts, healthcare and vaccine products in sufficient quantities during a pandemic and thus to have greater influence in negotiations with laboratories.
- Avoid the 'first come, first served' approach, notably during a pandemic, leading to counter productive competition acting against the safeguarding of public health.
- Allow an industrial level of security of supply in line with the deployment of Interpol's programme combatting pharmaceutical criminality.

Safety of medicines

3. The objective is to set up active supply processes to ensure the continuity of quality medical supplies while guaranteeing their safety.

4. Elements of a high-quality, active supply process comprise:

- Improvements in quantification, including forecasting.
- Direct communication between supply agents and the manufacturers on the question of sustainable capacity.
- Deliberate and well-considered approaches to a specific situation for each product (long term, short term, split contracts, etc.)
- Responsible pricing with the emphasis on quality
- Rational and necessary contracts.
- Establish frameworks which limit the excessive accumulation of medicines and the useless scrapping of unused medicines with the objective of preserving the quality of their pharmaceutical properties.
- Encourage governments to promote the sharing of public information on the real price of medicines. The authorities must regulate and limit the possibility of reaching

agreements on price and discounting confidentiality in the medicine evaluation process. The system must be made more transparent in all areas, including the evaluation of new medicines.

5. The WMA is clear on the fact that the quality of medicines is a public health priority and is recommending national medical associations and doctor members to:

   - Increase awareness among the public and medical practitioners of sub-standard and fake products.
   - Create a list of 'essential' medicines meeting a country's healthcare needs.
   - Create an early alert system, based around vital medicines and those intended to treat a debilitating pathology, in particular those for which no alternative therapeutic options are available. The activation of such a system would trigger a sequence of measures for all the stake-holders (licensed manufacturers, wholesalers, hospital pharmacists) alongside reporting obligations and a close monitoring of corrective actions.
   - Create a scenario and emergency programmes, including a stress test for manufacture and inspection systems at regular intervals, with appropriate communication strategies adapted to the different stake-holders.
   - Persue efforts to harmonise regulatory standards between the countries and beyond regions.
   - Set up proactive and productive collaboration between all the essential stake-holders in order to prevent medicine shortages and mitigate the harmful effects these have on patient care.
   - Work with healthcare user associations to fight against the growing culture of ill-advised self-diagnosis, self-prescription and self-medication, which could make the supply chain vulnerable to the introduction of non-approved or counterfeit products.
   - Restrict the prevalence of low quality medicines by implementing and applying current good practices in manufactuting, storage and distribution which respect the environment (cGMP) and by preventing the deterioration of medicines.
   - Encourage the pharmaceutical sector to undertake to guarantee the continuity of supply of medicines, in order to avoid any interruptions in treatment.

6. The WMA is insisting that national governments, in tandem with healthcare user associations and other stake-holders, do everything possible to ensure awareness of medicine safety for all patients.

   - At an international level and working together, Health Ministers and Medical Regulators should recommend that national medical associations actively oppose the illegal misappropriation of medicines, the illegal sales of medicines on the internet, the illegal importing of medicines and the counterfeiting of medicines.

- Improve regulation and monitoring of the online pharmaceutical market through national regulation of e-commerce activities.
- Regulations and mechanisms should be adopted to immediately close all websites illegally offering medical products not controlled by state authorities.
- Improve the identification and the revelation of counterfeit medical products all over the world.
- Launch international campaigns warning of the health risks linked to the use of counterfeit medical products, informing people about the dangers of buying medicines, or products offered as such, on the internet (counterfeit or fake medicines, etc.).
- Improvement in detecting falsified and sub-standard medicines, including vaccines and other medical products, and their reporting worldwide. Falsified and sub-standard medicines, including vaccines and other other medical products, should be reported to the appropriate authorities whenever they are discovered. Pharmacies, hospital pharmacies and patients must be prevented by whatever means from being supplied with falsified or sub-standard medicines. All adverse side-effects of a falsified or sub-standard medicine must be immediately highlighted via an efficient and adapted reporting system.
- Strengthen and align international rules against conterfeit medical products, allowing an efficient fight against the growing challenges of the systems of governance caused by the globalisation of manufacturing processes and supply chains.

Covid-19 health crisis

7. The Covid-19 health crisis has highlighted the fundamental problems of availability, quality and safety of medicines.

8. The already significant problems of availability, quality and safety of medicines have been starkly brought to light by the Covid-19 health crisis. The importance of these questions is even bigger, on a global scale, and the Covid-19 pandemic has created unprecedented challenges for the authorities of every State. A pandemic leads to a sharp increase in demand for certain medicines and major expectations of specific medicines and vaccines, creating the conditions for multiple tensions.

9. The problem of medicine availability is particularly apparent for anesthetics and curares in life support, which are subject to closely monitored delivery in order to avoid any break in supply. The prescription and delivery of certain other medicines have been closely supervised in order to maintain supply for chronic illnesses.

10. As a response to the unequal access to vaccinations, the implementation of the COVAX mechanism must be developed in the future so as to promote access to and distribution of vaccines, with the objective of protecting the people of all countries.

11. The WHO warns and cautions consumers, healthcare professionals and health authorities about medicine safety: the growing offer of falsified medical products in the context of the Covid-19 pandemic is aided by the possibility of shortages.

12. Concerning the quality of medicine, the health crisis has highlighted the risks of self-medication and the need for the States to set up information systems aimed at the general population. False hopes of possible cures for or prevention of Covid-19 by scientifically unproven methods have been known to have serious consequences for the health of the individual.

13. Economic and/or political interests must not be in competition with the health of the public. Pooling of public health interests must be developed in order that economic and/or political interests are not the cause of failure to manage the situation, of stock shortages or of anti-competitive behaviour.

14. The evolution of the current health crisis and notably the arrival of new variants show that States must be able to respond scientifically to this evolution without being hampered by overly-restrictive international regulations.

WMA STATEMENT
ON
ESSENTIAL SURGICAL CARE AS A PART OF ACCESS TO HEALTHCARE

Adopted by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

PREAMBLE

Surgery and anesthesia care encompass all clinical fields and all health care providers dealing with surgical disease and pathologies. This includes, but is not limited to anesthesia, obstetrics and gynaecology and surgery including all of its subspecialties. They have historically been a neglected part of global health with very little investments made in developing surgical health systems, while an estimated quarter of the burden of disease worldwide can be attributed to surgical diseases. Moreover, the majority of the world's population lacks access to safe, timely and affordable surgical care.

A workforce of 20 surgical, anesthesia and obstetric physician providers for every 100.000 members of the population is necessary to provide 80% of the world population essential and emergency surgical care within 2 hours. This includes emergency surgical and obstetric care such as caesarian sections and surgical care to prevent death and disability due to illnesses likely to benefit from surgical treatment such as injuries, cataracts and cancer. The majority of low- and middle-income countries (LMICs) fall far below this target, with the need being especially great in the poorest regions of the world.

Surgeon shortages may be exacerbated by a lack of gender equity in the surgical workforce which remains a challenge. Despite the fact that in a number of countries, there are more female than male medical students, men still outnumber women by far in the surgical workforce.

Surgery and anesthesia care have been proven to be cost-effective, especially in LMICs. Surgical interventions are as cost-effective as common public health interventions like malaria bed nets, HIV drugs or childhood vaccinations.

Sixty percent of cancer patients and eighty percent of trauma patients will need some form of surgical intervention throughout their treatment. Considering both non-communicable diseases (NCDs) and injuries are on the rise globally, the demand for surgical care is expected to continue to increase.

In 2015 the World Health Assembly recognized surgery and anesthesia care as a vital component of Universal Health Coverage (UHC) through their Resolution 68.15 "Strengthening emergency and essential surgical care and anesthesia as a component of universal health coverage".

RECOMMENDATIONS

WMA recommends that the relevant national authorities:

1. Integrate quality surgical and anesthesia care in all levels of health care, including comprehensive primary health care in order to realize UHC and Sustainable Development Goals by 2030.

2. Develop specific surgery and anesthesia guidelines and policies for their respective countries or jurisdictions adapted to local needs and capacities.

3. Implement policies regulating the process of task shifting in surgery and anesthesia care in line with the "WMA Resolution on Task Shifting from the Medical Profession".

4. Invest in health system strengthening and advocate for increased financing and budgetary allocation for surgery and anesthesia care without depriving other areas of necessary funds.

5. Provide the necessary infrastructure and procurement lines for hospitals to deliver safe, high-quality surgical care.

6. Ensure policies, including narcotic and regulated drugs policies, do not hamper access to necessary surgical medications including analgesia and anesthetic agents.

7. Create clinical protocols or guidelines at the national or regional level to assure antibiotics use in the peri-operative period are prescribed in a sustainable manner and in line with applicable antimicrobial resistance guidelines.

8. Include surgical care and diseases in relevant courses to fight the dogma that surgical care is too expensive and complex to provide in low-resource settings.

9. Offer equitable residency training opportunities to locally trained medical students of both genders in the field of surgery and anesthesia based on scientifically projected needs of the country or region in line with the "WMA Statement on Gender Equality" and contributing to the Global strategy on human resources for health: Workforce 2030.

10. Allow adaptive training and work schedules to accommodate the potential need for maternity or paternity leave, and a healthy work-life balance, in order to make training programs more accessible irrespective of the trainee's family responsibilities.

11. Seek regional, national and international collaboration in clinical and academic domains where local capacity and resources may be lacking and where exposure could be beneficial to those from areas without high capacity or resources, such as through bilateral exchange programs.

12. Support national initiatives on surgical data collection, capacity building, advocacy, policy planning and systems strengthening through collaboration with NGOs,

universities, research initiatives, local communities, development banks, governmental organizations, and other stakeholders;

WMA commits to:

13. Advocate at local, regional and national, and international fora in favor of person-centered care creating a more holistic health care system, offering medical, surgical, mental health and preventive health services in a national UHC approach, supporting WHA Resolution 68.15 “Strengthening emergency and essential surgical care and anesthesia as a component of universal health coverage”.

WMA STATEMENT
ON
SOLAR RADIATION AND PHOTOPROTECTION

Adopted by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

PREAMBLE

The sun is a great source of health benefits, but it is important to know its harmful consequences as well. The prevention of the harmful effects of the sun on our skin is advisable at all ages, especially in children and adolescents. Solar radiation generates a series of biological and physiological effects in the body that depend on the proportion and intensity of the radiation and that have beneficial effects, such as stimulating the synthesis of vitamin D, favoring the formation of hemoglobin and improving the mood, while other effects are harmful and aggressive to the skin, such as erythema, photoaging of the skin and precancerous or cancerous lesions. Dermatoses produced or aggravated by sun exposure are a health problem that healthcare professionals face most frequently.

Solar light is composed of a continuous spectrum of electromagnetic radiation divided into three major groups: ultraviolet (UV), visible and infrared. UV radiation is classified as UV-A, UV-B and UV-C.

The intensity of UV radiation can be measured by international standardized instruments such as the UV index which measures the strength of sunburn-producing solar UV radiation at a particular place and time.

Solar UV radiation, especially through UV-B, is an extremely important, yet neglected causative factor for skin cancers, both melanoma and non-melanoma, for ocular pathologies (e.g., cataracts, and age-related macular degeneration), and harmful effects on the immune system [3]. Recurrent and severe sunburns are a risk factor for non-melanoma skin cancer.

Solar radiation can also induce the onset and exacerbation of chronic actinic dermatitis (CAD) and melasma. Blue light plays an important role as well in the pathogenesis of melasma, therefore broad-spectrum photoprotection should be advocated and the intake of photosensitive foods and drugs should be reduced.

Risk of skin cancer differs according to skin type as well as the duration and intensity of solar light exposure. Chronic, long-term, cumulative UV exposure is associated with actinic keratosis and squamous cell carcinomas, while high-intensity, intermittent UV exposure, especially at a young age, is associated with basal cell carcinomas and melanomas. Therefore, photoprotection is important in young ages.

The World Health Organization (WHO), through the International Agency for Research on Cancer has raised the issue of solar UV radiation being a carcinogen since 1992 and since 2012 has classified solar UV radiation as a group 1 carcinogen (carcinogen to humans). Other well-known group 1 carcinogens are plutonium, asbestos and ionizing radiation.

Furthermore, current climate changes and the depletion of the ozone layer by approximately 4% per decade since the 1970s has led to a diminished filtration of UV-A and UV-B radiation and to increased UV radiation that reaches sea-level.

As a consequence, the incidence of melanoma and non-melanoma skin cancer is increasing worldwide.

WHO evidence indicates that four out of five cases of skin cancer can be prevented and simple preventive measures, such as limiting UV exposure in the midday sun, wearing UV protective clothing and hats or using mineral-based sunscreens, are recommended.

Photoprotection also includes make-up products, sunglasses, and windshields.

The WHO recognizes that while protection against UV exposure is recommended globally, there is concern that lack of UV exposure may reduce beneficial effects of vitamin D, including its potential to reduce the risk of some types of cancer.

RECOMMENDATIONS

1. Photoprotection is a key preventative health strategy as most skin cancers are a result of UV solar exposure.

National Governments should:

2. Inform health professionals and the public about the characteristics that sunscreen should meet (one that provides balanced, safe and easy-to-use protection) in order to avoid variability between the products supplied by laboratories, as well as improve safety and the labelling of the sunscreen.

3. Recognize solar UV exposure as an important risk factor for developing skin cancer. UV exposure also is a prime cause of some ocular diseases and immune system dysfunctions.

4. Work together to develop a Global Action Plan for the Prevention of Skin Cancer based on Photoprotective measures. This should include action against climate change to help reduce damage from ultra-violet radiation.

5. Support skin cancer screening campaigns.

6. Recognize prevention of skin cancer as a national health priority.

7. Improve skin cancer's screening, diagnosis and management.

8. Include all forms of skin cancer in all Nationals Cancer Registries and improve the reporting of UV induced skin cancers and legislative frameworks to protect outdoor workers (recognition as occupational disease).

9. Work with relevant stakeholders to liaise, engage and organize online and offline skin cancer prevention campaigns and educational programs on sun protection, with a primary focus on ages 0 – 18, in order to raise awareness of this health hazard and to encourage sun safety (use of protective clothing and hats, adequate sunscreen use, avoidance of excessive exposure) and healthy lifestyle choices among the young.

10. Promote policies to fight climate change and air pollution.

11. Consider the environmental impact of sunscreen.

WMA and its members should:

12. Interact with healthcare providers and medical practitioners who have a significant role in empowering and educating their patients in the promotion of skin cancer awareness, sun-protective measures and encouraging patient access to screening, diagnosis and treatment.

13. Educate primary care physicians and occupational physicians to recognise and refer patients with suspect lesions to dermatologists.

14. Support the development of national guidelines on photoprotective measures and continued scientific research in this field to derive the risk-benefit balance of UV exposure.

15. Support continued research and development of adequate protective clothing.

16. Promote campaigns to encourage the measurement of UV exposure within each nation.

17. Support media campaigns and educational programs that explain the harmful effects of UV exposure and optimal photoprotective measures targeting the most vulnerable, such as children and teenagers, fair skinned people, outdoor workers (e.g. agriculture, fishery, construction, forestry, athletes, swimming pool attendants).

18. Promote health education and information on sunscreens and the most recommended and healthy habits for the skin, establishing correct sun protection habits that make it possible to enjoy the beneficial effects of the sun and avoid sun damage.

Individual physicians should:

19. Counsel patients about the major health risks associated with excessive solar UV radiation exposure, inform patients about appropriate sun protective measures (e.g. skin coverage, sunscreen, and sunglasses) and encourage patients to undergo regular medical check-ups and to participate in skin cancer screening campaigns, where available.

20. Counsel patients to self-examine their skin.
21. Counsel those patients at risk (for example, patients on certain anti-cancer drugs) to understand the extra importance of protective measures.
22. Counsel employers on UV light as a work-related health risk.

WMA STATEMENT
ON
PHYSICIANS TREATING RELATIVES

Adopted by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

The interaction between the physicians and their relatives seeking medical care can be complex. Moreover, this possibility is highly conditioned by cultural aspects. Interaction can start with asking for simple advice, consultation for minor ailments, and general questions about healthcare and health promotion. This can escalate to seeking medical care and even surgery. Physicians are often their relatives' first point of call for medical and emotional support. Physicians may be able to offer immediate care in cases of emergency and contribute to well-informed, evidence-based self-care. Other than in emergencies, offering general health information or for minor health problems, physicians should avoid treating those close to them.

The ethical principles governing the work of physicians are equally important and valid when treating relatives. Respect for autonomy may be compromised by lack of privacy, unintentional breaches of confidentiality, and failure to seek informed consent. The relationship with the physician might compromise the patient's ability to make independent decisions.

Treating relatives may pose challenges in the following circumstances:

- When objectivity is compromised and decisively affected by emotional factors, there could be a risk of either under- or over-treating relatives or of encountering problems that are beyond the physician's expertise or abilities, which could cause serious harms.
- When there are potential barriers to considering sensitive medical history and/or conducting an appropriate physical examination, which may result in incorrect medical diagnosis and treatment.
- When the physician fails to fulfil requirements concerning patient clinical records, which may result in difficulties if the related patient needs follow-up treatment or when liability issues arise.
- When a negative medical outcome could compromise the relationship between the physician and the related patient.
- When the treatment is not in the best interest or against the will of the related patient.
- When the physician risks providing relatives, perhaps unintentionally and unconsciously, with undue advantages.

RECOMMENDATIONS

1. Physicians should avoid routinely acting as a relative's primary care physician or serving as the attending physician when treating a potentially life-threatening condition. Physicians may provide care to a relative in emergencies, for minor health problems or when there is no other qualified physician available.

2. Related patients may ask for a second opinion about another physician's care. If a second opinion is shared, it should be consistent with these recommendations and fulfil the duties of physicians to colleagues. Care should be taken to only discuss the treatment, which is most appropriate and recommended, rather than any judgements about the other treating physician's care and advice.

3. If a physician treats a relative, the physician should be mindful of the following:

    - Strict respect for medical ethics, the patient's autonomy and consent, with special consideration for minors.
    - The physician has the duty to respect a patient's right to confidentiality and should not share information with anyone else without a lawful basis, including other family members, with the exception of necessary clinical documentation when referring to other health care personnel.
    - If a relative indicates an intention to seek a second opinion about another physician's care, that intention must be respected.
    - Consent for treatment must be given by the patient, including competent minors, and for that consent to be valid, it must be fully informed.
    - Depending on the nature of the relationship, taking a sensitive history and performing a physical examination may be emotionally difficult or uncomfortable for the patient or the physician. In such situations the physician and the patient should consider consulting another physician.
    - Clear and concise patient records must be maintained at all times.

4. If the physician cannot accommodate the recommendations above, the physician should avoid treating relatives.

5. While physicians are encouraged not to treat relatives except in certain circumstances, it is acknowledged that physicians are often approached by their relatives for medical advice or treatment, and their help is frequently beneficial and appreciated.

6. In all circumstances, physicians shall maintain the highest professional and ethical standards, in accordance with the Declaration of Geneva, the WMA International Code of Medical Ethics, and the WMA Declaration of Lisbon on the Rights of the Patient.

WMA RESOLUTION
ON
ACADEMIC SANCTIONS OR BOYCOTTS

Adopted by the 40th World Medical Assembly, Vienna, Austria, September 1988
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015

WHEREAS

academic sanctions or boycotts are discriminatory restrictions on academic, professional and scientific freedoms that deny or exclude physicians and others from educational, cultural and scientific meetings and other opportunities for the exchange of information and knowledge, the purpose of such restrictions being to protest the social and political policies of governments, and

WHEREAS

such restrictions are in direct conflict with the major objectives of the WMA, viz., to achieve the highest international standards in medical education, medical science, medical art and medical ethics, and

WHEREAS

such restrictions adversely affect health care, particularly of the disadvantaged, and therefore thwart the WMA's objective of obtaining the best possible health care for all people of the world, and

WHEREAS

such restrictions discriminate against physicians and patients on grounds of political persuasion or of political decisions taken by governments and are therefore in conflict with the WMA's Declaration of Geneva, Statement on Non-Discrimination in Professional Membership and Activities of Physicians and Statement on Freedom to Attend Medical Meetings, and

WHEREAS

a basic rule of medical practice is "primum non nocere", i.e. first, do no harm,

THEREFORE BE IT RESOLVED,

that the WMA regards the application of such restrictions as arbitrary political decisions designed to deny international scholarly exchange and to blacklist particular physicians or

bodies of physicians because of their nationality or because of the political policies of their governments. The WMA is unalterably opposed to such restrictions and calls on all Na-tional Medical Associations to resist the imposition of such restrictions by every means at their disposal and to heed the WMA's Statement on Non-Discrimination in Professional Membership and Activities of Physicians and the WMA Statement on Freedom to Attend Medical Meetings.

WMA RESOLUTION
ON
ECONOMIC EMBARGOES AND HEALTH

Adopted by the 49th WMA General Assembly, Hamburg, Germany, November 1997
reaffirmed by the 58th WMA General Assembly, Copenhagen, Denmark, October 2007
reaffirmed with minor revision by the 207th WMA Council Session, Chicago, United States, October 2017
and reaffirmed by the 220th WMA Council Session, Paris, France, April 2022

RECOGNISING THAT:

all people have the right to the preservation of health; and,

the Geneva Convention (Article 23, Number IV, 1949) requires the free passage of medical supplies intended for civilians;

Recalling the standards of international human rights law, specifically the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights guarantees in its article 12 “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”;

The WMA urges national medical associations to ensure that Governments employing economic sanctions against other States respect the agreed exemptions for medicines, medical supplies and basic food items. Exemptions should not be exploited for inappropriate purposes.

WMA RESOLUTION
SUPPORTING THE OTTAWA CONVENTION

(Convention on the prohibition of the use, stockpiling, production
and transfer of anti-personnel mines and on their destruction)
Adopted by the 50th World Medical Assembly, Ottawa, Canada, October 1998
and amended by the 59th WMA General Assembly, Seoul, Korea, October 2008
and reaffirmed by the 209th WMA Council Session, Riga, April 2018

The World Medical Association:

- expresses its support for the Ottawa Convention (also known as the landmine ban convention); and
- urges its member National Medical Associations to press their governments to sign and ratify the Convention.
- urges its member National Medical Associations to press their governments to cease manufacture, sale, deployment and use of landmines.

WMA RESOLUTION ON MEDICAL WORKFORCE

Adopted by the 50th World Medical Assembly, Ottawa, Canada, October 1998
and amended by the 60th WMA General Assembly, New Delhi, India, October 2009

PREAMBLE

The health of our countries depends upon keeping the population healthy. Health care is a key right of individuals. This care is dependent upon access to highly-trained medical and other healthcare professionals. Well-functioning health care systems depend upon these sufficient human resources. Comprehensive and extensive planning on a national level is required in order to ensure that a country has a medical workforce in all fields of medicine that meets the present and future health needs of the entire population of that country.

There are currently significant shortages in the area of health human resources. These shortages are present in all countries but are especially pronounced in developing countries where health human resources are more limited.

The problem is made more severe by the fact that many countries have not invested adequately in the education, training, recruitment and retention of their medical workforce. The ageing population in developed countries has also been reflected by an ageing medical workforce. Many developed countries address their medical workforce shortages by employing health care professionals from developing countries to bolster their own health care systems.

The migration of health care professionals from developing countries to developed countries has, over the past ten years, impaired the performance of health systems in developing countries. Economic realities of insufficient investments in health care and inadequate facilities and support for health care professionals have continued to be responsible for this migration.

The World Health Organization has recognized that the crisis of health workforce shortages is impeding the provision of essential, life-saving interventions. It has therefore established structures such as the Global Health Workforce Alliance, a partnership dedicated to identifying and implementing solutions to the health workforce problems. The WHO is promoting the development of a cadre of medical/clinical assistants who propose to join the medical workforce to partially address these shortages.

RECOMMENDATIONS

Recognizing that health care systems require adequate numbers of qualified and competent health care professionals, the World Medical Association asks all National Medical Associations to participate and be active in addressing these requirements and to:

1. Call on their respective governments to allocate sufficient financial resources for the education, training, development, recruitment and retention of physicians to meet the medical needs of the entire population in their countries.

2. Call on their respective governments to ensure that the education, training and development of healthcare professionals meets the highest possible standards including:

   - The training and development of medical/clinical assistants where this is applicable and appropriate and
   - Ensuring clear definitions of scope of practice and conditions for adequate support and supervision;

3. Call on governments to ensure that appropriate ratios are maintained between population and the medical workforce at all levels, including mechanisms to address reduced access to care in rural and remote areas, based on accepted international norms and standards where these are available;

4. Take measures to attract and support individuals within their countries to enter the medical profession and also call on their respective governments to take such action;

5. Actively advocate for programs that will ensure the retention of physicians within their respective countries and ensure governments' recognition of this need;

6. Call on governments to improve the health care working environment (including access to appropriate facilities, equipment, treatment modalities and professional support), physician remuneration, physician living environment and career development of the medical workforce at all levels;

7. Advocate for the development of transparent memoranda of understanding between countries where migration of trained health care professionals is an issue of concern and enlist where possible the NMA of origin and receiving NMA's to support these physicians.

WMA RESOLUTION
ON
THE INCLUSION OF MEDICAL ETHICS AND HUMAN RIGHTS IN THE CURRICULUM OF MEDICAL SCHOOLS WORLD-WIDE

Adopted by the 51st World Medical Assembly, Tel Aviv, Israel, October 1999
and revised by the 66th WMA General Assembly, Moscow, Russia, October 2015
and reaffirmed by the 217th WMA Council Session, Seoul (online), April 2021

PREAMBLE

Medical School curricula are designed to prepare medical students to enter the profession of medicine. Increasingly, in addition to core biomedical and clinical knowledge, they teach skills including critical appraisal and reflective practice. These additional skills help to enable future doctors to understand and assess the importance of published research evidence, and how to evaluate their own practice against norms and standards set nationally and internationally.

In much the way same that anatomy, physiology and biochemistry are a solid base for understanding the human body, how it works, how it can fail or otherwise go wrong, and how different mechanisms can be used to repair damaged structure and functions, there is a clear need for physicians in training to understand the social, cultural and environmental contexts within which they will practice. This includes a solid understanding of the social determinants of health.

Medical ethics includes the social contract made between the health care professions and the societies they serve, based upon established principles, on the limits that apply to medical practice It also establishes a system or set of principles through which new treatments or other clinical interventions will be sieved before decisions are made on whether elements are acceptable within medical practice. There is a complex intermingling of medical ethics and the duties of physicians to patients, and the rights patients enjoy as citizens.

At the same time physicians face challenges and opportunities in relation to the human rights of their patients and of populations, for example occasions for imposing treatments without consent, and will also often be the first to observe and to itemize the infringement of these rights by others, including the state. This places very specific responsibilities upon the observing physician.

Physicians have a duty to use their knowledge to improve the wellbeing and health of patients and the population. This will mean considering social and societal change, including legislation and regulation, and can only be done well if doctors can take a holistic view within clinical and ethical parameters.

Physicians should press government to ensure legislation supports principled medical practice.

Given the core nature of health care ethics in establishing medical practice in a manner that is acceptable to society and that does not violate civil, political and other human rights, it is essential that all physicians are trained to perform an ethics evaluation of every clinical scenario they may encounter, while simultaneously understanding their role in protecting the rights of individuals.

Physicians' ability to act and communicate in a way that respects the values of the individual patient is a prerequisite for successful treatment. Physicians must also be able to work effectively in teams with other health care professionals including other physicians.

Failures of individual physicians to recognize the ethical obligations they owe patients and communities can damage the reputation of doctors both locally and globally. Therefore it is essential that all doctors are taught to understand and respect medical ethics and human rights from the beginning of their medical school careers.

In many countries ethics and human rights are an integral part of the medical curriculum, but this is not universal. Too often teaching is undertaken by volunteers, and can fail if those volunteers are unable or unavailable to teach, or if that teaching is unduly idiosyncratic or inadequately based upon clinical scenarios.

The teaching of medical ethics should become an obligatory and examined part of the medical curriculum within every medical school.

RECOMMENDATIONS

1. The WMA urges that medical ethics and human rights be taught at every medical school as obligatory and examined parts of the curriculum, and should continue at all stages of post graduate medical education and continuing professional development.

2. The WMA believes that medical schools should seek to ensure that they have sufficient faculty skilled at teaching ethical enquiry and human rights to make these courses sustainable.

3. The WMA commends the inclusion of medical ethics and human rights within post graduate and continuing medical education.

WMA RESOLUTION
ON
THE ABUSE OF PSYCHIATRY

Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002
and revised by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012
and reaffirmed by the 217th WMA Council Session, Seoul (online), April 2021

The World Medical Association (WMA) notes with concern evidence from a number of countries that political dissidents, practitioners of various religions and social activists have been detained in psychiatric institutions and subjected to unnecessary psychiatric treatment as a punishment and not to treat a substantiated psychiatric illness.

The WMA:

- Declares that such detention and unwarranted treatment is abusive, unethical and unacceptable;
- Calls on physicians and psychiatrists to resist involvement in these abusive practices;
- Calls on member NMAs to support their physician members who resist involvement in these abuses, and
- Calls on governments to stop abusing medicine and psychiatry in this manner, and on non-governmental organizations and the World Health Organization to work to end these abuses; and
- Calls on governments to uphold the United Nations International Covenant on Civil and Political Rights, which states that "all persons are equal before the law and are entitled without any discrimination to the equal protection of the law."

WMA RESOLUTION
ON
WOMEN'S RIGHTS TO HEALTH CARE
AND HOW THAT RELATES TO THE PREVENTION
OF MOTHER-TO-CHILD HIV INFECTION

Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002
and amended by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013

PREAMBLE

In many parts of the world the prevalence of HIV infection continues to increase. One of the Millennium Development Goals (MDG 6), specifically targets combating HIV/AIDS, malaria and other diseases, with 2015 being its target year to halt HIV/AIDS infection and to begin reversing the spread of HIV/AIDS. In addition, it was hoped that by 2010 universal access to treatment for HIV/AIDS for all those requiring it would be achieved. A December 2012 UN resolution declared that countries must develop programmes for Universal Health Access after 2015 when the MDGs end.

HIV/AIDS is a disease that disproportionately affects people in their reproductive years although today, due to better management of the condition, there are also many older people who are infected. In addition, many who were infected as infants are now reaching reproductive maturity.

In developed countries men who have sex with men and injection drug users constitute significant risk groups for contracting HIV. In many developing countries, women are at risk due to heterosexual contact with HIV infected partners. In 2011 approximately 58 percent of people living with HIV in sub-Saharan Africa were women, equating to about 13.6 million women living with HIV and AIDS, compared to about 9.9 million men (UNAIDS 'Global Fact Sheet 2012: World AIDS Day 2012).

In the absence of HIV, maternal mortality worldwide would be significantly (20%) lower (Murray et al. Maternal mortality for 181 countries, 1980~2008: a systematic analysis of progress towards Millennium Development Goal 5).

HIV infection increases the risk of invasive cervical cancer 2 to 22 fold. Some evidence exists that the use of antiretroviral therapy may decrease this risk. Hence, the appropriate management of patients infected with HIV may have a long-term impact on other aspects of women's health.

The WMA believes that access to healthcare, including both therapeutic and preventative strategies, is a fundamental human right. This imposes an obligation on government to

ensure that these human rights are fully respected and protected. Gender inequalities must be addressed and eradicated. This should impact every aspect of healthcare.

The promotion and protection of the reproductive rights of women are critical to the ultimate success of confronting and resolving the HIV/AIDS pandemic.

Many of the MDGs address empowering women and promoting their role in society and specifically in healthcare. MDG 5B, in particular, promotes universal access to reproductive health including contraceptive access, reduction in adolescent birth rate, antenatal care coverage and addressing unmet needs for family planning. In addition, MDG 3 which promotes gender equality and empowers women, and MDGs 1 and 2 will influence women's status in society and therefore their access to healthcare and health promotion.

RECOMMENDATIONS

The WMA requests all national member associations to encourage their governments to undertake and promote the following actions:

- Develop empowerment programs for women of all ages to ensure that women are free from discrimination and enjoy universal and free access to reproductive health education and life skills training. It is recommended that campaigns be initiated and activated in the media, including social media and popular programmes on radio and television in order to eradicate myths, stigma and stereotypes that might degrade or dehumanise women. This must include campaigns against genital mutilation and forced adolescent marriages and unwanted pregnancies. In addition, promoting the availability and choice of contraception for women, without necessarily having to get input from their partners, and promoting the availability of HIV testing and treatment are essential for reproductive health. It is also important to provide for the economic means for the infected populations in terms of prevention, treatment and medical follow-up.
- Women must have the same access as men, without discrimination to education, employment, economic independence, information about healthcare and health services.
- Laws, policies and practices that facilitate the full recognition and respect of human rights and the fundamental freedom of women should be initiated or reviewed and revised where appropriate. It is essential that women are empowered to make decisions regarding their children, their financial status and their future.
- All governments should develop programmes to provide prophylactic treatment in the form of antiretrovirals to women who have been raped or sexually assaulted. Universal and free access to antiretroviral therapy must also be provided to all HIV infected women.
- HIV infected women who are pregnant should receive counselling and access to anti-retroviral prophylaxis or treatment in order to prevent mother to child transmission of HIV.

WMA RESOLUTION
ON
THE DESIGNATION OF AN ANNUAL MEDICAL ETHICS DAY

Adopted by the 54th WMA General Assembly, Helsinki, Finland, September 2003
and reaffirmed by the 194th WMA Council Session, Bali, Indonesia, April 2013
and by the 215th WMA Council Session (online), Cordoba, Spain, October 2020

Whereas the World Medical Association has a specific focus and function in the field of medical ethics, and came into being on 18 September 1947 during the first General Assembly, it is resolved that NMAs are encouraged to annually observe the 18th September as "Medical Ethics Day".

WMA RESOLUTION
ON
THE RESPONSIBILITY OF PHYSICIANS IN THE DOCUMENTATION AND DENUNCIATION OF ACTS OF TORTURE OR CRUEL OR INHUMAN OR DEGRADING TREATMENT

Adopted by the 54th WMA General Assembly, Helsinki, Finland, September 2003
and amended by the 58th WMA General Assembly, Copenhagen, Denmark, October 2007
editorially revised by the 179th WMA Council Session, Divonne-les-Bains, France, May 2008
and by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

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

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

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

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

RECOMMENDATIONS

The WMA recommends that its constituent members:

1. Promote awareness among physicians of The Istanbul Protocol, including its Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment. This should be done at the national level.
2. Promote training of physicians on the identification of different methods of torture and cruel, inhuman and degrading treatment and punishments, to enable them to provide high quality medical documentation that can be used as evidence in legal or administrative proceedings.
3. Encourage professional training to ensure that physicians include assessment and documentation of signs and symptoms of torture or cruel, inhuman and degrading treatment and punishments in the medical records, including the correlation between the allegations given and the clinical findings.
4. Work to ensure that physicians carefully balance potential conflicts between their ethical obligation to document and denounce acts of torture or cruel, inhuman and degrading treatment and punishments and a patient's right to informed consent before documenting torture cases.
5. Work to ensure that physicians avoid putting individuals in danger while assessing, documenting or reporting signs of torture and cruel, inhuman and degrading treatment and punishments.
6. Promote access to immediate and independent health care for victims of torture or cruel, inhuman and degrading treatment and punishments.
7. Support the adoption of ethical rules and legislative provisions:
    - Aimed at affirming the ethical obligation on physicians to report and denounce acts of torture or cruel, inhuman and degrading treatment and punishments of which they become aware; depending on the circumstances, the report or denunciation should be addressed to the competent national or international authorities for further investigation.
    - Addressing that a physician's obligation to document and denounce instances of torture and cruel, inhuman and degrading treatment and punishments may conflict with their obligations to respect patient confidentiality and autonomy.
    - Physicians should use their discretion in this matter, bearing in mind paragraph 69 of the Istanbul Protocol (2).
    - cautioning physicians to avoid putting in danger victims who are deprived of freedom, subjected to constraint or threat or in a compromised psychological situation when disclosing information that can identify them.

- Work to ensure protection of physicians, who risk reprisals or sanctions of any kind due to the compliance with these guidelines.
- Provide physicians with all relevant information on procedures and requirements for reporting torture or cruel, inhuman and degrading treatment and punishments, particularly to national authorities, non-governmental organizations and the International Criminal Court.

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

---

(1) Codes and codifications:

1. The Preamble to the United Nations Charter of 26 June 1945 solemnly proclaiming the faith of the people of the United Nations in the fundamental human rights, the dignity and value of the human person.
2. The Preamble to the Universal Declaration of Human Rights of 10 December 1948 which states that disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind.
3. Article 5 of the Universal Declaration of Human Rights which proclaims that no one shall be subjected to torture or cruel, inhuman or degrading treatment.
4. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977, revised and adopted by the General Assembly on 17 December 2015.
5. The American Convention on Human Rights, which was adopted by the Organization of American States on 22 November 1969 and entered into force on 18 July 1978, and the Inter-American Convention to Prevent and Punish Torture, which entered into force on 28 February 1987.
6. The Declaration of Tokyo, Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975 Editorially revised by the 170thWMA Council Session, Divonne-les-Bains, France, May 2005 and the 173rdWMA Council Session, Divonne-les-Bains, France, May 2006.
7. Revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2017.
8. The Declaration of Hawaii, adopted by the World Psychiatric Association in 1977.
9. The Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the United Nations General Assembly on 18 December 1982, and particularly Principle 2, which states: "It is a gross contravention of medical ethics… for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment…".

10. The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which was adopted by the United Nations General Assembly on December 1984 and entered into force on 26 June,1987.
11. The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which was adopted by the Council of Europe on 26 June 1987 and entered into force on 1 February 1989.
12. The WMA Declaration of Hamburg, adopted by the World Medical Association in November 1997 during the 49th General Assembly, and reaffirmed with minor revision by the 207th WMA Council session, Chicago, United States, October 2017 calling on physicians to protest individually against ill-treatment and on national and international medical organizations to support physicians in such actions.
13. The Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), adopted by the United Nations General Assembly on 4 December 2000.
14. The Convention on the Rights of the Child, which was adopted by the United Nations on 20 November 1989 and entered into force on 2 September 1990.
15. The World Medical Association Declaration of Malta on Hunger Strikers, adopted by the 43rd World Medical Assembly Malta, November 1991and amended by the WMA General Assembly, Pilanesberg, South Africa, October 2006, and revised by the 68th WMA General Assembly, Chicago, United States, October 2017.

(2) Istanbul Protocol, paragraph 69: "In some cases, two ethical obligations are in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may refuse to give consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities: to the patient and to society at large, which has an interest in ensuring that justice is done and perpetrators of abuse are brought to justice. The fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions that promote justice without breaking the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases, this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters."

WMA RESOLUTION ON THE NON-COMMERCIALISATION OF HUMAN REPRODUCTIVE MATERIAL

Adopted by the 54th WMA General Assembly, Helsinki, Finland, September 2003
and revised by 65th WMA General Assembly, Durban, South Africa, October 2014
and reaffirmed by the 217th WMA Council Session, Seoul (online), April 2021

PREAMBLE

The rapid advances in biomedical technologies have led to growth of the reproductive assistance industry, which tends to be poorly regulated. Despite the fact that many governments have laws prohibiting commercial transactions of reproductive material, most have not been successful in universally preventing the sale of human ova, sperm and embryos on the internet and elsewhere. The market value of human material, including cells, tissues, and cellular tissue can be lucrative, creating a potential conflict for physicians and others between economic interests and professional ethical obligations.

For the purposes of this resolution human reproductive material is defined as human gametes and embryos.

According to the WHO, transplant commercialism "is a policy or practice in which cells, tissues or organs are treated as a commodity, including by being bought or sold or used for material gain."[1]

The principle that the "human body and its parts shall not, as such, give rise to financial gain"[2] is laid down in numerous international declarations and recommendations.[3] The 2006 WMA Statement on Human Organ Donation and Transplantation and the 2012 WMA Statement on Organ and Tissue Donation call for the prohibition of the sale of organs and tissues for transplantation. The WMA Statement on Assisted Reproductive Technologies (2006) also states that it is inappropriate to offer financial benefits to encourage donation of human reproductive material.

The same principles should be in place for the use of human reproductive material in the area of medical research. The International Bioethics Committee of the United Nations Educational, Scientific and Cultural Organization (UNESCO IBC) in its report on the ethical aspects of human embryonic stem cell research states that the transfer of human embryos must not be a commercial transaction and that measures should be taken to discourage any financial incentive.

It is important to distinguish between the sale of clinical assisted reproductive services, which is legal, and the sale of the human reproductive materials, which is usually illegal. Due to the special nature of human embryos, the commercialization of gametes is unlike that of other cells and tissues as sperm and eggs may develop into a child if fertilization is

successful.
Before human reproductive material is donated, the donor must give informed consent that is free of duress. This requires that the individual donor is deemed fully competent and has been given all the available information regarding the procedure and its outcome. If research is to be conducted on the material, it is subject to a separate consent process that must be consistent with the provisions in the WMA's Declaration of Helsinki. There must not be any inducement or other undue pressure to donate or offers of compensation.

Monetary compensation given to individuals for economic losses, expenses or inconveniences associated with the retrieval of donated reproductive materials should be distinguished from payment for the purchase of reproductive materials.

RECOMMENDATIONS

1. National Medical Associations (NMAs) should urge their governments to prohibit commercial transactions in human ova, sperm and embryos and any human material for reproductive purpose.

2. Physicians involved in the procurement and use of human ova, sperm, and embryos should implement protocol to ensure that materials have been acquired appropriately with the consent and authorization of the source individuals. In doing so, they can uphold the ethical principle of non-commercialization of human reproductive material.

3. Physicians should consult with potential donors prior to donation in order to ensure free and informed consent.

4. Physicians should adhere to the WMA Statement on Conflict of Interest when treating patients who seek reproductive services.

[1] Global Glossary of Terms and Definitions on Donation and Transplantation, WHO, November 2009
[2] European convention of human rights and biomedicine - Article 21 – Prohibition of financial gain
[3] Declaration of Istanbul guiding principle 5

WMA RESOLUTION
ON
WFME GLOBAL STANDARDS FOR QUALITY IMPROVEMENT OF MEDICAL EDUCATION

Approved by the 55th WMA General Assembly, Tokyo, Japan, October 2004
and reaffirmed by the 197th WMA Council Session, Tokyo, Japan, April 2014
and by the 217th WMA Council Session, Seoul (online), April 2021

Whereas the WMA:

1. Recognizes the need and importance for sound global standards for quality improvement of medical education;

2. Acknowledges the WMA's special relationship with the World Federation for Medical Education (WFME) as one of the founders of the Federation;

3. Recognizes that it is represented in the WFME Executive Council and in this capacity is co-responsible for the WFME Project on International Standards in Medical Education, conducted since 1997 [1];

4. Acknowledges the recent development of the WFME Trilogy of Documents of Global Standards in Medical Education for Quality Improvement, covering Basic Medical Education[2], Postgraduate Medical Education[3] and the Continuing Professional Development (CPD) of Medical Doctors[4];

5. Recognizes the endorsement[5] of the WFME Global Standards at the World Conference in Medical Education: Global Standards in Medical Education for Better Health Care, in Copenhagen, Denmark, March 2003[6];

It hereby:

1. Expresses its encouragement and support of the ongoing work of implementing the Trilogy of WFME Documents on Global Standards in Medical Education.

---

[1] The Executive Council, The World Federation for Medical Education: International standards in medical education: assessment and accreditation of medical schools´ educational programmes. A WFME position paper. Med Ed 1998; 32: 549-558.
[2] World Federation for Medical Education: Basic Medical Education. WFME Global Standards for Quality Improvement. WFME, Copenhagen 2003. http://www.wfme.org
[3] World Federation for Medical Education. Postgraduate Medical Education. WFME Global Standards for Quality Improvement. WFME, Copenhagen 2003. http://www.wfme.org
[4] World Federation for Medical Education: Continuing Professional Development (CPD) of Medical Doctors. WFME Global Standards for Quality Improvement. WFME Copenhagen 2003. http://www.wfme.org
[5] J.P. de V. van Niekerk. WFME Global Standards receive ringing endorsement. Med Ed, 2003; 37: 586-587.
[6] WFME website: http://www.wfme.org

WMA RESOLUTION IN SUPPORT OF TAIWAN'S PARTICIPATION IN ALL WHO HEALTH PROGRAMS AND INCLUSION IN THE INTERNATIONAL HEALTH REGULATIONS (IHR) MECHANISM

Adopted by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and amended by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

PREAMBLE

In line with the Charter of the United Nations, Member States of the WHO recognize the "enjoyment of the highest attainable standard of health" as a fundamental right of every human being "without distinction of race, religion, political belief, economic or social condition", uphold that "the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States" (Preamble of WHO's Constitution).

Taiwan, located at a key position in the Asia-Pacific region, has long enjoyed close relationship with countries and areas of the region, with over 20 million regional and international travelers per year. Thus, the devastating outbreak of the 2019 Novel Coronavirus further highlights the urgency and importance of inclusiveness and leaving no one behind in the global health network. By continuing to refuse to grant Taiwan observer status to the WHA and full access to its meetings, mechanisms and activities, the WHO fails to fulfill the principles of universality and equality established in WHO's constitution as well as the ethical standards of the organization.

From 2009 to 2016, Taiwan was invited to participate in the World Health Assembly (WHA) as an Observer, with very limited access to WHO technical briefings, mechanisms and activities. Since 2017, the WHO has not granted the Observer status to Taiwan anymore.

Although Taiwan has been officially included in the implementation framework of the International Health Regulations (IHR) since 2009, its contact point information is not included on the IHR Portal established by WHO, impeding timely exchange of information and communication to the detriment of Taiwan. Delayed and/or incomplete medical information can impact adversely on the Taiwanese population, causing a gap in Taiwan's domestic disease control network, with unavoidable implications for global health.

Allowing the participation of Taiwan to the World Health Assembly and fostering its inclusion in all WHO's health programmes and in the International Health Regulations would benefit the people in Taiwan, but also the WHO and its member states as well as all related parties.

RECOMMENDATIONS

1. Considering the Sustainable Development Goal 3 aiming to ensure healthy lives and promoting well-being for all at all ages and WHO's primary objective to "attain by all peoples the highest possible level of health" (article 1 of WHO's Constitution), both aims requiring a true inclusive strategy comprising all populations worldwide,

2. Reminding the ethical core value of the medical profession to serve humanity regardless of any other considerations than people's health and well-being, and firmly committed to the safeguard and promotion of health-related human rights, the WMA and its constituent members call on:

    - WHO to grant Taiwan observer status to the World Health Assembly and to ensure Taiwan's participation in all its health programs based on a substantive, timely and professional basis,
    - WHO and its Member States to include Taiwan as a full participating party to the International Health Regulations, allowing its critical contribution to the global health protection network.

WMA STATEMENT ON IMPLEMENTATION OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

Adopted by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and amended by the 67th WMA General Assembly, Taipei, Taiwan, October 2016
and reaffirmed with minor revisions by the 218th Council session (online), London, United Kingdom, October 2021

The World Medical Association:

1. Acknowledges the essential role of health professionals in tobacco control and urges its constituent members and other representatives of the medical community to use World No Tobacco Day each year to advocate for tobacco control measures;

2. Recognises the importance of the WHO Framework Convention on Tobacco Control (FCTC) as a mechanism to protect people from exposure and addiction to tobacco;

3. Encourages Member States to the Convention to recognize (ratify, accept, approve, confirm or accede) the Protocol to Eliminate Trade in Tobacco Products;

4. Encourages its constituent members to work assiduously and energetically to get their governments to implement the measures set out in the FCTC as a minimum;

5. In line with its Statement on Electronic Cigarettes, calls on Member States to include e-cigarettes and other electronic nicotine delivery systems in the scope of application of the WHO Framework Convention and to ensure that that these products be subjected to local regulatory approval and be entrenched in smoke free laws.

6. Urges governments to introduce regulations and other control measures as described in the FCTC including regulation of smokeless tobacco products. Governments should ban smoking and vaping in public places and workplaces as an urgent public health intervention and also consider additional measures, especially those tobacco control measures that have been proven to be successful in other countries;

7. Urges governments to introduce initiatives that break brand recognition, including plain packaging of cigarettes and other smoking products, as stated in its Resolution on Plain Packaging of Cigarettes, e-Cigarettes and Other Smoking Product

8. Strongly encourages governments to set a distinct method to ensure adequate funding for tobacco control and research;

9. Urges governments to promote ready access to smoking cessation advice and services to all smokers, including children;

10. Recognises the vital role of health professionals in public health education and in promoting smoking cessation;

11. Combats the tobacco industry's predatory marketing tactics by adopting comprehensive bans on advertising, promotion and sponsorship, as set forth in the WHO FCTC, in order to protect the health of individuals and communities;

12. Contributes to the improvements and updating of international tobacco control regulations as needed.

WMA STATEMENT
ON
CHILD SAFETY IN AIR TRAVEL

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and reaffirmed by the 203rd WMA Council Session, Buenos Aires, Argentina, April 2016
and reaffirmed with minor revisions by the 218th Council session (online), London, United Kingdom, October 2021

PREAMBLE

Air travel is a common mode of transportation and is used by people of all ages every day. The WMA notes that high standards of safety for adult passengers in air travel have been achieved, with strict safety procedures increasing greatly the chance of survival during emergency situations in aircraft.

Restraint and safety systems for infants and children have been successfully tested to reduce the risk of suffering injuries in case of emergency. Those systems have been approved for usage in standard passenger aircrafts and successfully introduced by several airlines. However, the practice of holding an infant or child in a lap or using a "loop belt" continues and is not a sufficient safety measure.

RECOMMENDATIONS

Therefore, the World Medical Association and its constituent members

1. Express grave concern regarding the fact that adequate safety systems for infants and children have not been generally implemented;

2. Call on all airline companies to take immediate steps to introduce safe, thoroughly tested and standardized child restraint systems;

3. Call on all airline companies to train their staff in the appropriate handling and usage of child restraint systems;

4. Call for the establishment of a universal standard or specification for the testing and manufacturing of child restraint systems, and

5. Call on national legislators and air transportation safety authorities to:

    - require for infants and children, as a matter of law, safe individual child restraint systems that are approved for use in standard passenger aircraft;

- ensure that airlines provide child restraint systems or welcome passengers using their own systems, if the equipment is qualified and approved for the specific aircraft;
- ban the usage of inappropriate “loop belts” frequently used to secure infants and children in passenger aircraft;
- provide appropriate information about infant and child safety on board of aircraft to all airline passengers.

WMA RESOLUTION
ON
NORTH KOREAN NUCLEAR TESTING

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006 and reaffirmed by the 203rd WMA Council Session, Buenos Aires, Argentina, April 2016 and reaffirmed with minor revisions by the 218th Council session (online), London, United Kingdom, October 2021

Recalling its Statement on Nuclear Weapons, the WMA:

- Denounces North Korean nuclear testing conducted at a time of heightened global vigilance on nuclear testing and arsenals;
- Calls for the immediate abandonment of the testing of nuclear weapons by any nation;
- Requests its constituent members and other representatives of the medical profession across the world to urge their governments to understand the adverse health and environmental consequences of the testing and use of nuclear weapons; and
- Requests its constituent members and other representatives of the medical profession across the world to advocate for the entry into force of the Comprehensive Nuclear-Test-Ban Treaty (CTBT) and for the prompt ratification and implementation of the UN Treaty on the Prohibition of Nuclear Weapons.

WMA RESOLUTION ON TUBERCULOSIS

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
revised by the 68th WMA General Assembly, Chicago, United States, October 2017
and reaffirmed with minor revisions by the 221st WMA Council Session, Berlin, Germany, October 2022

PREAMBLE

According to the World Health Organization, tuberculosis is a significant global public health problem. South East Asian and African countries are most affected.

In developing countries, the incidence of tuberculosis (TB) has risen dramatically because of high prevalence of HIV/AIDS, increasing migration of populations, urbanisation and over-crowding. The incidence and severity of the disease are closely associated with the social and economic living conditions within a population as well as the availability of resources within a health system.

Tuberculosis is also a significant threat to patients with cancers, organ transplants, and those receiving immunologic therapies for various diseases.

The emergence of strains of tuberculosis bacteria resistant to first line drugs have become a major public and global health threat in the forms of multidrug-resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDR-TB). MDR-TB and XDR-TB are indicators of the growing antimicrobial resistance whose drivers are multifactorial and complex and require a multisectoral approach.

Community awareness and public health education and promotion are essential elements of tuberculosis prevention.

Screening of high-risk groups including PLHIV (people living with HIV), health personnel from endemic countries as well as vulnerable populations including migrants, prisoners, and the homeless should be considered within each national epidemiological context as a component of tuberculosis prevention. Systematic screening of contacts of infected persons is also recommended.

Rapid diagnosis with molecular tests and starting supervised daily treatment early should help arrest the spread of disease.

BCG (Bacille Calmette-Guérin) vaccination as early as possible after birth should continue, in line with International Union against Tuberculosis and Lung Disease (IUATLD) criteria, until a new more effective vaccine is available.

Intensified research and innovation are also considered imperative if attempts to address the epidemic and emerging resistance are to be successful.

RECOMMANDATIONS

In line with its "Declaration of Oslo on Social Determinants of Health" and its "Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases", the World Medical Association emphasizes that tuberculosis is a disease associated with socioeconomic factors such as poverty, poor housing, malnutrition and stigma, and recommends that these factors are fully considered and integrated in policies to end TB.

The WMA supports WHO "End TB Strategy" and calls upon all governments, communities, civil societies and the private sectors to act together to end tuberculosis world-wide.

The WMA, in consultation with WHO and national and international health authorities and organizations, will therefore continue advocating to generate community awareness about symptoms of TB and increase capacity building of health personnel in early identification and diagnosis of TB cases and to ensure complete treatment utilizing patient-centered treatment support, including Directly Observed Treatment Short course or other appropriate therapy.

The WMA further calls:

Member States

1. To ensure equitable access to existing tuberculosis interventions;
2. To allocate adequate financial, material and human resources for tuberculosis and HIV/AIDS research and prevention, including adequately educated health care providers and adequate public health infrastructure;
3. To ensure to health care professionals full access to all required medical and protective equipment to guard against the risk of infection and spread of the disease;
4. To foster efforts to build up the capacity of health care professionals in the use of rapid diagnostics methods, the availability of these methods in the public and private sector and in the management of all forms of TB, including MDR and XDR.
5. To address the burden of MDR and XDR TB in prison populations by ensuring drug susceptibility tests on isolates from patients with active TB are performed as soon as possible, and when patient compliance is a problem, implementing programs of directly observed therapy.

Constituent Members

6. To support their National TB Programmes by generating awareness among healthcare professionals about TB management and early reporting of cases in the community.

7. To promote methods of TB prevention including respiratory hygiene, cough etiquettes, and safe sputum disposal.

8. To encourage their members to notify to relevant authorities, about all patients diagnosed with TB or put on TB treatment in a timely manner for initiation of contact screening and adequate follow up till the completion of treatment.

9. To encourage the development of strong pharmacovigilance and active TB drug-safety monitoring and management, to detect, manage and report suspected or confirmed drug toxicities, and encourage all their members to contribute actively to these systems.

10. To co-ordinate with their TB National Programme and promote the adopted guidelines to all members.

RESOLUTION
IN
SUPPORT OF THE MEDICAL ASSOCIATIONS
IN LATIN AMERICA AND THE CARIBBEAN

Adopted by the 58th WMA General Assembly, Copenhagen, Denmark, October 2007
and reaffirmed with minor revision by the 207th WMA Council session, Chicago, United States, October 2017

There are credible reports that arrangements between the Cuban government and certain Latin American and Caribbean governments to supply Cuban health workers as physicians to these countries are bypassing systems, established to protect patients, that have been set up to verify physicians' credentials and competence.

The World Medical Association (WMA) is significantly concerned that patients are put at risk by unregulated medical practices and recalls its Statement on Ethical Guidelines for the International Migration of Health workers, whereby "Physicians who are working, either permanently or temporarily, in a country other than their home country should be treated fairly in relation to other physicians in that country" (Parag.7) and that bilateral agreements require "due cognizance of international human rights law, so as to effect meaningful co-operation on health care delivery" (parag. 8).

There exist already duly constituted and legally authorized medical associations within this region that are charged with the registration of physicians and which should be consulted by their respective Ministries of Health.

Therefore, the WMA:

1. Condemns any actions by governments in policies and practices that subvert or bypass the accepted standards of medical credentialing and medical care;

2. Calls upon the governments in Latin America and the Caribbean to work with the medical associations on all matters related to physician certification and the practice of medicine and to respect the role and rights of these medical associations and the autonomy of the medical profession.

3. Urges, as a matter of utmost concern, that the governments in Latin America and the Caribbean respect the WMA International Code of Medical Ethics, the Declarations of Madrid on Professionally-led Regulation, and of Seoul on Professional Autonomy and Clinical Independence as well as the Statement on Ethical Guidelines for the International Migration of Health workers that guide the medical practice of physicians all over the world..

WMA RESOLUTION
ON
COLLABORATION BETWEEN HUMAN AND VETERINARY MEDICINE

Adopted by the 59th WMA General Assembly, Seoul, Korea, October 2008
and reaffirmed with minor revision by the 210th WMA Council Session, Reykjavik, Iceland, October 2018

PREAMBLE

The majority of the existing human infectious diseases, including the bioterrorist agents, are zoonoses. Zoonoses can, by definition, infect both animals and humans. By their very nature, the fields of human medicine and veterinary medicine are complementary and synergistic in confronting, controlling and preventing zoonotic diseases from infecting across species.

Collaboration and communication between human medicine and veterinary medicine have been limited in recent decades, yet the challenges of the 21st Century demand that these two professions work together in times when there is an increased risk of zoonotic diseases due to globalization and climate change, in addition to changes in human behavior.

An initiative, often called the "One Health" initiative, is being developed to improve the lives of all species through the integration of human and veterinary medicine. "One Health" aims to promote and implement close meaningful collaboration and communication between human medicine, veterinary medicine and all allied health scientists with the goal of hastening human public health efficacy as well as advanced health care options for humans (and animals) via comparative biomedical research.

The World Medical Association (WMA) recognizes the ways in which animals and animal care may affect human health and disease through its own current policies, particularly its statements on Animal Use in Biomedical Research, Resistance to Antimicrobial Drugs and Avian and Pandemic Influenza. The WMA also recognized the impact that climate change has on health, through the WMA Declaration on Health and Climate Change. The WMA already works with other health professions including dentists, nurses and pharmacists though the World Health Professions Alliance.

RECOMMENDATIONS

That the World Medical Association:

- Support collaboration between human and veterinary medicine.

- Support the concept of joint educational efforts between human medical and veterinary medical schools.
- Encourage joint efforts in clinical care through the assessment, treatment, and prevention of cross-species disease transmission.
- Support cross-species disease surveillance and control efforts in public health, particularly the identification of early disease and outbreak trends.
- Support the need for joint efforts in the development, integration and evaluation of screening tools, diagnostic methods, medicines, vaccines, surveillance systems and policies for the prevention, management and control of zoonotic diseases.
- Engage in a dialogue with the World Veterinary Association to discuss strategies for enhancing collaboration between human and veterinary medical professions in medical education, clinical care, public health, and biomedical research.
- Encourage National Medical Associations to engage in a dialogue with their veterinary counterparts to discuss strategies for enhancing collaboration between human and veterinary medical professions within their own countries.

WMA EMERGENCY RESOLUTION ON LEGISLATION AGAINST ABORTION IN NICARAGUA

Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009
and revised by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

WHEREAS,

In 2006, Nicaragua adopted a penal code that criminalises abortion in all circumstances, including any medical treatment of a pregnant woman which results in the death of or injury to an embryo or fetus.

According to the UN Population Fund (UNFPA), despite improvement of national sexual and reproductive health indicators, Nicaragua continues to have one of the highest teenage pregnancy and maternal mortality rates in the Americas region, in particular in lower income rural population groups.

This legislation:

- Has a negative impact on the health of women in Nicaragua resulting in preventable deaths of women and the embryo or fetus they are carrying.
- Places physicians at risk of imprisonment if they carry out abortions, even to save a pregnant woman's life, unless they follow the Nicaraguan Ministry of Health's (MINSA) 2006 Obstetric Protocols designed for high emergency care alone.
- Requires physicians to report to police, women and girls for suspected abortions, in breach of their duty of confidentiality towards patients and placing them in a conflict between the law and medical ethics.

The WMA Statement on Medically-Indicated Termination of Pregnancy (October 2018) provides that: "National laws, norms, standards, and clinical practice related to termination of pregnancy should promote and protect women's health, dignity and their human rights, voluntary informed consent, and autonomy in decision-making, confidentiality and privacy. National medical associations should advocate that national health policy upholds these principles."

The WMA reiterates its Resolution on Criminalisation of Medical Practice (October 2013) recommending that its members "oppose government intrusions into the practice of medicine and in healthcare decision making, including the government's ability to define appropriate medical practice through imposition of criminal penalties."

THEREFORE, the World Medical Association and its constituent members urge the Nicaraguan government to repeal its penal code criminalizing abortion and develop in its place a legislation that promotes and protects women's human rights, dignity and health,

including adequate access to reproductive healthcare, and that allows physicians to perform their duties in line with medical ethics and particularly medical confidentiality.

WMA RESOULUTION SUPPORTING THE RIGHTS OF PATIENTS AND PHYSICIANS IN THE ISLAMIC REPUBLIC OF IRAN

Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009
and amended by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

WHEREAS,

Physicians in the Islamic Republic of Iran have reported:

- Deliberate denial of medical care in detention, withholding of essential and readily available medications by physicians and other health professionals;
- Widespread use of torture and ill-treatments in detention;
- Concern about the veracity of documentation related to the death of patients and physicians being forced to produce clinically incorrect documentation;
- Lack of essential functioning medical equipment and supplies
- Denial of the rights of hunger strikers; and
- Physicians' complicity in facilitating the death penalty for juveniles in violation of children's rights.

THEREFORE, the World Medical Association

1. Reaffirms its Declaration of Lisbon on the Rights of the Patient, which states that whenever legislation, government action or any other administration or institution denies patients the right to medical care, physicians should pursue appropriate means to assure or to restore it.

2. Reaffirms its 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, which encourages doctors to honor their commitment as physicians to serve humanity and to resist any pressure to act contrary to the ethical principles governing their dedication to this task.

3. Reaffirms its Declaration of Tokyo – Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment, which:

- Prohibits physicians from participating in, or even being present during the practice of torture or other forms of cruel or inhuman or degrading procedures;
- requires that physicians maintain utmost respect for human life even under threat and prohibits them from using any medical knowledge contrary to the laws of humanity.

4. Reaffirms its Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment, which states that physicians should attempt to:

    - ensure that detainees or victims of torture or cruelty or mistreatment have access to immediate and independent health care;
    - ensure that physicians include assessment and documentation of symptoms of torture or ill-treatment in the medical records using the necessary procedural safeguards to prevent endangering detainees.

5. Refers to the WMA International Code of Medical Ethics, which states that physicians shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.

6. Reaffirms its Declaration of Malta on hunger strikers which prohibits force-feeding of hunger strikers as "degrading and inhuman," even when this is the only way to save their lives.

7. Refers to the United Nations Nelson Mandela Rules, which emphasizes that the provision of health care for prisoners is a State responsibility, and that the relationship between health-care professionals and prisoners is governed by the same ethical and professional standards as those applicable to patients in the community.

8. Refers to the WMA Statement on Access of Women and Children to Health Care, which categorically condemns violations of the basic human right of women and children, including violations stemming from social, political, religious, economic and cultural practices.

9. Refers to the WMA Statement on Natural Variations of Human Sexuality, which condemns all forms of stigmatization, criminalization and discrimination of people based on their sexual orientation.

10. Urges the government of the Islamic Republic of Iran to respect the International Code of Medical Ethics and the standards included in the aforementioned declarations to which physicians are committed.

11. Stresses that physicians who adhere to the professional and ethical obligations outlined in the entire WMA policy apparatus, including the aforementioned declarations, must be protected

WMA RESOLUTION
ON
TASK SHIFTING FROM THE MEDICAL PROFESSION

Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009
and reaffirmed by the 212th WMA Council Session, Santiago, Chile, April 2019

1. In health care, the term "Task Shifting" is used to describe a situation where a task normally performed by a physician is transferred to a health professional with a different or lower level of education and training, or to a person specifically trained to perform a limited task only, without having a formal health education. Task shifting occurs both in countries facing shortages of physicians and those not facing shortages.

2. A major factor leading to task shifting is the shortage of qualified workers resulting from migration or other factors. In countries facing a critical shortage of physicians, task shifting may be used to train alternate health care workers or laypersons to perform tasks generally considered to be within the purview of the medical profession. The rationale behind the transferring of these tasks is that the alternative would be no service to those in need. In such countries, task shifting is aimed at improving the health of extremely vulnerable populations, mostly to address current shortages of healthcare professionals or tackle specific health issues such as HIV. In countries with the most extreme shortage of physicians, new cadres of health care workers have been established. However, those persons taking over physicians' tasks lack the broad education and training of physicians and must perform their tasks according to protocols, but without the knowledge, experience and professional judgement required to make proper decisions when complications arise or other deviations occur. This may be appropriate in countries where the alternative to task shifting is no care at all but should not be extended to countries with different circumstances.

3. In countries not facing a critical shortage of physicians, task shifting may occur for various reasons: social, economic, and professional, sometimes under the guise of efficiency, savings or other unproven claims. It may be spurred, or, conversely, impeded, by professions seeking to expand or protect their traditional domain. It may be initiated by health authorities, by alternate health care workers and sometimes by physicians themselves. It may be facilitated by the advancement of medical technology, which standardizes the performance and interpretation of certain tasks, therefore allowing them to be performed by non-physicians or technical assistants instead of physicians. This has typically been done in close collaboration with the medical profession. However, it must be recognized that medicine can never be viewed solely as a technical discipline.

4. Task shifting may occur within an already existing medical team, resulting in a reshuffling of the roles and functions performed by the members of such a team. It may also create new types of personnel whose function is to assist other health professionals, specifically physicians, as well as personnel trained to independently perform specific tasks.

5. Although task shifting may be useful in certain situations, and may sometimes improve the level of patient care, it carries with it significant risks. First and foremost among these is the risk of decreased quality of patient care, particularly if medical judgment and decision making is transferred. In addition to the fact that the patient may be cared for by a lesser trained health care worker, there are specific quality issues involved, including reduced patient-physician contact, fragmented and inefficient service, lack of proper follow up, incorrect diagnosis and treatment and inability to deal with complications.

6. In addition, task shifting which deploys assistive personnel may actually increase the demand on physicians. Physicians will have increasing responsibilities as trainers and supervisors, diverting scarce time from their many other tasks such as direct patient care. They may also have increased professional and/or legal responsibility for the care given by health care workers under their supervision.

7. The World Medical Association expresses particular apprehension over the fact that task shifting is often initiated by health authorities, without consultation with physicians and their professional representative associations.

RECOMMENDATIONS

8. Therefore, the World Medical Association recommends the following guidelines:

   8.1 Quality and continuity of care and patient safety must never be compromised and should be the basis for all reforms and legislation dealing with task shifting.

   8.2 When tasks are shifted away from physicians, physicians and their professional representative associations should be consulted and closely involved from the beginning in all aspects concerning the implementation of task shifting, especially in the reform of legislations and regulations. Physicians might themselves consider initiating and training a new cadre of assistants under their supervision and in accordance with principles of safety and proper patient care.

   8.3 Quality assurance standards and treatment protocols must be defined, developed and supervised by physicians. Credentialing systems should be devised and implemented alongside the implementation of task shifting in order to ensure quality of care. Tasks that should be performed only by physicians must be clearly defined. Specifically, the role of diagnosis and prescribing should be carefully studied.

   8.4 In countries with a critical shortage of physicians, task shifting should be viewed as an interim strategy with a clearly formulated exit strategy. However, where conditions in a specific country make it likely that it will be implemented for the longer term, a strategy of sustainability must be implemented.

   8.5 Task shifting should not replace the development of sustainable, fully functioning health care systems. Assistive workers should not be employed at the expense of unemployed and underemployed health care professionals. Task shifting also

should not replace the education and training of physicians and other health care professionals. The aspiration should be to train and employ more skilled workers rather than shifting tasks to less skilled workers.

8.6 Task shifting should not be undertaken or viewed solely as a cost saving measure as the economic benefits of task shifting remain unsubstantiated and because cost driven measures are unlikely to produce quality results in the best interest of patients. Credible analysis of the economic benefits of task shifting should be conducted in order to measure health outcomes, cost effectiveness and productivity.

8.7 Task shifting should be complemented with incentives for the retention of health professionals such as an increase of health professionals' salaries and improvement of working conditions.

8.8 The reasons underlying the need for task shifting differ from country to country and therefore solutions appropriate for one country cannot be automatically adopted by others.

8.9 The effect of task shifting on the overall functioning of health systems remains unclear. Assessments should be made of the impact of task shifting on patient and health outcomes as well as on efficiency and effectiveness of health care delivery. In particular, when task shifting occurs in response to specific health issues, such as HIV, regular assessment and monitoring should be conducted of the entire health system. Such work is essential in order to ensure that these programs are improving the health of patients.

8.10 Task shifting must be studied and assessed independently and not under the auspices of those designated to perform or finance task shifting measures.

8.11 Task shifting is only one response to the health workforce shortage. Other methods, such as collaborative practice or a team/partner approach, should be developed in parallel and viewed as the gold standard. Task shifting should not replace the development of mutually supportive, interactive health care teams, coordinated by a physician, where each member can make his or her unique contribution to the care being provided.

8.12 In order for collaborative practice to succeed, training in leadership and teamwork must be improved. There must also be a clear understanding of what each person is trained for and capable of doing, clear understanding of responsibilities and a defined, uniformly accepted use of terminology.

8.13 Task shifting should be preceded by a systematic review, analysis and discussion of the potential needs, costs and benefits. It should not be instituted solely as a reaction to other developments in the health care system.

8.14 Research must be conducted in order to identify successful training models. Work will need to be aligned to various models currently in existence. Research should also focus on the collection and sharing of information, evidence and

outcomes. Research and analysis must be comprehensive and physicians must be part of the process.

8.15 When appropriate, National Medical Associations should collaborate with associations of other health care professionals in setting the framework for task shifting. The WMA shall consider establishing a framework for the sharing of information on this topic where members can discuss developments in their countries and their effects on patient care and outcomes.

WMA RESOLUTION
ON
DRUG PRECSRIPTION

Adopted by the 61st WMA General Assembly, Vancouver, Canada, October 2010
and reaffirmed with minor revisions by the 215th Council session (on line), Cordoba, Spain, October 2020

PREAMBLE

From the beginning of their studies and throughout their professional careers, doctors acquire the knowledge, training and competence required to treat their patients with the utmost skill and care.

Physicians determine the most accurate diagnosis and the most effective treatment to cure illness, or alleviate its effects, taking into consideration the overall condition of the patient.

Pharmaceutical products are often an essential part of the treatment approach. In order to make the right decisions in accordance with the ethical and professional principles of medical practice, the doctor must have a thorough knowledge and understanding of the principles of pharmacology and possible interactions among different drugs and their effects on the health of the patient.

The prescribing of medication is a significant clinical intervention, which should be preceded by multiple, integrated processes to assess the patient and determine the correct clinical diagnosis. These processes include:

- Taking a history of the current condition and past medical history;
- The ability to make differential diagnosis;
- Understanding any multiple chronic and complex illnesses involved;
- Taking a history of the medications currently being administered successfully or previously withdrawn and also being aware of possible interactions.

Inappropriate drug prescription without proper knowledge and accurate diagnosis may cause serious adverse effects on the patient's health. In view of the possible serious consequences that may result from an inappropriate therapeutic decision, the WMA affirms the following principles on high quality treatment and ensuring patient safety.

The WMA reiterates its support to its statements on the Relationship between Physicians and Pharmacists in Medicinal Therapy and on Biosimilar Medicinal Products.

PRINCIPLES

1. Prescription of drugs should be based on a correct diagnosis of the patient's condition and should be performed by those who have successfully completed a curriculum on disease mechanisms, diagnostic methods and medical treatment of the condition in question.

2. Prescriptions issued by physicians are vital for ensuring patient safety, which in turn is critical for maintaining the relationship of trust between patients and their physicians.

3. Although nurses and other healthcare workers cooperate in the overall treatment of patients, the physician is the best qualified individuals to prescribe independently. In some countries, laws may allow for other professionals to prescribe drugs under specific circum-stances, generally with extra training and education and most often under medical super-vision. In all cases, the responsibility for the patient's treatment must remain with the phy-sician. Each country's medical system should ensure the protection of public interest and safety in the diagnosis and treatment of patients. If a system fails to comply with this basic framework due to social, economical or other compelling reasons, it should make every effort to improve the situation and to protect the safety of the patients.

WMA RESOLUTION
ON
THE ACCESS TO ADEQUATE PAIN TREATMENT

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011
and amended by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

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

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

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

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

RECOMMENDATIONS

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

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

   Pain treatment and control education shall be provided to healthcare professionals including physicians, other medical professionals, and other health care workers.

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

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

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

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

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

   - Patients in pain shall be given access to effective pain medication, including

opioids. Depriving them of such right is a violation of their right to health and is medically unethical.

- Governments must ensure that controlled drugs, including opioids, are made available and accessible to help relieve the suffering. Relief of suffering and prevention against abuse shall be balanced in the management of controlled drugs.
- Government shall provide abundant resources and create a national pain management research institute to explore issues in pain treatment and to come up with solutions, in particular:
- Explore issues that become barriers to pain treatment, such as financial condition, socioeconomic status, patient race and ethnicity, urban and rural differences, logistics, insufficient training, and culture (the misunderstanding that people have about opioids, for example)
- Promote the use of validated pain assessment tools.
- Conduct studies of emerging therapies or non-medicinal therapies.
- Establish a system and a standard procedure to record and collect pain-related data for correct statistics and monitoring. Pain-related data includes the incidence and prevalence of pain, cause of pain, burden of pain, pain treatment status, reason for pain not properly treated, and number of people with drug abuse, etc.

5. Governments shall prepare a national pain treatment plan to be followed in pain prevention, pain treatment, pain education, and policies on the management of controlled drugs.
   - The national pain treatment plan shall be evidence-based.
   - Governments must take into consideration opinions of policymakers, medical professionals, and the general public in order to prepare a national pain treatment plan that is extensive, practical, and forward-looking, contributing to enhanced nationwide pain treatment efficacy.

WMA RESOLUTION ON BAHRAIN

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011

The WMA General Assembly notes that

A number of doctors, nurses and other health care professionals in the Kingdom of Bahrain were arrested in March 2011 after the civil unrest in that country and tried under emergency powers before a special court, led by a military judge. Twenty of this group were found guilty of a number of charges, on 29 September 2011 and sentenced to fifteen, ten or five years imprisonment.

These trials failed to meet international standards for fair trials, including the accused not being allowed to make statements in their own defence, and their lawyers not being allowed to question all the witnesses. Allegations from the accused and their lawyers of mistreatment, abuse and other human right violations during arrest and while in detention have not been investigated.

While various criminal charges were brought it appears that the major offence was treating all the patients who presented for care, including leaders and members of the rebellion. Other charges appear to be closely related to providing such treatment and were, in any case, not proven to the standard expected in court proceedings. In treating patients without considering the circumstances of their injury these health care professionals were honouring their ethical duty as set out in the Declaration of Geneva.

The WMA welcomes the announcement by the government of Bahrain of 6 October 2011 that all twenty will be re-tried before a full civil court.

Therefore, the WMA requires that no doctor or other health care professional be arrested, accused or tried for treating patients, regardless of the origins of the patient's injury or illness.

The WMA demands that all states understand, respect and honour the concept of medical neutrality. This includes providing working conditions which are as safe as possible, even under difficult circumstances, including armed conflict or civil unrest.

The WMA expects that if any individual, including health care professionals, are subject to trial that there is due process of law including during arrest, questioning and trial in accordance with the highest standards of international law.

The WMA demands that states investigate any allegations of torture or cruel and inhumane treatment by prisoners against its agents, and act quickly to stop such abuses.

The WMA recommends that independent international assessors are allowed to observe the trials and meet privately with the accused, so that the state of Bahrain can prove to the watching world that the future legal proceedings follow fair process.

The WMA recognises that health care workers and health care facilities are increasingly under attack during wars, conflicts and civil unrest. We demand that states throughout the world recognise, respect and honour principles of medical neutrality and their duty to protect health care institutions and facilities for humanitarian reasons.

WMA RESOLUTION REAFFIRMING THE WMA RESOLUTION ON ECONOMIC EMBARGOES AND HEALTH

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011

The World Medical Association is deeply concerned about reports of potential serious health impacts resulting from economic sanctions imposed by the European Union against Ivory Coast leader, Laurent Gbagbo, and numerous individuals and entities associated with his regime, including two major ports linked to Gbagbo's government. The sanctions aim to severely restrict EU-registered vessels from transacting business with these ports, which could inhibit the delivery of necessary and life-saving medicines.

The WMA General Assembly reiterates the following position from the ***WMA Resolution on Economic Embargoes and Health:***

- ***All people have the right to the preservation of health; and,***
- ***the Geneva Convention (Article 23, Number IV, 1949) requires the free passage of medical supplies intended for civilians;***

The WMA therefore urges the European Union to take steps immediately to ensure the delivery of medical supplies to the Ivory Coast, in order to protect the life and health of the population.

WMA RESOLUTION
ON
THE INDEPENDENCE OF NATIONAL MEDICAL ASSOCIATIONS

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011
and reaffirmed by the 217th WMA Council Session, Seoul (online), April 2021

National medical associations are established to act as representatives of their physicians, and to negotiate on their behalf, sometimes as a trade union or regulatory body but also as a professional association, representing the expertise of medical doctors in relation to matters of public health and wellbeing.

They represent the views of the medical profession, including attempting to ensure the practice of ethical medicine, the provision of good quality medical care, and the adherence to high standards by all practitioners.

These associations may also campaign or advocate on behalf of their members, often in the field of public health. Such advocacy is not always welcomed by governments who may consider the advocacy to have oppositional politics attached, when in reality it is based upon an understanding of the medical evidence and the needs of patients and populations.

The WMA is aware that because of those advocacy efforts some governments attempt to silence the medical association by placing it's own nominated representatives into positions of authority, to subvert the message into one they are better able to tolerate.

The WMA denounces such action and demands that no government interferes with the independent functioning of national medical associations. It encourages governments to understand better the reasons behind the work of their national medical association, to consider the medical evidence and to work with physicians to improve the health and well being of their populations.

WMA RESOLUTION
ON
PLAIN PACKAGING OF CIGARETTES, E-CIGARETTES AND OTHER SMOKING PRODUCT

Adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012
and reaffirmed with minor revision by the 217th WMA Council Session (online), Seoul, South Korea, April 2021

The WMA reaffirms its Resolution on Implementation of the WHO Framework Convention on Tobacco Control and emphasizes the importance of this global mechanism to protect people from exposure and addiction to tobacco and tobacco products such as nicotine.

The WMA also reaffirms its statement on e-cigarettes and the recommendation that these products be subjected to local regulatory approval and be entrenched in smoke free laws.

The WMA recognises that :

- Cigarettes offer a serious threat to the life and health of individuals that use them, and a considerable cost to the health care services of every country;
- Those who smoke predominantly start to do so while adolescents;
- There is mounting evidence that e-cigarette use predicts initiation of the use of traditional tobacco products among young people and/or non-smokers, and of additional health risks from the use of e-cigarette products.
- There is a proven link between brand recognition and likelihood of starting to smoke;
- Brand recognition is strongly linked to cigarette packaging;
- Plain packaging reduces the impact of branding, promotion and marketing of cigarettes and e-cigarette products.

The WMA strongly encourages national governments to support the introduction of initiatives that break brand recognition, including plain packaging of cigarettes, other tobacco products, and e-cigarettes and deplores strategies from the tobacco industry to oppose the adoption and implementation of such policy.

WMA RESOLUTION TO REAFFIRM THE WMA'S PROHIBITION OF PHYSICIAN PARTICIPATION IN CAPITAL PUNISHMENT

Adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012

There is universal agreement that physicians must not participate in executions because such participation is incompatible with the physician's role as healer. The use of a physician's knowledge and clinical skill for purposes other than promoting health, wellbeing and welfare undermines a basic ethical foundation of medicine---first, do no harm.

The WMA Declaration of Geneva states: "I will maintain the utmost respect for human life"; and, "I will not use my medical knowledge to violate human rights and civil liberties, even under threat."

As citizens, physicians have the right to form views about capital punishment based on their individual moral beliefs. As members of the medical profession, they must uphold the prohibition against participation in capital punishment.

Therefore, be it RESOLVED that:

- Physicians will not facilitate the importation or prescription of drugs for execution.
- The WMA reaffirms: "that it is unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process, including its planning and the instruction and/or training of persons to perform executions", and
- The WMA reaffirms: that physicians "will maintain the utmost respect for human life and will not use [my] medical knowledge to violate human rights and civil liberties, even under threat."

WMA RESOLUTION
IN
SUPPORT OF PROFESSOR CYRIL KARABUS

Adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012

The WMA welcomes the bail granted on the 11th of October to the retired South African paediatric haematologist, 78-year-old Professor Cyril Karabus, as a positive step given his state of health; he has cardiac disease. Dr Karabus had been detained in an Abu Dhabi, UAE prison since August 18th 2012. He was arrested in Dubai, whilst in transit to South Africa, owing to alleged charges emanating from a brief period that he worked in the UAE in 2002.

Professor Karabus was neither informed of the charges leveled against him nor the subsequent trial that was held in absentia relating to the unfortunate death of a child with acute leukemia under his care during his tenure in the UAE in 2002. His defense lawyer has also been unable to access any documents or files relating to the case that may assist in providing a fair defense.

Therefore,

The WMA General Assembly urgently calls on the authorities of the United Arab Emirates to ensure that Professor Karabus:

- Is guaranteed a fair trial according to international standards;
- Has access to the relevant documents or information he may require to prepare his defense.

WMA RESOLUTION
ON
CRIMINALISATION OF MEDICAL PRACTICE

Adopted as a Council Resolution by the 194th WMA Council Session, Bali, Indonesia, April 2013
and adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013
and reaffirmed by the 217th WMA Council Session, Seoul (online), April 2021

PREAMBLE

Doctors who commit criminal acts which are not part of patient care must remain as liable to sanctions as all other members of society. Serious abuses of medical practice must be subject to sanctions, usually through professional regulatory processes.

Numerous attempts are made by governments to control physicians' practice of medicine at local, regional and national levels worldwide. Physicians have seen attempts to:

- Prevent medically indicated procedures;
- Mandate medical procedures that are not indicated; and
- Mandate certain drug prescribing practices.

Criminal penalties have been imposed on physicians for various aspects of medical practice, including medical errors, despite the availability of adequate non-criminal redress. Criminalizing medical decision making is a disservice to patients.

In times of war and civil strife, there have also been attempts to criminalize compassionate medical care to those injured as a result of these conflicts.

RECOMMENDATIONS

Therefore, the WMA recommends that its members:

1. Oppose government intrusions into the practice of medicine and in healthcare decision making, including the government's ability to define appropriate medical practice through imposition of criminal penalties.

2. Oppose criminalizing medical judgment.

3. Oppose criminalizing healthcare decisions, including physician variance from guidelines and standards.

4. Oppose criminalizing medical care provided to patients injured in civil conflicts.

5. Implement action plans to alert opinion leaders, elected officials and the media about the detrimental effects on healthcare that result from criminalizing healthcare decision making.

6. Support the principles set forth in the WMA's Declaration of Madrid on Professional Autonomy and Self-Regulation.

7. Support the guidance set forth in the WMA's Regulations in Times of Armed Conflict and Other Situations of Violence.

WMA RESOLUTION
ON
THE HEALTHCARE SITUATION IN SYRIA

Adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013
and reaffirmed with minor revisions by the 215th Council session (online), Cordoba, Spain, October 2020

PREAMBLE

During wars and armed conflicts, hospitals and other medical facilities have often been attacked and misused and patients and medical personnel have been killed or wounded. Such attacks are a violation of the Geneva Conventions (1949), Additional Protocols to the Geneva Conventions (1977) and WMA policies, in particular, the WMA Statement on the Protection and Integrity of Medical Personnel in Armed Conflicts and Other Situations of Violence (Montevideo 2011) as well as WMA Regulations in Times of Armed Conflicts and Other Situations of Violence (Bangkok 2012).

The World Medical Association (WMA) has been active in condemning documented attacks on medical personnel and facilities in armed conflicts, including civil wars. The Geneva Conventions and their Additional Protocols are designed to protect medical personnel, medical facilities and their patients in international and non-international armed conflicts. The parties on both sides of the conflict have legal and moral duties not to interfere with medical care for wounded or sick combatants and civilians, and to not attack, threaten or impede medical functions. Physicians and other health care personnel must act as and be considered neutral and must not be prevented from fulfilling their duties.

RECOMMENDATIONS

1. The WMA recalls the United Nations Security Council Resolution 2286 adopted in 2016 condemning attacks and threats against medical personnel and facilities in conflict situations and demanding an end to impunity for those responsible.
2. The WMA calls upon all parties in the Syrian conflict to ensure the safety of healthcare personnel and their patients, as well as medical facilities and medical transport, and to respect the ethical obligation of health personnel to treat all patients, irrespective of who they are in line with the Ethical Principles of Health Care in Times of Armed Conflict and other Emergencies endorsed by civilian and military health-care organizations in 2015.
3. The WMA calls upon its members to approach local governments in order to facilitate international cooperation in the United Nations, the European Union or other international body with the aim of ensuring the safe provision of health care to the Syrian people.

WMA RESOLUTION
ON
THE PROHIBITION OF CHEMICAL WEAPONS

Adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013
and reaffirmed with minor revisions by the 215th Council session (online), Cordoba, Spain, October 2020

PREAMBLE

It has been recognised for centuries that certain chemical agents can affect consciousness, or other factors influencing the ability of an individual to take part in fighting, predominantly during warfare. More recently some agents have been used to temporarily disable participants in civil unrest, protests or riots. In warfare such agents have, historically, had a significant morbidity and mortality and included nerve gases and related agents.

Despite widespread condemnation such weapons were extensively used in the early 20th century. A global movement to outlaw the use of such weapons led to the development of the Chemical Weapons Convention (CWC), which entered into force in 1997 having been opened to signature in 1993. Currently only six countries have not ratified or acceded to the CWC.

The production, stockpiling and use of CW is prohibited. Despite this, such weapons have been used by state forces and by non-state actors in a number of countries. By their nature such weapons are indiscriminate. This use has led to deaths, injuries and human suffering in those countries.

Chemical agents used in policing actions, including by the military acting in a policing role, are allowed under the CWC. There is a significant international dialogue underway on the definition of such agents and the situations in which they can be used. It should be noted that the CWC appears to assume such agents will not be lethal, but the use of any agent might have fatal consequences. Those using them, or authorising their use, must seek to ensure that they are not used in a manner which risks death or serious injury to targeted persons.

RECOMMENDATIONS

1. The WMA notes that the development, production, stockpiling and use of Chemical Weapons is banned under the CWC, and that use of such weapons is regarded by some to be a crime against humanity, regardless of whether the target populations are civilian or military.
2. The WMA urges all relevant parties to make active efforts to abide by the CWC

ban on the development, production, stockpiling and use of Chemical Weapons.

3. The WMA urges support from all states party to the CWC for the safe destruction of all stockpiles of Chemical weapons.
4. The WMA calls for efficient independent accountabiliy measures bringing to justice those responsible for the use of Chemical Weapons.
5. The WMA urges states using chemical agents in riot control and related situations to carefully consider and minimise the risks and to, wherever possible, refrain from such use. Any use must follow the establishment of the necessary procedures to reduce the risk of death or serious injury. They should not be used in a manner, which deliberately increases the risk of injury, harm or death to their targets.
6. Reaffirming its Statement on the Protection and Integrity of Medical Personnel in Situations of Violence and its Declaration on the Protection of Health Care Workers in Situation of Violence, the WMA emphasizes the serious risk of exposing health professionals to chemical agents while performing their medical duties to provide first-aid to injured people in unrest contexts.

WMA RESOLUTION ON STANDARDISATION IN MEDICAL PRACTICE AND PATIENT SAFETY

Adopted as a Council Resolution by the 194th WMA Council Session, Bali, Indonesia, April 2013
and adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013
and reaffirmed by the 217th WMA Council Session, Seoul (online), South Korea, April 2021

Ensuring patient safety and quality of care is at the core of medical practice. For patients, a high level of performance can be a matter of life or death. Therefore, guidance and standardisation in healthcare must be based on solid medical evidence and has to take ethical considerations into account.

Currently, trends in the European Union can be observed to introduce standards in clinical, medical care developed by non-medical standardisation bodies, which neither have the necessary professional ethical and technical competencies nor a public mandate.

The WMA has major concerns about such tendencies which are likely to reduce the quality of care offered, and calls upon governments and other institutions not to leave standardisation of medical care up to non-medical self selected bodies.

WMA RESOLUTION
IN
SUPPORT OF THE BRAZILIAN MEDICAL ASSOCIATION

Adopted by the 64th WMA General Assembly, Fortaleza, Brazil, October 2013

There are credible reports that the Brazilian Government program "Mais Médicos" to create more medical schools, extend the duration of the medical course, compulsorily place last years medical students to work in public services and attract foreign physicians to work in remote areas of the country and in the poorest outskirts of big cities, was proposed without the appropriate consultation to the medical community and medical schools, and departs from a wrong diagnosis about the causes of the insufficient health care provided to the Brazilian population. The program as proposed bypass systems established to verify physicians' credentials, medical competence and language skills in order to protect patients.

The World Medical Association is concerned that patients are put at risk by unregulated medical license, inadequate medical competence and potential misunderstanding of patient communication and of drugs and medical supplies labels.

Therefore, the WMA:

- Condemns any policy and practice that disrupt the accepted standards of medical credentialing and medical care;
- Calls upon the Brazilian government to work with the medical community and medical schools on all matters related to medical education, physician certification and the practice of medicine, and to respect the role of the Brazilian Medical Association on behalf of the Brazilian physicians and population;
- Urges, as a matter of utmost concern, that the Brazilian government respect the WMA International Code of Medical Ethics that guides the medical practice of physicians all over the world.

WMA RESOLUTION ON EBOLA VIRAL DISEASE

Adopted by the 65th WMA General Assembly, Durban, South Africa, October 2014

BACKGROUND

A number of viral diseases have caused occasional health emergencies in parts of Africa, with local or wider spread epidemics. These include Lassa, Marburg and Ebola Viral Diseases (EVD). The 2013-14 outbreak of EVD in West Africa has proven far more difficult to control than previous epidemics and is now present in Sierra Leone, Liberia and Guinea with more than 2000 deaths. This epidemic appears to have a case related mortality of approximately 55% against a range for EVD of 50~95%.

Following infection, patients remain asymptomatic for a period of 2~21 days, and during this time tests for the virus will be negative, and patients are not infectious, posing no public health risk. Once the patient becomes symptomatic, EVD is spread through contact with body fluids including blood. Symptoms include diarrhoea, vomiting and bleeding, and all these body fluids are potential sources of infection.

Management is primarily through infection control, the use of personal protective equipment (PPE) by health care workers and those disposing of body fluids and of bodies, and supportive care for sick patients including using IV fluids and inotropes. Contact tracing is also important but may be difficult in many of the communities currently affected. Vaccines are in development as are some antivirals, but they will arrive late in this epidemic if they are proven successful.

Evidence from those treating patients in affected communities is that a shortage of resources, including health care workers and PPE, as well as poor infection control training of health care workers, caregivers and others at risk are making epidemic control difficult.

Some governments have indicated that they will build new treatment centres in affected areas as a matter of urgency, while others are directly providing personal protective equipment and other supplies.

RECOMMENDATIONS

1. The WMA honours those working in these exceptional circumstances, and strongly recommends that national governments and international agencies work with health care providers on the ground and offer stakeholders training and support to reduce the risks that they face in treating patients and in seeking to control the epidemic.

2. The WMA commends those countries that have committed resources for the urgent establishment of new treatment and isolation centres in the most heavily burdened countries and regions. The WMA calls upon all nations to commit enhanced support for combatting the EVD epidemic.

3. The WMA calls on the international community, acting through the United Nations and its agencies as well as aid agencies, to immediately provide the necessary sup-plies of PPE to protect health care workers and ancillary staff and reduce the risk of cross infection. This must include adequate supplies of gloves, masks and gowns, and distribution must include treatment centres at all levels.

4. The WMA calls on all those managing the epidemic, including local and national governments and agencies such as WHO, to commit to adequate training in infection control measures, including PPE for all staff and caregivers who might come into contact with infective materials.

5. The WMA calls on national and local governments to increase public communication about basic infection control practices.

6. The WMA calls upon WHO to facilitate research into the timeliness and effectiveness of international interventions, so that planning and interventions in future health emergencies can be better informed.

7. The WMA strongly urges all countries, especially those not yet affected, to educate health care providers about the current case definition in addition to strengthening infection control methodologies and contact tracing in order to prevent transmission within their countries.

8. The WMA calls for NMAs to contact their national governments to act as described in this document.

WMA RESOLUTION
ON
MIGRANT WORKERS' HEALTH AND SAFETY IN QATAR

Adopted by the 65th WMA General Assembly, Durban, South Africa, October 2014 and reaffirmed by the 217th WMA Council Session, Seoul (online), South Korea, April 2021

PREAMBLE

Reliable reports indicate that migrant workers in Qatar suffer from exploitation and violation of their rights. Workers basic needs, e.g. access to sufficient water and food, are not met. Less than half of the workers are entitled to health care. Hundreds of workers have already died in the construction sites since 2010 as the country prepares to host the 2022 FIFA1 World Cup. Workers are not free to leave when they see their situation hopeless or health endangered since their passports are confiscated.

Despite the pleas of international labour and human rights organizations, such as ITUC (International Trade Union Confederation) and Amnesty International, the response of the Qatar government to solve the situation has not been adequate. FIFA has been inefficient and has not taken the full responsibility to facilitate the improvements to the worker´s living and working conditions.

The World Medical Association reminds that health is a human right that should be safeguarded in all situations.

The World Medical Association is concerned that migrant workers are continuously put at risk in construction sites in Qatar, and their right to freedom of movement and right to health care and safe working conditions are not respected.

RECOMMENDATIONS

1. The WMA calls upon the Qatar government and construction companies to ensure the health and safety of migrant workers;

2. The WMA demands the FIFA as the responsible organization of the World Cup to take immediate action by changing the venue as soon as possible;

3. The WMA calls upon its members to approach local governments in order to facilitate international cooperation with the aim of ensuring the health and safety of migrant workers in Qatar.

---

[1] Fédération Internationale de Football Association

WMA RESOLUTION
ON
UNPROVEN THERAPY AND THE EBOLA VIRUS

Adopted by the 65th WMA General Assembly, Durban, South Africa, October 2014

In the case of Ebola virus, the WMA strongly supports the intention of Paragraph 37 of the 2013 revision of the Declaration of Helsinki, which reads:

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

WMA RESOLUTION TO STOP ATTACKS AGAINST HEALTHCARE WORKERS AND FACILITIES IN TURKEY

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

PREAMBLE

Several media report that over the last two months of conflict in Turkey, healthcare workers have been killed, wounded or threatened with guns. Some physicians have been taken out of ambulances and beaten. Access to wounded people is prevented by security forces, and ambulances as well as health facilities are regularly targeted. A rather comprehensive study conducted by the Turkish Medical Association confirms these facts.

There are indications that attacks on healthcare workers and the obstructions of service delivery are used as a deliberate political instrument to intimidate people, depriving them of their democratic rights.

Parties in armed conflict have the obligation to protect health care provision to wounded and sick and to prevent attack on or threat to medical activities, healthcare workers and facilities. Physicians and other healthcare workers should not be impeded to perform their duties. Such attacks constitute blatant violation of international human rights law, in particular the inherent right to life that shall be protected by law, and the right to enjoy the highest attainable standard of health[1].

These attacks undermine gravely as well fundamental medical ethics principles, in particular WMA international Code of Medical Ethics and the Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies endorsed by civilian and military health-care organisations[2], stating that: “Health-care personnel, as well as health-care facilities and medical transports, whether military or civilian, must be respected by all. They are protected while performing their duties and the safest possible working environment shall be provided to them » (article 10).

RECOMMENDATIONS

The WMA urges all parties to:

Stop attacks on healthcare workers and patients, health care facilities, and ambulances and ensure their safety,
Respect the professional autonomy and impartiality of healthcare workers,
Comply fully with international human rights law as well as other relevant international regulations that Turkey is a State Party to, and
Document and record all violations and duly prosecute their perpetrators.

[1] International Covenant on Economic, Social and Cultural Rights, article 12 – December 1966
[2] Adopted by the ICRC, the WMA, the International Committee of Military Medicine (ICMM), the International Council of Nurses (ICN) and the International Pharmaceutical Federation (FIP) – June 2015

WMA RESOLUTION
ABOUT THE BOMBING ON THE HOSPITAL OF MSF IN KUNDUZ

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

After the events of October 3 in Kunduz (Afghanistan), the WMA:

- Extends its deepest condolences to families, colleagues and friends of doctors, healthcare workers and patients killed in the bombing
- Deeply regrets and condemns the bombing of the Hospital of MSF , considering it a violation of human rights.
- Reaffirms its positional statements on “Healthcare in Danger” and calls on all countries to respect healthcare personnel in conflict situations
- Demands an immediate enquiry into the attack by an independent body and the assumption of responsibilities.

WMA STATEMENT ON THE PROTECTION OF HEALTH CARE FACILITIES AND PERSONNEL IN SYRIA

Adopted by the 67th WMA General Assembly, Taipei, Taiwan, October 2016
and reaffirmed with minor revisions by the 218th Council session (online), London, United Kingdom, October 2021

The World Medical Association notes with great concern the repeated attacks on health care facilities, health personnel and patients since the beginning of the war in Syria in 2011. These attacks have killed and injured civilian people, and the most vulnerable among them, children and patients. The WMA recalls that health care facilities and personnel must, according to the international law, be protected by all parties of the conflict.

Therefore, the WMA

- Deeply regrets and condemns the recurring attacks on health care facilities, health personnel and patients, considering these as a violation of human rights;
- Reaffirms its Declaration on the protection of healthcare in situation of violence and demands all countries to ensure the safety of healthcare personnel and patients in conflict situations;
- Reasserts the Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies adopted by civilian and military health-care organizations in 2015, and demands urgent action to guarantee the full respect of medical neutrality;
- Calls on all countries to fully implement the UN Resolution 2286 (2016) which demands all parties to armed conflicts to fully comply with their obligations under international law, to ensure the respect and protection of all health and humanitarian personnel exclusively engaged in medical duties, of their means of transport and equipment, as well as hospitals and other medical facilities;
- Demands an immediate and impartial enquiry into the attacks against health care facilities and personnel, and actions taken against those responsible in accordance with domestic and international law.

WMA RESOLUTION
ON
ZIKA VIRUS INFECTION

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015
and adopted by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

Recognizing that the WHO has designated the Zika virus infection a global health emergency, the WMA provides the following recommendations:

- WHO should work with ECDC, CDC and other disease control organisations to better understand the natural history and current epidemiology of Zika virus infection.
- Information should be disseminated widely to advise and protect all women and men who live in or must travel to Zika-affected areas and who are considering becoming parents. Advice should also include recommendations for women who are already pregnant who may have been directly exposed to the Zika virus or whose partners live in or have travelled to Zika-affected areas.
- Relevant agencies, including WHO, should gather data on the efficacy of different mosquito control methodologies, including the potentially harmful or teratogenic effects of the use of various insecticides.
- Work on diagnostic tests, antivirals, and vaccines should continue with an emphasis on producing a product that is safe for use in pregnant women and public funding should be assured for this research. When such products are developed states should ensure that they are available to, and affordable by, those most at risk.
- States which have witnessed the delivery of a number of babies with microcephaly and other fetal brain abnormalities must ensure that these infants are properly followed up by health and other services, and provide support to families seeking to cope with a child with developmental abnormalities. Wherever possible research on the consequences of microcephaly should be published, to better inform future parents, and to allow the development of optimal service provision.

WMA RESOLUTION
ON
PROHIBITION OF FORCED ANAL EXAMINATIONS TO SUBSTANTIATE SAME-SEX SEXUAL ACTIVITY

Adopted by the 68th General Assembly, Chicago, United States, October 2017
and reaffirmed with minor revisions by the 221st WMA Council Session, Berlin, Germany, October 2022

PREAMBLE

The WMA Declaration of Tokyo strictly forbids physicians to countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading treatment and requires them to respect the confidentiality of medical information.

The United Nations Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment prohibits health personnel from "participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment".

Since 2011, in at least eleven countries, physicians have participated in forced anal examinations of men and transgender women who are charged with consensual same-sex conduct.

The UN Special Rapporteur on Torture has described forced anal examinations as a form of torture or cruel, inhuman and degrading treatment that is "medically worthless" due to the lack of scientific validity of the tests.

Furthermore, in its Statement on Anal Examinations in Cases of Alleged Homosexuality, the Independent Forensic Expert Group, composed of forensic medicine specialists from around the world, has determined that "the examination has no value in detecting abnormalities in anal sphincter tone that can be reliably attributed to consensual anal intercourse".

The WMA is deeply disturbed by the complicity of physicians in these non-voluntary and unscientific examinations, including the preparation of medical reports that are used in trials to convict men and transgender women of consensual same-sex conduct.

In accordance with its Statement on Body Searches of Prisoners, the WMA reminds that forced examinations are not ethically acceptable and physicians must not perform them.

The ability of persons in custody to provide free and informed consent is limited. Even when consent is given, physicians should refrain from undertaking procedures that are scientifically unfounded, discriminatory and potentially incriminating.

RECOMMENDATIONS

Recognizing that persons who have undergone forced anal exams have described them as painful, humiliating, and amounting to sexual assault and recalling that physicians should never engage in acts of torture or other forms of cruel, inhuman or degrading treatment, the WMA:

1. Calls on its Constituent Members, physicians and other health professionals, to stand firmly against participation in forced anal examinations because they are medically invalid;

2. Urges its Constituent Members to issue written communications prohibiting their members from participating in such examinations;

3. Urges its Constituent Members to educate physicians and other health professionals about the unscientific and futile nature of forced anal exams and the fact that they are a form of torture or cruel, inhuman and degrading treatment;

4. Calls on the World Health Organization to make an official statement opposing forced anal examinations to prove same-sex sexual activity as unscientific and unethical in violation of medical ethics.

WMA RESOLUTION
IN SUPPORT OF DR SERDAR KÜNI

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

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

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

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

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

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

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

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

Thus, in view of the next hearing on 24 April regarding Dr. Küni case at the Şırnak 2nd

Heavy Penal Court, the WMA urges national medical associations and the international health community to mobilise in support of the immediate release of Dr. Serdar Küni and the charges based on his medical practice be dropped immediately and unconditionally.

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

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

WMA RESOLUTION
ON
PROHIBITION OF PHYSICIAN PARTICIPATION IN CAPITAL PUNISHMENT

Adopted by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

There is universal agreement that physicians must not participate in executions because such participation is incompatible with the physician's role as healer. The use of a physician's knowledge and clinical skill for purposes other than promoting health, wellbeing and welfare undermines a basic ethical foundation of medicine. The WMA Declaration of Geneva states: "I will maintain the utmost respect for human life", and "I will not use my medical knowledge to violate human rights and civil liberties, even under threat".

As citizens, physicians have the right to form views about capital punishment based on their individual moral beliefs. As members of the medical profession, they must uphold the prohibition against participation in capital punishment.

Therefore, the World Medical Association

AFFIRMS that it is unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process, including its planning and the instruction and/or training of persons to perform executions.

REQUESTS firmly its constituent members to advise all physicians that any participation in capital punishment as stated above is unethical.

URGES its constituent members to lobby actively national governments and legislators against any participation of physicians in capital punishment.

*The WMA Resolution on Prohibition of Physician Participation in Capital Punishment is a minor revision that merges two existing WMA policies, the Resolution on Physician Participation in Capital Punishment (2008) and the WMA Resolution to Reaffirm WMA's Prohibition of Physician Participation in Capital Punishment (2012). As a result of the new merged document, these two policies have been rescinded and archived.

WMA RESOLUTION
ON
CLIMATE EMERGENCY

Adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

Health professionals have an important role in advocating to protect the health of citizens around the world, and therefore have a responsibility to demand greater action on climate change.

The UN summit on climate action that took place in September 2019 further demonstrated the growing recognition that climate change action must be accelerated, with many countries making commitments to achieving net zero emissions by 2050 and others committing to boost national action plans by 2020.

There is emerging consensus within the medical profession globally that action on climate change must be accelerated.

The WMA and its constituent members and the international health community:

- declare a climate emergency and call the international health community to join their mobilisation;
- commit to advocate to protect the health of citizens across the globe in relation to climate change;
- urge national government to rapidly work to deliver carbon neutrality by 2030, so as to minimise the life-threatening impacts of climate change on health;
- must acknowledge the environmental footprint of the global healthcare sector, and act to reduce waste and prevent pollution to ensure healthcare sustainability.

WMA RESOLUTION
ON
THE REVOCATION OF WHO GUIDELINES ON OPIOID USE

Adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

The World Medical Association expresses concern about the abrupt discontinuation of WHO 2011 guidance "Ensuring balance in national policies on controlled substances: Guidance for availability and accessibility of controlled medicines", as well as its 2012 "WHO guidelines on the pharmacological treatment of persisting pain in children with medical illnesses".

This revocation, which took place last Summer without consulting the medical community, will deprive many physicians of support and regulation in countries without related national legislation, thus endangering their medically justified use of such substances. Ultimately, suffering patients will not have access to proper medication.

The WMA notes that the withdrawal was decided unilaterally, without providing any supporting evidence and without including any replacement or substitution. Moreover, the discontinued guidelines were fully removed from WHO online publications portal, thus impeding the ability of physicians to justify and validate retrospectively the use of controlled substances, exposing them potentially to criminal prosecution.

Without further information, the WMA considers it necessary to reinstate the mentioned guidelines until they are replaced by new or amended ones.

The WMA demands the adherence to the principle of evidence-based development of treatment guidelines. This should apply to the definition, amendment and discontinuation of such guidance in addition to the application of a precautionary principle. Evidence supporting the revocation of the opioid-guidelines must be published and made available for scientific scrutiny.

The WMA welcomes the efforts to assemble a new team of experts and strongly recommends an open and transparent process, including a reliable mechanism to ensure the disqualification of experts with conflicts of interest.

WMA RESOLUTION IN SUPPORT OF AN INTERNATIONAL DAY OF THE MEDICAL PROFESSION, OCTOBER 30

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

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

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

WMA RESOLUTION
IN SUPPORT OF
THE TURKISH MEDICAL ASSOCIATION

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

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

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

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

Recalling its Resolution on the Independence of National Medical Associations, the WMA opposes such governmental interference with the independent functioning of a national medical association and urges the government of Turkey and the members of the parliament to:

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

WMA RESOLUTION
ON
EQUITABLE GLOBAL DISTRIBUTION OF COVID-19 VACCINE

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

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

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

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

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

RECOMMENDATIONS

The World Medical Association

1. welcomes multilateral solutions in the global battle against COVID-19, in particular the COVAX platform, for ensuring equitable, global distribution of a safe and effective COVID-19 vaccine;

2. emphasises that no country should be left behind in the race to vaccinate its population against this global threat;

3. stresses the need to balance between the desire of each country to protect its citizens and the need for the vaccine to be distributed worldwide;

4. reiterates that all clinical trials must follow the ethical principles for medical research involving human subjects as set forth in the WMA Declaration of Helsinki;

5. states that longer-term, formal safety monitoring is necessary in cases where clinical trials have been accelerated to fast track vaccines for market authorisation;

6. calls attention to the heightened risk faced by health workers and vulnerable populations in a pandemic situation and therefore urges that these individuals be among the first to receive a safe and effective vaccine;

7. renews its call to all constituent members to increase awareness of immunisation schedules and calls upon individual physicians to pay special attention to addressing the concerns of vaccine-hesitant patients;

8. reaffirms its warning on vaccine hesitancy (April 2019) and reiterates the importance of maintaining other important routine vaccinations, e.g. against polio, measles and influenza;

9. calls for coordinated efforts to increase public trust in vaccination in the face of disinformation campaigns and anti-vaccine movements which undermine the health of both children and adults.

WMA RESOLUTION
ON
HUMAN RIGHTS VIOLATIONS AGAINST UIGHUR PEOPLE IN CHINA

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

- Article 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
- Article 9: No one shall be subjected to arbitrary arrest, detention or exile.
- Article 25 (i): Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[1]

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

RECOMMENDATIONS

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

1. formally condemn the treatment of the Uighurs in China's Xinjiang region and call upon physicians to uphold the guidelines set out in the WMA Declaration of Tokyo and the WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment;

2. support the requests made in the July 2019 letter to the UN Human Rights Council High Commissioner calling for international independent observers to be allowed into the Xinjiang region of China.

3. Reaffirm its Statement on Forced and Coerced Sterilisation, asserting that no person, regardless of gender, ethnicity, socio-economic status, medical condition or disability, should be subjected to forced or coerced permanent sterilisation, and call on its members medical associations to advocate against forced and coerced sterilisation in their own countries and globally; and

4. Reiterate support of its Declaration on Fair Trade in Medical Products and Devices and urge its medical association members to promote fair and ethical trade in the health sector, and insist that the goods they use are not produced at the expense of the health of workers in the global community. To do this, physicians should;

    - raise awareness of the issue of ethical trade and promote the development of fair and ethically produced medical goods amongst colleagues and those working within health systems.

    - play a leadership role in integrating considerations of labour standards into purchasing decisions within healthcare organizations.[1] https://www.un.org/en/universal-declaration-human-rights/

WMA RESOLUTION
ON
PROTECTING THE FUTURE GENERATION'S RIGHT TO LIVE IN A HEALTHY ENVIRONMENT

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

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

Health professionals have a duty to care, respect and protect the human life, as well as the right to live for future generations and all forms of the natural living world. WMA believes that all people, including future generations, have the right to the environmental, economic and social resources needed for healthy and productive lives; such as clean air, soil, water and food security. Therefore; WMA has a historical responsibility of acting proactively in order to initiate the necessary changes and solutions to struggle with the climate crisis.

RECOMMENDATIONS

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

1. Urge to ask its members to collaborate with relevant bodies in their countries in order to raise awareness about the necessity for legally binding sanctions and policies at the national and international level for the polluters that threaten the right to live for the future generations by emitting gases which are proven to cause climate crisis and air, soil and water pollution.

2. Urge all national governments, policy makers, researchers and health professionals to mobilize in order to develop and implement comprehensive policies to struggle with the problems due to the use of fossil fuels by industry as well as the individuals that lead to problems such as climate crisis air, water and soil pollution.

3. Urge all medical professionals, media, governmental and non – governmental institutions to refer climate change as 'climate crisis' and calls the leaders of national, state or provincial, regional, city, and local governments to declare a climate emergency in order to initiate a society-wide action. Moreover, encourage the media to promote the concept and meaning of the right to live for future generations.

4. Update the curriculum at medical schools and add compulsory sections on environmental health in order to educate health professionals that are able to think critically about the health impacts of the environmental problems, are aware of the reasons, impacts/dimensions of the climate crisis and able to offer solutions designed to protect the rights and health of future generations.

5. Advocate and organize interdisiplinary campaigns in order to stop the new permissions from being given to the industrial facilities using fossil fuels that cause climate crisis and pollution.

6. Urge national governments and international bodies such as WHO to adopt stricter regulations on environmental protection and evaluation, permission, monitoring and control procedures of new industrial facilities to limit the health impact resulting from their emissions.

7. Advocate actively for policies that will maximize health benefits by reducing air pollutants (such as ground ozone and particulate matter etc.) and carbon emissions, increase walking, cycling, and use of public transport, and consumption of nutritious, plant-rich diets to ensure climate justice. Urge international, national, state or provincial, regional, city, and local governments to adopt and implement air quality and climate change policies that will achieve the WHO Ambient Air Quality Guideline values.

8. Urge national, state or provincial, regional, city, and local governments through public campaigns and advocacy to cut subsidies given to fossil fuel industries and to direct these subsidies to support just transition, energy efficiency measures, green energy resources and public welfare.

9. Urge governments and private sector to invest in policies that support a just transition for workers and communities adversely impacted by the move to a low-carbon economy and to build social protection through investment in and transition to green jobs.

10. Urge national, state or provincial, regional, city, and local governments to act on other causes of climate crisis such as industrial agriculture, animal husbandry and deforestation, to promote legal trade and financing policies that prioritize and enable sustainable agro-ecological practices, end deforestation for the expansion of industrial agriculture and to reduce reliance on industrial animal-based agriculture and environmentally damaging agricultural and fisheries practices.

11. Urge national, state or provincial, regional, city, and local governments to invest in human capacity and knowledge infrastructure to spread regenerative agriculture solutions that can produce the change needed while providing myriad co-benefits to farmers and consumers, providing a global support network – on the ground – for farmers and capturing carbon in the soil. Emphasize building resilient and regenerative local food systems that can reduce carbon emissions, support the livelihoods of agricultural communities and provide food security for future generations.

12. Urge national governments, together with the involvement of health sector, to develop national adaptation plans and to conduct national assessments of climate crisis impacts, vulnerability, and adaptation for health.

WMA RESOLUTION
REGARDING
THE MEDICAL PROFESSION AND COVID-19

Adopted by the 71st WMA General Assembly (online), Cordoba, Spain, October 2020

PREAMBLE

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

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

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

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

RECOMMENDATIONS

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

1. Sufficient provision of equipment and personal protection material (PPE) for health professionals, which allows healthcare and guarantees the availability of this material in a situation of possible outbreaks.
2. Urge governments to adopt a multilateral and coordinated approach on a global

scale of the crisis to promote equality in interventions, access to health services, treatments and future vaccines.

3. Provide enough financing to healthcare systems so that they can face the costs of the pandemic and guarantee accessible and quality healthcare.
4. The National Medical Associations and the WMA encourage an active participation in the planning and management of all stages of the response to the epidemic.
5. Recognise that SARS CoV-2 infection be recognised as an occupational disease and that the medical profession be declared a "profession at risk". Likewise, we request that taking care of healthcare professionals be a priority, especially in the field of mental health.
6. Fight against violence towards doctors and against any sign of their stigmatisation by promoting zero tolerance of violence in healthcare settings.
7. Support the medical profession that continues to honour its commitment to science and patients. Because current medical professionalism is one of the few and last defence that the seriously ill, excluded and helpless patients have to maintain a minimum of health, quality of life and human dignity.
8. Urge governments to include health system strengthening and resilience as part of national COVID recovery plans.

WMA RESOLUTION IN SUPPORT OF THE COUNTRIES WORST AFFECTED BY THE COVID-19 CRISIS

Adopted by the 217th WMA Council Session, Seoul (online), April 2021
and adopted as a resolution by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

The World Medical Association is deeply concerned to see the alarming and worsening Covid crisis in many countries worldwide. We recognize the huge challenges doctors and other healthcare professionals are facing in maintaining healthcare systems in such harrowing conditions. The WMA calls on the international community and governments to urgently priorities support and aid to these the worst affected nations, including oxygen, drugs, vaccines, Personnal Protective Equipment (PPE) and other equipment as needed, and to strengthen healthcare system resilience in the face of future pandemics. The pandemic will not end until we tackle Covid in every nation and this is a time for global cooperation, solidarity and support for one another.

WMA RESOLUTION IN SUPPORT OF MEDICAL PERSONNEL AND CITIZENS OF MYANMAR

Adopted by the 217th WMA Council Session, Seoul (online), April 2021
and adopted as a resolution by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

The World Medical Association notes with increasing alarm, the continuing actions of the current police and Myanmar security forces including arbitrary arrests and detention of health personnel and other citizens, attacks against physicians and other health personnel and facilities, and continuing harassment and intimidation of protesters, human rights defenders and journalists. The WMA and its members are seriously disturbed by their terrorizing, arresting, kidnapping and murdering health care workers for treating protesters.

With a collapsed health system, the Covid pandemic is devastating Myanmar with lack of medical equipment and personnel and increasing deaths. Recent reports of forcing hundreds of physicians to secretly treat Covid patients and ambushing and arresting physicians after luring them to a non-existent Covid patient's home, are cause for further dismay.

These activities are in total opposition to the international recommendations in the WMA Declaration on the Protection of Health Care Workers in situation of Violence, the WMA Statement on the Protection and Integrity of Medical Personnel in Armed Conflicts and Other Situations of Violence as well as the United Nations Declaration on Human Rights Defenders.

Thus, the WMA and its members demand that the Myanmar security forces take immediate action to:

- Guarantee, in all circumstances, the physical and psychological integrity of protesters, including health personnel who are arrested;
- Release protesters and personnel immediately and unconditionally, and drop all charges against them since their detention is arbitrary as it only aims at preventing freedom of expression and their human rights activities;
- Put an urgent end to attacks against health personnel and facilities and ensure their protection to provide adequate health care provisions to all.
- Stop all acts of harassment, intimidation, and killing, against protesters, human rights defenders and journalists and comply with all the provisions of the United Nations Declaration on Human Rights Defenders;

- Ensure in all circumstances respect for human rights and fundamental freedoms in accordance with international human rights standards and international instruments, including the International Covenant on Economic, Social and Cultural Rights.
- Cooperate with international fact-finding commissions.

WMA RESOLUTION
ON
COVID-19 VACCINES AND INTERNATIONAL TRAVEL REQUIREMENTS

Adopted by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

While international travel has begun to normalize for many of those who have been vaccinated against SARS-CoV 2, fully vaccinated citizens of some countries are still subject to significant travel restrictions, as the vaccines they have received are not accepted as proof of full protection in all countries. Many countries only consider those who have received certain vaccines from specific countries to be fully vaccinated, while other vaccines are not recognized or available.

These practices effectively lead to discriminatory border restrictions against travelers who have been fully vaccinated using vaccine regimens approved in their home countries. This may restrict international cooperation and business, mainly disadvantaging poorer countries and regions. In some cases, it has even led fully vaccinated individuals to request third and fourth vaccine doses in order to provide proof of the required level of protection.

The WMA understands the reluctance of pharmaceutical authorities to allow the market introduction of vaccines for which an authorization has not been applied in their jurisdiction, or which are still in the process of authorization, or which may have been rejected because their ethical or technical standards of testing or production do not meet the required standards.

However, the WMA considers it necessary to evaluate Covid-19 vaccines based solely on their effectiveness against infection and severe illness when determining the reliability of their protection for travel purposes. Presently, there are enough data available to assess the protection offered by vaccines, independent of their marketing authorization status. Should vaccines be deemed to be ineffective, and therefore not acceptable as proof of protection, the reasons for such decisions should be made public.

We call on national governments and the European Union to immediately adopt fair, harmonized, and non-discriminatory rules to enable safe and fair travel opportunities, and to inform the public about any serious concerns that may hinder the acceptance of specific vaccines.

WMA RESOLUTION
ON
THE REPRESSION OF NICARAGUAN DOCTORS

Adopted by the 72nd WMA General Assembly (online), London, United Kingdom, October 2021

Nicaragua is currently in a phase of accelerated expansion and community transmission of Covid-19. It is urgent for health authorities to promote necessary and proportionate measures to contain the progress of the pandemic.

The exponential increase in Covid-19 cases has caused a collapse of Nicaragua's public and private healthcare system. The lack of basic medical devices has contributed to dozens of doctors and healthcare professionals becoming infected and a large number who have died.

The Nicaraguan medical profession, through more than 30 medical societies and the Covid-19 citizen observatory, has been denouncing this situation for a long time. Nonetheless, the Special Cybercrime Act approved by the Government of Nicaragua, in force since 30 December 2020, establishes sentences of 1 to 10 years in prison for all those who spread news that produces fear or anxiety in the population.

This situation of persecution is compounded by the approach to the Covid-19 pandemic, as doctors in the public sector who demanded protective measures like masks, gloves or vaccines, were dismissed under the accusation that they disrupted the public peace. Private-sector physicians who cared for patients or guided the population on self-protection measures against the pandemic were called to stop those statements, under penalty of withdrawing their licence to practice medicine or the imposition of criminal penalties, among other terrorism-related charges.

The General Assembly of the World Medical Association (WMA) hereby ratifies the letter from its president, Dr Barbe, sent on 31 August to the president of the Republic of Nicaragua, Mr Daniel Ortega, which outlines the dramatic situation suffered by Nicaraguan medical professionals and offers its support to the Declarations of 25 June 2018 and 23 August 2021 from CONFEMEL (Latin American and Caribbean Medical Confederation).

The World Medical Association (WMA) opposes and observes with extreme concern any governmental interference that threatens the freedom of professional practice and freedom of expression of any doctor. It also urges the government of Nicaragua and the members of its National Assembly:

- to protect all health professionals;
- to avoid or modify any legal regulation that may harm the professional autonomy of physicians.

The World Medical Association (WMA) also wishes to highlight the extraordinary role of Nicaraguan doctors, which is inherent to our ancient profession. It actively supports and promotes the right of everyone to receive information and medical care based solely on their clinical needs.

WMA RESOLUTION IN SUPPORT OF MEDICAL PERSONNEL AND CITIZENS OF UKRAINE IN THE FACE OF THE RUSSIAN INVASION

Adopted as Council Resolution by the 220th WMA Council Session, Paris (hybrid), France, April 2022
and as Resolution by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

Reminding that the World Medical Association was founded on the backdrop of the atrocities of war and how the medical profession was abused for violation of human rights and dignity;

Reaffirming the WMA Declaration of Geneva as a beacon of fundamental principles to which the world's physicians are committed;

Deeply shocked by the Russian army's bombing of Ukrainian civilians and hospitals, including maternity wards, thus infringing on medical neutrality in conflict zones. The WMA and its members express their solidarity with the Ukrainian people and provide their support for Ukrainian and international healthcare workers mobilized under extremely difficult conditions;

Recalling the WMA's Statements on the Cooperation of National Medical Associations during or in the Aftermath of Conflicts, on Armed Conflicts, the Regulations in Times of Armed Conflict and Other Situations of Violence, the Statement on the Protection and Integrity of Medical Personnel in Armed Conflicts and Other Situations of Violence, the Declaration on the protection of healthcare workers in emergency situations and the Statement on Medical Care for Migrants;

Emphasizing the need to respect the Geneva Conventions and their protocols as the core of international humanitarian law, as well as the United Nations Security Council Resolution 2286;

Considering the suffering and human tragedy caused by the Russian invasion of Ukraine, including a refugee crisis on a massive scale;

RECOMMENDATIONS

1. The Constituent Members of the WMA stand in solidarity with the Ukrainian Medical Association and all healthcare professionals.

2. The WMA condemns Russia's invasion of Ukraine and calls for an end to hostilities.

3. The WMA considers that Russia's political leadership and armed forces bear responsibility for the human suffering caused by the conflict.

4. The WMA calls on Russian and Ukrainian doctors to hold high the principles in the WMA Declaration of Geneva and other documents that serve as guidance for medical personnel during times of conflict.

5. The WMA demands that the parties to the conflict respect relevant Humanitarian Law and do not use health facilities as military quarters, nor target health institutions, workers and vehicles, or restrict the access of wounded persons and patients to healthcare, as set out in the WMA Declaration on the Protection of Health Workers in Situations of Violence.

6. The WMA stresses that the parties to the conflict must strive to protect the most vulnerable populations.

7. The WMA underlines that it is essential that access to medical care be guaranteed to all victims, civil or military, of this conflict, without distinction.

8. Physicians and all other medical personnel, both Ukrainian and international, involved in NGOs, must not under any circumstances be hindered in the exercise of their unwavering duty, in accordance with the international recommendations provided in the WMA declaration on the protection of healthcare workers in emergency situations, the WMA's position on the protection and integrity of medical personnel in armed conflicts and other violent situations and in the declaration of the United Nations General Assembly on the rights and responsibility of individuals, groups and organs of society to promote and protect human rights and universally recognized fundamental freedoms.

9. The WMA calls on the parties to ensure that essential services are provided to those within areas damaged and disrupted by conflict.

10. The WMA calls on the international community and governments to come to the aid of all persons displaced by this conflict who may choose their country as a destination following their departure from Ukraine.

11. The WMA urges all nations receiving persons fleeing the conflict to ensure access to safe and adequate living conditions and essential services to all migrants, including appropriate medical care, as needed.

12. The WMA calls on the parties to the conflict as well as the international community to ensure that when the conflict ends, priority must be given to rebuilding the essential infrastructure necessary for a healthy life, including shelter, sewerage, fresh water supplies, and food provision, followed by the restoration of educational and occupational opportunities.

WMA RESOLUTION FOR PROVIDING COVID-19 VACCINES FOR ALL

Adopted by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

SARS-COV-2 Pandemic caused more than 400 million cases and nearly 6 million deaths. It is quite comforting that vaccines that ensure protection from the disease have been produced, and data relating to the course of the pandemic in countries with high vaccination coverage is promising. 62.3% of the world population has received at least one dose of a COVID-19 vaccine. Only 11.4% of people in low-income countries have received at least one dose. Deep inequalities in access to vaccines are still observed globally and failure to achieve collective immunity leads to the -further spread of new, more contagious and immunity-evading variants of the disease through mutation. Worldwide application of vaccines is of critical importance in terminating the Covid-19 pandemic. Every minute of delay in vaccinations means further spread of the disease at global scale and more lives lost. It is not sufficient to immunize all citizens in any given country; immunization has to reach a sufficient level in the world as a whole to effectively combat and control the pandemic.

RECOMMENDATIONS

The WMA urges all parties to:

1. Remove barriers to promote equity of access to COVID-19 vaccines that are globally proven to be safe and effective;

2. Work with governmental and appropriate regulatory bodies to encourage prioritization of equity when providing COVID-19 pandemic-related resources such as diagnostics, free medications, therapeutics, vaccines, raw materials for vaccine production, personal protective equipment, and/or financial support, and guarantee universal accessibility and free distribution;

3. Establish vaccination strategies that consider the specific peculiarities, challenges and vulnerabilities of each region, prioritising the most vulnerable people, including health professionals;

4. Insist on the importance of vaccination and take action to achieve maximum coverage and protect the population in need;

In this context,

5. Confront vaccine hesitancy by providing evidence-based guidance on the safety and necessity of vaccines;

6. Share of knowledge required for vaccine production to the COVID-19 Technology Access Pool created by WHO to ensure that vaccines are produced at as many centres as possible and sharing of this knowledge;

7. Allocate public funds to improve the capacity of vaccine production centres and increase the channels of safe distribution so as to ensure fair access, to provide equitable and efficient vaccine supply and distribution;

8. Design national vaccine programmes that take into account a global analysis rather than only national considerations;

9. Promote sustainable solutions to patent issues. This may include the temporary lifting of patents on COVID-19 vaccines under the Trade-Related Aspects of Intellectual Property Rights (TRIPS) and similar agreements to promote equity of access in global emergency situations, while ensuring fair compensation for the intellectual property of the patent holders if asked, global investment in manufacturing sites, training of personnel, quality control, and the transfer of knowledge, technology and manufacturing expertise;

10. Support WHO efforts and initiatives to increase production and distribution of therapeutics and vaccines necessary to combat COVID-19 and future pandemics in order to provide vaccine doses to low and middle-income countries with limited access, including:

    - technological transfers relevant for vaccine production;
    - other support, financial and otherwise, necessary to scale up global vaccine manufacturing; and
    - measures that ensure the safety and efficacy of products manufactured by such means.

11. Call on governments and the United Nations to take all necessary measures to facilitate equitable access to vaccines throughout the world by supporting and promoting the sharing of all vaccine-related processes for combating pandemics (R&D, patenting, production, licensing, procurement and application).

WMA RESOLUTION
ON
HUMANITARIAN AND MEDICAL AID TO UKRAINE

Adopted by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

The ongoing war in Ukraine has led to millions of refugees who have experienced trauma and an unprecedented mental health crisis situation. Aid workers and some physicians who are assisting the refugees may not be well prepared to treat this war-related trauma.

Through the Ukraine Medical Help Fund, the WMA is leading a successful effort to provide material aid to Ukrainian refugees. The longevity and brutality of the war now require even more dedication to this effort and the expansion of aid to include mental health personnel trained in war-related trauma.

RECOMMENDATIONS

1. That the WMA, through the Ukraine Medical Help Fund and other appropriate means, its constituent members and the medical community, continue to send medical supplies to Ukraine and offer support to organizations providing humanitarian missions and medical care to Ukrainian refugees, resource permitting.

2. That the WMA, its constituent members and the medical community, advocate for early implementation of mental health measures, including suicide prevention efforts, and for addressing war-related trauma and post-traumatic stress disorder when assisting Ukrainian refugees. Special attention should be paid to disadvantaged groups.

3. That the WMA, its constituent members and the medical community, advocate for educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors for war-affected people such as employment, housing, and food stability, especially in disadvantaged groups.