Contents

Editorial ........................................................................................................................................... 1
Valedictory Address of WMA President Dr. Ketan Desai October 2017 ................................. 2
Inaugural Address of WMA President 2017–2018 Dr. Yoshitake Yokokura .......................... 5
WMA 2017 General Assembly Report ....................................................................................... 7
Junior Doctors And Students ........................................................................................................ 20
WMA Declaration of Geneva ......................................................................................................... 21
WMA Declaration of Malta on Hunger Strikers ........................................................................ 21
WMA Declaration on Alcohol ....................................................................................................... 24
WMA Declaration of Delhi on Health and Climate Change .................................................... 26
WMA Statement on Access to Health Care ................................................................................ 28
WMA Statement on Armed Conflicts ......................................................................................... 30
WMA Statement on Boxing ......................................................................................................... 31
WMA Statement on Bullying and Harassment Within the Profession ....................................... 32
WMA Statement on Child Abuse and Neglect ......................................................................... 33
WMA Statement on the Cooperation of National Medical Associations During or in the Aftermath of Conflicts .......................................................................................................................... 35
WMA Statement on Epidemics and Pandemics ..................................................................... 36
WMA Declaration on Fair Trade in Medical Products and Devices ....................................... 37
WMA statement on HIV/AIDS and the Medical Profession ..................................................... 38
WMA Statement on Medical Cannabis ..................................................................................... 41
WMA Statement on Medical Education ..................................................................................... 43
WMA Statement on Medical Ethics in the Event of Disasters ................................................ 46
WMA Statement on Organ and Tissue Donation ....................................................................... 48
WMA Statement on the Role of Physicians in Preventing Exploitation in Adoption Practices ........................................................................................................................................... 51
WMA Statement on Water and Health ...................................................................................... 52
WMA Resolution on Medical Assistance in Air Travel ........................................................... 53
WMA Resolution on Prohibition of Forced Anal Examinations to Substantiate Same-Sex Sexual Activity .................................................................................................................................................. 55
WMA resolution on Tuberculosis ............................................................................................... 55
Emergency Council Resolution on Poland .............................................................................. 56
End-Of-Life Conference at the Vatican ...................................................................................... 57
Message of the Holy Father to the President of the Pontifical Academy for Life on the occasion of the European Regional Meeting of the “World Medical Association” on “end of life” issues ........................................................................................................................................... 60
Health in Climate Change post COP 23 ..................................................................................... 61
The strength of doctors’ community lies in its diversity. Not as much in the diversity due to various ages, genders, with backgrounds in different countries or continents. Our strength is owing to our capability of thinking in different ways, and medicine is never going to become a dogma. There is so much difference between the way a family doctor with holistic approach thinks about the whole patient and the way a specialist of a very narrow and extremely complicated method who has elaborated own diagnostics or treatment method to perfection thinks. Shall we ask ourselves and our colleagues a question: do I believe in non-traditional medicine, and do you believe? After having received either an affirmative or negative reply, let us try to define the question more precisely: do I and do you believe in acupuncture, manual therapy, Ayurveda, homeopathy or maybe anthroposophical medicine? And it will turn out that either I or you more or less believe in one of these methods and do not believe at all in another. The question can be asked in a more complicated way, allowing rating your beliefs in a 10 point system, for example, I give 4 points to homeopathy and 2 to Ayurveda.

Why am I telling all this? The Latvian Medical Association conducted an anonymous survey among its colleagues, and out of 4000 addressed colleagues representing various age groups, genders and specialities 2644 responded. It makes the survey sufficiently representative which, apart from giving an insight in the way doctors think in Latvia, allows concluding that other European Union countries might report similar results. And we asked a very uncomfortable question where the answers had to be rated in a 10 point scale: do you believe in guidelines or maybe rather rely on your experience and colleagues’ advice? The result was surprising indeed: colleagues’ opinions dispersed widely across the entire 10 point scale, and one could say that more than 50% expressed a smaller or greater mistrust in guidelines. To a large extent, the impressive global influence of pharmacy on guidelines was mentioned as a reason, together with the failure by governmental bodies (e.g. Ministry of Health) to take an in-depth look into medicine and the attempts to guide medicine in the direction of „cookery book medicine“.

Mistrust to one or another guideline inevitably leads to doubts when standing next to a patient’s bed. A physician who does not have ultimate trust in vaccination against the influenza and has not vaccinated himself or herself, would not vaccinate his relatives (e.g. daughter-in-law who is pregnant or a baby grandchild), and also finds it hard to motivate his or her patients to take the vaccine. A doctor who is a smoker would much less frequently recommend that his or her patients quit smoking, and he or she would also find it hard to make this recommendation. An overweight doctor would be very reserved in prescribing a patient intensive exercise and active lifestyle.

Our diversity also refers to such general human issues as attitude towards death. Not only in Latvia but also elsewhere in the world doctors are much more cautious to assisted dying in respect to their patients compared to themselves: they would much less frequently wish to stay alive in case of a very grave, chronic and non-perspective illness.

The pride and wealth of the World Medical Association lies not only in the diversity of views of individual colleagues but in the diversity of opinions of national associations as well. The opinions of national associations depend on the national wealth, historic traditions, dominant religion, traditions of medicine and the stock of knowledge provided by universities. More often than not, the leader of the national medical association, when participating in discussions, undertakes to voice the opinion of the whole association from his or her own viewpoint, because there is no time for coordination. Despite of this, I am nevertheless always happy and full of admiration how balanced, coordinated and correct the joint statements and resolutions are. The Chicago General Assembly that adopted the new resolution on the Declaration of Geneva was an example how a compilation of very different opinions can become a driver of global medicine. Yet, next time I would like to supplement the Declaration of Geneva with one more paragraph, stating that a physician pledges to care for the air, water, nature and climate on the Earth, so that our children have where to live at all and doctors have somebody to treat.

Dr. med. H.c. Pēteris Apinis,
Latvian Medical Association,
Editor in chief of the World Medical Journal
It was on 21st October, 2016 that with all humility I had the profound privilege of taking over the reins of the prestigious World Medical Association as its President. In my presidential address delivered thereat, I had flagged off important and vital issues in various domains, which needed effective, prompt and timely tackling in the larger interest of medical profession, professionals and legitimate rights and interests of men and mankind beyond considerations of discrimination and differentiation.

My mission as WMA President brought out very clearly from the word go was to bring to the centre stage the core issue of ‘professional autonomy’, which is paramount and under any circumstances is not open to any concession, condonation, compromise or marginalization in any form, mode and manner.

In addition the other important issues that I had flagged pertained to augmentation of the membership of World Medical Association, emphasis on mental health, meaningful incorporation of the core concepts of equality, justice and equity.

Further, bringing to fore the inevitable necessity of zero tolerance against sexual violence, gender selection, cuts commission and kick-backs being resorted to by the medical professionals bringing shame to the profession as a whole was of equal priority and importance. Sex selective abortion was yet another important aspect brought out for the purposes of desired advocacy so as to generate impact of consequence.

Another arena which was emphasized upon was the concept of ‘World Health Keeping Force’ to be invoked by the desired initiative on part of all the National Medical Associations across the world on the lines of ‘World Peace Keeping Force’, which have proven to be of relevance for its targeted objectives and purposes.

At the second conference organized by World Veterinary Association and World Medical Association held in Japan on 10th and 11th November, 2016 on the thematic concept of ‘One health’ it was emphasized unequivocally that concept that integrates the meaningful rendering of health to men and animals alike along with environmental and plant health alone would genuinely cater to the cause of life and living in the world.

The mandate of Zero Tolerance in terms of the needs for invocation of a binding policy against sexual violence, gender selection has been emphasized in the keynote address delivered at the NATCON-2016 organized by Indian Medical Association at Amritsar, Punjab on 27th and 28th December, 2016.

On 14th January, 2017 the Annual Scientific Meeting of the Chinese Medical Association organized at Nanjing, China was inaugurated whereat the issue of membership of China and that of Taiwan in World Medical Association also came to be discussed at length with the counterparts.

In this very vein the issue of sex selective abortions was raised in the Annual Conference of FOGSI held at Ahmedabad in State of Gujarat in India on 26th January, 2017, which was attended by well over 12,000 Gynecologists drawn from different parts of the India and many other countries. Equal emphasis was laid pertaining to the issues of sex selection and also that of maternal mortality.

An International Summit on the vital theme of ‘Air Pollution’ organized by Indian Medical Association was inaugurated on 10th March, 2017, in the august presence of Dr. Yokokura the President of JMA and President Elect of WMA, whereat the significance of environmental health linked with Air Pollution was brought out in all its dimensions and manifestations and various advisories on the said count came to be generated for their necessary incorporation in the policy making frame by the various countries.

The emphasis on focused inculcation of the core concept of equality, justice and equity has been emphasized during the 12th World Conference on Bio-Ethics, Medical Ethics, and health laws held on March, 21–23, 2017 at Cyprus, so also it was brought into focus that the medical students anywhere in the world should not be subjected to any discrimination of any type resulting in any inequality issues. They need to be dealt by the appropriate authorities with firm hand in such a manner which should invoke the required deterrence on such issues.

At the Council meeting at Zambia on 20th April, 2017 addressing the media at a press
conference it was made known that it is imperative that the budgetary allocations for health on a priority basis is substantially increased so as to alter the health scenario in a positive and pragmatic way in the larger interest of the citizens of Zambia to give them meaningful life commensurate with legitimate expectations.

It was at the International congress on Heart Hypertension and Diabetes organized by Heart Foundation of India held at Dubai on 5th May, 2017 that the need of affordable tertiary healthcare was emphasized so that it is within the reach of even marginalized section of the impoverished society. In terms of this very initiative and venture of ensuring affordable healthcare, through appropriate policy interventions by the Government of India and the initiative of Indian Medical Association has resulted in the required ‘cost reduction’ by the Government of India, vide an appropriate ‘capping’ with reference to ‘knee replacement operations’ and ‘coronary stents’, which has brought the same into an ‘affordable zone’, to be within the reach of the common man which was illusive hitherto.

The initiatives successfully ventured into by the Indian Medical Association having paid significant meaningful dividends need to be replicated by the various National Medical Associations of the Member countries to reap similar dividends for the similarly placed, which in my opinion turns out to be a real service to the cause of humanity.

On 8th May at the 10th Geneva Conference on ‘Person Centric Medicine’ it was categorically emphasised that scientific evidence based medicine should be person centric in the best interest of the patient and precisely the same would be the face of the future medicine for the men and mankind in offing.

On 21st May, 2017 had the privilege of interacting with the office bearers of Common Wealth Medical Association, WONCA and Junior Doctors Network in United Nation Office during the World Health Professionals Alliance meeting whereat important issues pertaining to professional autonomy and ethical professional practice came to be discussed in their various manifestations and required initiatives to be initiated by the various countries in terms of required policies in consultation with their respective National Medical Associations.

The practice amongst the profession to resort to ‘kick-backs – cuts and commission’ in grossest possible breach of ethicality, morality and value based considerations has been condemned at all forums in no uncertain terms and accordingly the Indian Medical Association has come out with an explicit policy made known to all concerned to the effect that those members found to be indulging in the same, by invocation of disciplinary jurisdiction their membership of the Association would be summarily terminated. The same has resulted in appropriate signals reaching the professional community and the deterrent impact thereto is decipherable.

Under this very initiative Maharashtra a progressive State in India has ventured in to propose a legislation on imposing prohibition on the said unethical practices amongst the medical professionals, where under stringent penalties stand incorporated, which would be causing the required deterrent. The group constituted for the said purpose by the Govt. of the State of Maharashtra includes the President of the State Indian Medical Association as an Ex-officio Member and the contribution thereto in shaping the same is substantially significant.

On the front of uncompromised ‘professional autonomy’ the IMA invoked a public movement against the invocation of policy intervention, whereby an attempt is in vogue to repeal the present Indian Medical Council Act governing the regulatory Medical Council of India by National Medical Commission Bill, which is primarily aims at taking away the representative character of the regulatory body and replace it with a nominated body, which will also include non-professionals in a substantial number and would be reduced down to a sub-department under the government negating the much required professional autonomy in all its forms and manifestations. The movement has gathered a significant momentum under the aegis of Indian Medical Association.

The positive indulgence on part of the medical professionals in the larger human interest necessitates rendering them required ‘security and safety’. The infliction of violence at the drop of the hat merits to be done away with. It was on this very count that the Indian Medical Association gave a clarion call in response to which well over 10,000 medical professionals all over the country on 6th June, 2017 gathered at a historic rally in New Delhi, which aired its concern for extension of merited safety and security to the medical professionals in India by suitable policy interventions at all levels.

During the Annual meeting of the American Medical Association held between 10–14th June, 2017 undertook the privilege of having meaningful interaction with Dr. Madera CEO AMA, Ms Leah Wapner Secretary General Israel Medical Association, Dr. Yokokura President JMA, and President Thailand Medical Association Prof Dr. Saranatra Waikakul on vital areas of cause and concern alike.

In the address made at the meeting of Confederation of Medical Association of Asia and Oceanic countries on 29.09.17 in Tokyo, Japan, the Indian position in regard to legality, social ethos, medical norms and practices pertaining to ‘End of Life’ was brought to fore, wherein it was emphasized that the constitutional position bringing out
right to dignified life as a fundamental right vested with the citizen ought to include right to decent and dignified death.

Addressing the Central Working Committee meeting of the Indian Medical Association held between 23rd to 24th Sept. 2017 at New Delhi and also the celebration of Centenary of Medical Conference in India, the paramount need for ethics based medical practice was emphasized. The Centenary Indian Medical Association Award was also ceremonially conferred.

All over initiatives and efforts need to be viewed in the backdrop of the material reality that in all fairness we need to accept that the ‘Global tranquility’ has substantial reason to feel potently threatened. This is primarily due to broadening of the ‘disparities and inequities’ resulting in ‘discomfort’ and safety being put to stress and generating palpable discontent, which otherwise was simmering in character.

In the context of my yearlong occupancy as the President of the premier World Medical Association I need to state with all conviction at my disposal that it is imperative for all across the ‘geographical borders’ to be alert and conscious to the dictum that ‘poverty anywhere is an inevitable threat to prosperity everywhere’. On this very count the ‘Global Developmental Profile’ cannot turn a blind eye to this material reality. Independent of the cause and causation the fact remains that ‘inequity’ would inevitably entail ‘discontent’ resulting in ‘discomfort’ and manifesting in an ‘uncontrolled rebellion’. Whether world would be able to sustain the same in the context of its bitter experiences of the two worst fought ‘World Wars’ in the 20th Century, the ‘scars’ of which haunt us incessantly till date. The material question therefore is has the world taken right and desired lessons out of the same? The palpable answer, with its ugly raised head turns out to be ‘no’ and that operationally is the root cause of plaguing ‘inequities and inequality’.

As such, the human emancipation and development carved out across the geographical boundaries carved out on the Globe, mandates true and real essence of ‘equity’ and ‘equality’ in the domain of ‘legitimacy of fulfilment of human expectations’ and ‘desire of decent and dignified human life’ in the lap of ‘human culture and humanized civilisation’.

It is amongst such ‘distorted deviations’ that the medical profession has to rise to the occasion in the larger interest of ‘men, mankind, culture and civilization’ in unison to bridge the vital gaps that have been stonewalled for various reasons of ‘narrow mindedness, hate, bigotry and insensitivity’ plagued by utter and gross ‘selfishness’ paramount in nature and unending in character.

The challenge is huge in magnitude and gigantic in its existence. The efforts and the initiatives that have been undertaken have not been sufficient to even cause a dent to it much-less being sufficient for its eraser. The real test is not extension of ‘lip sympathy’ to the needy and helpless but the core requirement is extension of a ‘helping hand harbouring a healing touch’. The divine angel women Mother Teresa very candidly observed to deal such inclinations through her candid words to the effect that ‘a hand extended in help is far more superior to the two folded in prayer’. It is here that the real trajectory of doing good in a meaningful sense and a bonafide purpose lies.

We have been able to do reasonably well, but yet much is required to be done. This is possible only by a genuine hand holding and availing the prestigious and all important forum of World Medical Association to move with devoted commitment to impact various policy frames which would go a long way to make the mother planet earth a better place for human habitation and co-existence.

Under a notable initiative by the Indian Medical Association through series of ‘Public Advertisements’ in leading dailies, mass awareness on matters of health including public health and professional issues in a thematic manner were prominently focused in public and professional interest. The major thematic depictions prominently included “Avoidance of treatment from fake doctors, fair compensation for better accountability amongst medical professionals, ‘Beti Bachao’ (Save daughters), Zero tolerance for cuts and commissions and vital aspects of public health”, which evoked a very huge and powerful response from all the stakeholders. On 2nd October the World Non-violence Day which is the birth day of legendary Late Mahatma Gandhi an apostle of non-violence and who gave the world the modality of assertion through “fasting” the Indian Medical Association gave a call for “Dawn to Dusk” fast by all the members of IMA across the country to press for the acceptance of demand in the interest of professionals by the Government of India. In response to the clarion call well over 3,00,000 medical professionals, who are the members of IMA wholeheartedly participated at the said fast on the very lines of the global concept given by Mahatma Gandhi to the world.

I shall be failing in my duty if I do not record my sense of thankfulness and gratitude to all the members of the Council, officials of the World Medical Association and representatives of all the National Medical Associations of Member countries for their valuable support in my endeavours, which I revere and would love to cherish all my life. I am sure that coming times would see a new ‘twilight’ for a better ‘dawn’ for the entire humanity.
I would like to express my deepest respect to all our distinguished guests and participants at today's assembly, as well as my colleagues. Standing here before an audience comprising individuals with such great wisdom, experiences, and achievements to give my inauguration speech as President of the World Medical Association, WMA, is both the grandest moment in my life and the moment that I am most aware of the enormity of the responsibility this appointment brings.

I first of all vow to you all that I will do my utmost to fulfill my responsibilities in spite of any kind of difficulty in order to ensure the healthy life of all the people and further development of the WMA which supports it.

**Mission of the JMA**

In the Japan Medical Association, JMA, three presidents including myself have been appointed to the position of President of the WMA thus far. As an organization representing physicians in Japan, the JMA not only protects the health of the people of Japan but also proposes recommendations to ensure that Japanese healthcare is moving in the right direction, at times working in close collaboration with the government and ruling political party. Amongst the WMA's National Medical Associations, NMAs, I believe that there are only a few where physicians contribute to and are involved in formulating actual national healthcare policies as the JMA does. I greatly appreciate the high evaluation in which the JMA is held by many NMAs of the WMA.

**My roots**

I decided to stand as a candidate for President of the WMA at its General Assembly in Taipei last year because of something which I strongly believe in. This is that “I want to spread the concept of Japan’s healthcare system and know-how—which have raised the healthy life expectancy of Japanese people to amongst the highest in the world—throughout the world.” Today I would like to speak about this belief. This belief partly originates from my own roots.

I was born and raised in Takata Village in Fukuoka Prefecture. As there was no doctor in the village at that time, my father, who was a military physician, established a small clinic there. When I close my eyes, I can see my parents as they were then. My father readily accepted any patient who needed treatment. He poured effort into educating people about infectious diseases, and was a physician who endeavored to be always aware of the health status of local residents. My mother was a person who would sell her own clothes, kimonos in order to buy medicines for impoverished patients who could not pay their medical fees. Observing my parents as I grew up, I learned the spirit of healthcare, “To make every effort without regard for myself to help people before my eyes who are ill,” through my daily life.

Physician's mission is to “examine the patient”. The mission entails accompanying patients on their journey through life, from birth until death, working together with them to make their lives healthier.

When I remember my father—who tended to be with local people in his work—I feel anew that his actions and attitude should be the “basis of healthcare”. Looking to the current situation, the medical environment has been changing by rapid progress and use of ICT, AI and so on. Now is precisely the time when we must return to basis of healthcare when we each pledged to “consecrate my life to the service of humanity” under the WMA Declaration of Geneva.

Physicians must apply these advanced technologies to daily medical practice as effective and safe tools. The world moves at different speeds, and we are now rushing into a period of tremendous change—the aging society. Leading the world, Japan is plunging into an explosively ultra-aging society with the postwar baby boomers reaching the age of 75 years in 2025. As society ages, issues within the healthcare field are increasing.

I therefore propose realizing a “society of healthy longevity” in which people are able to continue to participate actively in life even in old age. This is a major issue that each country should cope with in the future.

**Universal Health Coverage**

In the rise in Japanese people's healthy longevity to the world’s top level, “universal health coverage”, “UHC” has played an essential role. We are certain that “UHC” is also a key to creating models to guide aging societies, unprecedented in the world, towards a "sense of security".
Japan achieved a rapid growth in the post-war period. This growth was possible to achieve because of the “UHC”, the purpose of which was to enable people to “work with a sense of security”. Japan’s healthcare system founded on UHC has even received high praise from the renowned medical journal The Lancet, and has also been lauded by the World Bank as a “global model” for UHC. Furthermore, achievement of UHC was adopted by the United Nations on September 25, 2015, as one of the Sustainable Development Goals (SDGs). This move was based on Japan’s performance record rooted in our experience with UHC over more than 50 years, and expectations are held for Japan’s leadership in this field. By continuing to globally disseminate this excellent healthcare system in the future, we will be contributing to the realization of happiness and prosperity for people throughout the world.

Countermeasures to Disasters and Pollution

People in Japan have a long history of doing battle with air pollution and natural disasters. With regard to air pollution and contamination during the period of high growth, it was the task of physicians to discover patients and identify causes of the disease. At the time of the Great East Japan Earthquake in 2011, we put together JMATs (JMA Teams), with approximately 10,000 participating medical professionals from throughout the country entering the disaster zone in turns. We have been able to move forward by transforming the past experience in overcoming various disasters into a source of strength and wisdom. Through the WMA, I intend to make good use of these experiences.

Infectious Diseases

Next, I would like to talk about infectious diseases. In Japan’s history, we have been able to reduce the number of tuberculosis patients in our nation. Thus I am able to speak to countries troubled by a prevalence of TB. Japan is also promoting countermeasures to emerging infectious diseases. In November 2016, the 2nd WVA-WMA Global Conference on One Health was held in Fukuoka Prefecture. By pooling their wisdom under the principles of “One Health”, physicians and veterinarians are now promoting further countermeasures to infectious diseases.

Junior Doctors Network: Training junior doctors for the future

The times are changing by the minute. Issues facing healthcare on a global scale are changing form one after the other, becoming increasingly complex. In order to tackle these issues seriously, training for junior doctors is absolutely essential. Physicians who make every effort, without regard for themselves, to help people before their eyes who are ill, surmounting national boundaries, religious and ethnic differences, gender and language barriers. Physicians who are deeply involved in improving the lives of the people living in the community, despite being a specialist in advanced medical care. It is my intention to pour my utmost energies into the training of junior doctors in response to the demands of the times.

Mission of the WMA

Due to the progression of globalization, healthcare-related issues are also causing obstacles across national borders. As a means of resolving these issues, the role of the WMA is growing day-by-day. The World Medical Association must endeavor to overcome these difficulties to address wide-ranging issues in the healthcare field. In order to achieve this, I believe that it will become increasingly important for healthcare professionals around the world to maintain close cooperation through the World Medical Association. Going forward, as President of the WMA I will intend to listen with even greater earnestness to all of your voices with regard to the healthcare issues of any country and region and accelerate WMA efforts to resolve these issues.

Conclusion

Lastly, I would like to talk about my vision of what healthcare should be. This was mentioned in a lecture by the late Japanese economist Hirofumi Uzawa when he was teaching at the University of Chicago’s Department of Economics in the 1960s. He referred to social systems for enabling all people to lead abundant lives and maintaining an attractive society as “Social Common Capital”. He positioned healthcare as one of these systems, alongside the natural environment, roads, water supply, electricity, and education. Professor Uzawa described the conditions as follows.

“The institutional, social, and financial conditions necessary for all people comprising the society to receive the very best healthcare that the society can provide at that time—regardless of their age or gender, and regardless of their economic or social circumstances—must be in place.”“Furthermore, once these conditions are in place, rules are necessary to ensure that they are maintained. Although these rules may be harsh for use physicians, they may have even greater fulfillment and honor. Professor Uzawa continued as follows.

“In both education and healthcare, professional specialists carry out their professional duties in accordance with professional standards and discipline, in the hope that all people in society will become happy and prosperous.”“Surely this expresses the essence of healthcare; the ideal form that healthcare should take. I hope that the concept of healthcare will become “Social Common Capital for the entire world” with everyone’s support.”I do also hope to lead the World Medical Association forward into the future.
WMA 2017 General Assembly Report
Chicago, USA, October 11–14

Wednesday October 11
At the invitation of the American Medical Society, delegates from more than 50 National Medical Associations met at the Renaissance Downtown Hotel, Chicago from October 11–14 for the WMA’s 2017 General Assembly.

Council
Dr. Ardis Hoven, Chair of the WMA, opened the Council session, by welcoming delegates to the city of Chicago. She said the Assembly was an amazing experience by opening up delegates’ views about many issues and challenges. They began the meeting sometimes with their own singular concerns, but when they left they had a much better understanding of the world in which they lived and the challenges which their physician colleagues and patients had to deal with.

The Secretary General, Dr. Otmar Kloiber welcomed two new members of the Council – Dr. Moojin Choo from Korea and Dr. Serafin Romero from Spain. Apologies had been received from three Past Presidents, Dr. Dana Hanson, Dr. Yank Coble and Dr. Wonchat Subhachaturas. Dr. Kloiber welcomed four Past Presidents to the meeting – Dr. Jon Snædal, Dr. Kati Myllymäki, Dr. Randolph Smoak and Dr. Cecil Wilson.

President’s Report
Dr. Ketan Desai reported on his activities during the year. He said he had raised many issues in relation to ethics, violence against the medical profession, person centred medicine, affordable health care and medical unity. He had addressed a number of meetings. He referred to the issue of affordable health care and the interventions by the Government of India and the initiative of the Indian Medical Association resulting in cost reductions, which he hoped would be replicated by other national medical associations.

Secretary General’s Report
The Council received an extensive written report on the work of the Secretariat. Dr. Kloiber referred to the end of life conferences that had been held to consider WMA policy on euthanasia and physician assisted death. Meetings had been held in Japan and Brazil, with further meetings planned in Rome and Nigeria.

Chair’s Report
Dr. Hoven submitted a written report on her activities. She reported that she had attended the 70th World Health Assembly in May in Geneva, where Dr. Tedros Ghebreyesus was elected the new Director General of the World Health Organisation to succeed Dr. Margaret Chan. The WMA looked forward to a productive relationship with Dr. Tedros.

He also referred to the issue of the membership of the Russian Medical Society in relation to dues payments.

She referred to the severe hurricanes that had been affecting the United States and went on: ‘Although I have always known how dramatic the destruction can be, not only on human health but on property and the economy, I have been painfully reminded of how our entire world suffers when water, wind, fire, earthquakes, and drought cause great devastation. In my current role in public health, learning about environmental health in emergencies has been an important part of my education. I fully appreciate the following as stated in the WHO guide on natural disasters: “A natural disaster is an act of nature of such magnitude as to create a catastrophic situation in which the day-to-day patterns of life are suddenly disrupted and people are plunged into helplessness and suffering, and, as a result, need food, clothing, shelter, medical and nursing care and other necessities of life and protection against unfavourable environmental factors’.

BACK TO CONTENTS
and conditions." On behalf of the physician community, I celebrate our unique ability to be able to respond to these needs, but also recognize that many of our physician colleagues throughout the world may be impacted in such a way as to prohibit or interfere with their ability to provide care to their patients’.

**Medical Ethics Committee**

Dr. Heidi Stensmyren (Swedish Medical Association) took the chair.

Dr. Kloiber, in his opening remarks, said it was important for the Council to look at new ways for members to participate. Successful regional meetings had been held on end of life issues. But there were other pressing issues which the WMA had yet to address. These included clinical independence, commercialisation of health care, artificial intelligence, and new technologies to modify the genome of humans and nanotechnology.

**Declaration of Geneva**

(‘The Physician’s Pledge’)

The Committee received an oral report from Dr. Ramin Parsa-Parsi, Chair of the Workgroup on the revised Declaration of Geneva. He reported on the open consultation that had taken place earlier in the year. WMA ethics advisor, Prof. Urban Wiesing, gave an overview of the history of the Declaration and explained the changes proposed by the workgroup. In the debate that followed, there was widespread support for the changes. There was a brief discussion about whether the Pledge should refer to ‘patients’ rather than ‘patient’. But in the end, the Committee recommended that the proposed Declaration, as written, be approved by Council and forwarded to the General Assembly for adoption.

On a recommendation from the Committee, the Chair of Council agreed to read the Declaration at the beginning of each ceremonial session of future General Assemblies.

**Declaration of Therapeutic Abortion**

The Committee received an oral report from Dr. Selealo Mametja (South Africa), Chair of the Workgroup on the proposed Declaration of Therapeutic Abortion. She said the workgroup had met shortly before the committee meeting and proposed some additional adjustments to the document, including changing the name of the document from “therapeutic abortion” to “medically indicated abortion”. The Committee agreed to this and recommended that the document be circulated to members for comments.

**Person Centered Medicine**

An oral report was given by Dr. Jon Snædal (Iceland) on a proposed Statement on Person Centered Medicine. Several committee members argued that the document did not add anything to WMA policy and was more about definitions. After a brief debate, it was decided not to approve the paper, but to recognize the work that had been carried out.

**Child Abuse**

The Committee considered a proposed Statement on Child Abuse submitted by the British Medical Association, setting out guidance to physicians on dealing with child abuse. It was agreed to forward the document to the Council for adoption by the General Assembly.

**Organ and Tissue Donation**

A proposed revision to the WMA Statement on Organ and Tissue Donation was considered. This led to a debate about donor consent by prisoners and other detainees. It was agreed that they should be eligible to donate after death, but speakers debated whether the document as written allowed for family members to override the wishes of the donor. This led to a debate about donor consent by prisoners and other detainees. It was agreed that they should be eligible to donate after death, but speakers debated whether the document as written allowed for family members to override the wishes of the donor. A new suggested wording was proposed stating that ‘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’.

The Committee considered that the proposed Statement, as amended, be approved by Council and forwarded to the General Assembly for adoption.

**Declaration of Hamburg**

A minor revision was considered to 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 proposed revision encourages physicians to report and document any acts of torture or punishment they are aware of. It also encourages member associations to take action so that physicians are held accountable before the law in case of complicity in acts of torture.

The Committee recommended that the revised Declaration be approved by Council and forwarded to the General Assembly for information.

**United Nations Rapporteur on the Independence and Integrity of Health Professionals**

The Committee considered changes to the WMA Proposal for a United Nations Rapporteur on the Independence and Integrity of Health Professionals. Ms Clarisse Deroyme, WMA Advocacy Advisor, gave an oral report, saying she had met with the Interna-
tional Committee of the Red Cross and the UN Rapporteur on the Independence and Integrity of Health Professionals to discuss the relevance of the existing statement and the proposed changes. They advised that this was not the right time for such changes. The Committee agreed that the original Proposal be rescinded and archived.

Ethics of Telemedicine
The South African Medical Association submitted a major revision to the WMA Statement on the Ethics of Telemedicine. There was a brief debate about the document’s statement that telemedicine must not be viewed as a cost-effective substitute for face-to-face healthcare. This was challenged by several speakers and it was agreed that the wording should be reconsidered. The Committee recommended that the amended Statement be circulated to members for comments.

Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences
Major revisions to the WMA Statement on Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences were re-submitted by the French Medical Association. The Committee recommended that the document should be circulated to members for comments.

End of Life Issues
The Committee received an oral report from the Secretary General on the regional end of life meeting held in Japan in September 2017 in conjunction with the Confederation of Medical Associations in Asia and Oceania with the support of the Japan Medical Association. He reported that the appetite for discussing euthanasia and physician assisted suicide in the Asia region was very low among most countries, with the exception of Australia and New Zealand. He noted that no medical association attending the meeting had policy that supported euthanasia or physician assisted suicide. He also noted that discussion of unwanted or futile treatment was a topic that was often discussed regionally.

Prof. Ulrich Montgomery (Germany) informed the Committee about the forthcoming end of life conference in the Vatican in November this year.

Human Rights
Ms Clarisse, the WMA Advocacy Advisor, referred to the Council report and highlighted a meeting with the UN Special Rapporteur on Health, Dr. Dainius Puras, regarding his latest report on mental health, human rights, and attacks on health professionals. The Executive Committee recommended that he be invited to address either the next Council meeting or the General Assembly in 2018.

In July 2017, the Treaty on the Prohibition of Nuclear Weapons, the first multilateral legally-binding instrument for nuclear disarmament, was adopted. On the occasion of the opening for signature of the Treaty, the IPPN together with the WMA, the International Council of Nurses and the World Federation of Public Health Associations, had adopted a joint Statement urging Member States to sign the Treaty and to ratify it as soon as possible so that it can enter into force.

Capital Punishment
The Secretary General was asked about the participation of physicians in execution. He reminded the meeting that since the 1970s the WMA had had very clear policy that there is no role for physicians to participate in any stage of an execution or before, including advising or educating physicians in performing executions or in stating fitness for execution or within the execution process itself. The only thing they could do was attest death, but this was only if this happened within a certain time in between, so that there could be no direct participation in the execution itself. He also reminded delegates that the WMA had joined the United Nations in calling for a moratorium on capital punishment.

Finance and Planning Committee
Dr. René Héman (Royal Dutch Medical Association) took the chair.

Human Rights
Ms Clarisse, the WMA Advocacy Advisor, referred to the Council report and highlighted a meeting with the UN Special Rapporteur on Health, Dr. Dainius Puras, regarding his latest report on mental health, human rights, and attacks on health professionals. The Executive Committee recommended that he be invited to address either the next Council meeting or the General Assembly in 2018.

In July 2017, the Treaty on the Prohibition of Nuclear Weapons, the first multilateral legally-binding instrument for nuclear disarmament, was adopted. On the occasion of the opening for signature of the Treaty, the IPPN together with the WMA, the International Council of Nurses and the World Federation of Public Health Associations, had adopted a joint Statement urging Member States to sign the Treaty and to ratify it as soon as possible so that it can enter into force.

Capital Punishment
The Secretary General was asked about the participation of physicians in execution. He reminded the meeting that since the 1970s the WMA had had very clear policy that there is no role for physicians to participate in any stage of an execution or before, including advising or educating physicians in performing executions or in stating fitness for execution or within the execution process itself. The only thing they could do was attest death, but this was only if this happened within a certain time in between, so that there could be no direct participation in the execution itself. He also reminded delegates that the WMA had joined the United Nations in calling for a moratorium on capital punishment.

Finance and Planning Committee
Dr. René Héman (Royal Dutch Medical Association) took the chair.
He was asked about funding from the pharmaceutical industry and stressed the need for transparency about where all funding came from, the amounts, and the projects or activities to which they were applied. It was WMA policy to avoid any undue influence on the work of the Association. He said that funding from outside sources was not used for the core work of the WMA, including the cost of statutory meetings.

**Dues Arrears**
The Committee received an oral report on 2016 Dues Arrears. The Treasurer said that virtually all the 2016 contributions had been received.

**WMA Budget and Membership**

**Dues Payments**
The Committee considered the Proposed WMA Budget for 2018 vs. Actual 2016 Expenditures and recommended that it be approved by the Council and forwarded to the General Assembly for adoption.

It also recommended that the Report on Membership Dues Payments for 2017 and the Dues Categories 2018 be forwarded to the General Assembly.

The Treasurer gave an oral report from the Finance Workgroup and said that it would review the WMA sponsorship policy, which should be done periodically to ensure that it is clear and current. He noted that the launch of the educational platform would take place late in 2017 or early 2018.

The Secretary General reported on the difficult situation in Venezuela and asked the Committee to support the Finance Group’s request that the dues for the Venezuelan Medical Association for 2017 be waived.

The Committee agreed to recommend this to Council.

**Auditor**
On the recommendation of the Treasurer, the Committee agreed to recommended to Council that KPMG be reappointed as auditor for the 2017 Financial Statement.

**WMA Statutory Meetings**
The Committee considered the planning and arrangements for future WMA meetings.

The Secretary General informed the committee that the recent unrest and the treatment of physicians, human rights defenders, and critics of the government in Turkey had led to a recommendation by the Executive Committee that the WMA reverse its decision last year to hold the 2019 General Assembly in Istanbul. The Secretary General said this was unfortunate, as it was WMA’s hope to be able to support the Turkish Medical Association by holding the meeting there, a view that was echoed by a number of delegates. Dr. Kloiber added that the Georgian Medical Association had agreed to host the General Assembly in 2019 instead of 2020.

The Committee recommended to the Council that the WMA postpone indefinitely the invitation of the Turkish Medical Association to host a meeting in 2019 and accept the Georgian Medical Association’s offer to host the 2019 General Assembly.

The Committee considered an invitation from the Portuguese Medical Association to host the 215th Council session in Porto in April 2020.

It was agreed to recommend to Council that this be accepted.

The Committee also considered an invitation from the German Medical Association to host the 73rd General Assembly in Berlin in October 2022. It was agreed to recommend to Council that this be accepted.

The Secretary General reported on concerns about holding the 2021 General Assembly in China. These related to free access by the press, issues related to electronic communications and disagreement over the name of the Taiwan Medical Association. He suggested that the Chinese Medical Association and the Taiwan Medical Association should meet to discuss the naming issue over the next year to see if they could reach a compromise agreement. The Committee could then wait until 2018 to consider any changes to the plan to hold the Assembly in China. This led to a lengthy debate, during which the China and the Taiwan medical associations agreed to discuss the matter together, with possible mediation from the WMA. The Committee recommended to forward the issue to the Assembly.

**WMA Special Meetings**
The Committee was told about several planned conferences.

Dr. Peteris Apinis spoke about the Council meeting planned for Riga, Latvia in April 26–28 2018.

Dr. Jon Snædal informed the Committee that the Icelandic Medical Association and the WMA would hold a Medical Ethics Conference in conjunction with the WMA General Assembly in Reykjavik, Iceland, from Oct 1–4 2018. He hoped the ethics conference would be of interest to WMA delegates, to national medical associations and to ethics experts.

Dr. Kloiber referred to the 13th UNESCO World Conference on Bioethics, Medical Ethics and Health Law in Jerusalem, Israel, to be held from 27–29 November 2018 and the WMA CPW Leadership course to be held from 3–8 December 2017 in cooperation with the Mayo Clinic and with financial support from Bayer and Pfizer.

**Membership**
The Committee considered applications for membership from the Czech Medical Chamber, the Belarusian Association of Physicians, the Pakistan Medical Association and the National Medical Chamber of Russia.

The Secretary General explained that the Czech Medical Association, a long time WMA member, recently terminated its membership in recognition of the fact that the Czech Medical Chamber was more representative of physicians in the country and a more appropriate organization to be the WMA member.

He said that the Pakistan Medical Association was previously a WMA member and had now been persuaded to re-join the WMA. With reference to the Russian Medical Chamber, he said this included organiza-
tions from 79 of the 82 regions in Russia, with the remaining three scheduled to join the NMC later this year. He considered the NMC the most representative of the national-level physician organizations in Russia, with a strong focus on self-governance, aiming to steer and supervise physician conduct and develop ethical standards. The committee agreed to recommend to Council that the applications be accepted.

Governance
The Committee received a report from the Governance Review Workgroup chaired by Prof. Dr. Rutger J. van der Gaag. He said that the work of the group, which began two years ago, was coming to a close. He reviewed some additional recommendations resulting from the workgroup meeting the previous day that were not contained in the written report and said it was a good idea for the WMA to set up a similar workgroup every 10 years. He said that the membership was often insufficiently aware of what was already being done by the organisation or how NMAs could get involved in the work of the WMA. More could be done to promote inclusiveness of all the NMAs so that doctors worldwide would see the value of the Association. Several NMAs and the Chair of Council commended Dr. van der Gaag for his exceptional leadership of the group, noting the progress made and trust built over time as the workgroup considered numerous difficult issues. Dr. Hoven said that there remained work to do in order to implement the changes recommended by the workgroup. She informed the Committee that she would take the workgroup report to the Executive Committee to discuss and develop a plan for moving forward. They would decide what incremental, short term, and long-term activities the WMA should undertake to continue to make progress on the topics and issues identified. She stressed the importance of tying this work to the Strategic Plan and to be creative, forward thinking, and deliberative about enacting change. She thanked the workgroup Chair and its members for their hard work.
The Committee agreed to recommend the report to the Council accept for forwarding to the General Assembly for information and discussion.

Review Committee
The Chair of the Review Committee, Dr. Mark Porter, reported that, following the formation of the committee in Livingstone, it had reviewed the new proposed policies for this meeting and was beginning cooperation with the Secretariat in the 10 year policy review process.

Revision of WMA Articles and Bylaws/Rules
The Committee considered a proposed revision of the Rules Applicable to WMA Associate Membership, recommending that medical students and junior doctors from NMAs be granted free Associate Membership for a period of five years. This would be on the understanding that they would not receive any WMA products other than online access to the WMA members’ area. They would also not have voting rights in the Associate Members meeting. The Committee agreed that this revision should be sent to the Council for forwarding to the Assembly for approval.

Socio-Medical Affairs Committee
Dr. Miguel Roberto Jorge (Brazil) took the chair.

Health and Environment
The Chair of Council reminded the Committee that Dr. Dong Shin, Co-Chair of the Health and Environment Caucus, resigned from his position a few months ago. Dr. Hoven said that she would appoint a new Chair to the Caucus and asked for constituent members to volunteer for this position.

Role of Physicians in Preventing Exploitation in Adoption Practices
The Committee considered a proposal for a Statement on the Role of Physicians in Preventing Exploitation in Adoption Practices. This condemns all forms of exploitation in child adoption practices, such as trafficking and sexual crimes. The Committee recommended that the proposed document be sent to the Council and forwarded to the General Assembly for adoption.

Medical Tourism
A proposed Statement on Medical Tourism on the issue of foreign patients who receive medical treatment abroad was submitted to the Committee by the Israel Medical Association. This had already received a number of written comments from NMAs and the meeting was told that work was still going on to finalise a draft Statement. A brief debate took place on the need to differentiate between cross border medical treatment from medical tourism. It was argued that these were two different concepts. The Committee recommended that the proposed Statement be sent back to the rapporteur for further work.

Tuberculosis
The Indian Medical Association submitted a proposed revision to the WMA Resolution on Tuberculosis. The Committee recommended that the proposed revision be approved by the Council and forwarded to the General Assembly for adoption.
Health and Climate Change
The Committee considered revisions to the Declaration on Health and Climate Change calling for national governments to provide designated funds for the strengthening of health systems to combat climate change. The document was submitted by the Junior Doctors Network. The Committee recommended that the document be approved by the Council and forwarded to the General Assembly for adoption.

Women in Medicine
A proposed Statement on Women in Medicine highlighting the opportunities and challenges prompted by the rise in female physicians, was presented by the Israel Medical Association. Several concerns were raised about the document, in particular about the phrase ‘the feminisation of medicine’, and a number of amendments were suggested by Committee members. The Committee decided to recommend that the document be re-circulated to constituent members for comments.

Fair Medical Trade
The proposed Statement on Fair Medical Trade was submitted by the British Medical Association. This condemns the abuses of labour standards, evidence of modern slavery and unethical working conditions involved in the manufacture of many medical products around the world and calls for a fair and ethical purchasing policy for medical goods. The Committee recommended that the document be sent to the Council for approval and forwarding to the General Assembly for adoption.

Plastic Bags & Ecological Issues
The Latvian Medical Association presented a Statement on Curbing Consumption of Plastic Bags to Address Growing Ecological Issues. This had received a number of written comments and in a debate committee members raised a number of concerns. The committee recommended appointing a rapporteur to further review the Statement. The Swedish Medical Association volunteered to undertake that work and suggested incorporating the issue of plastic bags into existing WMA policy.

Professional Autonomy of Physicians
The Committee considered the proposed revision of the WMA Declaration of Seoul on Professional Autonomy and Clinical Independence and the proposed revision of the WMA Declaration on Professionally-led Regulation. The Committee recommended that the two documents be circulated to constituent members for comments.

Sustainable Development
A proposed Statement on Sustainable Development was presented to the Committee. The statement builds on WMA policy on Social Determinants of Health as set out in the Declaration of Oslo, and on the basic principles of medical ethics set out in the Declaration of Geneva. The Committee recommended that the document be circulated to constituent members for comments.

Proposed Avian & Pandemic Influenza
The Committee received an oral report from the Secretary General, who explained that this 2006 policy document had undergone a major revision prepared by Dr. Caline Mattar. The Committee recommended that the document be circulated to constituent members for comments. The Committee recommended approval of four policy documents that had undergone minor revisions under the 10 year rule: Family Planning and the Right of a Woman to Contraception, Noise Pollution, Support of the Medical Associations in Latin America and the Caribbean, Economic Embargoes and Health.

Thursday October 12
The day began with two experimental breakout sessions organised by the Associate Members and live streamed to outsiders. The first was entitled ‘AMA Code of Medical Ethics & Professional Self-Regulation: Earning Society’s Trust’ and the second ‘Advocacy AMA-Style’.

Associate Members Meeting
Dr. Joseph Heyman was re-elected by acclamation as Chair of Associate Members for the period from 2017 to 2019. He thanked the Associate Members and vowed to do his best to increase the value of the Associate Members within the WMA.

Junior Doctors’ Network
The report of Junior Doctors’ Network was received. The Chair of the JDN, Dr. Caline Mattar, noted two points of information not contained in the written report. First, she said that the JDN was working on issues related to junior doctors’ working conditions as well as mental health among junior doctors. Secondly, she reported that the JDN had held an excellent two-day meeting in Chicago earlier in the week with presentations from top US experts on antimicrobial drug resistance and food, nutrition, sustainability, and public health. She thanked the AMA for hosting the JDN for the meeting.
appropriate tools, techniques, and technology. The assessment modes must be credible and cogent and required transparency in order to depict their relevance and timelines. A benchmark of the quality measurement must be set out by an appropriate accrediting agency. Periodic accreditation of the desired process for its certification must be made, ensuring that the parameters of the quality assessment are appropriately availed.

In the Indian context he said that accreditation was based on seven cardinal parameters, namely curriculum design, teaching and learning process, research and consultancy, student progression, governance, infrastructural facilities and academic ambiance and healthy practices.

He was followed by Dr. James Madara, CEO of the American Medical Association, who welcomed delegates to Chicago. He said medical education had been one of the AMA's core priorities for the past four years. The Association had seen that there was a need to ensure young doctors were graduating from medical school with the right education and the right training to thrive in health care today and far into the future. Despite tremendous advancements in medicine, the way young doctors were educated and trained had changed very little over the last hundred years. So, the AMA had created the Accelerating Change in Medical Education – or ACE – initiative in 2013 as a solution to that problem. It had set out to transform medical education by creating a diverse network of medical schools and inspiring them to push the boundaries of traditional medical education. The Association had sought to help create young doctors who were better prepared for the working environment they were entering … doctors who could affect change within health systems to improve the quality of care, the safety of care, and reduce the cost of care.

Four years later he was proud to say that changing medical education was no longer just their goal … it was a reality. The ACE consortium now included 32 top medical schools and reached more than 19,000 students – representing about one-fifth of all medical students in the U.S. It set out to bring together some of the country’s best and most influential medical schools. It set out to create a community of innovation, where some of the brightest young minds in medicine could share ideas. It set out to create new ways of working together, new approaches for learning, to cover new topics, to rethink the relationship of student to educator, education system to health system. And it had achieved all these aims.

The first session, entitled ‘Overview of Issues’ was introduced by Dr. Lou Ann Woodward, Chair of the Liaison Committee on Medical Education, the accrediting body for medical schools in the US. She said the responsibility of medical education was to the students and beyond that to the public that they served. The responsibility for accreditation was to the quality of the product and the integrity of the process. There had never been a point in time when it was more important that these two came together towards that common goal of quality medical education.

The first speaker was Dr. John Norcini, President and CEO of the Foundation for Advancement of International Education and Research, who spoke about ‘Medical school expansion globally and associated challenges for ensuring quality’. He said that a shortage of healthcare workers had existed for some time and part of the reason for this was that there were not enough medical schools. But the number of schools had dramatically increased from 900 in 1965 to almost 3,000 today. Most of the increase had been in Asia, and the country with the biggest increase was India. He talked about how each region had seen an expansion and said that the number of both private and public medical schools had increased in countries with the greatest growth. But there were now more private medical schools than public medical schools. Standards varied and there was a need for quality measures for schools.
Prof. David Gordon, President, World Federation for Medical Education, spoke on ‘Creation of Accreditation and Quality Systems: Challenges and Opportunities’. He talked about the need for quality measures for schools and what the WFME did in enhancing the quality and standards of medical education worldwide. The purpose of the standards programme was to provide a mechanism for quality improvement in medical education, in a global context, to be applied by institutions, organisations and national authorities responsible for medical education. Thus, not what should be taught and learned, but more, at what standard should it be taught, and to what standard it should be learned. He said standards were not a curriculum, and did not define the detail of the content of education.

Diversity of educational programmes was important, because of different educational, social, economic and cultural conditions, different patterns of disease, and the varying needs of society. He spoke about medical school self-evaluation and the progress that had been made with recognition of accreditating agencies.

Humayun J. Chaudhry, Chair of the International Association of Medical Regulatory Authorities, talked about accreditation of medical education programmes. He said the purpose of the Association was to “encourage best practice” among medical regulatory authorities worldwide in protecting, promoting and maintaining the health and safety of the public by ensuring proper standards for the profession of medicine. Their vision was that everyone around the world should be treated and cared for by safe and competent doctors. They did not promote one model of regulation, but instead encouraged the exchanging of views and examples of best practice.

He concluded that IAMRA supported and encouraged the development and implementation of robust, independent medical school accreditation systems that ensured the provision of high quality medical education, identified inadequate medical education programmes, and assisted education providers in improving the quality of their programmes and, ultimately, protect patients.

The second session focused on new models for medical education. Dr. George Mejicano, Associate Dean of Medical Education at Oregon Health and Sciences University spoke about competency-based education. He talked about the goal of the continuum of clinical professional development and the desired outcomes. He looked at the domains of competency and said they should include interpersonal and communications skills, professionalism and systems based practice.

Dr. Roger Strasser, Dean at Northern Ontario School of Medicine, Canada talked about community-based education and longitudinal learning in community settings, while Prof. Ducksun Ahn from South Korea, Vice-President of the World Federation for Medical Education South Korea, talked about professionalism in medical education for students.

The meeting then broke into different groups to talk in more detail about some of the morning’s presentations. In the afternoon there was a panel discussion to debate the findings from the different regions. The groups from the Americas identified three important areas – the need to decrease the student debt, the mismatch between the number of students and the number of post graduate training slots, and the need to increase the emphasis on humanistic characteristics of physicians and foster a culture of caring. The group representing the Asian area identified as their main concerns the growth of medical schools, the lack of personal traits in training and monitoring and certification. From the African group the main concerns were curriculum reform, resource development, the regulatory environment and developing physician leadership, while the European group mentioned student access to patients and assessment tools for evaluating students’ competencies.

Friday October 13

Resumed Council Meeting

Emergency Council Resolution

The Secretary General reported that he had received an Emergency Council Resolution on the situation relating to a strike of junior doctors in Poland. Dr. Grzegorz Mazur from the Polish Chamber of Physicians and Dentists presented the Resolution concerning junior doctors in Poland who had gone on hunger strike over poor pay and conditions, and healthcare funding. The Resolution expressed the WMA’s serious concern about the dispute and its full support for the junior doctors.

Dr. Mazur said that for many years Poland had not had enough public expenditure for healthcare, either for the patients or for paying doctors, and particularly junior doctors, a dignified salary. It was important that the WMA supported doctors in his country. Following a suggestion from Past President Dr. Daniel Johnson, the Resolution was amended to include a sentence stating that the physicians of the WMA stood in solidarity with the physicians of Poland.

The Resolution was approved.

Medical Ethics Committee

The Council agreed to forward to the General Assembly the following documents for adoption:

- The revised Declaration of Geneva
- The Statement on Child Abuse
- The revised Statement on Organ and Tissue Donation

The Council approved minor revisions to the Declaration of Hamburg and agreed to send the document to the Assembly for information.

The Council agreed that the following documents be circulated for comment:

- Declaration of Therapeutic Abortion
- Statement on the Ethics of Telemedicine
- Statement Licensing of Physicians Fleeing Prosecution for Serious Criminal Offence
The Council agreed that the proposed Statement on Person Centered Medicine not be pursued at this time.

**Finance and Planning**

The Council approved the Audited Financial Statement for 2016 and forwarded it to the General Assembly for adoption.

The Council approved the proposed WMA Budget for 2018 and forwarded it to the General Assembly for adoption.

The Council approved a document on the WMA Dues Categories 2018 and forwarded it to the General Assembly for information.

The Council agreed to waive the membership dues of the Venezuela Medical Association.

The Council approved the appointment of KPMG as auditor of the 2017 WMA Financial Statement.

The Council recommended to the Assembly that the WMA postpone indefinitely the invitation to the Turkish Medical Association to host a meeting in 2019 and accept the Georgian Medical Association’s offer to host the 2019 General Assembly.

The Council recommended to the Assembly that the invitation of the Portuguese Medical Association to host the 215th Council Session in Porto in April 2020 be accepted.

The Council recommended to the Assembly that the invitation of the German Medical Association to host the 73rd General Assembly in Berlin in October 2022 be accepted.

The Council agreed that its decision to recommend that the Chinese Medical Association host the meeting in 2021 remains on the agenda.

The Council agreed that the Czech Medical Chamber, the Belarusian Association of Physicians, the Pakistan Medical Association and the National Medical Chamber of Russia be admitted to the Constituent Membership.

The Council accepted the report of the Governance Workgroup and agreed to present it to the General Assembly for information and discussion.

The Council approved the proposed Revision of the Rules Applicable to WMA Associate Membership and forwarded it to the General Assembly for approval.

The Council approved the Appendix of the JDN Terms of Reference.

**Socio-Medical Affairs Committee**

The Council agreed to forward to the General Assembly the following documents for adoption:

- Statement on the Role of Physicians in Preventing Exploitation in Adoption Practices
- Revision of the Resolution on Tuberculosis
- Revised Declaration on Health and Climate Change
- Statement on Fair Medical Trade

The Council agreed that the proposal for a WMA Statement on Medical Tourism be sent back to the rapporteur for further work.

The Council recommended to the Assembly that a rapporteur be appointed to review the WMA Statement on environmental degradation and sound management of chemicals in order to incorporate the issue of plastic bags pollution.

The Council agreed that the following documents be circulated for comment:

- Statement on Women in Medicine
- Revised Declaration of Seoul on Professional Autonomy and Clinical Independence
- Revised Declaration of Madrid on Professionally-led Regulation
- Statement on Sustainable Development
- Statement on Avian and Pandemic Influenza

The Council agreed that the following documents that had undergone minor revision be approved and sent to the Assembly for information:

- Statement on Family Planning and the Right of a Woman to Contraception
- Statement on Noise Pollution

- Resolution on Support of the Medical Associations in Latin America and the Caribbean
- Resolution on Economic Embargoes and Health

**Environment Caucus**

The Council heard an oral report from the Environment Caucus, the next stage of the climate negotiations in Bonn, the My Green Doctor online project and what NMAs were doing in relation to climate change. It was reported that work would be undertaken on bringing together in one policy document several WMA statements on the environment.

**Assembly Ceremonial Session**

The Session was called to order by the President, Dr. Ketan Desai, and Dr. David O. Barbe, President of the American Medical Association, welcomed delegates and guests. He introduced a vocal ensemble, Musicality, a group of Chicago high school students, who gave a much-acclaimed musical entertainment.

The Secretary General conducted the annual Roll Call and Introduction of Delegates and Observers.

Dr. Ardis Hoven, Chair of Council, then paid tribute to the outgoing President Dr. Desai, who delivered his valedictory address.

The ceremony of installing the new President, Dr. Yoshihake Yokokura, then took place and after he had taken the oath of office as the 68th President of the WMA, Dr. Yokokura gave his inaugural address (see box)

**Saturday October 14**

**Assembly Plenary Session**

The Session was called to order by the Chair of Council, Dr. Ardis Hoven. The Secretary General gave apologies from Past President Sr Michael Marmot, who was attending an important meeting at the United Nations.
The Session began with a keynote speech from Dr. Anthony S. Fauci, Director of the National Institute of Allergy and Infectious Diseases. He spoke about HIV/AIDS from a Washington perspective. From his experience of more than 30 years’ experience, he spoke about how he had dealt with the various US administrations. He had served five Presidents since 1981, when HIV/AIDS first appeared. Since the first 100 patients infected with HIV, there had been close to 80 million infections. Currently 36 million people were living with HIV and there had been one million deaths. However there had been enormous advances in treatment, leading to a situation where people with HIV/AIDS could now expect to lead an almost normal life. He also talked about other viruses and epidemics and the importance of putting resources into global health. He asked what the future would bring – the return of Zika? Emerging infections? Strange viruses? The answer was they didn’t know. But it was important to develop a universal influenza vaccine.

Dr. Fauci concluded by saying that the lessons he had learned from the last three decades were the need for global surveillance, transparency in communication, healthcare infrastructure, co-ordination and collaboration and a stable funding mechanism. He said that emerging infections had always been with them, was with them now and would continue to be with them. That was why they should always be prepared.

Ms Erin Downey, from the International Committee of the Red Cross, then gave a presentation about the ICRC’s Health in Danger project. Her two objectives were to provide the delegates with some background about the programme and secondly to provide them with tools to pass on to their members. She talked about where violence was occurring, affecting personnel, transport, hospitals, the wounded and the sick. And she spoke about HCid’s strategic objectives for the next two years. There was a need for more evidence-based research to find out exactly what the magnitude of this problem was. It was also important that there were communities of concern to enable national networks to be strengthened.

She concluded by setting out how WMA members could assist the ICRC’s project. They could educate their members on existing tools and aids. They could identify national legislation which needed strengthening. They could promote national communities of concern and action. They could engage with National Red Cross and Red Crescent Societies. They could strengthen access to, and preparedness of, security of health-care facilities and ambulances. They could ensure health-care personnel knew their rights and responsibilities and they could augment data systems to account for attacks on health incidents.

Election of President for 2018–2019
Two candidates put their names forward for election, Dr. Leonid Edelman (Israel) and Dr. Heikki Pälve (Finland).

Each candidate addressed the Assembly for five minutes. Dr. Eidelman, professor of anaesthesiology and intensive care medicine at the Sackler Faculty of Medicine at Tel Aviv University and President of the Israel Medical Association for the past eight years, said that one of the most important issues facing the medical profession was a pandemic of burn out. Repeated findings showed that close to half of all practicing physicians reported burn out, preventing them from providing optimal care to their patients.

Dr. Pälve, a former CEO of the Finnish Medical Association, said he had been working for the WMA since 2001. It was important to have a strong WMA. Employers, insurers, consumers, regulators and payers were all trying to interfere more and more in clinical decision-making. Doctors were frustrated all over the world and the WMA was there to safeguard professional autonomy and medical ethics.

In a vote, Dr. Eidelman was elected and will take over the Presidency in a year’s time. He thanked the Assembly for electing him.

Report of the Council to the General Assembly

Advocacy
Dr. Ashok Paul, Chair of the Advocacy Panel, reported to the Assembly on the work of the Panel, whose task was to consider how to increase the visibility and impact of the WMA and its policies. Improving communications with members must be the first priority, he said, as some NMAs still had a poor grasp of the WMA’s activities and policies.

The WMA needed to broaden the channels of communication with NMAs, in particular through the use of social media. He suggested that NMAs with journals and periodicals could devote space to WMA policies or statements. The WMA should seek ways to expand its reach, and reaching out to non-member NMAs must be a continuous process.

Emergency Resolution
The Assembly agreed to the Emergency Resolution on Poland.

‘The World Medical Association notes with serious concern the dispute between physicians in specialist education and the government of Poland, in relation to health sector funding and the salaries of junior doctors, many of whom are having to work several jobs to achieve a living wage.

‘We note that a number of these doctors have been on hunger strike for some days, and also that negotiations with the Health Minister have broken down.

‘It is essential that a resolution is found before these physicians suffer irreversible harm, or die, as they seek to improve working conditions for their colleagues and a better financial basis for health care provision for the population.

‘We urge the Prime Minister to step in and negotiate an acceptable solution to protect the lives of physicians in specialist education, especially those currently on hunger strike, as well as taking the opportunity to better fund health services for all the population.

‘We, the physicians of the World Medical Association, stand in solidarity with the physicians in Poland.’
Medical Ethics

Declaration on Quality Assurance in Medical Education

The Assembly agreed to the adoption of the Declaration and decided it should be named the Declaration of Chicago.

Declaration of Malta on Hunger Strikers

Dr. Mark Porter (British Medical Association) proposed the removal of paragraph 20 from the revised Declaration of Malta on Hunger Strikers. This declared: ‘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 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’.

He argued that this paragraph stating that it might be justifiable to override the wishes of a hunger striker diluted other paragraphs in the document saying that forced feeding was never ethically acceptable. He invited the Assembly to debate whether the paragraph was an unacceptable breach of ethical standards or a necessary compromise to protect doctors working in state detention facilities.

Ms Leah Wapner (Israel Medical Association) said that paragraph 20 was a definite compromise included in the Declaration to cover a situation where hunger strikers may be forced to sign advance directives. In that situation, where this was not the wish of the hunger striker, an advance directive could be disregarded.

Dr. Andy Gurman (American Medical Association) said this paragraph did not give carte blanche to physicians. It was, as it stated, to be used only ‘rarely and exceptionally’.

Ms Wapner, emphasising why the paragraph should remain, said there had already been lengthy discussions about this. In Israel, they had had over the past year more than a thousand hunger strikers, none of whom was force fed and none of whom had died. Everyone had stopped their hunger strike. So, she was speaking from experience when she said that the most important thing was the trust between the medical staff and the individual hunger striker. A motion to delete the paragraph was defeated. The Assembly adopted the Declaration unamended.

Statement on Reproductive Technologies

The Assembly considered the proposed revision of the Statement on Reproductive Technologies. But Dr. Fernando Rivas (Spanish Medical Association) proposed that the document should be sent back for further consideration so that there could be in depth discussion about the issue of vicarious pregnancy. He was supported by Prof. Pablo Requena (Vatican Medical Association), who argued that the document raised several important moral issues. He believed due attention should be paid to the value of human life at its inception. In the case of vicarious motherhood, this raised the issue of the integrity of a woman’s body. And when it came to the issue of anonymity, he believed that everyone was entitled to know who their biological mother and father were.

A motion to refer the document back to the Medical Ethics Committee for reconsideration was supported.

Declaration of Geneva

The Assembly considered the revised Declaration subtitled ‘The Physician’s Pledge’. A proposal was put forward by the Nigerian Medical Association to expand the Declaration to include specific reference to doctors’ working conditions. It was argued that insensitive governments sometimes used the Hippocratic Oath as an instrument of blackmail against physicians when they were taking action over their welfare and working conditions, and that the Oath had become an albatross for physicians. This view was supported by the Ugandan Medical Association. However, it was argued that these were political points, not appropriate for inclusion in this Pledge.

In a vote, the proposal to amend the Declaration was defeated. However, the Secretary General, Dr. Kloiber, offered all colleagues, especially in Africa, the help of the WMA leadership if they found the Declaration being used as an instrument against them.

To great applause, the Assembly then voted to adopt the Declaration as tabled.

Dr. Ramin Parsa-Parsi, Chair of the Workgroup on the revised Declaration, spoke about the lengthy process that had been gone through to reach this final revised version. The Declaration was one of the WMA’s core documents and was adopted at the Association’s second General Assembly in 1948. He said the revision process had been handled with great care and sensitivity and evidence had been taken from NMAs, experts, other stake holders and from a three-week public consultation. The most notable difference in the revised document was the clear recognition of patient autonomy. It also incorporated the concept of physician well-being and the idea that knowledge should be forwarded to the next generation of physicians.

Dr. Hoven then announced that in future all General Assemblies would begin with delegates reciting the Pledge. The Assembly agreed to adopt the following documents:

- Medical Ethics in the Event of Disasters (see p. 46)
- Statement on HIV/AIDS and the Medical Profession (see p. 38)
- Resolution on Prohibition of Forced Anal Examinations to Substantiate Same-Sex Sexual Activity (see p. 55)
- Statement on Bullying and Harassment (see p. 32)
- Revised Statement on Child Abuse (see p. 33)
Revised Statement on Organ and Tissue Donation (see p. 48)
The Assembly agreed that the proposed revision of the Proposal for a United Nations Rapporteur on the Independence and Integrity of Health Professionals be rescinded and archived.

Socio-Medical Affairs
The Assembly agreed to adopt the following documents:
- Statement on Armed Conflict (see p. 30)
- Statement on Boxing (see p. 31)
- Statement on Medical Cannabis (see p. 41)
- Resolution on Medical Assistance in Air Travel (see p. 53)
- Statement on Access to Health Care (see p. 28)
- Statement on Medical Education (see p. 43)
- Declaration on Alcohol (see p. 24)
- Water and Health (see p. 52)
- Statement on the Cooperation of National Medical Associations during or in the Aftermath of Conflicts (see p. 35)
- Statement on Epidemics and Pandemics (see p. 36)
- Statement on the Role of Physicians in Preventing Exploitation in Adoption Practices (see p. 51)
- Resolution on Tuberculosis (see p. 55)
- Declaration on Health and Climate Change (see p. 26)
- Statement on Fair Medical Trade (see p. 37)

Governance
Prof. Dr. Rutger J. van der Gaag, Chair of the Governance Review Workgroup, talked about the work of his group. He said there were several things that needed their ongoing attention. One was representation. There were fewer than half the NMAs at the Assembly and some countries said they could not afford to come. They would have to address this problem. Another issue was openness. It was important that they were open and transparent in their way of working. They should be welcoming to new associations and participants. He concluded by saying that he hoped the work of the group would continue.

Treasurer’s Report
The WMA Treasurer, Dr. Andrew Dearden, reported on the Association’s surpluses in 2015 and 2016 and its healthy equity situation. Expenses were well controlled and regulated and the new educational platform would be launched shortly. He set out in detail the finances of the Association, including the dues paid and income, and said the Association’s stable financial situation allowed for more flexibility in its future activities. He also spoke about the budget for 2018.

Finance and Planning
Future Meetings
The Assembly considered the Council recommendation to postpone a decision on whether the 2021 General Assembly should be held in China. The Secretary General reported that an issue had arisen over China’s ‘One China’ policy and the use of the name of the Taiwan Medical Association. This had presented the possibility of a conflict if the Assembly was held in China. However, the Chinese and Taiwan Medical Associations had agreed to discuss this issue together over the coming year and the Council was recommending that a final decision on holding the Assembly in Shanghai or Beijing should be taken at the next General Assembly meeting in 2018.

Questioned about why a decision could not be taken at this meeting, Dr. Kloiber replied that there was a lot at stake with two member associations regarding this as a very serious issue. The WMA did not want to get involved in political issues and had no right to press one of its constituent members to do something they did not want to do. The Council had thought allowing the two parties to find a solution was a good way forward.

The recommendation to postpone the decision for a year was accepted.

The Assembly then considered a recommendation from the Council to postpone...
indefinitely holding a General Assembly in Turkey. This followed an earlier decision for the Turkish Medical Association to host a meeting in 2019.

Dr. Kloiber reported that the decision to hold the meeting in Turkey was a sign of solidarity with their Turkish colleagues. But since then, the situation in the country had changed considerably. Many people had criticised the Turkish President and Government over the arrests that had taken place of human rights defenders, with whom the WMA worked. It was therefore thought that it was no longer secure enough for the WMA to hold its Assembly in Turkey and so the Council was recommending that the invitation be postponed until a future date.

In the meantime, it was proposed that the 2019 meeting should be hosted by the Georgian Medical Association in Tbilisi. The recommendation to postpone the Assembly in Turkey was accepted.

The Assembly accepted an invitation from the Portuguese Medical Association to host the 215th Council Session in Porto in April 2020 and a further invitation from the German Medical Association to host the 73rd General Assembly in Berlin in October 2022.

Membership
The Assembly agreed that the Czech Medical Chamber, the Belarusian Association of Physicians, the Pakistan Medical Association and the National Medical Chamber of Russia be accepted as new constituent members.

Memorandum of Understanding
The Assembly agreed that a Memorandum of Understanding be signed with the International Federation of Associations of Pharmaceutical Physicians.

International organisations
Dr. Johnson Chiang, President of the World Veterinary Association, addressed the Assembly on the work of the WVA. He said that one of the most important issues for the WVA and the WMA was the promotion of ‘One Health’, an emerging concept around the world. According to data about 60 of the human diseases, such as rabies, SARS and West Nile, originated from animals. By working together, the WMA and the WVA would achieve more.

Memorandum of Understanding
The WMA and the International Committee of Military Medicine then signed a Memorandum of Understanding. Dr. Kloiber said that the two organisations had been collaborating for many years, going back as far as 1953. Dr. Roger van Hoof, Secretary General of the ICMM, talked briefly about the history of his organisation, which had started in 1921. He said it was a neutral, inter-governmental organisation, not of individuals but of states. Military physicians had two hats. They were physicians who followed the rules and conventions of other physicians, such as the Declaration of Geneva. But they were also under the authority of their military command. A second Memorandum of Understanding was signed with the International Federation of Associations of Pharmaceutical Physicians.

Dr. Gustavo Kesselring, International Affairs, IFAPP, said his organisation was established in 1972 with the mission to promote pharmaceutical medicine. They were a federation of 30 national member associations with more than 7,000 individual members all over the world. He spoke about the collaboration between the WMA and IFAPP and the organisation’s educational activities.

Open Session
In the final session giving delegates an opportunity to talk about a medical topic of their choice, Dr. Heidi Stensmyren (Swedish Medical Association) spoke about physician leadership and management. She referred to a report in her country that had examined the issue and found that physicians in leadership had a positive effect on management. Health care centres had a social responsibility. They made good decisions, leading to higher staff satisfaction with a good effect on retention performance and less burn out. The development of information technology was also better. It showed, she said, that physicians needed to engage with this issue. The profession needed to see physicians as leaders.

The Assembly ended with the Secretary General thanking everyone for contributing to what had been a highly successful meeting.

Mr. Nigel Duncan
Public Relation Consultant,
WMA
The Chicago Assembly was an opportunity for junior doctors and medical students to engage with the week’s events.

Junior Doctors

A perspective from the Junior Doctors’ point of view came from two Resident Doctors of Canada, Dr. Saahil Vij and Dr. Nauman Malik, who wrote a blog about the meeting. What follows is an excerpt.

We had the remarkable opportunity to attend the Junior Doctor’s Network and World Medical Association General Assembly. We attended this meeting as representatives for the Resident Doctors of Canada.

Stepping into this unfamiliar landscape, we quickly realized our experiences were limited to the post-graduate training in Toronto, and to some extent, Ontario and Canada. The benefits of this meeting were many. Our agenda involved facilitating and collaborating in workshops to develop ideas and formulate policy to put forth to the WMA. We also participated in small-group sessions and lectures given by world leaders in the medical field on advocacy of important topics of relevance to junior doctors, such as national and international leadership, medical education challenges and paradigm shifts, post-graduate research, physician wellbeing challenges, promoting action on antimicrobial resistance and creating short and long-term action plans for this international organization.

Naturally, as you sit with a delegation of junior doctors who are championed advocates spanning across continents, you have a lot of “WOW” moments. We tend to think of doctors as this cookie cutter phenomenon and get lost in our daily hustle. However, the reality is very different. There is a vast diversity of physician experiences, with each region of the world dealing with its own set of challenges stemming from healthcare resources, medical training environments, post graduate support amongst many others. There also remains however an element of congruency which leads us to talking about the global phenomenon of antimicrobial resistance.

The large body of discussion on day one of the Junior Doctors Network meeting looked at the issue of growing worldwide antimicrobial resistance affected significantly by the overuse of inappropriate antibiotic use in our livestock, specifically poultry, beef and pork. Much to our surprise, the human use of antibiotics is far surpassed by antibiotic use in animals. This argument was not an attack on antibiotics as a whole but instead on the practice of empirically treating healthy livestock with prophylaxis for disease prevention and growth purposes. Our guest speakers included local physicians at hospitals systems in the Chicago area who had successfully sparked change in the industry by getting involved with the supply chain. Work was done by Dr. Aparna Bole, sustainability advisor for University Hospitals of Cleveland, to get their local hospital system to source poultry from sources which limited antibiotic use to those livestock which demonstrate an ailment and are working to get beef and pork vendors on board as well. Part of our Canadian Can Meds roles revolve around a pillar of physician advocacy. I don’t expect that physicians will be the leading content experts in the area of antibiotic microbial biology but, we do have that unique responsibility and position to advocate for the care of our patients and our communities. We need to address this issue alongside our veterinarian colleagues and other community organizations.

International Federation of Medical Students Associations

IFMSA was present at the General Assembly and the preceding JDN meeting. Our Vice President for External Affairs, Batool Alwahdani, represented IFMSA in these two meetings. Our aims from attending these two meetings were to explore opportunities of collaboration and identify key areas in which JDN and WMA can work together with IFMSA, through joint campaigns, projects, and advocacy in high level meetings as the World Health Assembly, The Global Forum on Human Resources for Health and the Conference of Parties.

During the JDN meeting, IFMSA participated in discussions related to the theme of the meeting: Antimicrobial Resistance. We shared our work experience in this area and discussed the opportunities of collaboration with JDN on the Antimicrobial Resistance Awareness Week. In addition, IFMSA attended the elections of the next board of JDN and discussed the process of engaging IFMSA alumni in JDN.

Mr. Nigel Duncan
Public Relation Consultant, WMA
WMA Declaration of Geneva


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 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 revised 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 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 neurodevelopmental process 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 adversely 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.

Recommendations

The 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 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 is 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 diseases 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.

7. Recommendations

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 fulfillment 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;
- Make climate change an agenda item on the health policy agenda at all levels of government;
- Promote health policy research on climate change and health co-benefits and develop training for health professionals in climate change and its impacts on health;
- Make climate change an integral part of health and medical education curricula;
- Promote the development of evidence-based knowledge on climate change and its impacts on health;
- Advocate for their respective governments to finance, promote research and implement climate change policies and initiatives that mitigate the effects of climate change on health.

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 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 care workers

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 cooperate 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, solidarity 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 Armed Conflicts

Adopted by the 68th General Assembly, Chicago, United States, 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 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. Boing 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 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 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, Rambo Mirage, CA., USA, October 1990; 44th World Medical Assembly, Marbella, Spain, September 1992; 47th WMA General Assembly, Bali, Indonesia, September 1995; 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 towards 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 issues 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 programs.

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.


[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.
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.

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 Declaration on Fair Trade in Medical Products and Devices
Adopted by the 68th 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.

Recommendations
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 promotion of 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 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 healthcare 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 bART 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 Activities
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 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.

Basic Principles of Medical Education
2. Medical education consists of training aimed at ensuring physicians acquire the competencies, skills and aptitudes 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 collabo-
rate 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. 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 counseling 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.

BACK TO CONTENTS


**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 can be Continuing Medical Education, which in many jurisdictions is specially defined and possibly required for licensure.

---

**WMA Statement on Medical Ethics in the Event of Disasters**

*Adopted by the 46th WMA General Assembly, Stockholm, Sweden, September 1994 and revised 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. 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 postgraduate 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 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

1. 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

2. 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.

3. 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.

4. 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.

5. 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.

6. 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

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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 and the process of withdrawing consent.

13. Prospective donors or their substitute health care decision makers should be given the opportunity to ask questions about do-
nation and should have their questions answered sensitively and intelligibly.

14. 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.

15. 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.

16. 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.

17. 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.

18. Their death is from natural causes and this is verifiable.

19. 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

20. 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.

21. 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.

22. 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

23. 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).

24. 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.

25. Prospective donors should be given the opportunity to ask questions about donation and should have their questions answered sensitively and intelligibly.

26. 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 taken 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.

27. 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).

28. 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.

29. 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.

30. 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.
31. 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
32. 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.
33. 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
34. Organs or tissue suspected to have been obtained through unlawful means must not be accepted for transplantation.
35. 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.
36. 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
37. National Medical Associations should work with governments and relevant institutions to ensure that appropriate, effective structures and processes are in place to:
• support relevant traceability and follow-up of all transplant recipients and living donors including those who require ongoing medical management receive care and support;
• record information on donation and transplantation rates and outcomes;
• assess the short and long-term outcomes, quality, safety and efficacy of organ donation and transplantation activities;
• assess the adherence to ethical and clinical protocols of organ donation and transplantation activities;
38. The data arising from these activities should be publicly accessible and open to scrutiny (notwithstanding appropriate protection of donor and recipient confidentiality).

Future Options
39. 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.
40. 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 Role of Physicians in Preventing Exploitation in Adoption Practices
Adopted by the 68th General Assembly, Chicago, October 2017

Preamble
1. 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.
2. 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.
3. 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.
WMA General Assembly

World Medical Journal

Recommendations
4. The WMA condemns all forms of exploitation in child adoption practices. Unacceptable practices may include criminal acts, including trafficking and sexual crimes.
5. WMA calls on National Medical Associations and physicians to actively participate in preventing exploitation in adoption practices.
6. 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.
7. 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.
8. 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.
9. 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.
10. Physicians should be educated about the existence of tools that may help identify family members of adopted children, including DNA identification testing.
11. The WMA encourages scientific and professional activities that could support local authorities’ efforts to deter exploitation in adoption practices.

WMA Statement on Water and Health

Approved by the 55th WMA General Assembly, Tokyo, Japan, October 2004 and revised by the 56th WMA General Assembly, Durban, South Africa 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 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 Resolution on Medical Assistance in Air Travel

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. 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.
2. 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 and 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.
3. 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 authority. Detailed requirements of the cabin crew training program are also determined by the 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.”
4. 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.
5. Physicians are often concerned about providing assistance due to uncertainty regarding legal liability, especially on international flights or flights within the airspace of the United States.
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. “Good Samaritan” legislation should be adopted in all jurisdictions to allow physicians to provide emergency care during flights without fear of legal reprisals.

6. Some important steps have been taken to protect the life and health of airline passengers, yet the situation 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.

7. National Medical Associations have an important leadership role to play in promoting measures to improve the availability and efficacy of in-flight medical care. Physicians should decide whether or not to make the flight crew aware of their availability to provide medical assistance if needed.

Recommendations

8. Therefore the World Medical Association calls on its members to encourage national airlines, especially those providing medium and long range passenger flights, to take the following actions:

8.1 Equip their airplanes with a sufficient and standardised set of medical emergency materials and drugs that:

8.1.1 Are packaged in a standardised and easy to identify manner;

8.1.2 Are accompanied by information and instructions in English as well the main languages of the countries of departure; and

8.1.3 Include Automated External Defibrillators, which are considered essential equipment in non-professional settings and ensure that at least one crew member is competent in the use of that particular AED.

8.2 Provide stand-by medical assistance 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.

8.3 Develop medical emergency plans to guide airline personnel in responding to the medical needs of passengers.

8.4 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.

8.5 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.

8.6 Lobby for Good Samaritan laws.

9. The World Medical Association calls on its members 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.

10. The World Medical Association calls on its members to encourage their legislators to enact legislation to provide immunity from legal action to physicians who provide appropriate emergency assistance during in-flight medical incidents.

11. In the absence of legal immunity for physicians, the airline must accept all legal and financial consequences of any assistance provided by a physician.

12. The World Medical Association calls on its members to:

12.1 Advocate so that potential challenges of in-flight medical emergencies are included in the ordinary emergency training courses for physicians;

12.2 Inform physicians of training opportunities or provide or promote the development of training programs where they do not exist;

12.3 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, and

12.4 Encourage physicians to discuss potential problems with their own patients who are at high risk for requiring in-flight medical attention prior to their flight.

12.5 Encourage medical physicians to determine if their liability insurance includes cover for Samaritan deeds.

12.6 Inform and encourage physicians to attend appropriate training programs so they can make informed decisions when declaring their patients fit to travel by air.

13. The World Medical Association calls on IATA to further develop precise standards in the following areas and, where appropriate, work with governments to implement these standards as legal requirements:

13.1 Medical equipment and drugs on board medium and long range flights;

13.2 Packaging and information materials standards, including multilingual descriptions and instructions in appropriate languages;

13.3 Medical emergency procedures and training programs for medical personnel.
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

Preamble

1. The World Medical Association’s 1975 Declaration of Tokyo strictly forbids medical personnel from engaging in acts of torture or other forms of cruel, inhuman or degrading treatment and requires them to respect the confidentiality of medical information.

2. In addition, 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”.

3. Since 2011, in at least eight countries, medical personnel have participated in forced anal examinations of men and transgender women who are charged with consensual same-sex conduct.

4. The UN Special Rapporteur on Torture and other forms of Cruel, Inhuman and Degrading Treatment has described forced anal examinations as a form of torture or cruel, inhuman and degrading treatment that is “medically worthless”.

5. Furthermore, the Independent Forensic Experts 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”.

6. The WMA is deeply disturbed by the complicity of medical personnel 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.

7. Although some medical personnel argue that accused persons provide “consent” for such exams, the ability of persons in custody to provide free and informed consent is limited. Even when consent is given freely, medical personnel should refrain from undertaking procedures that are medically worthless, 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, the WMA:

8. Calls on its members, and other medical professionals, to abstain from participation in forced anal examinations;

9. Urges national medical associations (NMA’s) to issue written communications prohibiting their members from participating in such examinations;

10. Urges national medical associations to educate doctors and 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.

11. 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 on Tuberculosis

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. According to the World Health Organization, tuberculosis is a significant global public health problem. South East Asian and African countries are most affected.

2. In developing countries, the incidence of tuberculosis 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 is closely associated with the social and economic living conditions within a population.

3. The emergence of strains of tuberculosis bacteria resistant to first line drugs have become a major public 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. MDR-TB and XDR-TB is a significant threat to development and the safety of global health.

4. Community awareness and public health education and promotion are essential elements of tuberculosis prevention.

5. Screening of high risk groups including PLHIV (people living with HIV) and 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.

6. Rapid diagnosis with molecular tests and supervised daily treatment started early should help arrest the spread of disease.

7. 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.

8. Intensified research and innovation is also considered imperative if attempts to address the epidemic and emerging resistance are to be successful.

Recommandations

9. The World Medical Association, in consultation with WHO and national and international health authorities and organizations, will continue its work to generate community awareness about symptoms of TB and increase capacity building of health care providers in early identification and diagnosis of TB cases and to ensure complete treatment utilizing Directly Observed Treatment Short course or other appropriate therapy.

10. The WMA supports the WHO “End TB Strategy” and its visions, goals and milestones.

11. The WMA supports calls for adequate financial, material and human resources for tuberculosis and HIV/AIDS research and prevention, including adequately trained health care providers and adequate public health infrastructure, and will participate with health professionals in providing information on tuberculosis and its treatment.

12. Health care professionals should have access to all required medical and protective equipment to guard against the risk of infection and spread of the disease.

13. The WMA encourages continuing efforts to build up the capacity of health care professionals in the use of rapid diagnostics methods, their availability in the public and private sector and in the management of all forms of TB, including MDR and XDR.

14. The WMA calls on National Medical Associations to support their National TB Programmes by generating awareness among healthcare professionals about TB management and early reporting of cases in the community.

15. The WMA calls on National Medical Associations to promote methods of TB prevention including respiratory hygiene, cough etiquettes, and safe sputum disposal.

16. National Medical Associations should encourage their members to notify in a timely manner to relevant authorities, about all patients diagnosed with TB or put on TB treatment for initiation of contact screening and adequate follow up till the completion of treatment.

17. In addition, National Member Associations should 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.

18. National Medical Associations should co-ordinate with their TB National Programme and promote the adopted guidelines to all members.

19. The WMA supports WHO’s efforts and calls upon all governments, communities, civil society and the private sector to act together to end tuberculosis world-wide.

Emergency Council Resolution on Poland

Adopted as a Council Resolution by the 207th Council Session, and by the 68th General Assembly, Chicago, US, October 2017

Background

Doctors in specialist education in Poland are protesting against underfunding of the health services, resulting in poor access to health care for the population, and very low salaries for doctors in specialist training. Currently health expenditure in Poland is 6.1% of GDP (Global average around 9.8%) Doctors in specialist education have salaries of around 510–580 Euro per month after tax, and many are working several jobs to afford housing and other living expenses. For over 8 days a number of doctors have been on hunger strike in Warsaw while negotiations with the Health Minister were underway. Those negotiations have now broken down.

Resolution

The World Medical Association notes with serious concern the dispute between physicians in specialist education and the government of Poland, in relation to health sector funding and the salaries of junior doctors, many of whom are having to work several jobs to achieve a living wage. We note that a number of these doctors have been on hunger strike for some days, and also that negotiations with the Health Minister have broken down.

It is essential that a resolution is found before these physicians suffer irreversible harm, or die, as they seek to improve working conditions for their colleagues and a better financial basis for health care provision for the population.

We urge the Prime Minister to step in and negotiate an acceptable solution to protect the lives of physicians in specialist education, especially those currently on hunger strike, as well as taking the opportunity to better fund health services for all the population.
End-Of-Life Conference at the Vatican

The WMA's rolling programme of regional conferences on end-of-life issues moved to Rome on November 16 and 17, when the WMA, the German Medical Association and the Pontifical Academy for Life organised a memorable European meeting in the Vatican.

The two-day conference took place in the Aula vecchia del Sinodo, a unique and historic meeting venue more used to hosting the college of cardinals. Around a hundred participants gathered from all over Europe, including WMA leaders and members, experts in palliative care, ethicists, lawyers and religious leaders. The presentations on euthanasia and physician assisted suicide (PAS) and the views expressed covered the full spectrum of opinion. The purpose of the event, which followed similar conferences in Buenos Aires and Tokyo, was to explore ethical dilemmas relating to end-of-life issues to assist the WMA in deciding whether or not to change its policy on these issues. The conference was not intended to reach any conclusions.

The highlight of the event was a welcoming message from Pope Francis, read to the meeting by Cardinal Peter Turkson. In his 1,260-word address (see box for full text), which received widespread media coverage throughout the world in the days after the conference, the Pope said it was clear that not adopting, or else suspending, disproportionate measures, meant avoiding overzealous treatment. From an ethical standpoint, this was completely different from euthanasia, which was always wrong, in that the intent of euthanasia was to end life and cause death. He also condemned inequality in health care, particularly in rich countries.

On the first day, in his introductory remarks, Professor Dr. Frank Ulrich Montgomery, President of the German Medical Association, and one of the principal organisers of the event, explained that the WMA had always had a very clear position on end-of-life issues – it condemned euthanasia and PAS as unethical. But medicine and public opinion had changed and it was time to debate these issues again.

In his presentation later, Prof. Montgomery said he found none of the arguments in favour of PAS compelling. Like euthanasia, PAS was unethical and must be condemned by the medical profession. Medical ethics should not simply follow public opinion. He outlined the arguments that had taken place in Germany, leading to the decision that doctors should not perform PAS. He said he was convinced that PAS would eventually lead to euthanasia.

Archbishop Vincenzo Paglia, President of the Pontifical Academy for Life, said it was important for the Vatican to be involved in the dialogue, even though some participants at the meeting disagreed with the teaching of the church and the position of the Association. "We aren't billiard balls that meet only when knocking against each other," he said, but human beings interested in listening to one another and trying to emphasize essential human values. Pope Francis' message, he said, reaffirmed and added precision to previous papal texts about end-of-life care by restating the church's "opposition to euthanasia, PAS and therapeutic abandonment" of dying patients.

'He emphasized the obligation of continuing care,' which is not always the same thing as continuing medical treatment, the archbishop said.

The WMA President Dr. Yoshitake Yokokura said that as they turned their eyes to the future, physicians had to help maintain a healthy longevity society. He referred to the symposium on end-of-life held by the Confederation of Medical Associations in Asia and Oceania in Tokyo in September, where most national medical associations had opposed euthanasia and PAS.

But Dr. Rene Héman, Chairman of the Royal Dutch Medical Association, took a different view. He quoted the recently revised Declaration of Geneva and the pledge that 'I will respect the autonomy and dignity of my patient'. He explained the situation in the Netherlands, where euthanasia was still a punishable offence and was forbidden unless specific requirements were met. These included where there had been a voluntary and well considered request, where there was unbearable suffering and no prospect of improvement and where one other independent physician was consulted. Also, there had to be a conviction that no other reasonable solution for the patient's situation was available and that termination of life or assisted suicide were performed with due care.

He said that appropriate, accessible and affordable end-of-life care for all people was crucial. While there had been an increase of palliative care in the Netherlands in the last few years, euthanasia could be the last resort in the sequence of end-of-life care. It did not undermine the trust in the physician-patient relationship.

Dr. Héman said it would never be good to end a person's life. But sometimes it would be worse not to. He argued that euthanasia was based on the principles of respect for a patient's autonomy and on compassion. Mercy and an understanding way of working were the cornerstones for appropriate medical care.

Dr. Yvonne Gilli, from the Swiss Medical Association, outlined the situation in Switzerland, where there had been an increase in the rate of assisted suicides in the last ten years. She referred to revised guidelines just issued by the Swiss Academies of Arts and Sciences, which included more focus on
guiding physicians through a professional dialogue with a dying patient. They made more specific recommendations on palliative sedation and on assisted suicide.

During a debate on Theological Approaches, the meeting heard presentations from the perspective of the Catholic, Jewish, Islamic and Orthodox faiths. This was followed by presentations on the legal aspects of end-of-life issues.

Prof. John Keown, Professor of Christian Ethics at the Kennedy Institute of Ethics, Georgetown University, explained the common and criminal law relating to euthanasia and physician assisted suicide and relating to withholding and withdrawing life-preserving treatment for competent and incompetent patients.

Prof. Dr. Volker Lipp, Professor of Civil Law, Procedural Law, Medical Law and Comparative Law, at Georg-August-Universität, Göttingen spoke about the diversity in various legal systems. There was no consensus amongst Council of Europe member states. He said they should be careful about using the word euthanasia as it was an ambiguous concept. He examined the definitions, saying that euthanasia was intentionally killing another person in order to relieve this person’s suffering, whereas ‘letting die’ referred to limiting, terminating, or withholding life-sustaining treatment because it was futile or according to the patient’s will, sometimes also called ‘passive euthanasia’.

Dr. Laurence Lwoff, Head of the Bioethics Unit, Human Rights Directorate, Council of Europe, talked about the Council of Europe Guide on the decision-making process regarding medical treatment in end-of-life situations. This gave rise to complex situations relating to equity of access to health care, professional obligations, free and informed consent and previously expressed wishes.

The idea of the Guide was to propose reference points for the implementation of the decision-making. The primary audience was health professionals, but it was also useful for patients, their relatives and family or other support providers.

Throughout the day the presentations were followed by lively panel discussions and robust question and answer sessions, during which supporters and opponents of euthanasia and PAS made their views known forcefully. Dr. Jeff Blackmer, from the Canadian Medical Association, defended the role of doctors in Canada, where medically assisted dying became legal in 2016, questioned several of the presentations and responded to questions himself.

The first day concluded with speeches from two prominent members of the WMA, Prof. Dr. Leonid Eidelman, President of the Israeli Medical Association, and President elect of the WMA, and Prof. Pablo Requena, Professor of Moral Theology at the Pontifical University of the Holy Cross, and the delegate of the Vatican Medical Association at the WMA.

Dr. Eidelman referred to the experience of the Netherlands and said that one of the most important factors separating physicians who did or did not accept PAS and euthanasia was whether they saw their actions as similar to or different from other regular medical treatments they gave their patients. Was it a regular medical intervention like treatment with antibiotics or was it something extraordinary demanding a different attitude?

In his view physicians should not be involved in physician assisted death or euthanasia for several reasons. Many requests disappeared with symptom control and psychological support. Patients should be sure about medical professionalism — physicians were trying to heal and relieve suffering and they never intentionally caused harm.

Prof. Pablo Requena said that compassion was not a good reason for euthanasia and unbearable suffering was not a medical reason. They will have taken a step in the wrong direction if they considered suffering in this context, as medicine could do much about human suffering.

He said he doubted that society had the moral sense to protect physicians on this issue. That was why it was important that physicians protected themselves and that medical societies and the WMA continued to oppose euthanasia as a medical aid.

Finally, he quoted the Hippocratic Oath, which, 2,500 years ago stated ‘I will not give a lethal drug to anyone if I am asked nor will I advise such a plan’.

The first day then concluded for participants to be taken on a tour of the Vatican Museum and to enjoy a Gala dinner in the Vatican Museum.

The second day of the conference began with the question ‘Is there a right to determine one’s own death?’

The opening speaker was Prof. Dr. Urban Wiesing, from the Institute for Ethics and History of Medicine at the University of Tuebingen in Germany. He argued for the concept of plurality, saying that there was no consensus on end-of-life issues from an ethical point of view. Despite the thousands of books that had been written about the matter, a broad range of answers could be found. Even within Christian ethics there was no consensus. He said the answer to ethical plurality was a political one. He argued that there was no slippery slope involved as a result of PAS. This was the experience from the state of Oregon in the USA. Nor was there any loss of trust in physicians. He believed that in the absence of a consensus, they would have to live with plurality.

Prof. Dr. Christiane Druml, Chairperson of the Austrian Bioethics Commission and UNESCO Chair of Bioethics at the Medical University of Vienna, said it was a clear and
undisputed principle that treatments which were not or no longer indicated or treatments which the patient refused must not be performed. But there were still cases where disproportionate treatment was initiated. This resulted in diagnostic, therapeutic or care-related interventions whose benefit for the individual patient was highly questionable and which might expose the patient to a stressful situation that became problematic. Medical interventions which provided no benefit for the patient or which were more burdensome than potentially beneficial to the patient, and which might lead to a prolongation of the dying process in end-of-life situations, were ethically and medically unjustified because they came at a disproportionate burden. The legal conditions for complex end-of-life decisions should take due account of this fact to allow for carefully weighed decisions without fear of criminal prosecution.

Dr. Anne de la Tour, President of the French Society of Palliative Care spoke about end stage decisions on medication, feeding and terminal sedation, and the differences between sedation and euthanasia. She said France had clearly decided so far against euthanasia, in favour of worthy and friendly caring. Doubt and reflexion could not be avoided by means of a law. Patients talked about their ambivalence. Few patients said they were willing to die and even fewer would say this when they felt relieved and cared for. The daily goals of a palliative care team were to provide tailored and personal care.

Dr. Gunnar Eckerdal, from the Department of Oncology at Sahlgrenska University Hospital in Sweden, talked about shared decision making. He argued that PAS and euthanasia were not secure and involved wrong diagnoses and wrong prognoses, as well as underdiagnosed and undertreated depression. The patient’s condition was better addressed with treatment that did not shorten life.

Dr. Marco Greco, President of the European Patients’ Forum, talked about public opinion. He said his organisation did not have an official position on euthanasia and PAS. But empowerment was a multi-dimensional process that helped people gain control over their own lives and increased their capacity to act on issues that they themselves defined as important. It enabled people to make meaningful choices. No-one was beyond empowerment, though some people might need more support. Healthcare was fundamentally about human interactions. Being treated with respect, dignity and compassion, and being seen as a human being was the starting point of empowerment.

He emphasised the importance of the partnership between patients and those caring for them. Shared decision-making was absolutely fundamental. Patients’ wishes should always be ascertained, even when there was an advance directive.

But there was a need to increase the availability and quality of palliative care services. Medical professionals also needed to shift to a shared decision-making approach, and this required not only specific communication skills and attitudinal change but also resources.

Dr. Heikki Pälve, former CEO of the Finnish Medical Association, spoke about dealing with public opinion from his recent experience in Finland. He said that public opinion had been strongly in favour of euthanasia as were 46 per cent of physicians. But the national medical association was opposed. This change was fundamental and was not positively received. But he said doctors performing euthanasia should not be called unethical. However, Prof. Montgomery repeated his view that there should be no change in WMA policy opposing euthanasia and PAS. The decision, however, was for the WMA General Assembly to decide.

At the end of the conference, WMA leaders held a press conference for the local media. Dr. Ardis Hoven, Chair of the WMA, said that one of the beautiful things about the meeting had been the transparency of the discussion and conversation. She said it was very important for their patients and for the public. It was important that they knew physicians were having these discussions in order to improve the quality of their care, particularly on end-of-life issues. One of the things that came out of the meeting was that physicians must do a better job to make sure that every person had access to appropriate end-of-life care.

She said that the WMA would be holding its next regional conference in Africa.
Message of the Holy Father to the President of the Pontifical Academy for Life on the occasion of the European Regional Meeting of the “World Medical Association” on “end of life” issues (Vatican, 16–17 November 2017), 16.11.2017

Message of the Holy Father

To My Venerable Brother
Archbishop Vincenzo Paglia
President of the Pontifical Academy for Life

I extend my cordial greetings to you and to all the participants in the European Regional Meeting of the World Medical Association on end-of-life issues, held in the Vatican in conjunction with the Pontifical Academy for Life.

Your meeting will address questions dealing with the end of earthly life. They are questions that have always challenged humanity, but that today take on new forms by reason of increased knowledge and the development of new technical tools. The growing therapeutic capabilities of medical science have made it possible to eliminate many diseases, to improve health and to prolong people’s life span. While these developments have proved quite positive, it has also become possible nowadays to extend life by means that were inconceivable in the past. Surgery and other medical interventions have become ever more effective, but they are not always beneficial: they can sustain, or even replace, failing vital functions, but that is not the same as promoting health. Greater wisdom is called for today, because of the temptations to insist on treatments that have powerful effects on the body, yet at times do not serve the integral good of the person.

Some sixty years ago, Pope Pius XII, in a memorable address to anaesthesiologists and intensive care specialists, stated that there is no obligation to have recourse in all circumstances to every possible remedy and that, in some specific cases, it is permissible to refrain from their use (cf. Acta Apostolicae Sedis XLIX [1957], 1027–1033). Consequently, it is morally licit to decide not to adopt therapeutic measures, or to discontinue them, when their use does not meet that ethical and humanistic standard that would later be called “due proportion in the use of remedies” (cf. Congregation for the Doctrine of the Faith, Declaration on Euthanasia, 5 May 1980, IV: Acta Apostolicae Sedis LXXII [1980], 542–552). The specific element of this criterion is that it considers “the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources” (ibid.). It thus makes possible a decision that is morally qualified as withdrawal of “overzealous treatment”.

Such a decision responsibly acknowledges the limitations of our mortality, once it becomes clear that opposition to it is futile. “Here one does not will to cause death; one’s inability to impede it is merely accepted” (Catechism of the Catholic Church, No. 2278). This difference of perspective restores humanity to the accomplishment of the dying, while not attempting to justify the suppression of the living. It is clear that not adopting, or else suspending, disproportionate measures, means avoiding overzealous treatment; from an ethical standpoint, it is completely different from euthanasia, which is always wrong, in that the intent of euthanasia is to end life and cause death.

Needless to say, in the face of critical situations and in clinical practice, the factors that come into play are often difficult to evaluate. To determine whether a clinically appropriate medical intervention is actually proportionate, the mechanical application of a general rule is not sufficient. There needs to be a careful discernment of the moral object, the attending circumstances, and the intentions of those involved. In caring for and accompanying a given patient, the personal and relational elements in his or her life and death — which is after all the last moment in life — must be given a consideration befitting human dignity. In this process, the patient has the primary role. The Catechism of the Catholic Church makes this clear: “The decisions should be made by the patient if he is competent and able” (loc. cit.). The patient, first and foremost, has the right, obviously in dialogue with medical professionals, to evaluate a proposed treatment and to judge its actual proportionality in his or her concrete case, and necessarily refusing it if such proportionality is judged lacking. That evaluation is not easy to make in today’s medical context, where the doctor-patient relationship has become increasingly fragmented and medical care involves any number of technological and organizational aspects.

It should also be noted that these processes of evaluation are conditioned by the growing gap in healthcare possibilities resulting from the combination of technical and scientific capability and economic interests. Increasingly sophisticated and costly treatments are available to ever more limited and privileged segments of the population, and this raises questions about the sustainability of healthcare delivery and about what might be called a systemic tendency toward growing inequality in health care.
This tendency is clearly visible at a global level, particularly when different continents are compared. But it is also present within the more wealthy countries, where access to healthcare risks being more dependent on individuals’ economic resources than on their actual need for treatment.

In the complexity resulting from the influence of these various factors on clinical practice, but also on medical culture in general, the supreme commandment of responsible closeness must be kept uppermost in mind, as we see clearly from the Gospel story of the Good Samaritan (cf. Lk. 10:25-37). It could be said that the categorical imperative is to never abandon the sick. The anguish associated with conditions that bring us to the threshold of human mortality, and the difficulty of the decision we have to make, may tempt us to step back from the patient. Yet this is where, more than anything else, we are called to show love and closeness, recognizing the limit that we all share and showing our solidarity. Let each of us give love in his or her own way—as a father, a mother, a son, a daughter, a brother or sister, a doctor or a nurse. But give it! And even if we know that we cannot always guarantee healing or a cure, we can and must always care for the living, without ourselves shortening their life, but also without futilely resisting their death. This approach is reflected in palliative care, which is proving most important in our culture, as it opposes what makes death most terrifying and unwelcome—pain and loneliness.

Within democratic societies, these sensitive issues must be addressed calmly, seriously and thoughtfully, in a way open to finding, to the extent possible, agreed solutions, also on the legal level. On the one hand, there is a need to take into account differing world views, ethical convictions and religious affinations, in a climate of openness and dialogue. On the other hand, the state cannot renounce its duty to protect all those involved, defending the fundamental equality whereby everyone is recognized under law as a human being living with others in society. Particular attention must be paid to the most vulnerable, who need help in defending their own interests. If this core of values essential to coexistence is weakened, the possibility of agreeing on that recognition of the other which is the condition for all dialogue and the very life of society will also be lost. Legislation on health care also needs this broad vision and a comprehensive view of what most effectively promotes the common good in each concrete situation.

In the hope that these reflections may prove helpful, I offer you my cordial good wishes for a serene and constructive meeting. I also trust that you will find the most appropriate ways of addressing these delicate issues with a view to the good of all those whom you meet and those with whom you work in your demanding profession.

May the Lord bless you and the Virgin Mary protect you.

From the Vatican, 7 November 2017

---

Health in Climate Change post COP 23

The 23rd Conference of Parties (COP 23) to the United Nations Framework Convention on Climate Change (UNFCCC) presided by Fiji, was held in Bonn from November 6 to 17 2017. After the historic adoption of the Paris Agreement (PA), parties have been negotiating to reach consensus on the implementation steps to move the PA forward. Despite the fact that not all parties have ratified the Paris Accord, only 170 out of 197, all Member States have been engaging actively in the climate negotiation as urgent actions are needed to decrease the carbon emissions. The UN’s environmental program UNEP showed in its Emissions Gap Report 2017 that the gap between current commitments and the emission reductions required to comply with the Paris agreement is “alarmingly high” and

---

Meteorological Organization WMO reported that levels of CO₂ surged at “record-breaking speed” to new highs in 2016. These alarming facts and figures increased

---

1 UNFCCC. “The Paris Agreement”. Available at: http://unfccc.int/paris_agreement/items/9485.php


---

Yassen Tcholakov Lujain Alqodmani Alice McGushin Sofia Lindegren Hammarstrand Mardelangel Zapatía Ponze de Leon Ghaisani Fadiana Diogo Martins
the urgent demand for taking the negotiations forward and implementing the PA at national and global levels. Despite the complex discussions, COP 23 was able to adopt for the first time in history of UNFCCC, the Gender Action Plan to support and enhance the implementation of the gender-related decisions and mandates so far adopted in the UNFCCC process through a set of specific activities to be conducted within the next 2 years. Another historic moment was the adoption of decision on “Issues Relating to Agriculture”, that recognized the importance of agriculture and food security for the PA implementation as well as the strengthening of the indigenous people’s platform through the agreement of the purpose and functioning of the platform. Discussion, set the tone for the difficult negotiations which will take place in 2018 leading up to COP 24 where the Paris Rulebook detailing how the modalities of the PA will need to be realised.

The WMA delegation at COP 23

An international delegation representing World Medical Association (WMA) attended COP 23. It was composed of 10 physicians from Canada, Australia, Germany, Romania, Portugal, Peru, Kuwait, Sweden, Indonesia and Nigeria. The delegation represented WMA’s views and position toward climate change as expressed through the recently adopted WMA Declaration of Delhi on Health and Climate Change. and the WMA Statement on Divestment in Fossil Fuels. The delegates followed the negotiations closely throughout COP and focused on 4 key areas where health impacts were addressed:
- Adaptation through the Nairobi Work Program (NWP);
- Loss and damage associated with climate change impacts;
- Nationally Determined Contributions (NDCs); and
- The Paris Agreement Rulebook.

In addition to the negotiations, the delegations also attended several health-related side events organized by UNFCCC, WHO and health-related NGOs during COP 23.

Health on the side

Aside from political negotiations, the COP also brings together scientists and civil society interested in the topic of climate change and represents a good opportunity for sharing of knowledge. Some of the most important such events related to health are described below.

Climate and health summit

The annual Climate and Health Summit organized by the Global Climate and Health Alliance, the World Health Organization and its European Center for Environment and Health and the Health and Environment Alliance took place once again alongside the COP. The 2017 Climate and Health Summit featured both key-note speeches and “World Cafe” style sessions. Among the plenary speakers was the recently appointed WHO Assistant Director-General for Climate Change and Other Determinants of Health, Dr. Joy St. John, who emphasized the need for real change and a clear path for action on climate change and health. Cook Islands Health Minister, Nandi Glassie, also addressed summit delegates, outlining what he describes as the “Triple Burden of Disease” faced by Pacific islands: the growing burden of noncommunicable diseases, ongoing endemic and outbreaks of infectious diseases and the changing health impacts of climate change. And Lancet Countdown Director, Nick Watts, presented his ambitious aims and scope of the Lancet Countdown, its three key messages of the 2017 report of “impact, delay, optimism” and the worldwide attention the report is receiving. The World Cafe sessions took place in parallel and were aimed to provide more detailed analysis of health sector measures and activities to address climate change and health. Sessions were structured around six topics under the following three headings: health impacts; cities, regions climate and health; and health sector readiness and leadership.

COP 23 Presidency Event: Health actions for the implementation of the Paris Agreement

A High Level event bringing together the COP Presidency, the Secretary General of the UNFCCC and the Director General Of the World Health Organization took place on the 12th of November 2017, under the umbrella of the Planetary Health momentum of change. The event was moderated by Dr. Maria Neira, Director of Public Health, Environmental and Social Determinants of Health from the WHO, and it brought together

---


5 UNFCCC. “COP23 Addresses the Local Communities and Indigenous Peoples Platform”. Available at: http://www4.unfccc.int/sites/NWP/NewsPages/TPP-PrCOP23_Articles.aspx

6 WMA. “WMA Declaration of Delhi on Health and Climate Change”. October 2017. Available at: https://www.wma.net/policies-post/wma-declaration-of-deli-on-health-and-climate-change/

7 WMA. “WMA Statement on Divestment in Fossil Fuels”. October 2016. Available at: https://www.wma.net/policies-post/wma-statement-on-divestment-from-fossil-fuels/

8 Global Climate and Health Alliance. “Climate and Health Summit 2017: Ramping Up Action on Climate and Health in Cities and Regions”. Available at: http://www.climateandhealthalliance.org/events/summit-cop23

many climate champions including the former Governor of California Hon. Arnold Schwarzenegger, the Minister of health of Barbados, the Minister of Climate and Environment of Norway, the HRH Princess Sarah Zeid of Jordan, the Minister of Health of Cook Islands, the Special Representative of UN as well as the Executive Mayor of Tshwane, South Africa.

During the discussion, WHO announced a special initiative to protect the health of the people of Small Island Developing States from climate risks, and to amplify the voices of the most vulnerable, for both climate change adaptation and mitigation. The WHO Director General Dr. Tedros Adhanom Ghebreyesus was present and he talked about the WHO’s commitment to continue addressing climate health impacts and his excitement for the new initiative for the Small Islands Developing States hoping that this will be the first step for similar initiatives for other countries. The UNFCCC Executive Secretary Patricia Espinosa highlighted the urgent need to link human health with the health of the planet through monitoring planetary health effects and the use of evidence-based policies by Member States. The Hon. Arnold Schwarzenegger urged Member States to take urgent actions to address the climate change and its health effects and take concrete steps toward the use of clean renewable energy resources as well as enhanced the necessity to address better the communication of climate change and health. Finally, a panel discussion between different countries, namely Barbados, Cook Islands, Norway, Jordan and South Africa showcased the ongoing initiatives in implementing the health commitments of the Paris Agreement, and the health and climate agenda.

Health as a driver of Climate Policy and Green Behaviour

Another side event addressed health’s potential policy driver for sustainable behavior. In the format of a panel organized by Sauvons Le Climat, the guests discussed how the evidence regarding different aspects of climate change and its relationship with health could be used to catalyze difficult negotiations. Examples like that of the Norwegian Household Consumption and the subsequent carbon footprint showed that the way in which we count emission matters. Professor Sahuerborn, a paediatrician and Public Health specialist, presented a very comprehensive set of reasons why putting health on the negotiation arena is relevant:

• health is a powerful motivator argument, it can solve the time reference of achievements (immediate health co-benefits);
• health impacts of climate change threaten economic growth
• the health sector contributes to climate change (emissions by health facilities);
• it is a motivator for evidence creation and could be used as a model for risk communication.

Finally the mainstreaming of health in environmental debates since 1992 to the present day was shown.

Health in the negotiations

The COP is a high-level political meeting where environment ministers and their representatives engage in political negotiations, key elements pertaining to health are described in the following section.

Adaptation – The Nairobi Work Programme (NWP)

Adaptation refers to preparing for the changes impacts in order minimise their impact and avoid disruption of human systems. Adaptation includes the assessment of climate impacts and vulnerability as well as the planning, implementing, monitoring and evaluation of adaptation activities\(^\text{10}\). The main mechanism to aid in the development of adaptation policies and practices is the Nairobi Work Programme (NWP), which was established at COP 11 in Nairobi in 2005 and is coordinated by the Subsidiary Body for Science and Technological Advice (SBSTA) through the development and dissemination of information and knowledge\(^\text{11}\). At the 47th Session of SBSTA at COP 23, progress on four key issues were noted: ecosystems, water resources, human settlements and health\(^\text{12}\). The 11th Focal Point Forum of the Nairobi Work Programme also took place during COP 23. The Forum provided the opportunity to enhance engagement of experts and expert organisations and provide an informal and interactive space for Parties, partner organisations, experts and other relevant organisations to share their views and collaborate\(^\text{13}\). Mitigation co-benefits were also acknowledged by the Chair who noted the importance of the NWP to the work of other UNFCCC bodies, notably the Adaptation Committee and the Least Developed Countries Expert Group. The NWP will attempt to address health impacts through adaptation policies at a national and global levels; however, the exact mechanism through which it will do so still

---

11 UNFCCC. “Nairobi work programme on impacts, vulnerability and adaptation to climate change (NWP)”. Available at: [http://unfccc.int/adaptation/workstreams/nairobi_work_programme/items/9201.php](http://unfccc.int/adaptation/workstreams/nairobi_work_programme/items/9201.php).
remains undecided as the negotiations were not concluded in Bonn. The UNFCCC will continue to gather inputs from Parties about the relevance and the effectiveness of NWP and how to engage partner organizations and will then generate a synthesis report to be considered at SBSTA 48 in 2018.

Loss and Damage – Warsaw International Mechanism (WIM)

The underlying concepts of loss and damage have existed for a long time within global environmental negotiations but action on loss and damage was not formalized until COP 16 where it was decided to establish a working program to “address loss and damage associated with climate change impacts in developing countries that are particularly vulnerable to the adverse effects of climate change,” which would eventually be formed at COP 19 as the Warsaw international mechanism for loss and damage associated with climate change impacts (WIM). At COP 21, with the adoption of the Paris Agreement, loss and damages were recognized to be distinctive from adaptation and thus appeared a third pillar of climate action.

Despite COP 23 being hosted by Fiji, an island nation amongst those most affected by climate change impacts, and despite the expressed priority given by the COP president to loss and damage, progress on this issue was slow and hard to see. At COP 23, while parties acknowledged the work done by the WIM’s Executive Committee (ExCom), they also identified the challenges faced in this area considering that the mandate of the WIM is much broader than that of the ExCom and that minimal financial resources have been made available for the execution of that mandate. Furthermore, despite repeated calls by developed countries and most affected countries to increase the profile of the WIM by having regular meetings outside of COP the only compromised that could be reached is that a special expert dialogue in 2018 to inform the WIM’s report for 2019. Progress on this issue was largely stalled due to the magnitude of the problem and the fact that loss and damage is often interpreted as meaning only liability and compensation due to historical emissions. Hopefully, the expert dialogue will represent a less political space during the next meeting of the subsidiary bodies in 2018 and will allow progress on the most contentious elements related to loss and damage.

National Plans – Nationally Determined Contributions (NDCs)

The Nationally Determined Contributions (NDCs) reflect what each party to the PA intends to do in order to address climate change: they are informed by national climate actions and plans, including climate-related targets, policies, and measures by the governments. The Paris Agreement requires that each Party prepare, communicate, and maintain successive NDCs. Guidance on NDCs have been negotiated under the Ad Hoc Working Group on the Paris Agreement (APA). Based on Parties’ views, the guidance should recognize that NDCs must be in accordance with the provisions of the Paris Agreement and relevant decisions of the CMA and have certain characteristics that are set out in Paris Agreement, supporting developing country Parties in moving over time towards economy-wide emission reduction targets. During COP 23, common time frames for NDCs were discussed. The SBI invited Parties and observers to submit their views on common time frames for NDCs, including on, but not limited to, the usefulness, the advantages and disadvantages of those options, for consideration in next SBI 48 session in 2018.

Paris Agreement (Rulebook)

Ad Hoc Working Group on the Paris Agreement (APA) sessions were expected to continue the work on a draft “Paris Agreement Rulebook” which would establish the technical rules and implementation steps in order to fulfill the PA ambition. While this work started at COP 22, the task is now getting urgent since the deadline for the work is coming up, in next year’s COP 24 in Poland. The delegations followed the negotiations as closely as possible, although, not all negotiations were open for observer organizations. The work progressed slowly, given the contentious nature of some of the discussions and the difficulty of finding agreement on certain subjects such as finance mechanisms, framework for the NDCs and how to monitor compliance of the PA. The decisions for the draft were postponed several times and as the COP continued one day over schedule, the final draft was finally set. In the text, the so called “Talanoa dialogue” is referenced and

---


15 UNFCCC. “Report of the Conference of the Parties on its eighteenth session, held in Doha from 26 November to 8 December 2012” February 2013. Available at: http://unfccc.int/resource/docs/2012/cop18/eng/08a01.pdf


19 UNFCCC. “Agenda item 4. Preparations for the implementation of the Paris Agreement and the first session of the Conference of the Parties serving as the meeting of the Parties to the
this can be considered one of the major successes for the COP 23 to ensure transparency and inclusiveness in the further negotiations processes. Talanoa is a traditional expression used in the Pacific meaning an “inclusive, participatory and transparent” process. It will be a platform for the parties and other stakeholders to share views on contentious issues including amongst other things their advances on the pre-2020 climate action and the 1.5 degree target. The negotiations throughout APA sessions did not show much progress throughout COP mainly because the request of developing countries to include the modalities of financial resources in the text to ensure that its properly addressed in the final text to which developed countries were unwilling to commit. The COP also recognised the need for additional work through the APA and committed to hold an extra inter-sessional meeting during 2018 to ensure that the rulebook is finished in time for negotiations at COP 24.

What’s next

Climate negotiations currently ongoing will dictate the future of the much-acclaimed Paris Agreement. This agreement can serve as one one of the most important public health treaties of the 21st century, however its agenda can only be realised if the rules of implementation are fair, clear, and encourage ambition and most of those rules will be decided in 2018.

Despite strong presence of the health sector in the periphery of climate change meetings in recent years, the health sector has only minimally interacted with the climate negotiations21 with a majority of health sector activities occurring outside negotiation spaces and serving mainly as meeting points for the health sector researchers to discuss sector specific interventions rather than interfacing with the issues negotiated through the political process. Nevertheless, the new Director General of the World Health Organization (WHO) Dr. Tedros Adhanom has repeatedly expressed his commitment to engaging with climate change, and this will probably mean a closer interaction between the two UN bodies and hopefully between other health sector non-governmental organizations. We have already witnessed the appointment appointment of Dr. Joy St John to the position of Assistant Director General for Climate and Other Determinants of Health, the involvement of climate champion and past Governor of California, Arnold Schwarzenegger at the latest COP; and a greater interest of health NGOs to participate in political advocacy within the UNFCCC to ensure health is addressed in the negotiations.

Hopefully, the health sector will not only expand its activities but most importantly focus them on the issues most central to the protection of health while interfacing advocacy activities with the core issues discussed by environmental negotiators in the policy space which is fundamentally theirs. The most important issues, which some health NGOs have already identified as being important in climate change negotiations,4 22 and which we would hope other members of the health sector to support are:

• Strong rules implementation of the Paris Agreement: allowing countries to rapidly increase their ambitions;
• Support of a low temperature increase target of 1.5 degree Celsius;
• Fulfillment and strengthening of past commitment on Loss and damages associated with climate change;
• Consideration of health in development of national determined contributions;
• Continued work on health sector adaptation and mitigation to climate change;
• Increased transparency and accountability through mechanisms such as the Talanoa Dialogue;
• True implementation of the pre-2020 climate action through mitigation policies and practices.

All eyes are will be on COP 24 in Poland where negotiations will continue and Paris Rulebook will hopefully be adopted. The UNFCCC, parties to the convention and partner organizations still have lot of work to do far ahead to ensure true implementation of the Paris Agreement addressing the concerns of both developed and developing countries while highlighting the urgent need for ambitious transparent climate actions.

Yassen Tcholakov, MD MIH CCFP, McGill University (Canada)
E-mail: yassentch@gmail.com

Lujain Alqodmani, BMSc, MBBS, Kuwait Medical Association (Kuwait)
E-mail: alqodmani@kma.org.kw

Alice McGushin, MBBS, University of Tasmania (Australia)
E-mail: alice.mcgushin@gmail.com

Sofia Lindegren Hammarstrander, MD, University of Gothenburg (Sweden)
E-mail: sofia.lindegren@outlook.com

Mardelangel Zapata Ponze de Leon, MD, MSc, University of Liverpool (Peru)
E-mail: mzapatapdl@gmail.com

Ghaisani Fadiana, MD, Universitas Indonesia (Indonesia)
E-mail: ghaisani.fadiana@gmail.com

Diogo Martins, MD MS;PH DrPH, LSHTM (Portugal)
E-mail: Diogo.Martins1@lshtm.ac.uk
WMA Declaration of Geneva


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.