The revised International Code of Medical Ethics: an exercise in international professional ethical self-regulation

Ramin W Parsa-Parsi [iD],[1] Raanan Gillon [iD],[2] Urban Wiesing [iD][3]

[1]Department for International Affairs, German Medical Association, Berlin, Germany
[2]Department of Primary Care and Public Health, Imperial College London, London, UK
[3]Institut für Ethik und Geschichte der Medizin, University of Tübingen, Tubingen, Germany

Correspondence to
Dr Ramin W Parsa-Parsi, Department for International Affairs, German Medical Association, Berlin 10623, Germany; rparsa@baek.de

[Linked logo]

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ABSTRACT
The World Medical Association (WMA), the global representation of the medical profession, first adopted the International Code of Medical Ethics (ICoME) in 1949 to outline the professional duties of physicians to patients, other physicians and health professionals, themselves and society as a whole. The ICoME recently underwent a major 4-year revision process, culminating in its unanimous adoption by the WMA General Assembly in October 2022 in Berlin. This article describes and discusses the ICoME, its revision process, the controversial and uncontroversial issues, and the broad consensus achieved among WMA constituent members, representing over 10 million physicians worldwide. The authors analyse the ICoME, including its response to contemporary changes and challenges like ethical plurality and globalisation, in light of ethical theories and approaches, reaching the conclusion that the document is a good example of international ethical professional self-regulation.

One of the core missions of the World Medical Association (WMA), which was established in 1947 as the global representation of the medical profession, has been and continues to be to achieve consensus on high standards of medical ethics and professional competence.[1] Of its various medical-ethical documents, three are especially prominent in fulfilling this mission by outlining the basic ethical principles for physicians in clinical and research settings: The WMA's Declaration of Geneva (DoG), now also known as The Physician's Pledge and often referred to as the modern version of the Hippocratic Oath; the WMA's Declaration of Helsinki (DoH) which focuses on research involving human subjects; and the WMA's International Code of Medical Ethics (ICoME) which expands on the DoG and focuses on the professional duties of physicians to patients, other physicians and health professionals, themselves, and society as a whole.

The ICoME was first adopted in 1949 and last amended in 2006.[2] In a 4-year revision process, it has now been completely revised and was unanimously adopted by the General Assembly of the WMA in October 2022 in Berlin.[3] This process was led by an international workgroup and reinforced by the evaluations of stakeholders, international organisations and experts in the field of medical ethics. This paper describes and discusses the ICoME, its revision process, the broad consensus achieved, the controversial paragraphs, and the historical and philosophical background.

GLOBALISATION AND MEDICAL ETHOS: THE HISTORICAL BACKGROUND

The WMA, as an international association of most of the world's national medical associations, was set up in the aftermath of the Second World War to re-establish the norms of medical research and practice after some egregious ethical failures of physicians that occurred during that time. Medical ethics increasingly faces the need to consider a variety of ethical theories, perspectives and convictions, magnified by the ever-increasing phenomenon of globalisation, which impacts medical professionals and patients alike. Therefore, in recent years, it became clear that one of the WMA's first documents, the ICoME, must respond to contemporary changes and challenges, especially—among others—those of ethical pluralism and globalisation. Doctors and the professional organisations that represent them must be prepared to respond to these developments. In the same vein, with ever more extensive global travel and migration by physicians and patients alike, people are increasingly likely to be treated by physicians they've never met and whose cultural background may be unfamiliar.

A crucial necessity of medical practice is the establishment and maintenance of patients' trust in their doctors and in the medical profession. To achieve such trust, demonstrated integrity and conformity to a professional code of ethics are key objectives and national medical codes and regulation help to achieve such trust. The increasing intranational and international moral pluralism just mentioned, amplified by globalisation, led the WMA to further expand on its founding mission of cultivating international agreement among its members on a common international code of professional ethics representing a global medical ethos. Such a code should provide reassurance to all patients, regardless of their cultural background, that they can reliably expect professional ethical behaviour, mindsets and adherence to an agreed code of good medical practice from every member of the international medical profession.

It was to achieve such an outcome that the WMA ICoME international revision workgroup was established, representing nearly all continents. One of the top objectives of the workgroup was to ensure that the revised ICoME would be applicable globally—to different cultures, denominations—religious and secular—and political environments.

THE REVISION PROCESS

To this end, the workgroup gathered information about the principles and practices described in professional codes of conduct of WMA constituent members and medical ethical guidelines. The WMA also co-organised a series of regional and international conferences to allow for global participation in the revision process. Preliminary drafts of the revised ICoME were also shared during several international bioethics conferences, and a global public consultation garnered hundreds of comments, which were assessed and debated by the workgroup. Held in May 2021, the public consultation lasted 3 weeks, throughout which the draft was accessible on the WMA website and proactively shared with WMA constituent members and medical ethics experts worldwide with an invitation to provide feedback. During this process, it emerged that many ethical principles were uncontroversial, while others were contentious to varying degrees.

UNCONTENTIOUS NEW GUIDANCE

On most of the issues, the workgroup was able to achieve consensus quite early in the process. The workgroup restructured the ICoME, introducing a new preamble, new headings and gender-inclusive language. Furthermore, the ICoME was reviewed for its compatibility with the DoG and DoH and other WMA policies. Principles that had been added to the DoG during its most recent revision in 2017[4] were incorporated into the revised ICoME. For example, the principle of patient autonomy, while already an integral part of the DoH and many other WMA policies, had only been added to the DoG during its most recent revision and was now integrated into the ICoME. Similarly, while the principle of fairness/justice had been implicitly endorsed in earlier WMA documents, it was explicitly affirmed for the first time in the revised ICoME. The new Code also includes advice on physicians' well-being, an issue added to the DoG in 2017.

Within the 40 paragraphs of the revised ICoME (there were 22 much shorter paragraphs in its previous version), several of the new additions are fairly uncontentious and appear in many existing national codes of medical ethics. Examples include the need to avoid or, when unavoidable, declare and 'properly manage' conflicts of interest (para 5); the need 'where medically appropriate' to collaborate with other physicians and other health professionals (para 7); the need to 'engage in continuous learning throughout professional life' (para 11); the need to 'be considerate of and communicate with others, where available, who are close to the patient, in keeping with the patient's preferences and best interests and with due regard for patient confidentiality' (para 19); the need to 'ensure accurate and timely medical documentation' (para 21); and the need to 'maintain appropriate professional boundaries' (para 27).

When working in teams, doctors are reminded that they must 'ensure that ethical principles are upheld' (para 30); and that they should 'report to the appropriate authorities conditions or circumstances which impede the physician or other health professionals from providing care of the highest standards or from upholding the principles of this Code' (para 32). Such impediments include 'any form of abuse or violence against physicians and other health personnel, inappropriate working conditions, or other circumstances that produce excessive and sustained levels of stress' (para 32). As health experts, 'physicians must be prudent in discussing new discoveries, technologies or treatments in non-professional, public settings, including social media, and should ensure that their own statements are scientifically accurate and understandable' (para 35). Physicians must indicate 'if their own opinions are contrary to evidence-based scientific information' (para 35) and they 'must support sound medical scientific research' (para 36).

To make reference to the physician's obligations at global level, the workgroup added (para 38) a responsibility of physicians to 'share medical knowledge and expertise for the benefit of patients and the advancement of healthcare, as well as public and global health'.

As previously stated, many of the normative requirements for members of the medical profession proved to be uncontroversial, providing an undisputed core of a global medical ethos.

POTENTIALLY CONTENTIOUS NEW GUIDANCE

The workgroup also introduced some potentially contentious ethical guidance on issues including remote treatment, environmental sustainability, consent and confidentiality. Paragraph 26, for example, requires doctors to ensure that remote treatment is 'medically justifiable', that the patient is informed about its 'benefits and limitations', that confidentiality is guaranteed, and that the patient's consent is obtained. Although the COVID-19 pandemic led to an increase in remote treatment in some parts of the world,[5] the degree of openness towards remote treatment still varied among workgroup members. Therefore, the following wording was added: 'Wherever medically appropriate, the physician must aim to provide care to the patient through direct, personal contact' (para 26).

Another innovation enjoins doctors to 'strive to practise medicine in ways that are environmentally sustainable with a view to minimising environmental health risks to current and future generations' (para 12). While the need to address this issue is undisputed, there is a potential conflict arising from the ICoME provisions if the actions of physicians are influenced by environmental considerations to the detriment of patients.

Several concepts from previous versions of the ICoME were fleshed out and clarified, sometimes potentially controversially, in the revised version. For example, the need to 'respect the patient's right to be informed in every phase of the care process' and to 'obtain the patient's voluntary informed consent prior to any medical care provided' (para 15), while fundamentally supported by the workgroup, was regarded by some workgroup members as overprescriptive, likely to undermine trusting patient–doctor relationships and the efficient use of scarce medical time in busy real-life medical practice. However, it was agreed that the more demanding formulation was an important counterweight to the power imbalances between patients and their doctors. Unsurprisingly, these informed consent requirements were tempered by further advice on dealing with patients with 'substantially limited, underdeveloped, impaired or fluctuating decision-making capacity' (paras 16–18).

Previous advice on patient confidentiality has been expanded (para 22), adding two additional potential exceptions to those specified in the previous version. The 2006 version of the ICoME (unlike the DoG) did not explicitly state that confidentiality should be maintained after a patient had died; this now appears in the revised ICoME. And the specific potential justification for breaking confidentiality in the previous version of ICoME ('real and imminent harm to the patient or others') has been replaced by the more general justification of 'a significant and overriding ethical obligation'. Thus, the new paragraph reads:

22. The physician must respect the patient's privacy and confidentiality, even after the patient has died. A physician may

disclose confidential information if the patient provides voluntary informed consent or, in exceptional cases, when disclosure is necessary to safeguard a significant and overriding ethical obligation to which all other possible solutions have been exhausted, even when the patient does not or cannot consent to it. This disclosure must be limited to the minimal necessary information, recipients, and duration.[2]

As with most paragraphs, the workgroup avoided detailed descriptions or specific examples in what is intended to be a universally applicable and reasonably succinct normative document. However, 'to safeguard a significant and overriding ethical obligation' seemed a preferable potential justification for rare cases where confidentiality might be justifiably over-ridden even if harm to the patient or others was not the justification for doing so. Suppose, for example, that significant benefits to other family members might result from infringing a patient's confidentiality by providing genetic information in the absence of consent that it was no longer possible to obtain.

SPECIFICITY VERSUS ROOM FOR PROFESSIONAL JUDGEMENT

These examples illustrate a problem that the revision workgroup repeatedly encountered: the tension between stating unambiguous, specific and detailed duties vs providing more general and/or more nuanced accounts of duties that left more room for judgement and interpretation. With the advice on informed consent there was a definite need to expand on the earlier ICoME's only implicit reference to the issue viz: 'A physician shall respect a competent patient's right to accept or refuse treatment'.[6] The revised ICoME has therefore produced, in paragraphs 15–18, a considerably expanded account which is quite specific for competent patients and more nuanced for patients with less decisional capacity.

CONTROVERSIAL ADDITIONS

Several of the new additions are undoubtedly controversial, and the revision process included some intense debates. These concerned especially those issues that closely straddle the line between physicians' duties to patients, including beneficence, minimal harm and respect for patients' autonomy, on the one hand, and their own safety, rights, personal autonomy and professional independence on the other.

One such subject concerned the duty of physicians in emergency situations. Although many members of the workgroup and others contributing to the revision process wanted a very rigorous commitment of physicians to help in emergency situations ('a physician must offer help'), others proposed changing the 'must' to 'should', arguing that the safety and expertise of physicians should be taken into account. Furthermore, physicians in resource-poor health systems may be faced with more persistent emergency situations. A strict obligation to provide such help, including potential extreme difficulty and risks in doing so, could lead to the opportunity cost of doctors' failure to meet non-emergency obligations to their existing patients.

Thus, during the final workgroup meeting held in August 2022 in Washington, DC, workgroup members, advised by ethics experts, came to a compromise, agreeing (para 9) that the physician 'should provide help in medical emergencies, while considering the physician's own safety and competence, and the availability of other viable options for care'.[2]

Also controversial was the subject of advertising and marketing, including social media activities, restriction of which to some extent limits physicians' rights. There were vigorous

ethical arguments in the workgroup, among WMA constituent members, and in the public debate, proposing that strict limits should be set for advertising, even a far-reaching ban. But the reality in some countries has long been different, with more permissive rules, in some cases underpinned by national antirestrictive practices legislation. The revision workgroup was faced with the dilemma of either prescribing a regulation that was not regarded as strict enough by many physicians and public commentators or prescribing a strict ban that would be unworkable for others living in countries where such a ban would be considered disproportionate. Ultimately, a complete restriction on physicians' freedom to advertise and market products related to their professional activity, called for by some, did not achieve consensus. The workgroup decided on the ultimately accepted compromise wording in paragraph 24 on the grounds that, on the one hand, a strict ban was not clearly required ethically, and, on the other hand, such a ban would be politically unrealistic. The final paragraph 24 reads as follows:

> The physician must refrain from intrusive or otherwise inappropriate advertising and marketing and ensure that all information used by the physician in advertising and marketing is factual and not misleading.[2]

Other disputed content includes the requirement in paragraph 6 that doctors 'must not alter their sound professional medical judgements on the basis of instructions contrary to medical considerations'. The objection was considered that sometimes employed doctors were properly required to carry out the instructions of their employers—for example, if their employers limited the provision of free medical services or if their employers explicitly rejected provision of specific types of medical services. The revision workgroup considered that paragraph 6 does not preclude doctors from obeying such instructions while 'not altering their sound professional medical judgements' where these differ from their employers' judgements— an example of wording that deliberately facilitates consensus, taking into account medical reality without jeopardising good medical practice.

Another potentially difficult issue was the requirement in paragraph 10 to 'never participate in or facilitate acts of torture, or other cruel, inhuman, or degrading practices and punishments'. The fundamental justification for this decision was that the ICoME was to be consistent with WMA existing policy and this included the WMA's own Declaration of Tokyo[7] forbidding doctors to 'countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife'.

In some jurisdictions, doctors are required to participate in the oversight of procedures involving capital punishment, bodily mutilation, oppressive interrogation of prisoners, and forced feeding of hunger-striking prisoners. The norm in paragraph 10, in addition to the one in the preamble not to allow 'national ethical, legal and regulatory norms and standards' to 'reduce the physician's commitment to the ethical principles set forth in this code' require of doctors whose work includes oversight of such procedures a very great degree of personal courage to follow the ICoME rather than the national norms of their jurisdictions. Nonetheless, these are examples of the importance of having an international medical professional standard of medical ethics to set against such conflicting national norms and give the medical

profession an international professional standard they may refer to in such situations.

A COMPROMISE ON CONSCIENTIOUS OBJECTION

The most contentious paragraph during the revision process was the one on conscientious objection. This is, first of all, because the frequent and most prominent cases of conscientious objection (abortion, voluntary euthanasia, physician-assisted suicide) are among those where there is no consensus within ethics. It is unrealistic to expect that the ICoME could have resolved this dissensus and it does not comment directly on these specific examples. Second, the issue of physician conscientious objection is so controversial because it concerns a tension between a doctor's duties and rights.

The ICoME is a document of ethical duties, not physicians' rights, but outraged objections by many doctors to an initially proposed requirement for conscientiously objecting doctors to refer patients to colleagues who did not share their objections led to much vigorous debate, culminating in a dedicated conference on the subject of physician conscientious objection co-hosted by the Indonesian Medical Association in Jakarta in July 2022.

At one end of the ethical spectrum were those who argued that doctors had no right to impede in any way patients' access to lawful medical interventions, even if those doctors had conscientious objections to those interventions; on the contrary, their professional duty to benefit their patients with as little harm as possible required such doctors, it was argued, to provide such interventions themselves or else at least refer patients to a suitably qualified colleague who did not share their objections. At the other end of the spectrum were those who argued that no one should impose on a doctor any obligation to participate in any way in behaviour that the doctor, as an autonomous moral agent, believed to be morally unacceptable.

The final paragraph represents a compromise between these polar and mutually exclusive moral positions.

> 29. This Code represents the physician's ethical duties. However, on some issues there are profound moral dilemmas concerning which physicians and patients may hold deeply considered but conflicting conscientious beliefs.
> The physician has an ethical obligation to minimise disruption to patient care. Physician conscientious objection to provision of any lawful medical interventions may only be exercised if the individual patient is not harmed or discriminated against and if the patient's health is not endangered.
> The physician must immediately and respectfully inform the patient of this objection and of the patient's right to consult another qualified physician and provide sufficient information to enable the patient to initiate such a consultation in a timely manner.[2]

How can this compromise between the two polar positions just outlined be justified? In order to answer this question, the nature of the ICoME should first be examined in more detail.

A CANON OF ETHICAL PRINCIPLES FOR THE MEMBERS OF THE MEDICAL PROFESSION WORLDWIDE

As the preamble declares, the document contains basic ethical principles. However, the term 'principles' has a variety of meanings. In the ICoME, as the preamble explains, it covers a range of moral norms that should govern the attitudes and behaviour of members of the medical profession worldwide in relation to their patients, other physicians and health professionals, themselves and society as a whole. These include references to

benefiting patients', populations' and future generations' health and well-being, respect for human life and dignity, respect for patient autonomy and rights, and the requirement for fairness/justice. These principles were unreservedly accepted without controversy.

The well-known phenomenon in ethics that principles may conflict with each other is also visible in parts of the ICoME. The need to reconcile potentially competing principles appears early on where in paragraph 3 'The physician must strive to use healthcare resources in a way that optimally benefits the patient, in keeping with fair, just and prudent stewardship of the shared resources with which the physician is entrusted'—a concern that is reinforced by the objective of environmentally sustainable medical practice in paragraph 12. There are no simple solutions to these ethical conflicts, and any attempted solutions would require textbooks not codes. For these reasons, the ICoME does not go into extensive detail, does not include comprehensive explanations nor any rules or guidance on how to reconcile its principles when they conflict.

The ICoME's ethical principles also demand several virtues. Paragraph 4, for example, requires the physician to 'practise with conscience, honesty, integrity and accountability, while always exercising independent professional judgement and maintaining the highest standards of professional conduct'. Other virtues required by the code include integrity in the proper management of conflicts of interest (para 5), a collaborative approach (para 7), honesty in certification (para 8) and, implicitly, the very specific virtue of keeping up to date with the latest developments in medicine in paragraph 11's requirement that doctors 'must engage in continuous learning throughout professional life' in order to 'maintain and develop their professional knowledge and skills'.

Thus, the sections headed 'general principles' can be seen to comprise basic ethical principles; specifications of such principles; required virtues and virtuous behaviours; and specific deontological obligations/rules/duties. This range of ethical content in the ICoME may be understood as simply reflecting the ways doctors across the world actually conceive of their ethical obligations. It echoes 'the lived experience' of doctors internationally and represents the considered common morality of the profession.

Does this common medical-ethical morality correspond to any of the three main types of ethical theory: deontological/rule-based ethics, virtue-based (aretaic) ethics and consequentialist ethics, of which of course utilitarianism is the main example; and does the increasingly used approach of 'principlism' or the 'four principles approach' have a contribution to make to the interpretation and systematisation of the global medical ethos as represented in the ICoME?

A DEONTOLOGICAL DOCUMENT ALSO CONCERNED WITH VIRTUES AND CONSEQUENCES

At first glance, the ICoME might be regarded simply as a deontological document listing a variety of ethical instructions drawn up by a profession for its professionals. The ICoME does not purport to choose between the different overarching moral theories and approaches to morality variously adhered to by doctors worldwide. Instead, it sets out to be consistent with the widely acceptable components of these theories and approaches in relation to the norms of medical practice. Stemming as it does from the tradition of the Hippocratic Oath, the ICoME provides a contemporary set of the duties required of doctors and is thus primarily a deontological document. However, as demonstrated

above, it is also concerned with some virtues considered necessary for being a good doctor. Considering the commitment of physicians to the health and well-being of their individual patients and the importance of individual patient–physician relationships, utilitarianism is not the main guiding principle of the WMA. While maximising welfare is an appropriate moral concern in many circumstances, it is not the only relevant moral concern for doctors. So, while the ICoME is certainly concerned with good consequences and also, as previously stated, advises to 'share medical knowledge and expertise for the benefit of patients and the advancement of healthcare, as well as public and global health'—and in that sense is not only a deontological and an aretaic or virtue-orientated code of ethics, but also a consequentialist code—it is not utilitarian. In summary, while we regard the ICoME as primarily deontological, it has important virtue-based and consequentialist aspects.

DOES THE REVISED ICOME COHERE WITH 'PRINCIPLISM' OR 'THE FOUR PRINCIPLES APPROACH' TO MEDICAL ETHICS?

In recent times, doctors have increasingly used the moral framework of 'principlism', developed over eight editions of the seminal textbook by Beauchamp and Childress,[8] and sometimes called 'the four principles approach' in reference to its underlying claim that medical ethics can be helpfully considered by reference to the four prima facie[i] basic moral principles of beneficence, non-maleficence, respect for autonomy and justice/ fairness.

There are at least two plausible arguments for why the ICoME cannot be said to be based on principlism as a theory of medical ethics. First, there is no claim in the ICoME that it is based on any particular moral theory. Second, the ICoME refers to two important additional principles—'the utmost respect for human life and dignity' (para 1), each of which may or may not be encompassable within some combination of the four principles: alternatively, they may themselves be high-level basic principles that need to be added to the four.

But while it is clear to us that the ICoME is not based on principlism or the four principles approach, it is equally clear that all four of these basic principles are incorporated within the approach to medical ethics taken by the WMA. Thus, beneficence and non-maleficence have been key medical ethical principles since Hippocratic times and key WMA principles since it was founded; respect for patient autonomy was relatively recently added to the DoG and the ICoME, and, as previously stated, the principle of justice or fairness, long implicit in WMA documents, has now been explicitly added to the ICoME. In the context of the contribution of principles to medical ethics in a globalised world, there was widespread agreement that these four principles were very basic, widely acceptable prima facie moral commitments for doctors globally. In the context of the ICoME, they are helpful for organising and explaining the very many more specific principles in the Code and the various specified virtues. They can also clarify the importance of consequences and hence of 'consequentialism' as an important aspect of medical ethics, despite not requiring or implying its adherence to the overarching 'monistic' and 'maximising' philosophical theories of utilitarianism. And the four principles approach, used as an 'approach' to medical ethics rather than as a basic moral theory, and added to (as in the ICoME), rather than replacing

whatever overarching moral theory a doctor adheres to, can provide a set of prima facie moral commitments that all doctors can share. The ICoME is also compatible with claims that these principles could provide important basic elements of an international and intercultural moral language and even of a basic moral analytic framework that can be shared with colleagues and patients, regardless of the wide variety of 'overall' moral perspectives that those colleagues and patients themselves might adhere to in our increasingly globalised world.

An ethical document, adopted in a political procedure

Given the structure of the WMA and the voluntary consensus nature of all its agreements and publications, it is important to realise that the organisation is essentially a political organisation, a major part of whose self-imposed remit is ethical self-regulation. While consensus was easily achieved on the large majority of the ethical issues contained in the ICoME, there were some ethically highly controversial issues involving profound ethical dilemmas that called for a politically accepted ethical compromise.

The most contentious issue, conscientious objection, is an example of this: on the one hand, no doctor should be ethically required to perform actions that, though legally permitted and desired by the patient, violate the doctor's profound moral beliefs, but on the other hand, if the doctor pursues such conscientious objection, the doctor must take clearly defined measures to reduce potential negative consequences for the patient. This is the ethical compromise that ultimately was subject to a political decision by the WMA's General Assembly, as is the case with all the WMA's publications.

As already explained, a workgroup of the WMA was mandated to develop a text on ethical principles, consistent with WMA policies and in consultation with its constituent members, with the public, and with international bioethical experts. The drafts were recurrently reviewed by the WMA's own Medical Ethics Committee and Council. At the end of a 4-year iterative process, the final ethical document was presented to and approved by the WMA's General Assembly, which is a political but not a moral authority. Thus, on the one hand, the resulting document contains, to some extent, ethical compromises and a consensus that represents the common morality of the constituent members of the WMA. On the other hand, it was ultimately adopted by the General Assembly of the WMA and has gained its authority through a (unanimous) vote in a representative parliament. In this respect, the ICoME embodies an ethical consensus that includes some compromises, adopted and authorised in a political procedure.

Critics might perceive a global document like the ICoME as a medical-ethical 'lowest common denominator'. However, we believe the document should instead be recognised as a remarkably high common denominator, ethically speaking, with consensus reached firmly and rapidly. It reflects the unanimous considered ethical commitment of the WMA membership, representing over ten million physicians worldwide.

Is the WMA the appropriate body to take on the responsibility of establishing this global medical ethos?

Another potential criticism might be that the WMA is not the appropriate body to take on the responsibility for eliciting and establishing a 'global medical ethos'. There are other organisations, such as and notably the WHO and UNESCO that do important work in medical and especially bioethics, but neither of these organisations has dedicated itself to the task of establishing a global medical ethos. The WHO, being focused on improving health throughout the world, is not concerned with

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[i]In some recent discussions the term 'pro tanto' has been preferred to 'prima facie': the nuances of the distinction between these Latin terms are peripheral to our present discussion.

establishing a core ethos for individual doctors, though it does extensive work in running a Global Network of WHO Collaborating Centres for Bioethics[9] and a Global Summit of National Bioethics Committees. UNESCO created its Universal Declaration on Bioethics and Human Rights in 2005, but it does not primarily address the medical profession. As Article 2, 2 explains: 'This Declaration is addressed to States.'[10]

Thus, of the existing international medical organisations (and it would hardly make sense to create a new one), the WMA seemed and seems to be the only suitable organisation to take on this responsibility. Another important justification for the WMA taking on this role is its strong ties with, and the mutual consent of, its members, the world's medical associations and regulators representing the majority of the world's doctors. Of course, some of the national medical organisations also have strong medical ethics departments and codes and regulations, but national institutions cannot plausibly prescribe for other nations. At the same time, the WMA is not itself a regulatory body and it depends on the national medical associations and regulators to implement the ICoME within their nations.

The objective of establishing a global medical ethos is to contribute toward maintaining and enhancing trust in the global medical profession by reassuring the world's patients and populations of the agreed core moral commitments of the world's doctors. The moral answer to globalisation is a global ethos. The ICoME is a document with the claim to such a global ethos in the limited context of medical ethics. Created by the global profession for its professionals, the document is therefore a good example of international ethical professional self-regulation.

ORCID iDs
Ramin W Parsa-Parsi http://orcid.org/0000-0001-7908-7740
Raanan Gillon http://orcid.org/0000-0002-1237-4937
Urban Wiesing http://orcid.org/0000-0003-4957-4323

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