The WMA on medical ethics

The WMA on medical ethics—some critical comments

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Because the WMA's new manual contains a partially partisan view of what constitutes medical ethics, if used for teaching it needs to be balanced by other materials

The recent publication of the World Medical Association's (WMA) *Medical Ethics Manual* should be welcomed since it gives people all over the world, or at least those people who are on the internet and who have a reasonable printer, access to an introduction to medical ethics that can be used as the basis for an introductory course in medical ethics or for self study.¹ The manual covers a wide range of ethical issues in medicine, but much of the focus is on the interaction between the physician and other individual agents—for example, patients and other healthcare professionals.

Although there is much that is uncontroversial in the manual, there are a number of places where it is either (deliberately?) vague or straightforwardly tendentious. In my short review I will focus on some of these problematic sections.

One problem in reviewing this publication is that it is not quite clear to what degree it reflects the views of the WMA. On page two we find the following disclaimer:

This Manual is a publication of the Ethics Unit of the World Medical Association. It was written by John R Williams, Director of Ethics, WMA. Its contents do not necessarily reflect the policies of the WMA, except where this is clearly and explicitly indicated (WMA,¹ p 2).

In the foreword by the WMA Secretary General, however, we read that the manual is the result of:

... a process [that] was started to develop a basic teaching aid on medical ethics for all medical students and physicians that would be based on WMA policies, but not be a policy document itself (WMA,¹ p 5).

I will therefore assume that no part of the manual directly contradicts the policies of the WMA.

WHAT IS MEDICAL ETHICS?

The manual defines medical ethics in the following way in the introduction:

The focus of this Manual is medical ethics, the branch of ethics that deals with moral issues in medical practice. Medical ethics is closely related, but not identical to, *bioethics* (*biomedical ethics*). Whereas medical ethics focuses primarily on issues arising out of the practice of medicine, bioethics is a very broad subject that is concerned with the moral issues raised by developments in the biological sciences more generally. Bioethics also differs from medical ethics in so far as it does not require the acceptance of certain traditional values that, as we will see in Chapter Two, are fundamental to medical ethics. (WMA,¹ p 9).

Here medical ethics is distinguished from bioethics along two dimensions: first with regard to its restricted scope, and second with regard to its value commitments. The first of these distinctions is relatively uncontroversial, although it is important to note that in some countries the term medical ethics is used for the wider field of ethics in health care, and one might wonder how the narrow definition made here in terms of "moral issues in medical practice" allows the WMA to include areas like macroallocation of healthcare resources within the scope of medical ethics. That it is a very narrow definition of medical ethics that is intended by the WMA is furthermore substantiated by the glossary entry on Bioethics/biomedical ethics (WMA,¹ p 120) where bioethics is claimed to have four subdivisions: clinical ethics; research ethics; professional ethics (of which medical ethics is seen as a subtype), and public policy ethics. Given, however, that the manual deals with both research ethics and clinical ethics, and given that these

are seen as being at the core of medical ethics by most people writing on medical ethics, it cannot really be the case that medical ethics is only a subtype of professional ethics.

The second distinction made between medical ethics and bioethics in the introduction is both controversial and tendentious. It is tendentious first of all by claiming by pure stipulation that one cannot do medical ethics in the true sense of that word, if one does not accept certain traditional values. I think it will come as a great surprise to many of the people who have been thinking about and teaching medical ethics for years, that they have not really been thinking about and teaching medical ethics unless they have accepted these traditional values.

It is furthermore close to libellous, and would probably be libellous if specific persons were mentioned as representatives of a bioethics that did not accept the traditional values. If we look at what these values are in chapter two of the manual, they are compassion, competence, and autonomy (WMA,¹ p 17). I submit that it will be very difficult to find any reasonable person, much less any reasonable bioethicist, who will deny the role of these three values. Anyone who, for instance, denied the value of compassion would be a moral monster. What the bioethicist might do is of course deny that the manual's specific understanding of these values is correct. To get autonomy to be a traditional value in medicine, the manual for instance has to posit that the fact that physicians traditionally had autonomy shows that autonomy is a traditional value in medicine. This is clearly, however, a completely different conception of autonomy than the modern one, and the only thing they share is the label.

But, given that one of the purposes of the WMA is to further the interests of the medical profession worldwide, we should perhaps not be surprised by this blatant attempt at exclusion by stipulation.

THE ROLE OF OATHS

Another peculiar feature of the manual's understanding of medical ethics is that it claims that medical ethics differs from general ethics because it is professed in an oath, I quote:

Besides its adherence to these three core values, medical ethics differs from the general ethics applicable to everyone by being publicly *professed* in an oath such as the World Medical Association Declaration of Geneva and/or a code (WMA,¹ p 19).

Does this mean that in countries, or medical schools, where no oaths are sworn there is no medical ethics? Clearly not, I hope, but what is the manual then getting at in this section? It may be getting at the idea that swearing an oath makes medical ethics more binding than general ethics. There are, however, at least four problems with this idea. First, the binding force of oaths, in those cases where they are not legally binding, can only rely on the binding force of promises generated by general ethics. Swearing an oath is therefore only as binding as general ethics is. Second, most medical doctors do not know the content of the oath they have sworn when they are a few years from graduation.² It is thus highly unlikely that their oath can be guiding their actions. Third, it is a fact that some oaths that are still sworn today are outdated and contain conditions that no one would want to fulfil. Fourth, national and international oaths change their content over time. If I am a medical doctor who has sworn one of the old versions of the WMA's Declaration of Geneva, am I now bound by that oath, or have I and my oath mysteriously been transferred to the new text as amended by the WMA Assembly?

END OF LIFE DECISIONS

In the brief section on end of life issues the manual again engages in hiding

ethical disagreement by stipulation. It defines euthanasia in the following way:

EUTHANASIA means knowingly and intentionally performing an act that is clearly intended to end another person's life and that includes the following elements: the subject is a competent, informed person with an incurable illness who has voluntarily asked for his or her life to be ended; the agent knows about the person's condition and desire to die, and commits the act with the primary intention of ending the life of that person; and the act is undertaken with compassion and without personal gain. (WMA,¹ p 57–8).

This definition is longer than most definitions of euthanasia, and it differs considerably from the standard ones found in the literature.

According to this definition there is no such thing as non-voluntary or involuntary euthanasia (here the WMA seems to follow the Dutch in using the term euthanasia as equivalent to voluntary euthanasia). There is furthermore no such thing as dispassionate euthanasia because euthanasia on this definition apparently requires "compassion". Does this mean that a doctor who performs euthanasia because she respects the patient's autonomous decision, but has no special feelings of compassion or any compassionate

thoughts, does not really perform euthanasia, but some other act. And what would that other act be? Murder?!

CONCLUSION

Many of the comments in this review have been critical. This does not mean that I think the manual is a failure, but just that the reader and user of the manual needs to be aware that it promotes a certain partially partisan view of what medical ethics is and should be. If used for teaching it therefore cannot stand alone, but needs to be balanced by other materials.

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Conflicts of interest: Søren Holm is a member of the Danish Medical Association and of the British Medical Association, both of which are members of the World Medical Association. He swore the Danish Physicians' Oath in 1991 despite not being in total agreement with its text, which was originally written in 1815.

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