The ICoME and the Legitimacy of Professional Self-Regulation

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After an intensive four-year process, the World Medical Association (WMA) has revised its International Code of Medical Ethics (ICoME). In their report outlining this process, Parsa-Parsi et al. not only describe how the WMA sought to *"cultivat[e] international agreement"* on a "*global medical ethos*," but also outline the philosophical framework of the ICoME: how the WMA, as the "*global representation of the medical profession*," created and revised the ICoME through the process of international professional self-regulation.[1] However, there is a significant tension to be found in this framework—one which contrasts the *international* scope of the ICoME with the supposed source of its legitimacy. Here, we seek to characterize this tension and the doubt which it casts on the legitimacy of the ICoME.

The privileged relationship between the physician and their larger community has, since at least the 1980s, been described as a social contract. Writing in *The Social Transformation of American Medicine*, the sociologist Paul Starr was the first to describe the patient-physician relationship as contractual, with later authors, drawing on the broader tradition of Enlightenment philosophy, developing the idea of the *social* contract between the physician and their community.[2] On this view, the social contract engages both the physician and their community in a series of obligations: in return for the physician's services as a competent and ethical healer, for example, the community returns to them respect, trust, professional autonomy, and—vitally, for our purposes here—the right of *professional self-regulation*. The idea of the medico-social contract has since become deeply influential in organized medicine, with the British, American, and World Medical Associations explicitly referring to it in their guiding documents.[3-5] Parsa-Parsi et al., gesturing towards this tradition, make similar reference to the transactional nature of the community-physician relationship, describing how a code of medical ethics (and the continued conformity of medical practitioners with it) is vital in establishing and maintaining patient trust.

If we understand the legitimacy of professional self-regulation as arising from a social contract, then we can begin to see the tension inherent within the idea of *international* professional self-regulation. At all levels of medical practice, providers understand that each patient is unique, from their anatomy and physiology to their values and beliefs. In much the same way, the communities which physicians serve across the globe are unique: each community has its own cultures, values, moral norms, challenges, and needs. This much is uncontested—however, it is important to realize that the terms of the social contract between physician and community will, necessarily, be dependent on these cultures, values, norms, and needs. Parsa-Parsi et al. explicitly describe this line of thought in the context of medical emergencies, writing that "*physicians in resource-poor health systems may be faced with more persistent emergency situations*," and may, therefore, be unfairly burdened if strictly obligated to always provide aid in such emergencies. This variability entails, however, that the terms of the medico-social contract *must* differ between differing communities, and, logically, would differ more between communities that are less alike. Herein lies the challenge to the idea of *international* professional self-regulation and the ICoME: if a code of ethics is an act of professional self-regulation and professional self-regulation is community-dependent, then a code of ethics cannot be abstracted from a particular community, and, therefore, cannot be truly international.

Consider a not-so-distant hypothetical. Imagine that Country *A* values dignity in death more than the prolongation of life, and develops a social contract with their physicians based on this understanding of health and well-being; in Country *B*, conversely, the prolongation of life is valued more than dignity in death, and a corresponding contract is developed. We can see, from this understanding of cultures and values, how medical aid-in-dying might be a normalized part of medical practice and universally expected of physicians in Country *A*, and universally forbidden in Country *B*. We contend that the WMA, in such a case, would be unable to "*cultivat[e] international agreement*" and establish a "*global medical ethos*," as the obligations of physicians in Country *A* are incompatible with those in Country *B*. To do so, the ICoME would either (i) need to be diluted to the point of providing *no* guidance, or (ii) prioritize obligations to certain communities over others. If the WMA were to take either of these paths and ignore obligations owed to certain communities, then the ICoME would not reflect the social contract between those communities and their physicians, and would therefore be illegitimate. Though it might be argued that the WMA accounts for this concern by creating a global community of physicians, the ICoME, in its current form, is composed of compromises primarily made among a group of physicians and bioethicists—not, vitally, compromises between physicians and their communities.

These concerns do not pose a merely theoretical challenge to the ICoME; they bear heavily on the issues which Parsa-Parsi et al. describe. They discuss at length a series of compromises made on contentious issues, including conscientious objection, rendering aid in emergencies, and advertising in medicine, among others—and it is plausible to claim that the disagreements which necessitated these compromises are reducible to differences in the cultures, values, norms, and needs of communities around the globe. To provide guidance to physicians and respect the source of its legitimacy, we argue that the WMA should take two substantive steps. First: the WMA should explicitly acknowledge the justification upon which it engages in professional self-regulation. Although the notion of the social contract has insofar been popular in the literature and has been alluded to by the WMA, it is by no means the only potential justification for professional self-regulation; and if a different justification has been employed, bypassing the concerns raised here, that justification should be stated. Second: the WMA should move the ICoME towards a model which stresses, rather than minimizes, the interdependence of medicine and the community, and, further, acknowledges that ethical medical practice is context dependent. Without these changes, the legitimacy of the ICoME will continue to be in doubt.

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