COA Code of Ethics
Approved by COA Board of Directors: June 12, 2024

I. Preamble

This edition of the Canadian Orthopaedic Association Code of Ethics has been reorganized to identifying the foundational ethical principles of the Association followed by discussion of specific topics as it relates to them. Included in these topics are the new mission and strategic plan that the Canadian Orthopaedic Association has embarked on since the last edition of the Code of Ethics.

The intention of this Code of ethics is to supplement the ethical and professional obligations of Canadian Orthopaedic Surgeons. They must continue to abide by the codes, policies, and regulations of provincial medical colleges, institutions, governments, and other professional associations.

II. Foundational Ethical Principles

The overriding principle of the Canadian Orthopaedic Association Code of Ethics is the primacy of patient welfare. Within this are the principles of beneficence, nonmaleficence, autonomy, honesty, and justice.

III. Professional Responsibilities

1. The Patient-Physician Relationship

(i) Consent

(ii) Informed consent

Surgeons must seek consent before providing diagnostic tests or treatment because patients have the right to make informed choices about the health care they receive. This follows the principles of respect for autonomy and honesty. The patient must be informed about the treatment and its expected effects, relevant alternative option's benefits and risks, and the consequences of declining or delaying treatment. This includes information about any material risks, that is, risks that are common or serious and if the treatment is new or experimental. The surgeon's goal is to disclose information that a reasonable person in the patient's position would need in order to make an informed decision. The patient must be given the opportunity to ask questions and have them answered. There is no acceptable substitute for talking to the patient and assuring comprehension. In emergency situations the extent of disclosure may be less than in the elective situation as the result of the urgency of the situation.

Surgeons will provide information that will have a bearing on medical care decision-making and communicate that information in a way that is comprehensible to the patient. If there is any uncertainty or the patient does not ask, the surgeon should provide an opportunity by asking the patient if they wish to know. If the patient wishes to know, he/she must be told. If the patient has requested not to know the surgeon is under no obligation to tell him/her, except perhaps where further investigation or treatment is required and knowing the information is a component of informed consent. The surgeon should not comply with a request by family or other interested parties to withhold the truth.

(iii) Patients lacking capacity to provide consent

The patient's right to know is grounded in the principle of respect for persons which encompasses both: (I) the need to respect the autonomy of individuals and (II) the need to respect the inherent dignity and intrinsic worth of all persons, and thus also respect and protect persons with diminished autonomy (such as those who lack capacity for medical decision- making). Patients who lack capacity to consent still retain the right to consent (grounded in the principle of respect for persons); this right is executed on their behalf through a substitute decision- maker who is expected to make decisions on the basis of prior express wishes, values and beliefs, and best interests or through advanced directives.

(iv) Consent in emergency situations

A true emergency is an exception to the usual requirement to obtain informed consent. The rationale for this exception is that a reasonable person would normally consent to the treatment and that the delay necessary to obtain consent would have adverse consequences for the patient. This justification is grounded in the ethical principle of beneficence.

If the physician knows that a particular patient would not want treatment in the situation that has arisen then the physician should not provide treatment. The justification for this limit to the emergency exception to the usual requirement for informed consent is that the particular patient's competent refusal of the indicated treatment is well known.

(v) Confidentiality

Respect the patient's right to confidentiality by obtaining their consent prior to disclosing personal health information to a third party, unless such disclosure is required by law, or where the maintained of confidentiality would result in significant risk of substantial harm to others, or to the patient if the patient is incompetent. In such cases, take all reasonable steps to inform the patient that confidentiality will be breached. The physician shall not use patient information for any purposes other than for the original intent.

(vi) Competence

(vii) Competence to practice

Competence is possession of the required knowledge, skill, and experience to perform a particular task reliably and produce an appropriate outcome. Surgeons have an ethical obligation to attain and maintain competence. This obligation derives from our primary ethical obligation of beneficence, that is, to consider first the well-being of the patient. Surgeons should ensure that they have the required skills to perform new or unfamiliar elective procedures. In emergency circumstances, lifesaving treatment may be provided as the result of the urgency of the situation.

(viii) Impairment

Impairment of competence is an issue for surgeons individually and collectively. It may be caused by illness, fatigue, age, physical or emotional stress, alcohol, drugs, or other factors. The surgeon whose competence is impaired or in question should not perform surgical procedures or be involved in the care of patients.

(ix) Reporting

The surgeon has an obligation to intervene if he/she is aware that a colleague is incompetent whether on the basis of addiction, lack (or loss) of training, skills or knowledge, or if the care provided is below the accepted standard. There must be appropriate grounds for reporting a colleague that are fair, objective and without malice. These concerns should be made to the proper authority and not be expressed to residents, students, or referring physicians. There is collective responsibility of the surgical community to assure the competence of its members. This should be addressed through peer review.

(x) Disclosure of Medical error

Surgeons should disclose the occurrence of adverse events or errors to patients. This should be based on the principles of truthfulness and nonmaleficence. The disclosure should be accurate and factual and avoid discussion of attribution of responsibility or suggestion that they resulted from negligence. It should be assumed that the patient would want full disclosure, particularly when harm may occur or when its potential occurrence requires departure from the usual care plan.

Negligent actions should be distinguished from honest mistakes. The former are preventable, harmful errors that result from falling below the standard expected of a reasonably careful and knowledgeable practitioner acting in a similar situation. The admission of error is not an admission of substandard practice.

When practitioners witness errors made by other health care providers, they have an obligation to act on that information. Depending on the circumstances and the magnitude of the error, options range from encouraging disclosure by the erring practitioner to discussing the situation with an appropriate authority.

Surgeons must avoid making statements or gestures that could bring on negative or unjust consequences when discussing or referring to a colleague.

(xi) Conflict of interest

Conflict of interest exists when other interests of the physician could influence professional judgment concerning the best interest of the patient. Secondary self-interests of the surgeon may be financial, but also can involve the physician's reputation or time (personal or family). There is nothing inherently unethical in finding oneself in a position of conflict of interest, however the conflict must be recognized and managed appropriately.

Professional judgment is trusted by patients and society because of the fiduciary duty doctors accept to rank their primary interest of appropriate patient care above all secondary interests. This duty derives from the covenant of trust and the principles of justice and integrity.

Doctors profess their intention to serve patients and society in this way. The expectation is that primary interests or purposes will be placed above secondary gains when conflicts arise. Surgeons have an obligation to recognize conflicts of interest, disclose them to the patient and/or public, and resolve any conflict in favor of the patient or otherwise recuse themselves from care and ensure that an alternative is found. Simple disclosure of competing interests is not adequate.

A problem arises when doctors and others do not recognize the interference of secondary gain. A second problem is the perception of interference with primary duties even when no such interference occurs. The goal is not to eliminate all conflicts of interest, as they are inextricable from our lives, but to prevent secondary gain from dominating or appearing to dominate professional decisions or choices. If patient care is not compromised by the surgeon's choice, conflict of interest is not deemed to be present. A surgeon should not directly benefit in ways other than what is considered acceptable and customary (e.g. fee for service payment or salary payment) from patient care.

The imbalance of power between physicians and patients adds to the need for a protective framework. Patients are in a vulnerable position and are dependent on the care of their physicians. Their relatively powerless position makes patients inclined to trust their physicians'
In this context, it seems fair to limit physicians' freedom to engage in activities that could compromise or unduly influence patient care.

2. Education

(i) CME

Surgeons should participate in and comply with programs designed to assess and aid in the maintenance of competence.

(ii) Students, Residents, and Fellows

Students, Residents, and Fellows should be given clinical responsibility befitting their level of training.

(iii) Relationship with Industry

(iv) CME

Surgeons and their families should not accept industry funding to attend CME accredited educational events, nor should they accept other associated enticements. If wishing to learn a new technique or how to use a new product, surgeons should not accept funding from industry unless the event is endorsed and approved by their local hospital, program, division or department. Only tuition, travel and modest hospitality can be accepted and the focus of the event must be education. For faculty at courses/meetings support for travel and modest hospitality is appropriate. Reasonable honoraria are acceptable. Expenses for accompanying persons should not be included.

Financial support from industry for meeting organization is acceptable. Orthopaedic meeting organizers must not be in a position of conflict of interest with the industrial supporters, and must retain control over all aspects of the meeting. The supporters will be acknowledged in printed announcements without reference to specific company products.

(v) Residents and Fellows

There should be no health care industry associated money, gifts, sponsorship or equivalent accepted directly by individual residents/fellows. Residency/Fellowship Training Programs can receive unrestricted industry grants or support for specific activities as long as there is full, transparent disclosure by the Program of these sources of support through some local processes (on meeting materials, annual reports, website, etc).

3. Research

(i) Involving Patients

A study must employ a scientifically valid design to answer the research question. A study must address a question of sufficient value to justify the risk posed to participants. Exposing subjects even to low risk to answer a trivial question is unacceptable. Placebo arms of clinical trials are not acceptable where a standard treatment is known to be of benefit. A study must have ethics review, ethical research conduct, research integrity, patient consent, and avoid and manage conflicts of interest. Study findings must be reported accurately and promptly. Methods, results and conclusions must be reported completely and without exaggeration to allow practising clinicians to draw reasonable conclusions.

The demand for scientific rigour introduces changes from everyday therapeutic practice. Researchers who have no clinical responsibility for patients may gain access to their medical records, raising concerns about confidentiality. The requirements of research design might force physician-researchers to accept limitations on the exercise of their clinical judgment. However, the norms that guide ethical research are the principle of respect for persons.

The principle of beneficence imposes on the surgeon an obligation to recommend interventions that, according to the surgeon's judgment, are best for a particular patient. The requirements of good scientific design may take this judgment out of the physician's hands. This occurs most obviously when the alternative treatments are assigned randomly. The response to this argument lies in recognizing how the physician's clinical judgment must be tempered by the opinions of professional colleagues. Professional consensus creates boundaries within which individual clinical judgments may operate.

It follows the principle of integrity to offer patients participation in a trial only if *clinical equipoise* exists within the expert medical community. *Clinical equipoise* exists when the expert medical opinion remains divided over the best choice among treatment options; The supporters of each alternative realize that the available evidence is inconclusive. The physician who has a decided treatment preference is not obligated to participate in the trial, but should ensure that his or her patients are informed about the differing opinions.

Justice demands that the benefits that may be enjoyed by research participants should be available to all who would willingly participate. It also demands that the potential burdens of participation should be equally shared. Issues of justice should be dealt with when clinical trials are being designed. Those responsible for the design of protocols should ensure that the inclusion and exclusion criteria are justifiable on moral and scientific grounds.

(ii) Finder's fees

Finder's fees and related schemes are not acceptable. Surgeons act in breach of fiduciary duty and in conflict of interest if they use their professional knowledge of a patient for personal gain. Names may not be given to third parties without patient consent. A surgeon who believes that entry in a study may benefit an eligible patient should inform that patient and let the patient decide whether to participate. Surgeons must not accept a fee based on the number of names provided.

(iii) Relationship with Industry

Funds involved when collaborating with industry for sound, ethical research (approved by a local peer review and/or ethics committee review of their research protocol) may be acceptable. Questions concerning the propriety of a research arrangement are best dealt with by full disclosure and accessing ethics review board expertise.

4. Professional relationships

(i) Equity, Diversity and Inclusion

Promotion of equality, diversity and inclusion within the organization is the cornerstone behind the COA strategy's priority of engagement (collaboration, recruitment and retention of diverse membership and stakeholders). The COA will also be support of this principle of justice and respect for persons outside of the organization.

(ii) Consultancy activities

For consultancy activities, a legal contract that is established in advance is essential. Compensation should be at a level that reflects fair market value and is appropriate for the work done. If a surgeon is asked to consult on patients' records or to do other searches, they may be remunerated for the time required to perform that service and for incidental expenses, whether or not any patients are identified and consent to participate. If a surgeon receives material benefit from the use of a medical device or product, he or she should not accept payment such as royalties or the like from the use of that product on his or her own patient. It is acceptable to receive royalties or the like when products are used outside the surgeon's home institution.

5. Resource allocation

(i) wait lists

Not all medical goods and services can be supplied to all patients who might want or need them at a time of their convenience. When resources are in short supply so that they are not available to all who might benefit from them, their allocation is referred to as rationing. The appropriate ethical framework from which to approach rationing decisions is procedural justice. The

appropriate criteria for distributing health care services are need and benefit. The criteria should be applied using transparently fair procedures. It is unfair to ration based on criteria that may vary from physician to physician. Rationing criteria must be explicit, evenly applied, publicly known, and open to review.

(ii) privatized medicine

Such activities have the potential to benefit patients and society through the development of greater access and/or more (cost) effective care and treatment. However, it is important that they are conducted in a manner that upholds the obligation to prioritize patient welfare and avoid or appropriately manage conflicts of interest so as not to inadvertently cause harm under the principles of beneficence and nonmaleficence respectively.