Joint statement on preventing and resolving ethical conflicts involving health care providers and persons receiving care

https://policybase.cma.ca/link/policy202

POLICY TYPE	Policy document
LAST REVIEWED	2019-03-03
DATE	1998-12-05
TOPICS	Ethics and medical professionalism

Documents

JOINT STATEMENT ON PREVENTING AND RESOLVING ETHICAL CONFLICTS INVOLVING HEALTH CARE PROVIDERS AND PERSONS RECEIVING CARE

This joint statement was developed cooperatively and approved by the Boards of Directors of the Canadian Healthcare Association, the Canadian Medical Association, the Canadian Nurses Association and the Catholic Health Association of Canada

Preamble

The needs, values and preferences of the person receiving care should be the primary consideration in the provision of quality health care. Ideally, health care decisions will reflect agreement between the person receiving care and all others involved in his or her care. However, uncertainty and diverse viewpoints sometimes can give rise to disagreement about the goals of care or the means of achieving those goals. Limited health care resources and the constraints of existing organizational policies may also make it difficult to satisfy the person's needs, values and preferences.

The issues addressed in this statement are both complex and controversial. They are ethical issues in that they involve value preferences and arise where people of good will are uncertain of or disagree about the right thing to do when someone's life, health or well-being is threatened by disease or illness. Because everyone's needs, values and preferences are different, and because disagreements can arise from many sources, policies for preventing and resolving conflicts should be flexible enough to accommodate a wide range of situations.

Disagreements about health care decisions can arise between or among any of the following: the person receiving care, proxies,[1] family members, care providers and administrators of health care authorities, facilities or agencies. This joint statement deals primarily with conflicts between the person receiving care, or his or her proxy, and care providers. It offers guidance for the development of policies for preventing and resolving ethical conflicts about the appropriateness of initiating, continuing, withholding or withdrawing care or treatment. It outlines the basic principles to be taken into account in the development of such policies as well as the steps that should be followed in resolving conflicts. The sponsors of this statement encourage health care authorities, facilities and agencies to develop policies to deal with these and other types of conflict, for example, those that sometimes arise among care providers.

Principles of the therapeutic relationship[2]

Good therapeutic relationships are centered on the needs and informed choices of the person receiving care. Such relationships are based on respect and mutual giving and receiving. Observance of the following principles will promote good therapeutic relationships and help to prevent conflicts about the goals and means of care.

Principles concerning physician information

https://policybase.cma.ca/link/policy208

POLICY TYPE	Policy document
LAST REVIEWED	2019-03-03
DATE	2002-06-02
TOPICS	Health information and e-health Ethics and medical professionalism

Documents

CMA POLICY

PRINCIPLES CONCERNING PHYSICIAN INFORMATION

Putting Patients First : Comments on Bill C 6 (Personal Information Protection and Electronic Documents Act) : Submission to the Senate Standing Committee on Social Affairs, Science and Technology

https://policybase.cma.ca/link/policy1979

POLICY TYPE	Parliamentary submission
LAST REVIEWED	2019-03-03
DATE	1999-11-25
TOPICS	Ethics and medical professionalism Health care and patient safety Health information and e-health

Documents

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

BRIEF

MÉMOIRE

"Putting Patients First"

Comments on Bill C-6
(Personal Information Protection and Electronic Documents Act)

Submission to the Senate Standing Committee on Social Affairs, Science and Technology

Nov. 25 1999
Ottawa, Ontario

For further information, contact
CMA's Public Affairs Directorate : 1 800 267-9703

Leadership for Physicians – Mobilité for Canadians
Leadership pour les médecins – Mobilité pour les Canadiens

"Putting Patients First"

Comments on Bill C-6
(Personal Information Protection and Electronic Documents Act)

Submission to the Senate Standing Committee on Social Affairs, Science and Technology

Nov. 25 1999

Executive Summary

CMA commends the federal government for taking this important first step that begins the debate on privacy and the protection of personal information. The issues are complex and the interests at stake significant. CMA welcomes the opportunity to provide comments on Bill C-6 and hopes that its input will strengthen the Bill by ensuring that patient privacy and the confidentiality of medical records are adequately protected.

CMA's chief concern with Bill C-6 is the inadequacy of its provisions to protect the right of privacy of patients and the confidentiality of their health information. The right of privacy encompasses both the right to keep information about ourselves to ourselves if we so choose and to exercise control over what subsequently happens to information we confide in trust for the purpose of receiving health care. In recent years, this right, and the ability of physicians to guarantee meaningful confidentiality, have becoming increasingly threatened.

Computerization of health information facilitates easy transfer, duplication, linkage and centralization of health information. Captured in electronic form, patient information is potentially more useful for the purpose of providing care. However, thus captured, it also becomes much more valuable and technically accessible to various third parties -- private and public, governmental and commercial -- wishing to use this information for other purposes unrelated to providing direct care. An additional concern is that the demand for health information, referred to by some commentators as 'data lust', is growing, partly as a consequence of "information hungry" policy trends such as population health. There is also a disturbing tendency toward 'function creep', whereby information collected for one purpose is used for another, often without consent or even knowledge of the individual concerned and without public knowledge or scrutiny.

Furthermore, initiatives concerning health information technology tend to be dominated by those who seek access to this information for secondary purposes. From this perspective, privacy may appear less as a fundamental right than as a hindrance or even roadblock. As we move further into the information age there is some danger that we will become so spell-bound by the promise of information centralization and database linkages that we lose sight

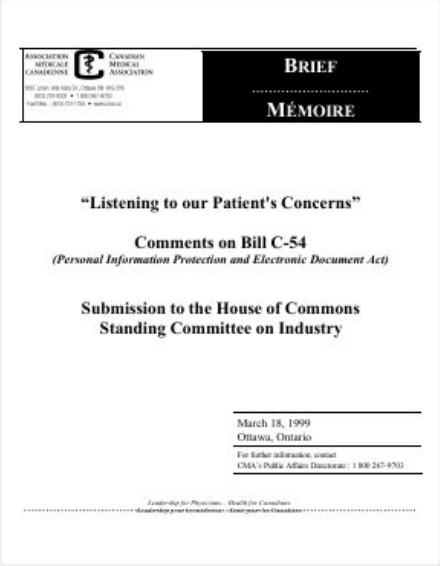
Bill C-6 (Personal Information Protection and Electronic Documents Act), Nov. 25, 1999

Listening to our Patient's Concerns : Comments on Bill C 54 (Personal Information Protection and Electronic Document Act) : Submission to the House of Commons Standing Committee on Industry

https://policybase.cma.ca/link/policy1980

POLICY TYPE	Parliamentary submission
LAST REVIEWED	2019-03-03
DATE	1999-03-18
TOPICS	Health care and patient safety Health information and e-health Ethics and medical professionalism

Documents



BRIEF

MÉMOIRE

"Listening to our Patient's Concerns"

Comments on Bill C-54

(Personal Information Protection and Electronic Document Act)

Submission to the House of Commons
Standing Committee on Industry

March 18, 1999
Ottawa, Ontario

For further information, contact
CMA's Public Affairs Directorate : 1 800 267-9703

"Listening to our Patient's Concerns"

Comments on Bill C 54
(Personal Information Protection and Electronic Document Act)

Submission to the House of Commons Standing Committee on Industry
March 18, 1999

Executive Summary

Over the last year, CMA has become increasingly concerned that debate on the issues concerning health information have been framed in terms of access to information with an attendant erosion of privacy and confidentiality. This one-sided approach comes at a time of expansion in our capacity to collect, store, merge, transfer and access information, coupled with trends both in the health care sector and generally related to the use of information. To address these concerns and to ensure that privacy and confidentiality in the medical context are valued, protected and preserved, CMA developed and adopted a Health Information Privacy Code. This Code should form the basis of all legislation governing the collection, use and disclosure of health information.

Health information is special by its nature. Rules relating to health information must be developed in recognition of its special nature. Ensuring protection of privacy and confidentiality of the patient record must take precedence over other considerations. Bill C-54 fails to do this. Bill C-54 is written from the perspective of encouraging commerce. It appears to have access to information as its dominant value. CMA considers the world of health care to be very different from that of commerce and consequently requiring distinct rules.

Health information use must, in all but exceptional and justifiable circumstances, occur only under the strict control of the patient. The patient must be able to exercise control through voluntary, informed consent. Bill C-54 permits the collection, use and disclosure of information without knowledge or consent on grounds such as expediency, practicality, public good, research, offence investigation, historic importance and artistic purpose. The evident lack of protection accorded health information based on each ground, is unacceptable. The absence of protection undermines the integrity of the patient-physician relationship and has the potential to erode the trust patients have in their physicians - a trust that is essential to patients' willingness to provide the complete information needed to provide them with care. Moreover, distinctions must be made between a patient's right to know what use or must happen to health information and the right to consent to such use.

Not all purposes for the collection and use of health information are equal. Collection and use beyond the therapeutic context should be subjected to rigorous scrutiny before they are permitted to occur. Bill C-54 fails to make such a distinction and treats all purposes that could be identified for information collection or use as equal. Moreover,

Caring in a Crisis: The Ethical Obligations of Physicians and Society During a Pandemic

https://policybase.cma.ca/link/policy9109

POLICY TYPE	Policy document
LAST REVIEWED	2019-03-03
DATE	2008-02-23
TOPICS	Ethics and medical professionalism Population health, health equity, public health

Documents

CMA POLICY

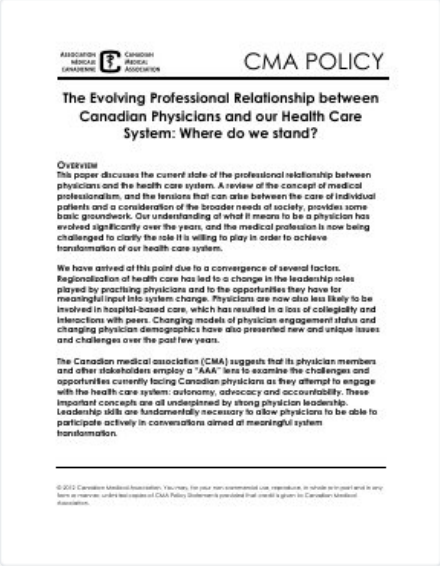
CARING IN A CRISIS: THE ETHICAL OBLIGATIONS OF PHYSICIANS AND SOCIETY DURING A PANDEMIC

The evolving professional relationship between Canadian physicians and our health care system: Where do we stand?

https://policybase.cma.ca/link/policy10389

POLICY TYPE	Policy document
LAST REVIEWED	2019-03-03
DATE	2012-05-26
TOPICS	Ethics and medical professionalism

Documents



CMA POLICY

The Evolving Professional Relationship between Canadian Physicians and our Health Care System: Where do we stand?

OVERVIEW

This paper discusses the current state of the professional relationship between physicians and the health care system. A review of the concept of medical professionalism, and the tensions that can arise between the care of individual patients and a consideration of the broader needs of society, provides some basic groundwork. Our understanding of what it means to be a physician has evolved significantly over the years, and the medical profession is now being challenged to clarify the role it is willing to play in order to achieve transformation of our health care system.

We have arrived at this point due to a convergence of several factors. Regionalization of health care has led to a change in the leadership roles played by practising physicians and to the opportunities they have for meaningful input into system change. Physicians are now also less likely to be involved in hospital-based care, which has resulted in a loss of collegiality and interactions with peers. Changing models of physician engagement status and changing physician demographics have also presented new and unique issues and challenges over the past few years.

The Canadian medical association (CMA) suggests that its physician members and other stakeholders employ a "AAA" lens to examine the challenges and opportunities currently facing Canadian physicians as they attempt to engage with the health care system: autonomy, advocacy and accountability. These important concepts are all underpinned by strong physician leadership. Leadership skills are fundamentally necessary to allow physicians to be able to participate actively in conversations aimed at meaningful system transformation.

CMA’s formal submission to the Federal External Panel on assisted dying

https://policybase.cma.ca/link/policy11750

POLICY TYPE	Parliamentary submission
LAST REVIEWED	2019-03-03
DATE	2015-10-19
TOPICS	Ethics and medical professionalism

Documents

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

October 19, 2015

Harvey Max Chochinov, MD, PhD, FRCPC
Chairman of the Panel

Catherine Frazee, D. Litt., LL.D.
Member of the Panel

Benoît Pelletier, O.C., Ad. E., LL.B., LL.M., LL.D, LL.D.
Member of the Panel

Re: CMA Submission to the Federal External Panel on Options for a Legislative Response to Carter vs. Canada (Federal External Panel)

Dear Members of the Federal External Panel:

On behalf of the Canadian Medical Association (CMA), I appreciate the opportunity to provide input toward the Federal External Panel’s national consultation to support the federal government’s legislative response following the Supreme Court of Canada’s ruling in Carter v. Canada.

As the national professional association representing Canada’s physicians, the CMA has played an important role in leading the public dialogue on end-of-life care, including assisted dying. In 2014, the CMA led a national consultation on end-of-life care which included a series of public and member town hall consultations across the country. This national dialogue focused on three main issues: advance care planning, palliative care, and physician-assisted dying. As highlighted in the summary report (enclosed as Appendix 1), the Canadian public emphasized the need for strict protocols and safeguards if the law on physician-assisted dying were to change.

This initial consultation provided valuable insights to inform the concurrent CMA’s in-depth and comprehensive consultation with its membership as well as medical and health stakeholders as an intervener before the Supreme Court and following the Carter decision. This consultation included engagement of the CMA’s Ethics Committee, policy debates as part of the CMA’s Annual Meetings in 2014 and 2015, in-person member forums across the country, and an online dialogue. This consultation was critical to the development of the CMA’s Principles-based Recommendations for a Canadian Approach to Assisted Dying (enclosed as Appendix 2).

.../2

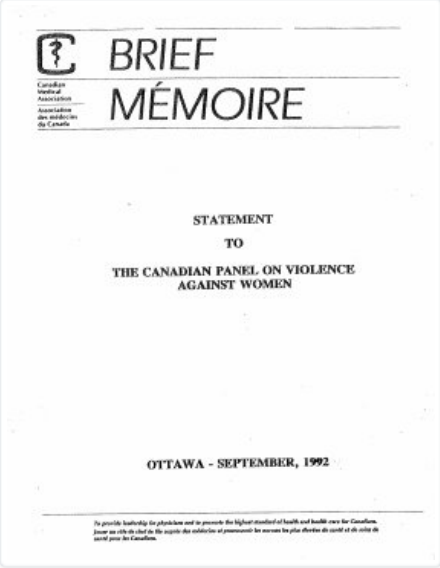
Helping physicians care for patients / Aider les médecins à prendre soin des patients

Statement to the Canadian panel on violence against women Ottawa - September, 1992

https://policybase.cma.ca/link/policy11956

POLICY TYPE	Parliamentary submission
LAST REVIEWED	2019-03-03
DATE	1992-09-15
TOPICS	Health care and patient safety Ethics and medical professionalism

Documents



BRIEF
MÉMOIRE

STATEMENT
TO
THE CANADIAN PANEL ON VIOLENCE
AGAINST WOMEN

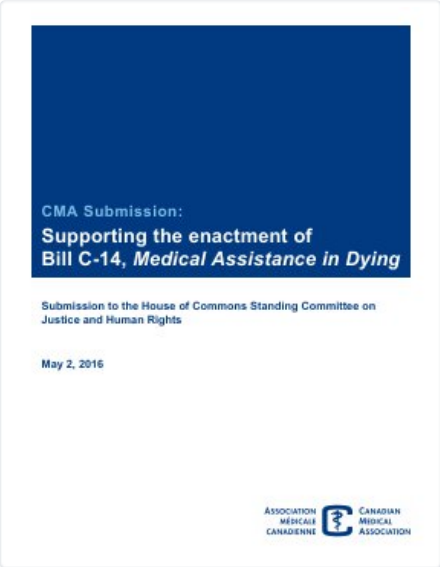
OTTAWA - SEPTEMBER, 1992

Supporting the enactment of Bill C-14, Medical Assistance in Dying

https://policybase.cma.ca/link/policy13693

POLICY TYPE	Parliamentary submission
LAST REVIEWED	2019-03-03
DATE	2016-05-02
TOPICS	Ethics and medical professionalism

Documents



Standing Committee on Health's study on violence faced by healthcare workers

https://policybase.cma.ca/link/policy14052

POLICY TYPE	Parliamentary submission
DATE	2019-05-14
TOPICS	Health care and patient safety Ethics and medical professionalism Health human resources Physician practice, compensation, forms

Documents

May 14, 2019

Bill Casey, M.P.
Chair, Standing Committee on Health
House of Commons

Re: Standing Committee on Health's study on violence faced by healthcare workers

Dear Mr. Casey:

I am writing on behalf of the Canadian Medical Association (CMA) to submit recommendations for consideration by the Standing Committee on Health (the Committee) as part of the study on violence faced by healthcare workers.

The CMA is deeply concerned with the state of workplace safety in all health care settings, including hospitals, long-term care, and home care settings. As in all experiences of violence, it is unacceptable for healthcare workers to be victims of violence in the provision of care to patients. While there is limited data nationally to understand the incidence of violence against healthcare workers, anecdotal evidence suggests that these experiences are increasing in frequency and severity.

A 2010 survey of members of the College of Family Physicians of Canada shockingly found that, in the previous month, nearly one-third of respondents had been exposed to some form of aggressive behaviour from a patient (90%) or patient's family (70%). The study concluded that "Canadian family physicians in active practice are subjected to regular abuse from their patients or family members of their patients."[1]

These concerns were brought to the CMA's General Council in 2015, where our members passed a resolution calling for:

> "the federal government to amend the Criminal Code by making it a specific criminal offence to assault health care providers performing their duties."

The CMA is prioritizing initiatives that support physician health and wellness. Increasingly, there is a recognition of the role of the workplace, primarily health care settings, and safe working conditions as having an important influence of physician health and wellness.

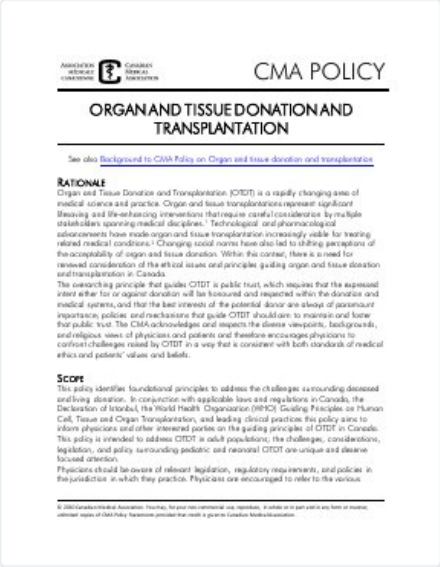
.../2

Organ and tissue donation and transplantation

https://policybase.cma.ca/link/policy14126

POLICY TYPE	Policy document
DATE	2019-12-07
REPLACES	Organ and tissue donation and transplantation (update 2015)
TOPICS	Ethics and medical professionalism Health care and patient safety

Documents



CMA POLICY

ORGAN AND TISSUE DONATION AND TRANSPLANTATION

See also Background to CMA Policy on Organ and tissue donation and transplantation

RATIONALE

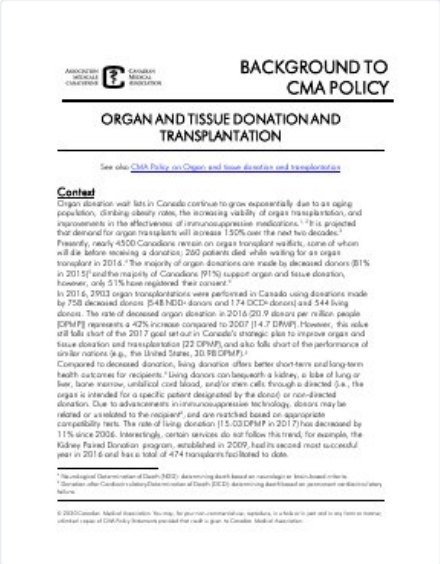
Organ and Tissue Donation and Transplantation (OTDT) is a rapidly changing area of medical science and practice. Organ and tissue transplantations represent significant lifesaving and life-enhancing interventions that require careful consideration by multiple stakeholders spanning medical disciplines.[1] Technological and pharmacological advancements have made organ and tissue transplantation increasingly viable for treating related medical conditions.[2] Changing social norms have also led to shifting perceptions of the acceptability of organ and tissue donation. Within this context, there is a need for renewed consideration of the ethical issues and principles guiding organ and tissue donation and transplantation in Canada.

The overarching principle that guides OTDT is public trust, which requires that the expressed intent either for or against donation will be honoured and respected within the donation and medical systems, and that the best interests of the potential donor are always of paramount importance. policies and mechanisms that guide OTDT should aim to maximize and foster that public trust. The CMA acknowledges and respects the diverse viewpoints, backgrounds, and religious views of physicians and patients and therefore encourages physicians to confront challenges raised by OTDT in a way that is consistent with both standards of medical ethics and patients' values and beliefs.

SCOPE

This policy identifies foundational principles to address the challenges surrounding deceased and living donation. In conjunction with applicable laws and regulations in Canada, the Declaration of Istanbul, the World Health Organization (WHO) Guiding Principles on Human Cell, Tissue and Organ Transplantation, and leading clinical practices this policy aims to inform physicians and other interested parties on the guiding principles of OTDT in Canada. This policy is intended to address OTDT in adult populations; the challenges, considerations, legislation, and policy surrounding pediatric and neonatal OTDT are unique and deserve focused attention.

Physicians should be aware of relevant legislation, regulatory requirements, and policies in the jurisdiction in which they practice. Physicians are encouraged to refer to the various



BACKGROUND TO CMA POLICY

ORGAN AND TISSUE DONATION AND TRANSPLANTATION

See also CMA Policy on Organ and tissue donation and transplantation

Context

Organ donation wait lists in Canada continue to grow exponentially due to an aging population, climbing obesity rates, the increasing viability of organ transplantation, and improvements in the effectiveness of immunosuppressive medications.[1,2] It is projected that demand for organ transplants will increase 150% over the next two decades.[3] Presently, nearly 4500 Canadians remain on organ transplant waitlists, some of whom will die before receiving a donation; 260 patients died while waiting for an organ transplant in 2016.[4] The majority of organ donations are made by deceased donors (81% in 2015)[5] and the majority of Canadians (91%) support organ and tissue donation, however, only 51% have registered their consent.[6]

In 2016, 2903 organ transplantations were performed in Canada using donations made by 758 deceased donors (548 NDD+ donors and 174 DCD+ donors) and 544 living donors. The rate of deceased organ donation in 2016 (20.9 donors per million people [DPMP]) represents a 42% increase compared to 2007 (14.7 DPMP). However, this value still falls short of the 2017 goal set out in Canada's strategic plan to improve organ and tissue donation and transplantation (22 DPMP), and also falls short of the performance of similar nations (e.g., the United States, 30.98 DPMP).[7]

Compared to deceased donation, living donation offers better short-term and long-term health outcomes for recipients.[8] Living donors can bequeath a kidney, a lobe of lung or liver, bone marrow, umbilical cord blood, and/or stem cells through a directed (i.e., the organ is intended for a specific patient designated by the donor) or non-directed donation. Due to advancements in immunosuppressive technology, donors may be related or unrelated to the recipient*, and are matched based on appropriate compatibility tests. The rate of living donation (15.03 DPMP in 2017) has decreased by 11% since 2006. Interestingly, certain services do not follow this trend; for example, the Kidney Paired Donation program, established in 2009, had its second most successful year in 2016 and has a total of 474 transplants facilitated to date.

Equity and diversity in medicine

https://policybase.cma.ca/link/policy14127

POLICY TYPE	Policy document

DATE 2019-12-07

TOPICS Ethics and medical professionalism

Documents

CMA POLICY

EQUITY AND DIVERSITY IN MEDICINE

See also Background to CMA Policy on Equity and Diversity in Medicine

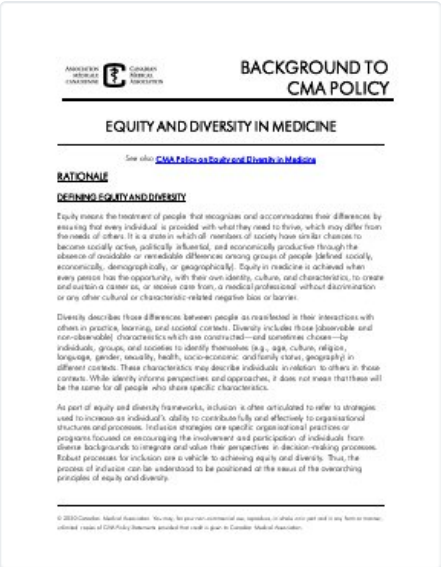
A. RATIONALE

The objective of this policy is to provide guidance to physicians and institutions by identifying a set of guiding principles and commitments to promote equity and diversity in medicine (as defined in the Guiding Principles section). We address equity and diversity in medicine to improve circumstances and opportunities for all physicians and learners as part of our efforts to create a safe, inclusive, and health-promoting culture and practice of medicine , and in recognition that individual protection from bias and discrimination is a fundamental right of all Canadians.

To achieve this, we must redress inequities, bias, and discrimination in learning and practice environments. By embracing the principles of equity and diversity, we can systematically address root causes and reduce structural barriers faced by those who have been excluded from participation in the medical profession or deprived of fair opportunity once practicing medicine because of their ethnicity, gender, ability, or other group-identifying characteristic. This requires that we all work towards fundamental shifts in power structures and power dynamics that perpetuate systemic and structural inequities, systemic discrimination, and systemic racism.

The principles of equity and diversity, and the corresponding duty to commit to anti-racist efforts, are grounded in the fundamental commitment of the medical profession to respect for persons. This commitment recognizes that everyone has equal and inherent worth, has the right to be valued and respected, and to be treated with dignity. When we address equity and diversity, we are opening the conversation to include the voices and knowledge of those who have historically been under-represented and/or marginalized. It is a process of empowerment—where a person can engage with and take action on issues they define as important. Empowerment involves a meaningful shift in experience that fosters belonging in the profession and draws on community supports.

As part of equity and diversity frameworks, inclusion is often articulated to refer to strategies used to increase an individual's ability to contribute fully and effectively to organizational structures and processes. Inclusion strategies are specific organizational practices or programs focused on encouraging the involvement and participation of individuals from diverse backgrounds to integrate and value their perspectives in



BACKGROUND TO CMA POLICY

EQUITY AND DIVERSITY IN MEDICINE

See also CMA Policy on Equity and Diversity in Medicine

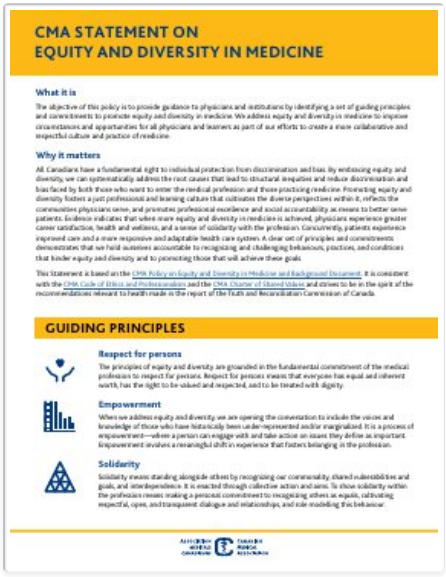
RATIONALE

DEFINING EQUITY AND DIVERSITY

Equity means the treatment of people that recognizes and accommodates their differences by ensuring that every individual is provided with what they need to thrive, which may differ from the needs of others. It is a state in which all members of society have similar chances to become socially active, politically influential, and economically productive through the absence of avoidable or remediable differences among groups of people (defined socially, economically, demographically, or geographically). Equity in medicine is achieved when every person has the opportunity, with their own identity, culture, and characteristics, to create and sustain a career as, or receive care from, a medical professional without discrimination or any other cultural or characteristic-related negative bias or barrier.

Diversity describes those differences between people as manifested in their interactions with others in practice, learning, and societal contexts. Diversity includes those (observable and non-observable) characteristics which are constructed—and sometimes chosen—by individuals, groups, and societies to identify themselves (e.g., age, culture, religion, language, gender, sexuality, health, socio-economic and family status, geography) in different contexts. These characteristics may describe individuals in relation to others in those contexts. While identity informs perspectives and approaches, it does not mean that these will be the same for all people who share specific characteristics.

As part of equity and diversity frameworks, inclusion is often articulated to refer to strategies used to increase an individual's ability to contribute fully and effectively to organizational structures and processes. Inclusion strategies are specific organizational practices or programs focused on encouraging the involvement and participation of individuals from diverse backgrounds to integrate and value their perspectives in decision-making processes. Robust processes for inclusion are a vehicle to achieving equity and diversity. Thus, the process of inclusion can be understood to be positioned at the nexus of the overarching principles of equity and diversity.



CMA STATEMENT ON EQUITY AND DIVERSITY IN MEDICINE

What it is

The objective of this policy is to provide guidance to physicians and institutions by identifying a set of guiding principles and commitments to promote equity and diversity in medicine. We address equity and diversity in medicine to improve circumstances and opportunities for all physicians and learners as part of our efforts to create a more collaborative and respectful culture and practice of medicine.

Why it matters

All Canadians have a fundamental right to individual protection from discrimination and bias. By embracing equity and diversity, we can systematically address the root causes that lead to structural inequities and reduce discrimination and bias faced by both those who want to enter the medical profession and those practising medicine. Promoting equity and diversity fosters a just professional and learning culture that cultivates the diverse perspectives within it, reflects the communities physicians serve, and promotes professional excellence and social accountability as means to better serve patients. Evidence indicates that where more equity and diversity in medicine is achieved, physicians experience greater career satisfaction, health and wellness, and a sense of solidarity with the profession. Concurrently, patients experience improved care and a more responsive and adaptable health care system. A clear set of principles and commitments demonstrates that we hold ourselves accountable to recognizing and challenging behaviours, practices, and conditions that hinder equity and diversity and to promoting those that will achieve these goals.

This Statement is based on the CMA Policy on Equity and Diversity in Medicine and Background Document. It is consistent with the CMA Code of Ethics and Professionalism and the CMA Charter of Shared Values and strives to be in the spirit of the recommendations relevant to health made in the report of the Truth and Reconciliation Commission of Canada.

GUIDING PRINCIPLES

Respect for persons

The principles of equity and diversity are grounded in the fundamental commitment of the medical profession to respect for persons. Respect for persons means that everyone has equal and inherent worth, has the right to be valued and respected, and to be treated with dignity.

Empowerment

When we address equity and diversity, we are opening the conversation to include the voices and knowledge of those who have historically been under-represented and/or marginalized. It is a process of empowerment—where a person can engage with and take action on issues they define as important. Empowerment involves a meaningful shift in experience that fosters belonging in the profession.

Solidarity

Solidarity means standing alongside others by recognizing our commonality, shared vulnerabilities and goals, and interdependence. It is enacted through collective action and aims. To show solidarity within the profession means making a personal commitment to recognizing others as equals, cultivating respectful, open, and transparent dialogue and relationships, and role-modelling this behaviour.