

# GMC Guidance on 'Personal Beliefs and Medical Practice'

## Submission from Christian Medical Fellowship

### Executive Summary

- The Christian Medical Fellowship (CMF) has over 4,000 doctor members and around 1,000 medical student members and is the UK's largest faith-based group of health professionals
- Our [doctrinal beliefs](#) and [ethical values](#) are outlined on our [website](#).
- We have previously made submissions on [Personal Beliefs and Medical Practice \(2008\)](#), [Good Medical Practice \(2006\)](#) and [Good Medical Practice \(2012\)](#)
- Christians in the UK face problems in living out their faith which have been mostly caused and exacerbated by social, cultural and legal changes over the past decade. These changes affect both Christian doctors and Christian patients.
- We welcome the fact that the previous version of the guidance attempted to deal with the so called 'myth of secular neutrality' by recognising that 'all doctors have personal beliefs which affect their day to day practice' (paragraph 6).
- We welcome the recognition that 'personal beliefs and values' go together (paragraph 4) and, as much of the document deals with ethics, suggest that the term 'beliefs' should be replaced by 'beliefs and values' as appropriate throughout the document including in section titles.
- We would particularly welcome in the revised guidance an acknowledgement about the importance of holistic care, spiritual care and the benefits of certain beliefs and practices to health.
- We are in agreement with the general principles under 'Personal Beliefs and Medical Practice' (paragraphs 1-3) but feel that the references to paragraph 8 (referral) and paragraph 33 (expressing personal beliefs) need further clarification (see below).
- We were generally happy with paragraphs 10-16 about blood transfusions and circumcision but were puzzled by the fact that the examples given deal specifically only with issues that are relevant for Jehovah's Witnesses and those of Jewish or Islamic faith.
- We were happy with the general principles outlined in paragraphs 17 and 18 but felt that paragraph 19 was too restrictive and did not give adequate scope for faith-based or personal discussions within the context of the doctor patient consultation provided that these were undertaken with mutual consent in an atmosphere of sensitivity, permission and respect.
- We felt that paragraphs 21 and 22, in the way that they were worded, imposed on those who were not willing to provide certain treatments or procedures on conscientious grounds, an obligation to refer to others who would. We believe this approach risks overriding a doctor's lawful right to conscientious objection especially with respect to abortion referrals.
- We advise more clarification on the face of the guidance about doctors' obligations in authorising, clerking and referring for abortion and refer you to an earlier GMC letter.

- We believe that the guidance could be usefully shortened to include just general principles by placing the ‘examples where patients’ personal beliefs may affect care’ and ‘examples of situations where doctors’ personal beliefs may affect care’ into an expanded appendix.
- With regard to patients we recommend additional examples be put in to deal with infertility treatments, contraception, prenatal screening and withdrawal of treatment.
- With regard to doctors we recommend sections on abortion, infertility treatments, contraception, pre-natal screening, withdrawal of treatment (particularly with regard to advance refusals of artificial nutrition and hydration), organ donation and gender reassignment surgery.

## **Main Submission**

The Christian Medical Fellowship (CMF) is an interdenominational organisation in the UK with over 4,000 doctor members and around 1,000 medical student members. All members are Christians who desire their professional and personal lives to be governed by the Christian faith as revealed in the Bible. Members practise in all branches of the profession, and through the International Christian Medical and Dental Association are linked with like-minded colleagues in over 100 other countries.

Our [doctrinal beliefs](#) and [ethical values](#) are outlined on our [website](#).

CMF regularly makes submissions on ethical and professional matters to government committees and professional bodies. All of our submissions are available on our website (<http://www.cmf.org.uk/publicpolicy/submissions/>) including our submissions on earlier drafts of [Personal Beliefs and Medical Practice](#) (2008) and [Good Medical Practice](#) (2006). We also made a submission to the current consultation on the 2012 version of [Good Medical Practice](#) earlier this year.

As the largest faith-based group of health professionals in the UK we are grateful for this opportunity to participate in this revision process for [Personal Beliefs and Medical Practice](#) prior to a redraft being issued for formal consultation.

## **Wider Cultural and Professional Context**

A number of cultural and professional changes have taken place in Britain over the last 40 years leading to the perceived need for guidance of this kind.

First, Britain has become a multi-faith, multi-cultural society with a broad diversity of world views, personal beliefs and values. This has increased the potential for conflict both within the medical profession and in the context of the doctor-patient relationship.

Second, there has been a significant shift in ethical views within the profession. In particular the principle of ‘the sanctity of all human life’, which is fundamental to the Judeo-Christian ethic and historic ethical codes like the Hippocratic Oath, the Declaration of Geneva (1948) and the International Code of Medical Ethics (1949), no longer has wide support. These codes prohibited abortion, upheld the ‘utmost respect for human life from the time of conception’ and stressed ‘the importance of preserving human life from conception until death’. This means that procedures like embryo research and disposal, prenatal screening, post-coital contraception and abortion, which would previously have been regarded as unethical, are now considered acceptable by the majority of doctors. Many Christians, however, and a significant number of those of other faiths or no faith, still hold to these historic values.

Third, particularly in the last decade, progressive secularisation has resulted in some marginalisation of Christians in public life. The key finding of the recent parliamentary enquiry, [‘Clearing the Ground’](#), published in February 2012, was that ‘Christians in the UK face problems in living out their faith and these problems have been mostly caused and exacerbated by social, cultural and legal changes over the past decade’.

These changes have impacted on Christian doctors and medical students, particularly in the areas of articulating their personal beliefs and values and in facing pressure to participate in procedures or practices which they regard as unethical.

There have been parallel difficulties for Christian patients who sometimes feel judged for their beliefs and values, feel pressure to consent to treatments or procedures to which they have an ethical objection or feel excluded from some treatment options because their values are not being easily accommodated.

The GMP Review Working Group has posed a number of questions about [Personal Beliefs and Medical Practice](#) (2008) which we attempt to answer below.

## **1. Additions and Alterations**

We were pleased that the previous version of the guidance attempted to deal with the so called ‘myth of secular neutrality’ by recognising that ‘all doctors have personal beliefs which affect their day to day practice’ (paragraph 6) and that it is not just those with religious faith who bring presuppositions, beliefs and values to every consultation.

It is also noteworthy that two-thirds of doctors (according to our own research) have an atheistic world view and two-thirds of patients (according to national surveys) have a theistic world view (ie. belief in a personal creator God). This means that the most common doctor-patient consultation in Britain involves an atheist doctor and a theist patient.

We are in agreement with the underlying aim of the guidance of attempting to balance doctors’ and patients’ rights and advising on what to do when those rights conflict.

We welcome the recognition that ‘personal beliefs and values’ go together (para 4) and, as much of the document deals with ethics, suggest that the term ‘beliefs’ should be replaced by ‘beliefs and values’ as appropriate throughout the document including in section titles.

In addition we feel that the term ‘religious or moral beliefs’ (para 1) should also be replaced by ‘personal beliefs and values’. This would help to underline the fact that all ‘doctors and patients’ (including those who have no religious faith) have ‘personal beliefs and values’ which are ‘central to their lives’ (para 4) and would avoid creating a perception of there being different guidance for those who follow a specific religious faith and those who do not.

Perhaps the document itself should be renamed ‘Personal beliefs and values and medical practice’ to make it clear that it applies to every doctor and patient without exception.

We would particularly welcome in the revised guidance an acknowledgement about the importance of holistic care, spiritual care and the benefits of certain beliefs and practices to health.

Whilst we recommend the recognition (paragraph 9) that patients’ beliefs (and values) should be acknowledged and that they ‘may be an important aspect of holistic approach to their care’ it also needs to be recognised in the main body of the guidance that there is a growing evidence base demonstrating that some personal beliefs enhance health through providing patients with meaning and purpose, encouraging healthy lifestyle choices and promoting strong family and faith community

support for those facing illness. We would refer the Council to the following publications which specifically review research on the relationship between Christian faith and health.

1. [Realized Religion – research on the relationship between religion and health](#) – Theodore J. Chamberlain and Christopher A. Hall
2. [Handbook of Religion and Health](#) – Koenig, McCullough and Larson
3. [Health Benefits of Christian Faith](#) – Alex Bunn and David Randall
4. [Spirituality and Health Research](#) – Harold Koenig

The writers of the first publication conclude, 'The scientific evidence convincingly demonstrates that the natural by-product of religion realised is longer life, less illness, better physical and mental health, more marital stability, less divorce, less suicide and less abuse of alcohol and other substances'.

The other two publications (2,3) outline evidence from over 1,200 studies and 400 reviews showing an association between faith and a number of positive health benefits, including protection from illness, coping with illness, and faster recovery from it. Of the studies reviewed in the definitive analysis, (3) 81% showed benefit and only 4% harm.

There is also a growing emphasis in the medical literature on spirituality and health and the GMC itself acknowledges the importance of taking a spiritual history in the latest draft of *Good Medical Practice*. Similarly, there is increased emphasis in Mental Health policy on 'recovery based' mental health services which recognise the patient's faith as an important part of making sense of what has happened to them and restoring their hope for the future.

The regular major conference '[Spirituality and Healing in Medicine](#)', sponsored by Harvard Medical School, has drawn public opinion and professional attention as never before to this issue of incorporating spirituality into professional medicine. It was there reported that that 86% of Americans as a whole, 99% of family physicians, and 94% of HMO professionals now believe that prayer, meditation, and other spiritual and religious practices exercise a major positive role within the healing process.

The question is therefore not whether health practitioners should introduce spiritual topics but how to do so without causing offence. The World Health Organisation has stated that wellbeing in the physical, emotional, social and spiritual realms, is the definition of health. So failing to address spiritual issues is failing to practise holistic medicine.

Our comments below apply to the sections of *Personal Beliefs and Medical Practice* (2008).

#### **A. Personal Beliefs and Medical Practice**

We are in agreement with the general principles under 'Personal Beliefs and Medical Practice' (paragraphs 1-3) but feel that the references to paragraph 8 (referral) and paragraph 33 (expressing personal beliefs) need further clarification (see below).

#### **B. Personal Beliefs and the doctor patient relationship**

We were generally happy with paragraphs 4-7 but strongly recommend that the word 'all' be added between 'of' and 'doctors and patients' in paragraph 4 and that the term 'personal beliefs and values' be substituted for 'personal beliefs' in section 5, 6, 7 and 8.

We were most concerned by the suggestion that the GMC expects doctors 'to be prepared to set aside their personal beliefs where this is necessary to provide care in line with the principles in *Good Medical Practice*' both because the final version of the latter has not yet

been published and also because we had serious reservations about some of those principles as stated in the consultation draft. The implication that doctors should either act contrary to deeply-held personal and moral beliefs or face discipline is inappropriate, heavy-handed and displays a lack of respect for doctors as professionals. We expound on this in our comments about conscientious objection below.

### **C. Patients' personal beliefs**

We suggest that the second and third sentences in paragraph 9 be amended to read as follows: 'Patients may find it difficult to trust you and talk openly and honestly with you if they feel you are judging them on the basis of their religion, culture, values, *personal or* political beliefs or other non-medical factors. Acknowledging their beliefs, values or religious practices may *well be* an important aspect of the holistic approach to their care.'

'Personal beliefs' should be amended to 'personal beliefs and values' where it appears (three times) later in paragraph 9.

### **D. Examples of situations where patients' personal beliefs may affect care**

We were happy with paragraphs 10 and 11 about Jehovah's Witnesses and blood transfusions which we felt were fairly and concisely worded. We were also happy with paragraphs 12-15 relating to circumcision but felt that paragraph 16 gave too much unnecessary technical detail which would be better suited to a footnote or case study.

We particularly applaud the principle in 13 that 'the GMC does not have a position on this issue' (circumcision) nor 'general authority to determine public policy on issues that arise within medical practice'.

We encourage the GMC to apply this same principle to other contentious issues like abortion, embryo research, post-coital contraception and the withdrawal of treatment.

In this connection we were puzzled by the fact that the examples given deal specifically only with issues that are relevant for Jehovah's Witnesses and those of Jewish or Islamic faith.

We suggest that extra sections be included to deal with infertility treatments, contraception, pre-natal screening and withdrawal of treatment which are important for many Christian patients who not uncommonly feel their views are neither understood nor respected by doctors who do not share their beliefs and values.

### **E. Doctors' personal beliefs**

We were happy with the general principles outlined in paragraphs 17 and 18 but felt that paragraph 19 was too restrictive and did not give adequate scope for faith-based or personal discussions within the context of the doctor patient consultation provided that these were undertaken with mutual consent in an atmosphere of sensitivity, permission and respect. The GMC should not be overly prescriptive or intrusive with respect to what can and cannot be discussed in the context of the consultation.

We suggest that the first sentence be redrafted as follows '*Within a consultation* you should not normally discuss your personal beliefs *or values* with patients unless *the patient invites you to do so* or those beliefs *or values* are directly relevant to the patient's care.

We suggest also that the second sentence be worded positively rather than negatively as follows: '*If you express your personal beliefs (including political, religious and moral beliefs)*

*to patients you must do so in a way that is sensitive and appropriate and after obtaining permission’.*

We suggest that the first sentence in paragraph 20 be worded to read ‘Patients have a right to information about their condition and the *legal* options available to them. The word ‘legal’ should also be added before ‘procedure or treatment’ in the next sentence and ‘religious or moral beliefs’ should be replaced by ‘personal beliefs and values’ as in paragraph 1.

We felt that paragraphs 21 and 22, in the way that they were worded, imposed on those who were not willing to provide certain treatments or procedures on conscientious grounds, an obligation to refer to others who would. We believe this approach risks overriding a doctor’s lawful right to conscientious objection especially with respect to abortion referrals.

Many doctors believe that to refer someone for a procedure they believe is unethical is morally equivalent to participating in and condoning that procedure. It would also fall foul of the conscientious objection clause in the 1967 Abortion Act, because to refer is to participate in abortion. Referral is not merely an administrative act.

Parliament has already legislated on this and we believe it is not for the General Medical Council to overrule this right. The Council may be aware of a recent case in New Zealand<sup>1</sup> where a group of doctors challenged the New Zealand Medical Council about similar wording leading ultimately to the withdrawal of a draft statement on ‘Beliefs and Medical Practice’.

The judicial review validated the lawful right of a medical practitioner to practise independently in accordance with his or her conscience and confirmed that this right lies at the heart of being a true health professional. This means that New Zealand doctors are now reassured that they do not have to make referrals for abortion but are simply left with an obligation to ‘inform the person who requests this service that she can obtain the service from another health practitioner or from the family planning clinic’.

We therefore recommend a similar approach to the GMC.

## **F. Examples of situations where doctors’ personal beliefs may affect care**

We are happy with these paragraphs but felt that paragraph 26 needs to distinguish between medical care to which the doctor has no conscientious objection and procedures to which he or she does. We suggest that it be redrafted as follows: ‘Where a patient who is awaiting or has undergone a termination of pregnancy needs *non-routine medical care that does not involve participating in or facilitating the termination*, you have no legal or ethical right to refuse to provide it on grounds of a conscientious objection to the procedure.’ We have no concerns with paras 27-29.

## **2. Further matters requiring clarification**

As a result of what we felt were ambiguities in the 2008 guidance we wrote to the General Medical Council asking specifically whether the current guidance obliged doctors to provide particular services:

- A. Will doctors be obliged to sign abortion authorisation forms?
- B. Will doctors be obliged to clerk patients for abortion? (ie. carry out pre-operative examination and assessment)

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<sup>1</sup> HALLAGAN And Anor V MEDICAL COUNCIL OF NZ HC WN CIV-2010-485-222 [2 December 2010]

C. Will doctors be obliged to refer patients seeking abortions to other doctors who will authorise it?

We were assured by the Chairman of the GMC's Standards and Ethics Committee that the answer to all of these questions was 'No'. He stipulated at the time that the intention of the guidance was 'to distinguish between doctors refusing to participate directly, or facilitate the execution of, procedures to which they have a conscientious objection on the one hand, and on the other, refusing to provide any other care on the grounds that the patients concerned were about to undergo, or about to undergo, or had undergone such procedure'. The [letter](#) also emphasised that 'it is the procedure to which the doctor objects and not the patient'.

Although these reassurances were most welcome we felt that they need to be spelt out much more clearly in the next edition of the guidance so that all doctors are aware of them.

### **3. Changes to the Structure**

We believe that the guidance could be usefully shortened to include just general principles by placing the 'examples where patients' personal beliefs may affect care' and 'examples of situations where doctors' personal beliefs may affect care' into an expanded appendix.

### **4. Examples given in 2008 guidance**

We felt that the examples given in paragraph 10-16 were helpful but applied only to Jehovah's Witnesses and those of Jewish and Islamic faith.

We recommend additional examples be put in to deal with infertility treatments to cater for those patients whose personal beliefs and values preclude embryo freezing, experimentation and disposal research or the use of donor gametes. Such people should still be able to access techniques of artificial reproduction which avoid these practices and reasonable accommodation should be made for them.

Additional examples dealing with contraception, prenatal screening and withdrawal of treatment should also be added.

With regard to examples of situations where doctors' personal beliefs may affect care we would appreciate sections on abortion, infertility treatments, contraception, pre-natal screening, withdrawal of treatment (particularly with regard to advance refusals of artificial nutrition and hydration), organ donation and gender reassignment surgery.

As mentioned above we think it would be wise to remove the existing examples from the guidance itself but include them in an attached appendix.

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