CMF Submission – Personal Beliefs and Medical Practice

1 Do you think it's helpful to have guidance on this topic?

Answer – Yes

Cultural, legal and ethical changes have impacted on Christian doctors particularly in the areas of expressing their personal beliefs and values, providing spiritual care and in facing pressure to participate in procedures or practices which they regard as unethical.

The key finding of the recent parliamentary enquiry, 'Clearing the Ground' (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'.

There has also been a significant shift in ethical views within the medical 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.

Guidance in this area is therefore necessary to clarify the specific rights and duties of doctors in this new cultural and legal environment.

The guidance provides more detail about what doctors should do if their beliefs conflict with carrying out particular procedures, or giving advice about them. Currently we allow doctors to withdraw from providing or arranging treatments or procedures on the grounds of conscience, whether or not this is covered by legislation.

2. Do you think this is a reasonable position for us to maintain?

Answer – Yes

Doctors should be able to withdraw from providing or arranging treatments or procedures on grounds of conscience, whether or not this is covered by legislation. The doctor's duty should end with the obligation to inform a patient that he/she has a right to see another doctor.

However the guidance in its present form does not fully allow this and we recommend that it be amended so that it clearly does so.

The guidance states (p3) 'we don't wish to prevent doctors from practising in line with their beliefs and values, as long as they also follow the guidance in Good Medical Practice' but also makes it explicit (p4) that in situations of conflict 'we expect doctors to be prepared to set aside their personal beliefs'. This means in essence that when there is any conflict, 'Good Medical Practice' trumps the doctor's conscience.

The guidance also says that doctors who 'have a conscientious objection to a treatment or procedure' (p7) 'must make sure that arrangements are made – without delay – for another suitably qualified colleague ('who does not hold the same objection' – p8c) to advise, treat or refer the patient' (p9) in circumstances where 'it's not practical for a patient to arrange to see another doctor' (p9)

This is effectively a duty to refer and thereby forces doctors to participate in treatments or procedures that they believe are clinically inappropriate, not in a patient's best interests or unethical. If doctor's

professional judgement is that a certain ‘treatment’ is unethical or inappropriate then to refer the patient to another doctor who would carry out this treatment would be equally unethical or inappropriate. Also the wording too easily lays open doctors to vexatious complaints in that a patient could too easily complain that it is ‘not practical’ for him/her ‘to arrange to see another doctor’.

At paragraph 5, we explain that gender reassignment is only sought by a particular group of patients who have ‘protected characteristics’ as defined in the Equality Act. Gender reassignment can not be withheld because of doctors’ personal beliefs, without breaching the Act.

3. Is the guidance on gender reassignment clear? If no or not sure, please say why.

Answer – No

The guidance is not clear on gender reassignment and appears not accurately to reflect the requirements of the law.

In the footnote to p5 it states that doctors have no right to ‘opt out of providing’ ‘gender reassignment’ but it does not clearly define what ‘providing gender reassignment’ actually entails. Does it include just gender reassignment surgery and/or hormone treatment or does it also entail being part of the referral pathway? If this paragraph is left in it needs clearer definition. But for the reasons given below we recommend that the confusing footnote to p5 on gender reassignment be removed altogether.

The treatment of gender identity disorder (alternatively gender dysphoria) is extremely controversial and many doctors do not believe that surgery or hormone treatment is clinically appropriate or ethical in many (or even any) cases. To force such doctors to ‘provide’ such ‘treatment’ with no option to opt out is ethically and professionally inappropriate.

In addition the argument that provision of ‘gender reassignment’ is required is we believe a misapplication of the Equality Act 2010. The protected characteristic of gender reassignment in s7 of the Equality Act applies to a person who is proposing to undergo, is undergoing or has undergone gender reassignment.

This does not mean that a doctor is obliged to provide gender reassignment. Rather it means that a doctor must not discriminate against a patient who is proposing to undergo, is undergoing or has undergone gender reassignment. In other words doctors should not refuse to treat these patients if they are suffering from conditions for which they would treat other patients (eg. Infections, heart disease etc). This is a very different thing from providing gender reassignment to those diagnosed with gender identity disorder.

Making the provision of ‘gender reassignment’ a duty is thereby ethically, professionally and legally wrong. It would also be open to legal challenge.

4. Are there any references to supporting information we could include to make the guidance more helpful to doctors?

Answer – Yes

There is strong support for a right to conscientious objection in international law and historic ethical declarations. This should be made clear alongside the reference to article 9 of the ECHR in the footnote on page 2.

The right of conscience has been recognised as a fundamental human right in all of the post-Second

World War international human rights instruments (Universal Declaration of Human Rights (1948), article 18; European Convention on Human Rights (1950), article 9; International Covenant on Civil and Political Rights (1966), article 18)

The International Code of Medical Ethics of the World Medical Association (WMA) (1949) says that ‘a doctor must always maintain the highest standards of professional conduct’ and that it is unethical to ‘collaborate in any form of medical service in which the doctor does not have professional independence’.

The WMA Declaration of Geneva (1948) (Physician's Oath) states, ‘I will practise my profession with conscience and dignity… I will maintain the utmost respect for human life from the time of conception, even under threat, I will not use my medical knowledge contrary to the laws of humanity’

Article 18 of the Universal Declaration on Human Rights says: ‘Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.’

The European Commission has held in 1993 that a right to conscientious objection can be derived from article 18 of the International Covenant on Civil and Political Rights (ICCPR)

The Parliamentary Assembly of the Council of Europe (See ICCPR Article 8 and 18) supports the right to conscientious objection

5. Is the guidance clear?

Answer – No

The guidance is ambiguous and unclear on a number of crucial points.

P1 advises that good care involves ‘adequately assessing the patient’s conditions, taking account of their history (including the symptoms, and psychological, spiritual, religious, social and cultural factors)’. However p13 says that during a patient consultation doctors ‘may talk about (their) own personal beliefs only if a patient asks them directly about them or if you have reason to believe (eg. The patient has a Bible or Quran with them or some outward sign or symbol of their belief) the patient would welcome such a discussion’

We suggest that the guidance be amended to make it clear that patients may indicate they would welcome such a discussion in the course of giving a spiritual or religious history in response to sensitive questioning. Doctors should not have to rely solely on unlikely nonverbal clues (such as carrying a Bible or Quran!) to obtain this information.

Endnote 5 is insufficiently clear in its main text and footnote about doctors’ obligations with respect to abortion. The Abortion Act 1967 protects the right to refuse to participate in termination of pregnancy and the GMC made it clear in a letter to CMF in 2008 that this included the right to refuse to participate in preoperative preparation (eg, pre op assessment and clerking), signing authorisation forms and the duty to refer to other doctors who would carry out the task. This should be made explicit in the guidance.

In addition it should be made clear that doctors have a right to refuse to participate in routine postoperative care of abortion patients as this is part of the abortion procedure but not to refuse to provide treatment for postoperative complications in an emergency.

The inclusion of the Janaway case in support of the guidance is misleading as this involved a typist who was required to fulfil a clerical rather than a medical function.

P3 is currently ambiguous and should make it clear that ‘personal beliefs and cultural practices are central to the lives of all (rather than many) doctors and patients’ so as to make it clear that both religious and non-religious patients have personal beliefs and cultural practices.

6. Do you have any other comments on Personal beliefs and medical practice?

Answer – Yes

The guidance attempts to deal with two quite different areas – providing care which addresses the needs of the whole person and conscientious objection – and this results in some overlap and confusion. These two areas should either be separated out clearly in the guidance or placed in two separate guidance documents.

The draft guidance speaks (p1c (60)) of not ‘unfairly’ discriminating against patients on all the protected grounds. However this sets up a higher standard than discrimination law requires. We suggest ‘unfairly’ be amended to ‘unlawfully’.

Endnote 2 requires that doctors have an absolute duty to provide contraception to unmarried women. This should make clear that there are situations (eg. Suspected sexual abuse and coercion, Gillick incompetence) where this would be quite inappropriate.

We also believe that the grounds given (that this is required under the Equality Act 2010) are open to legal challenge for two reasons. First, ‘unmarried women’ are not a protected group under the Equality Act. The protected characteristic applies only to a person who ‘is married or is a civil partner’. Secondly, according to s28 (1) of the Equality Act the protected characteristic of ‘marriage and civil partnership’ I sonly relevant in the field of employment and does not apply to the provision of services including the provision of medical services. This is also open to a legal challenge.

It should be clearly stated that reasonable accommodation should be made for doctors who have a conscientious objection to providing certain forms of treatment. Whilst surgeries and hospitals cannot lawfully discriminate at the point of service delivery, this is a very different question to whether an individual could be accommodated in practice.