

Response of the Christian Medical Fellowship to the General Pharmaceutical Council consultation on 'Religion, Personal Values and Beliefs'

The Christian Medical Fellowship (CMF) was founded in 1949 and is an interdenominational organisation with over 5,000 British doctor members in all branches of medicine, and around 1,000 medical student members. We are the UK's largest faith-based group of health professionals. A registered charity, we are linked to about 80 similar national bodies in other countries throughout the world.

Consultation Questions:

Q1. Do you agree with the proposed changes to the wording of the examples under Standard 1 – about religion, personal values and beliefs?

No

1. Respect for conscience is essential to person-centred care

We all aspire to person-centred care. In any 'care' scenario there are (at least) two parties – the carer and the one receiving care – each of whom has rights. The GPhC proposal would shift the balance between the patient's right to 'access' and the pharmacist's right to freedom of conscience (FOC) disproportionately in favour of the patient. The proposal tips this balance so far as to suggest that 'conscientiousness' on the part of the pharmacist is a hindrance to patient care. If the pharmacist is obliged to act against his or her conscience, care is effectively coerced, the care-giver exploited and the receiver made complicit. **Person-centred care is not thereby safeguarded – it is a casualty.**

Pharmacists' professional duty is to safeguard the health interests of their patients. This will sometimes mean declining a request. Person-centred care should not be defined as meeting all requests regardless of any harm or risk this might create for the patient. Of course, a refusal to supply should be made courteously and sensitively, whether it is because the pharmacist deems the drug to be harmful or inappropriate to the best interest of the patient or because it is a request to which the pharmacist conscientiously objects.

Freedom of conscience has been a core ethical value, foundational to healthcare practice as a moral activity, from the Hippocratic Oath¹ to the GMC's Good Medical Practice.² The right of conscientious objection is not a minor or peripheral issue. It goes to the heart of medical practice as a moral activity. It helps to preserve the moral integrity of the individual clinician, acts as a safeguard against coercive state power, and provides protection from discrimination for those with minority ethical beliefs.

Respect for conscience protects society from the unthinkable. Almost every British person would disagree with the provision of medicines for use in female genital mutilation, or in state-sponsored

¹ https://www.nlm.nih.gov/hmd/greek/greek_oath.html

² http://www.gmc-uk.org/guidance/ethical_guidance/21177.asp

torture, punitive amputations or in organ removal from prisoners without their consent. These practices are legal in some jurisdictions abroad. Their existence illustrates why FOC must be retained and respected by regulatory bodies.

2. Respect for conscience is protected by laws and conventions

It is striking that the new standard and guidance lack any mention of ‘conscience’ or ‘freedom of conscience’, preferring the expression ‘religion, personal values and beliefs’. The GPhC draft proposal states that ‘Pharmacy professionals must work within the legal framework of human rights’ but fails to reflect Article 9(1) of the ECHR,³ that clearly states that everyone has the right to freedom of thought, **conscience** and religion.

We note that the European Court of Human Rights has been a robust defender of the right to freedom of conscience generally. To concisely capture the essence of the Court’s view on conscience, it is helpful to note the case of *Bayatyan v. Armenia*⁴ (Application No 23459/03, judgment of 7 July 2011). The case concerned an applicant who was looking to be exempted from military service, and the Court considered Armenia’s refusal to accommodate the applicant’s request to be a violation of Article 9 of the European Convention on Human Rights (the right to freedom of thought, conscience and religion.)

The Court held that Armenia had failed to strike a fair balance between the interests of society as a whole and those of the applicant in question. It held that the protection of the right to freedom of conscience ‘ensures cohesive and stable pluralism, and promotes religious harmony and tolerance in society’,⁵ and that a situation where no allowances were made for the exigencies of a person’s conscience and beliefs could not be seen as a necessary measure in a democratic society. The Court further reiterated that pluralism, tolerance and broadmindedness are hallmarks of a democratic society. Although individual interests must on occasion be subordinated to those of a group, democracy does not simply mean that the views of a majority must always prevail: a balance must be achieved which ensures the fair and proper treatment of people from minorities and avoids any abuse of a dominant position.⁶

In 2015 the Spanish Constitutional Court ruled that individual pharmacists have a right to refuse to sell the morning after pill for conscience reasons.⁷

With regard to pressure to resign from employment, the *Eweida* court reasoned that: ‘Given the importance in a democratic society of freedom of religion, the Court considers that, where an individual complains of a restriction on freedom of religion in the workplace, rather than holding that the possibility of changing job would negate any interference with the right, the better approach would be to weigh that possibility in the overall balance when considering whether or not the restriction was proportionate’.⁸

³ http://www.echr.coe.int/Documents/Convention_ENG.pdf, p.10

⁴ ECHR, *Bayatan v. Armenia* [GC], (2012) 54 E.H.R.R. 15.

⁵ *Id.* at § 124, 125

⁶ *Id.* at § 126

⁷ <http://www.telegraph.co.uk/news/worldnews/europe/spain/11723511/Spanish-pharmacy-wins-right-to-refuse-to-sell-morning-after-pills.html>

⁸ *Eweida and Others v. the United Kingdom*, nos. 48420/10, 59842/10, 51671/10, 36516/10, 15 January 2013.

The US Supreme Court, in its landmark 2013 ruling in *Burwell v Hobby Lobby Stores*,⁹ held that closely held corporations enjoyed the right to express religious beliefs *including with regard to contraception*. If US legislation were to have any influence on the reasoning for limiting FOC by the General Pharmaceutical Council, note should be taken of this ruling.

In 2016, the US Supreme Court did not take up the case of *Stormans v. Wiesman*, a case involving Washington state rules that force pharmacy owners and pharmacists to sell morning-after and week-after abortion pills contrary to their religious beliefs, instead of allowing them to refer customers to nearby pharmacies. Had they taken it up, the ruling in *Burwell v Hobby Lobby Stores* suggests they would have found in favour of the pharmacy owners, *Stormans*. In line with the 9th Circuit's assessment,¹⁰ it should be noted that more than just being a growing trend in the United States to protect the right of conscience of medical service providers, it is becoming the norm. The 9th Circuit ruling should therefore be viewed as more of an anomaly than anything else.

All UK health professionals are currently protected by a conscience clause¹¹ in the Human Fertilisation and Embryology Act 1990 from having to participate in 'any activity' governed by that Act. FOC is similarly protected in the 1967 Abortion Act which states: '*...no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection*'. A Parliamentary Report into Freedom of Conscience in Abortion Provision (2016) suggested several practical recommendations to strengthen provision of the protection, and also that the concept of 'Reasonable Accommodation' be incorporated into legislation in this country. The current GPhC proposals would seem to fly in the face of such recommendations.

The General Medical Council's (GMC) Good Medical Practice guidance respects the professional judgment of the doctor by stating clearly that '*the law does not require doctors to provide treatments or procedures that they have assessed as not being clinically appropriate or not of overall benefit to the patient*'. The same guidance confers protection of conscience for doctors, stating: '*You may choose to opt out of providing a particular procedure because of your personal beliefs and values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients.*'¹² Similarly, conscience is protected in Resolution 1763(2010) of The Parliamentary Assembly of the Council of Europe.¹³ As health professionals, pharmacists should enjoy similar respect and protection, and we suggest that GPhC guidance should make explicit such provision.

The GPhC could follow the example of the pharmacists' professional body, the Royal Pharmaceutical Society (RPS), in their 2013 policy statement¹⁴ designed to preserve freedom of conscience in the event of assisted suicide being legalised. This suggested an 'opt in' arrangement with a register of those pharmacists willing to dispense barbiturates for assisted suicide. Could not a similar opt-in system be brought in for those willing to dispense contentious drugs, rather than making a blanket imposition on all pharmacists?

⁹ https://www.supremecourt.gov/opinions/13pdf/13-354_olp1.pdf

¹⁰ <http://cdn.ca9.uscourts.gov/datastore/opinions/2015/07/23/12-35221.pdf>

¹¹ <http://www.legislation.gov.uk/ukpga/1990/37/section/38>

¹² http://www.gmc-uk.org/guidance/ethical_guidance/21177.asp

¹³ <http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=17909&lang=en>

¹⁴ <http://www.rpharms.com/policy-pdfs/assisted-suicide---201301.pdf>

We contend that the weight of international and national laws, conventions and professional guidance, taken together, affords strong protection for the right of conscientious objection. If the GPhC presses ahead with imposing a 'duty to dispense' it will not only be running roughshod over the professional status of pharmacists, but could also be opening itself up to a legal challenge.

3. Respect for conscience reflects the greater clinical responsibilities being undertaken by pharmacists

The contribution of community pharmacists to the provision of primary care is being actively promoted by the profession.¹⁵ According to reports, one in four GP appointments will be conducted by pharmacists or nurses under plans to relieve pressure on family doctors.¹⁶ The public are being encouraged to view their local pharmacist as first port of call, when struggling with winter coughs and colds, through NHS awareness campaigns. That the GPhC wants to diminish the space given to FOC would seem to be at odds with the increasing roles and profiles of pharmacists. Given that they are now taking on many of the roles once seen as the preserve of doctors, the GPhC should surely be protecting their freedom of conscience in a way commensurate with that shown to doctors by the GMC.

4. Respect for conscience clauses in regulations governing other healthcare professionals would be undermined if these proposals are implemented

If the GPhC presses ahead with the proposed changes, there would be implications for FOC clauses in regulations governing other healthcare professionals and government bodies. Narrowing the scope of FOC for pharmacists will likely be seen as encouragement by those who wish to remove completely the right of conscientious objection generally.

5. Respect for conscience in 'new' areas of treatment will be impeded

The proposals are not future-proofed. Most pharmacists who currently exercise their right to refer on grounds of conscience do so in response to requests for Emergency Hormone Contraception (EHC) or other, potentially abortifacient contraceptives. Future developments are likely to lead to a wider range of issues where FOC, and the right to refer, will be highly relevant. For example, the use of pre-pubertal hormone blockade, transgender hormone treatment and, if regulations on licensed premises are relaxed, the use of mifepristone and misoprostol for medical abortions in the home. If assisted suicide or euthanasia were to be legalised, the provision of barbiturates for this purpose would also be at issue.

Q2. Does the revised guidance adequately cover the broad range of situations that pharmacy professionals may find themselves in?

No.

The proposed guidance equates person-centred care with unhindered access to pharmaceuticals. It marginalises the beliefs, values and religion of pharmacists disproportionately and unnecessarily,

¹⁵ <https://www.ucl.ac.uk/pharmacy/departments/practice-policy/primarycare-twentyfirst-century>

¹⁶ <http://www.thetimes.co.uk/article/a20fb218-f3ca-11e6-b1cf-e834bbdfda95>

and trivialises their right to freedom of conscience under the law. It suggests their role is primarily to 'keep the customer satisfied' or to act as a 'rubber stamp' to decision made by others.

As it stands, the tone and language used in the draft proposal appears to require pharmacists to set aside their convictions in order to provide whatever is wanted upon request. Further, it states that if pharmacists have a problem with this, they should consider whether or not they are in the right profession. This is a needlessly confrontational posture to adopt and, as we note in section 5 below, will deter people from the profession.

The legality of treatments in connection with contraception, abortion, assisted reproduction and gender transition is not a strictly binary concept – a range of practice, varying with individual circumstances, is permitted under the law.¹⁷ A 2011 case in the US found: 'A woman's right to an abortion or to contraception does not compel a private person or entity to facilitate either'.¹⁸ The draft proposals do not fairly reflect this – they are unfairly weighted in favour of client access.

Q3. Is there anything else, not covered in the guidance that you would find useful?

It is far from clear whether or not the 'right to refer' remains. The conclusion to 'Applying the standards in practice' (p.16) says 'whilst we recognise....we want to ensure...' The choice of wording suggests a disparity of value in favour of access, if necessary at the expense of conscience.

As it stands, the proposed new Standard appears to exclude the right to refer whilst the draft Guidance appears to leave open that possibility. Greater clarity and consistency here is required.

It is also not clear to what extent the RPS and GPhC are 'on the same page'. The RPS, on the issue of assisted suicide proposed an 'opt in' approach in order to protect FOC.¹⁹ Might a similar arrangement be possible for those pharmacists who are comfortable to provide EHC and other, potentially abortifacient contraception?

We have seen no evidence that there have been widespread complaints under the present provisions. GPhC council meeting notes from 12 April 2012, specifically state that no data is collected but that 'you are aware that a *small number* of complaints are received annually on fitness to practice.'²⁰ (Emphasis added.) It is not clear how many, if any of these few complaints relate to pharmacists' FOC. We see no evidence that the new draft Standard is a *proportionate and necessary* response to, at worst, a tiny number of complaints. Could not operational changes/flexible rostering arrangements meet the actual need in most cases?

¹⁷ Matthew S. Bowman and Christopher P. Schandavel, The Harmony Between Professional Conscience Rights and Patients' Right of Access, 6 Phoenix Law Review 31, 49 (2012).

¹⁸ Planned Parenthood Ariz., Inc. v. Am. Ass'n of Pro-Life Obstetricians and Gynecologists, 257 P.3d 181 (Ariz. Ct. App. 2011) (Nos. 1 CA-CV 09-0748 & 1 CA-CV 10-0274 (consolidated)) at 196.

¹⁹ <http://www.rpharms.com/policy-pdfs/assisted-suicide---201301.pdf>

²⁰ <http://www.pharmacyregulation.org/sites/default/files/April%202012%20Council%20Review%20of%20standard%203.4.pdf>; p.3 para 4.2

Q4. Will our proposed approach to the standards and guidance have an impact on pharmacy professionals?

Yes.

Q5. Mostly negative

The new standards and guidance would have the effect of driving out of the profession those pharmacists who currently make the right to signpost/refer work for them on matters of conscience. We know of at least one pharmacist who has left the profession, in part as a result of pressures to refer.

It is likely that in at least some cases this will lead to legal proceedings against the GPhC.

Some currently in training, and others considering a career in pharmacy, will be deterred.

Existing pharmacists, who were employed under the previous standards and guidance, and for whom the right to refer protects their FOC, will be faced with a dilemma – whether to ignore the new guidance and risk disciplinary proceedings, or quit their employment.

A nominal right to freedom of conscience but denial of the right to outwork deeply held convictions would reflect badly on the pharmaceutical profession. Members of the public who are concerned about justice in the workplace would be scandalised. It would also mean that patients who have strong moral convictions may be unable to find a pharmacist who is sympathetic with their views. It is the job of the pharmacist, like any healthcare professional, to assess what is in the best interests of the patient, which necessitates having an understanding of the worldview and values of that patient. If a patient cannot access a pharmacist who shares, or at least has sympathy with her values, then she will lack confidence in the advice given by another, especially in matters such as modes of action of contraceptives. The best pharmacists see their role not simply as functional, but as building a relationship of trust with the patient, understanding her beliefs and values and advising accordingly.

The evidence base for the promotion of EHC is lacking. Indeed, there is evidence that its ready availability over the counter without prescription does nothing to decrease the number of unplanned pregnancies in a community and actually increases the level of sexually transmitted disease.²¹ Those pharmacists who wish to practise to be evidence-based will be pressured by the new proposals if adopted, regardless of their religion, beliefs and values.

Q6. Will our proposed approach to the standards and guidance have an impact on employers?

Yes.

Q7. Mostly negative

The GPhC, like any other professional body, is obliged by the Equality Act 2010 to recognise religion as a 'protected characteristic'. Under the Human Rights Act 1998, it is similarly obliged to remain

²¹ <https://www.ncbi.nlm.nih.gov/pubmed/21288585>

neutral in the application of its guidance and policies where Article 9 is involved. In our view, the new proposals fail to meet these obligations and set a bad example to other regulatory bodies.

The proposals fail adequately to observe the legal obligation upon employers to balance their own interests with respect for the sincerely held religious and moral beliefs of employees. If adopted without amendment, the proposals would set a precedent - 'coercion to comply' or 'duty to dispense' - that some other employers might find convenient to emulate.

It is likely that employers will face legal action brought by pharmacists who lose their jobs as a result of a refusal to provide certain contentious drugs for reasons of conscience.

Those employers who set great store by the welfare of their employees will experience this as a negative change, because it will be clear that staff who face issues of conscience over the provision of certain contentious drugs are unsettled and effectively coerced by the new standards and guidance. To avoid losing those staff they may have to ensure that another pharmacist, who does not share the same scruples, is always available alongside, with consequent impact on rosters, efficiency and costs.

Q8. Will our proposed approach to the standards and guidance have an impact on people using pharmacy services?

Yes

Q9. Mostly negative

The proposal would act as a bar into the profession for future pharmacists and thus deny some clients the option of access to pharmacists who share their own views on life and ethics. For such clients, this would not be consistent with person-centred care. True access should enable clients to see pharmacists whom they are confident will act in their best interests because they share the same values.

The GPhC exceeds its competency in suggesting what should be the boundaries of a pharmacist's moral views or those of a client who may wish to be cared for by health professionals who share her values.

Service users want service providers to be protected from coercive management practices.

Q10. Do you have any comments?

In summary, the proposals:

- take a 'sledgehammer to a walnut' approach. No evidence is given that the present guidance has undermined person-centred care;
- replace the current 'right to refer' with a 'duty to dispense' along with 'coercion to comply';

- fail to account for the fundamental importance of FOC as central to the practice of ethical healthcare;
- do not properly reflect the protection in law provided for FOC and as such are open to legal challenge;
- unfairly discriminate against both pharmacists who hold the (mainstream) view that life begins at fertilisation, and those clients who wish to be cared for by them;
- will drive some currently practising pharmacists out of the profession and discourage others from applying to enter it;

We propose:

- that the word ‘conscience’ or the phrase ‘freedom of conscience’ should be included in both the title of the consultation and as appropriate in the text. The wording should recognise that some pharmacists will object conscientiously on ethical grounds that are not religiously inspired;
- that the wording of the examples under Standard 1 (p. 11) be changed to:
People receive safe and effective care when pharmacy professionals:
 - a) use their professional expertise and judgment to act in the best interests of their patients
 - b) person-centred care is consistent with sometimes declining a request sensitively and courteously, either because it is deemed harmful or inappropriate or because the pharmacist conscientiously objects;
- that the sentences “recognise that in some cases a referral may not be the right option, or enough, to ensure person-centred care is not compromised” and “work with the person to come to an informed decision about how they can access the care and services they need” be removed. As they stand, the wording implies the pharmacist is under an obligation to provide medication he or she may not think is in the best health interests of the patient. The guidance is intended to define ethical standards for the profession; it cannot require its members to act in a way they would consider unethical;
- that reference be made to ECHR legislation, not simply the Equality Act;
- that one of the following be used (we prefer the third):
 - i) the original wording, allowing a ‘right to refer’ rather than imposing a ‘duty to dispense’;
 - ii) an equivalent phrasing to that used in the GMC document ‘Personal, Beliefs and Medical Practice’ that permits the clinician to ‘opt out of providing a particular procedure because of [your] personal beliefs and values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients’. In such situations, a doctor must ensure the patient understands her right to see another practitioner and has the necessary information to exercise that right;
 - iii) an opt-in system as suggested by the Royal Pharmaceutical Society for assisted suicide.

