Submission by the Catholic Medical Association (UK) to the General Medical Council public consultation on 13/06/2012 in response to:-

Personal beliefs and medical practice. A draft for consultation.

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

YES.

It could be helpful to have guidance from the GMC on the issue of religious belief of both patients and doctors and then separately on the issue of conscientious objection to treatment or non-treatment options on the part of either party.

However, whilst there are sections which demonstrate equal respect for all involved in the clinical relationship in which no one remains completely unaffected by the encounter of at least two sets of human rights and needs, much of the draft betrays bias in favour of aggressive secularism as the only accepted source of objectivity. This undermines the authority of constructive sections which appear more respectful of all in our multi-cultural society, forgetting that doctors are drawn from this society and will be, on occasion, both patients and relatives of patients.

There are fundamental errors in the draft.

In the 2001 census, 9 million declared themselves of no religious belief. Whether atheists, agnostics, secular humanists or others, at that time they comprised 20% of the total population in Britain. The National Secular Society, whose previous submission in 2007 appears to be the inspiration of much of the draft guidance numbers 7 000 to 10 000 based on declared income. The British Humanist Association numbers 28 000 members and supporters.

In the 2001 census, 41 million recorded some religious or philosophical belief system. It is difficult to understand why 80% of the population are regarded with such suspicion by the draft's authors to the degree that the believing majority are judged unfit to produce future doctors. Should such doctors qualify with their belief systems intact, these must be sacrificed on the assumption that they could be detrimental to patients' effective, competent and compassionate care.

It is not the experience of members of the 'Catholic Medical Association (UK) that their non-believing relatives, friends and colleagues are uniformly opposed to the freedom of expression of believers. Nor are they all in favour of abortion, euthanasia or the creation and destruction of human life as a result of those contraceptives which prevent the implantation of a fertilised egg in the uterus.

There is a difference between religious belief resulting in objection to procedures which destroy human life or respect for its status at any age and conscientious objection in which individuals may reach the same conclusions. Neither can be devalued or trampled underfoot

without uncritically embracing other philosophies which, historically, have caused the vulnerable to suffer on a huge scale.

It is an error to deny doctors the same level of human rights as their patients for holding beliefs which are permitted in all reputable countries of the world. To do this on the pretext that this is positive discrimination in favour of the more vulnerable in the clinical relationship patronises patients and reduces doctors to automatons.

Finally, the lack of appreciation of the positive effects on clinical practice of a carefully considered religious belief system appears to unleash an overtly adversarial tone throughout most of the draft. That a doctor treating a patient happens to be a Catholic who believes in a Creator of unconditional love with whom they are in a prayer relationship and that this experience spills over into the belief that every patient before them is of equal importance to their own status is hardly the stuff of patient nightmares.

Question.

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 object to treatments or procedures on the grounds of conscience, even if the right to conscientiously object is not supported by legislation.

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

YES.

Comments.

Self-determination is given maximal status in legal cases where a competent patient is refusing treatment. There is often a 'lag phase' between the provision of a new procedure and case law in the British legal system. Therefore, prohibiting conscientious objection for months and even years until case law is established by precedent would infringe a doctor's right to self-determination as a human being with equal rights to their patient.

If a conscientious objection forms part of a doctor's integral world view on an issue, compelling them to comply with the provision of a treatment which they believe to be inherently morally wrong and therefore damaging to the patient or to others who will be adversely affected will inevitably also adversely affect the doctor over time. Increased mental health problems, relationship breakdowns or emigration of those who have been trained at considerable expense in Britain could be predictable consequences.

Any acceptance of the denial by the GMC of the right of doctors to freedom of thought, conscience and religion, as enshrined by Article 18 of the United Nations Universal Declaration of Human Rights in 1948, would do little to enhance the international status of doctors practising in Britain.

Short-term political expediency and legislation crafted by lobbyists with views not necessarily held by the majority may occur in any apathetic democracy. Requiring doctors to adhere uncritically to orders which result in jettisoning conscientious standards of care would ill become the GMC unless it wishes to finally renounce on our behalf the claim of medicine to be one of the professions, with all which this should entail.

Question.

At paragraph 5, we explain that gender reassignment is only sought by a particular group of patients and cannot therefore be subject to a conscientious objection.

Question 3 Is the guidance on gender reassignment clear?

NO.

The footnote to paragraph 5 is bizarre and appears to be a misreading of the intention of the Equality Act 2010 in ensuring normal standards of treatment for these particular groups of patients, not the provision of such characteristics.

Those seeking gender reassignment are not medically one distinct group and the evidence-base behind treatment options and their timing is currently under debate between specialists of world renown.

Of significance are the ethical issues involved in the management of distressed, pre-pubertal children with gender dysmorphism and the long-term implications of hormonal treatment before puberty in the event of psychological or social influences, long before any considerations of surgery. It seems that it is only surgery which is being addressed here.

It appears rather dismissive of the rights of families to be given honest information, including current levels of apparent uncertainty to demand that no doctor could have a conscientious objection to the provision of hormonal treatment to pre-pubertal children when there is still clinical debate about best practice and eventual gender identity differences asserted by specialists at different centres of excellence.

The footnote also ignores the group born with ambiguous genitalia who have publicly expressed regret about decisions made on their behalf by doctors and their parents whilst they were very young.

This is too complex and sensitive an area to simply label all such adults and children as a particular group covered by the Equality Act regardless of their individual needs, apparently requiring high profile protection from doctors hampered in their judgement by religious beliefs: this smacks of coercive and poorly informed political correctness.

Question.

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

YES.

References to international law and the rights and duties of doctors to act according to their consciences need to be included. The lack of such references would give the impression that the GMC does not intend to comply with such law and that omissions could facilitate disciplinary test cases against doctors who would inevitably appeal in both domestic and European courts.

The following references would be a minimum:-

The right to conscientious objection concerning abortion and euthanasia was upheld by the Parliamentary Assembly of the Council of Europe Articles 8 and 18, also resolution 1763 in 2010 in the face of an attempt to cancel the right of healthcare workers with reference to abortion. Whilst local guidance to interpret this was suggested for member states, only the Swedish parliament has indicated their intention to try to reverse this resolution and prevent any conscientious objector rights to healthcare workers regarding abortion.

The right of conscience is found in the Universal Declaration of Human Rights (1948) Article 18, the European Convention on Human Rights (1950) Article 9, the International Covenant on Civil and Political Rights (1966) Article 18. In 1993, the European Commission held that a right to conscientious objection can be derived from the latter.

Considering national law. With the exception of Northern Ireland, the Abortion Act (1967) Section 4(1), is permissive of abortion in certain circumstances but has always protected the right of doctors and others to refuse to participate in abortions.

In 2008 the GMC clarified the remit of this right and this should be included in the guidance on personal beliefs. The Christian Medical Fellowship were informed that the right of refusal includes not only pre-operative preparation of the patient but also signing authorisation forms, the duty to refer to other doctors who would carry out the procedure and routine post-operative care of abortion patients "as this is part of the abortion procedure". Clearly, there is no right to refuse to provide treatment for post-operative complications in an emergency.

The Human Fertilization and Embryology Act 1990 prevents any duty being placed on an individual to participate in any activity governed by the Act.

Finally, the aims of the NHS Employers' Organisation in relation to equality and diversity would give a more positive and constructive example to the authors of the draft guidance with their statements as follows:-

"Investing in a diverse NHS workforce enables us to deliver a better service and improve patient care in the NHS".

"Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential".

"Diversity is about recognising and valuing difference in its broadest sense."

Question

Question 5. Is the guidance clear?

NO.

In paragraph 4, the freedom of doctors to practise medicine in accordance with their beliefs depends on the avoidance of "causing distress to patients." This is fair and requires courtesy and respect from the doctor. However, there must be awareness in the GMC that spurious complaints are not unknown and this phrase needs refining to protect doctors from malice.

The phrase referring to the denial of patients' access to "appropriate medical treatment" implies that if a doctor exercises a conscientious objection, when they cannot support a treatment option in an individual circumstance or because it is inherently harmful, that doctor must lack objective judgement and the patient is assumed to have selected an appropriate option by virtue of selecting it.

In paragraph 3 it is stated:-

"**Neither do we wish to prevent patients from receiving care which is consistent with or meets the requirements of their beliefs and values."**

There is a lack of clarity and foresight in this statement since, if the draft guidance were implemented, such patient access would clearly be threatened. If many doctors with belief systems held by a substantial proportion of the population are hounded out of practice, how will such patients access a doctor who is comfortable with patients who also have religious or conscientious objections to some treatment options?

To protect access to a fertility management option, should all GPs and all gynaecologists be required to become proficient in offering modern methods of Natural Family Planning since this is the only method acceptable to some religious and ecological groups of patients?

Endnote 5: Care of patients pre- and post- termination of pregnancy.

"When a patient who is awaiting or had undergone a termination of pregnancy needs medical care, you have no legal right to refuse to provide it on grounds of a conscientious objection to the procedure."

The term "medical care" needs clarifying. If this refers to treatment of other concurrent conditions or of postoperative emergency complication of the abortion, then this is already accepted by conscientious objectors. Out of respect to the freedom of the woman in the days

before an abortion, her final decision should not be taken for granted. Women do change their minds until the last minute and new medications should not be selected which are associated with a high risk of miscarriage or foetal abnormalities whilst established ones should be discussed with the patient.

If the term "medical care" is an attempt to undermine the current GMC advice of 2008 to the Christian Medical Fellowship or to reduce the impact of the conscience clause of the 1967 Abortion Act, this will not be legally or ethically acceptable.

Question.

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

YES.

The draft guidance states in paragraph 4:-

"However, in many cases there is no law that specifies patients or doctors' rights in relation to individual procedures. In these cases doctors should be free to practise medicine in accordance with their beliefs, provided that in doing so they are not denying patients access to appropriate medical care or services, or causing distress to patients.

In these circumstances we expect doctors to be prepared to set aside their personal beliefs so they can provide effective patient care in line with 'Good Medical Practice'.

The draft in Question 2 already asks whether doctors should still be allowed a conscientious objection where a treatment or procedure has not been the subject of legislation specifying this right. Since this is clearly in the minds of authors as an area where they wish to circumscribe such freedom, in this context, the assumption that such doctors will inevitably deny patients "appropriate" and "effective" medical care and distress them implies that doctors with either religious or secular conscientious objections are inappropriate and ineffectual in their approach to patient care. Such doctors, however respectful, honest and courteous their approach to patients and colleagues with different ethical views, apparently present a problem which must be firmly suppressed.

Many of these matters involve killing other human beings and the euphemisms used fail to conceal the reality to anyone in clinical practice – whatever their ethical views.

The assertion that as soon as a doctor's views become irksome to systems and colleagues or potentially distressing to patients, they must abandon central beliefs has confirmed the resolve of many doctors that should the draft guidance be approved with its current injustice, domestic and European courts will be kept occupied with legal challenges for many years to come and international law would mandate opposition to such threats to human rights.

Considering the inevitable consequences of failing to value those who reflect conscientiously on the ethics of current and future medical practice – whether as patients or doctors – these include a tendency towards extreme practices and a lower standard of clinical care in the long-term. This would occur most rapidly in the area of assuming there should be no problem

with conscientious objectors facilitating referral to colleagues selected for their greater compliance in administering treatment not believed to be in the best interest of the patient by the referring doctor. Catholic moral theologians describe this as 'co operating in evil'.

Conscientious objectors cannot be expected to contribute to such a decrease in ethical standards as even the most heinous procedure – unacceptable to nearly all clinicians – would then be facilitated by the majority whilst seeking a colleague who would comply with the patient's wishes. Medical confidentiality would further increase the tendency for pockets of shocking practice in a geographical area or specialist department. The GMC would then express consternation that no one blew the whistle early on in the deterioration in ethical standards.

Re Endnote 2: Contraception.

The acceptance of the right of conscientious objections to providing contraception is welcome, especially as so many have a mode of action which, on occasion, includes an anti-nidatory effect. The prohibition against distinguishing between married and unmarried women will not affect doctors who prescribe to neither group. However this does not deal with the far more common concern amongst GPs when they are faced with a young girl who is accompanied by her mother or her new, older boyfriend and it is feasible that the girl is under duress to accept treatment which is not without potential side-effects. The mother may be insisting on an appointment for her 14 year old daughter for administration of a long-acting contraceptive including implants "to get her fixed up" when both insist that she is not sexually active. The older boyfriend may be coercing her into early sexual activity and well-versed in how to coach her to pass any area of competence, whether Gillick or Fraser.

The area of focus for issues relating to children and young people in **Endnote 7 is on what to do "if you have concerns that a child's physical or emotional wellbeing is being compromised by their parent's religious or cultural beliefs or practices."**

It is laudable to remind doctors of their serious duty of care to children who are vulnerable to forced marriage or being taken abroad for female genital mutilation. It is less laudable to ignore the positive aspects of religious parents' wish to protect their children from predation from paedophiles or the spiritual, psychological and physical risks of sexual activity in the early teens and, indeed, outside the more stable environment of marriage between consenting adults.

If this draft guidance from the GMC on personal beliefs and medical practice is not radically overhauled to reflect a multi-cultural society with a need for mutual respect and willingness to find common ground and systems which do not attempt to ban the rights of the 80% of those with a religious belief system in Britain, then it will become notorious for its lack of balance and eventually for its deleterious effect on standards of care and professionalism of doctors working in Britain.

The guidance represents a low point in attitudes towards religious belief and rights of conscience. Being couched in suspicious and adversarial language, it disrespects religious patients as well as clinicians. It is to be hoped that there will be reflection within the GMC on how the august body advising doctors and regulating their practice permitted such an unbalanced draft document to reach public consultation stage with religious bigotry misrepresented as tolerance and the protection of all in our multi-cultural society.