RESPONSE OF THE CATHOLIC MEDICAL ASSOCIATION TO THE GENERAL PHARMACEUTICAL COUNCIL CONSULTATION ON 'RELIGION, PERSONAL VALUES AND BELIEFS'.

This response is not confidential

Submitted on behalf of the Catholic Medical Association by Dr Philip Howard, President of the CMA

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Please provide a brief description of what your organisation does and its interest in this consultation:

The Catholic Medical Association (UK) represents Catholic doctors, nurses, pharmacists, hospital chaplains and other healthcare professionals within the UK. It celebrated its centenary in 2011. The CMA has its own charity, the Catholic Medical Missionary Society, to support medical projects in the Developing World.

5.03.17

Standards

Standard 1 says that:

Pharmacy professionals must provide person-centred care

Applying the standard

Every person is an individual with their own values, needs and concerns. Person-centred care is delivered when pharmacy professionals understand what is important to the individual and then adapt the care to meet their needs – making the care of the person their first priority. All pharmacy professionals can demonstrate 'person-centredness', whether or not they provide care directly, by thinking about the impact their decisions have on people. There are a number of ways to meet this standard, and below are examples of the attitudes and behaviours expected.

It is proposed that the wording of the examples under Standard 1, regarding religion, personal values and beliefs, will say:

People receive safe and effective care when pharmacy professionals:

• *Recognise their own values and beliefs but do not impose them on other people [unchanged / retained example]*

• *Take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs [revised example]*

1. Do you agree with the proposed changes?

No

1a. Please explain your reasons for this.

The Catholic Medical Association welcomes this opportunity to respond to the consultation on the proposed amendment to Standard 1 of the Standards for Pharmacists and on the accompanying guidance. We agree with the General Pharmaceutical Council (GPhC) that "*This is a complex and difficult area for pharmacy professionals, with significant and emerging case law.... Pharmacy professionals should familiarise themselves with the law as it applies to them and obtain legal or other professional advice, as needed. They should also keep up to date with any changes to the law, which might impact on them."*

The GPhC has statutory roles both in 'professional' regulation of individual pharmacists as well as in relation to 'system' regulation of registered pharmacies. Nevertheless, the GPhC also warns that the guidance "*cannot cover every situation in practice and it does not provide legal advice on equality related issues. Additionally, pharmacy professionals must consider the contractual responsibilities of their employer, including any in the NHS Terms of Service".*

In this submission we explore some of the ethical and legal complexity particularly as it affects those with conscientious objections and the issue of referral where the proposed treatment is ethically problematic. We also consider this proposed radical change to the approach to ethics within the Pharmacy profession. We are concerned that the new standards and guidance effectively prioritises the views and wishes of the patient over the ethical position of the pharmacist. This reduces an objective set of ethical standards to a subjective standard set by the views and wishes of the user of pharmacy services. This new approach not only affects freedom of conscience, thought and religion but may also breach the Equality Act 2010.

Freedom of thought conscience and religion.

The new Standard 1 shifts the previous emphasis on treatment which aims to benefit the patient whilst maintaining safety and avoiding harm towards an ethic which prioritises the patient's wishes in the provision of goods and services even when there is a conflict between the person's views and the professional and ethical judgement of the pharmacist.

We note that there have been fundamental changes to Standard 1 which were not part of the initial consultation. In the original consultation in April 2016, Standard 1 included under person centred care a need to "*recognise their own values and beliefs but do not impose them on other people [and] tell relevant health professionals, employers or others if their own values or beliefs prevent them from providing care, and refer people to other providers."* This has since been changed to a requirement to "*recognise their own values and beliefs but do not impose them on other people [and] take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs".*

The GPhC has now advised that:

> *"These proposals will change the expectations placed on pharmacy professionals when their religion, personal values or beliefs might – in certain circumstances – impact on their ability to provide services. They will shift the balance in favour of the needs and rights of the person in their care.*
>
> *We also want to highlight that, under the new proposals, a referral to another service provider might not be the right option, or enough, to ensure that person-centred care is not compromised. This is a significant change from the present position and it is vital that we hear from the public and the profession about this.*
>
> *The standards are explicit in calling for pharmacy professionals to use their professional judgement to ensure the care they provide reflects the needs of the person and is not influenced by personal or organisational goals".*

This is a radical and recent departure from the previous ethical code of the Pharmaceutical Council and the Royal Pharmaceutical Society. It is also very different to the position taken by the Pharmaceutical Society of Northern Ireland. The GPhC has hitherto stressed that *"our role is to protect, promote and maintain the health, safety and wellbeing of patients and the public who use pharmaceutical services in England, Scotland and Wales."* Furthermore, the GPhC has previously and rightly acknowledged that the Standards for Registered Pharmacists *"must ensure they have adequate governance arrangements in place to protect the health, safety and wellbeing of patients and the public and specifically safeguarding children and adults at risk."*

The Council minutes for 8th September 2016 set out the GPhC's approach to assessing the impact of its regulatory policy work in terms of equality, diversity and inclusion.

> *"1.1 Our commitment to equality encompasses and builds on our duty, as a public authority to:*
>
> *• eliminate unlawful discrimination, harassment and victimisation and any other conduct outlawed under the Equality Act 2010*
>
> *• advance equality of opportunity between people who share a legally protected characteristic and those who do not; and*
>
> *• foster good relations between people who share a protected characteristic and those who do not*
>
> *1.2 Our commitment to diversity is founded on our positive appreciation of the differences between people as a social good and as a business asset. The public whom we serve, and the professions with which we work, are themselves extraordinarily diverse. We see diversity in our organisation as a source of strength and innovation, with the potential to improve the quality and outcomes of what we do. In valuing diversity we appreciate the benefits that we as individuals and teams can gain from the fact that we all think and work in different ways.*
>
> *Our commitment to inclusion is about being proactive in facilitating opportunities for people with the widest possible range of experiences and perspectives to engage with and influence our values, our culture, our strategy and the work we do. We aim in this way to take an*

inclusive approach to working with users of pharmacy services, registrants, stakeholders and indeed people affected in any way by our decisions, as well as our own GPhC workforce (in the widest sense).

The standards of conduct, ethics and performance (July 2012) rightly prioritised the seven key principles for pharmacy professionals:

1. *Make patients your first concern*
2. *Use your professional judgement in the interests of patients and the public*
3. *Show respect for others*
4. *Encourage patients and the public to participate in decisions about their care*
5. *Develop your professional knowledge and competence*
6. *Be honest and trustworthy*
7. *Take responsibility for your working practices.*

Under the first principle it was made clear that "*The care, well-being and safety of patients are at the heart of professional practice".* To this end services should be safe and of an acceptable quality to promote the health of patients and the public. Pharmacists should use their "*professional judgement in the interests of patients and the public."*

Where there was a conflict between the ethical position of the pharmacist and patient it was important "to respect and protect people's dignity and privacy [and] make sure that if your *religious or moral beliefs prevent you from providing a service, you tell the relevant people or authorities and refer patients and the public to other providers."*

The GPhC has previously advocated openness, honesty and integrity in order to maintain the trust and confidence of patients and the public. Where actual or potential ethical difficulties may affect the provision of services, the pharmacists should make their views known in advance and there should be reasonable accommodation so as to avoid actual or potential conflicts.

The new standard.

According to the consultation, pharmacists must now provide person centred care which applies when "*pharmacy professionals understand what is important to the individual and then adapt the care to meet their needs – making the care of the person their first priority."*

There are a number of reasons why this new approach of the GPhC is deeply problematic.

First, it redefines the purpose of healthcare which is no longer seen primarily as for the benefit of patients and the avoidance of harm but viewed as a means of satisfying their wishes.

Second, it substitutes an objective view of ethics with a subjective standard. Ethics are no longer to be judged objectively but rather subjectively according to the wishes of the patient. Hence, what is deemed right or wrong will vary between individuals according to circumstances.

Third, the views and wishes of the individual patient will be prioritised over those of the Pharmacist and the profession. This may occur even when there is a wide spectrum of views amongst patients and the public on particular issues.

The purpose of healthcare

The purpose of medicine and all healthcare is to benefit the sick. According to the Hippocratic Oath "*I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing*." The fundamental purpose of benefit has three separate but related aspects. First, the treatment and cure of disease. Second, the relief of symptoms (palliation). Third, the restoration of mental and physical functioning.

The purpose of medicine, within the Hippocratic tradition, is essentially positive but necessarily also involves the avoidance of deliberate harm and especially of direct killing through physician assisted suicide, euthanasia or abortion. "*I will give no deadly drug to any though it be asked of me, nor will I counsel such...I will not give a woman a pessary to induce an abortion."* A necessary precondition of all ethical clinical practice is that the practitioner acts with integrity according to objective standards.

Objective versus subjective ethics

The proposed new ethical standard is subjectively defined in relation to the known or presumed views of the patient. This poses the obvious difficulty for the Pharmacist of actually knowing what the views and wishes of the patient are other than that the customer wants a particular prescription. This could encourage enquiries by the Pharmacist which might be regarded as intrusive. Alternatively, if the views of the client must be taken at face value, it would reduce the dispensing of medication to a simple transaction justified only by the customer's wishes. This means that the Pharmacists would no longer be employed to provide a professional service for the patient. Instead they would be employed on a contract to supply goods to the customer.

As discussed below, a subjective ethics, determined by the customer, would create difficulties if the medication was not required, or even contraindicated, in the case of safeguarding issues or when the pharmacist knew or suspected that the customer might use the medication for harmful or illegal purposes.

Under the proposed recommendations a requirement of the pharmacist to explore and understand the views of the patient might be seen to be unduly intrusive. In addition, in the event of any disciplinary proceedings against the pharmacist there would be a serious risk of breaching the confidentiality of the patient in any public hearing. There is also a risk of a tribunal applying arbitrary or even conflicting standards, over controversial issues such as the prescription of contraceptives to underage girls, especially where safeguarding issues were involved (see below).

It must be borne in mind that pharmacists are taking on ever increasing roles which traditionally would have been the responsibility of a physician. For instance some pharmacists run open clinics within GP surgeries and prescribe drugs autonomously. Therefore, pharmacists must be allowed to exercise their professional judgment in the care of patients in the same way as a doctor rather than being subject to standards based on subjective ethics.

Pharmacists must be able to maintain their integrity and consciences and to decline to participate in care that they reasonably believe to be harmful to the patient or to others.

Conscientious objection

Freedom of conscience is essential for the freedom of every human being and should be recognised in professional practice and safeguarded by law. No authority has the right to interfere with a person's conscience. Conscience bears witness to the unique importance and freedom of the individual and as such is inviolable.

Conscience bears a relationship to objective truth and ethical standards. To deny an individual freedom of conscience — and in particular the freedom to seek the truth — or to attempt to impose a particular way of seeing the truth, constitutes a violation of that individual's most personal rights. To claim that one has a right to act according to conscience, but without at the same time acknowledging the duty to conform one's conscience to the truth, means nothing more than relying on one's own limited personal opinion.

Religion and religious belief

The European Court of Human Rights has held that "*the right to freedom of religion as guaranteed under the Convention excludes any discretion on the part of the State to determine whether religious beliefs or the means used to express such beliefs are legitimate*." Religion must have a clear structure and belief system. Therefore a regulatory framework that operates within the law must not deny professionals the rights of freedom of conscience, religion and belief.

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

No

Patient care and the values and beliefs of Pharmacists.

It would not be possible to deal in detail with the range of issues which might involve actual or potential conflicts between the wishes of the client and the values and beliefs of Pharmacists. The examples given below are therefore used to illustrate the type of problems that could arise if the views of the patient were to become determinative as a matter of principle.

Harmful or inappropriate treatment

By substituting the customer's wishes for a decision regarding beneficial treatment, there is a risk that the professional role of the pharmacist will be reduced including their essential role in ensuring the safety and wellbeing of the patient. Moreover, it might also imply a duty to provide treatment where it is otherwise considered inappropriate or harmful. An example of this would be the excessive use of hydrocortisone cream for facial rashes. This is in contrast to the GMC advice for doctors in 'Personal beliefs and medical practice, 2013) 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''*.

Prescription of contraceptives

Caroline Bacon was 14 when she was first prescribed oral contraceptives without the knowledge or consent of her parents. She suffered from basilar migraine and sustained a brain stem stroke from which she died on 1st May 1994. The inquest gave bronchopneumonia as the cause of death. The then Prime Minister, Tony Blair, ordered a review in to the circumstances of her death. Basilar migraine is recognised as a contraindication to the use of contraceptives (Source BBC News 11.8.1998).

This case clearly raises a number of issues aside the moral issue of contraceptive usage, per se. First, the issue of prescribing contraceptives to girls under the age of 16 years at a time when sexual intercourse with a minor is criminal. Second, the issue of potential side effects, which in the above instance proved fatal. Third, the issue of parental involvement and consent to treatment.

Lord Fraser commented in the case of Gillick: "*in the overwhelming majority of cases, the best judges of a child's welfare are his or her parents.*" The Fraser Guidelines, arising from the House of Lords decision in Gillick provide legal guidelines on medical treatment and advice on sexually transmissible diseases, contraception and abortion. The Guidelines cover a range of professional considerations which have to be strictly observed, including the maturity and understanding of the girl to all the relevant matters including family and moral aspects, the inability to persuade her to involve her parents on sexual matters, or find another adult for support, that the girl is likely to continue to engage in sexual intercourse and that without advice and treatment her physical or mental health is likely to suffer and it is considered to be in her best interest to receive such advice and treatment on sexual matters.

The application of the Fraser Guidelines therefore requires professional discretion and emphatically does not permit an approach which simply seeks to determine and fulfil the wishes of the client without the option of professional discretion or referral. As Lord Fraser stated at page 174E the Guidelines were "*not to be regarded as a licence for doctors to disregard the wishes of parents on this matter whenever they find it convenient to do so. Any doctor who behaves in such a way would be failing to discharge his professional responsibilities, and I would accordingly expect him to be disciplined by his own professional body accordingly*."

Prescription and dispensing of abortifacient drugs

Abortion raises the issue of conscientious objection and the conscience clauses of the Abortion Act 1967 and the Human Fertilisation and Embryology Act 1990. Hence, under section 4(1) of the Abortion Act "*no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment…to which he has a conscientious objection*." At the time of the Abortion Act most terminations of pregnancy were surgical though currently most abortions are medically induced. They will therefore involve hospital pharmacists for 'late' and community based pharmacists for 'early' abortions. For medical abortions, the prescription and dispensing of medication is a necessary and integral part of the procedure. The rights of conscientious objection should therefore be recognised by the GPhC and pharmacists who refuse to take part in abortion should not be penalised or disciplined. Many of our Jewish and Muslim pharmacist colleagues would share our objection to participating in abortion.

Assisted suicide and euthanasia.

Assisted suicide and euthanasia are currently illegal. However, we are concerned that the GPhC Scotland would seek to accommodate assisted suicide if the Assisted Suicide (Scotland) Bill was

enacted. In their response to the proposed legislation the GPhC stated that whilst it "is our job to protect, promote and maintain the health, safety and wellbeing of patients and the public who use pharmaceutical services" the GPhC works within "*the relevant legal and political context.*" Whilst recognising that the GPhC "*standards of conduct, ethics and performance already recognise that a pharmacist or pharmacy technician's religious or moral beliefs may prevent them from providing a particular professional service. If this is the case, our standards require that pharmacists and pharmacy technicians tell the relevant people or authorities and refer patients and the public to other providers."Furthermore, it was made clear that "If legislation on assisted suicide were to be passed in Scotland, the GPhC would wish to engage with Scottish Government, regulatory bodies, patients, the pharmacy profession and others to ensure our standards took account of the new legislative framework and its wider implications."*

In the light of new Standard 1 the implication would be that the individual ethical views of the pharmacist would be not be taken into account and pharmacists would be required to provide the necessary medication for assisted suicide (or euthanasia) to satisfy the wishes of the person.

This is in sharp contrast to the principled position taken by Pfizer in April 2016 regarding the use of their medication in capital punishment. "*Pfizer makes its products to enhance and save the lives of the patients we serve. Consistent with these values, Pfizer strongly objects to the use of its products as lethal injections for capital punishment. Pfizer's obligation is to ensure the availability of our products to patients who rely on them for medically necessary purposes*." Both the American Medical Association and the American Nurses Association have consistently held that participation in executions is unethical.

3. Is there anything else, not covered in the guidance that you would find useful? Please give details.

Safeguarding and protection against abuse and neglect

The GPhC is setting a new standard in relation to person centred care and is in danger of overlooking the needs of children and vulnerable adults in relation to abuse, neglect and safeguarding issues.

For example, in the Caroline Bacon case, there are issues in relation to fatal harm and parental involvement in decision-making. Where there is underage sexual activity it is important to consider sexual crime and exploitation in line with UK law.

Harassment and victimisation in the workplace.

It is also important to emphasise that customers must also recognise and respect the religious views and beliefs of Pharmacists and the need to respect their views in the workplace. There must be recognition that some Pharmacists will not feel able to provide certain services. It also means that staff have a right to be protected from abusive behaviour from customers and from discrimination by employers.

Contractual arrangements.

It is essential that the roles and responsibilities of employers towards staff are acknowledged. There should be reasonable accommodation of the views of Pharmacists. The need to notify employers of any ethical difficulties which may arise as a result of conscientious objection should be emphasised.

Conversely, in relation to the role as regulators of Pharmacies, the GPhC must emphasise the importance of the provisions of the EU2000 Employment Equality Directive and the Equality Act 2010. This is particularly relevant in relation to contracts for service provision, employment contracts and disciplinary processes.

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

Yes

5. Will the impact be:

- ○ Mostly positive
- ○ Partly positive
- ○ Positive and negative
- ○ Partly negative
- ◉ Mostly negative

5a. Please explain and give examples

The GPhC is a regulator of Pharmacists and Pharmacies and other providers. It has a role in setting standards and in disciplinary processes. As a public body and regulator it is subject to the provisions of EU law, the Human Rights Act 1998 and the Equality Act 2010.

European and domestic equality legislation

The 2000 Employment Equality Directive imposed a duty on the EU Member States to provide protection against discrimination on the grounds – among others - of religion or belief in the areas of employment, occupation and vocational training. Freedom of religion and belief is a fundamental human right guaranteed by the European Union Charter of Fundamental Rights (EUCFR) and Article 9(1) of the European Convention on Human Rights (ECHR). The EUCFR became binding in 2009 with the coming into force of the Lisbon Treaty and contains the right to freedom of thought and conscience in Article 10 which echoes Article 9(1) of the ECHR. Protection against religion and belief discrimination in the EU and in the Member States is provided in two different ways: through human rights law and through anti-discrimination law. Freedom of belief, conscience and religion is protected by domestic law in the Human Rights Act 1998 and the Equality Act 2010.

The effective implementation of the principle of equality requires adequate judicial protection against victimisation and harassment. Protection is particularly important in relation to employment and occupation, including selection, recruitment, training, working conditions, dismissals and pay. It is particularly important to members of professions and the membership and benefits of professional organisations. Under both European and domestic law there must be adequate judicial and/or administrative and regulatory procedures to ensure compliance and for the avoidance of discrimination. Where persons consider themselves wronged, the burden of proof rests with the respondent to prove that there has been no breach of the principle of equal treatment. Employees

must be protected against harassment and victimisation within the legal and judicial procedures. Equal treatment should be fostered by dialogue, collective agreements, codes of conduct and good practice.

Under section 53 of the Equality Act 2010 a qualifications body must not discriminate in the way a qualification is conferred or withdrawn or subject anyone to harassment. A relevant qualification is an authorisation, qualification, recognition, enrolment, approval or certification which is needed for, or facilitates engagement in, a particular trade or profession.

Harassment and discrimination

Harassment in relation to religion or belief is a form of prohibited discrimination which has the purpose or effect of violating the dignity of a person and of creating an intimidating, hostile, degrading, humiliating or offensive environment.

In the UK, the Equality Act 2010 contains both a subjective and an objective element in the definition of harassment. It involves a consideration of the subjective perception of the person and whether it is reasonable for the conduct to have that effect.

Therefore, discrimination could apply if pharmacists were disciplined by the GPhC for their religious beliefs and ethical views with regards to the conferring or withdrawal of professional recognition. Pharmacists could well feel victimised when facing disciplinary proceedings for their religious beliefs. Harassment can also occur when employees are harassed by others or by a third party, for example a customer. By effectively preventing pharmacists with conscientious objections from working in pharmacies, employers and service providers could be liable for charges of harassment. Under EU and domestic law an instruction to discriminate as well as causing or inducing another person to discriminate is deemed to be discrimination.

Victimisation might occur if pharmacists were not protected against dismissal or other adverse treatment by an employer on the basis of their religion or beliefs.

The Equality Act 2010 imposes a "Public Sector Equality Duty", a duty on public authorities, in the exercise of their public functions, including those in relation to religion and belief:

> *"to have due regard to the need to (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act; (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it*". (S 149(1) Equality Act 2010.)

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

Yes

7. Will the impact be:

- Mostly positive

- ○ Partly positive
- ○ Positive and negative
- ○ Partly negative
- ◉ Mostly negative

7a. Please explain and give examples.

Under equality legislation employers must not discriminate on the basis of the religious beliefs of their employees. They must not directly discriminate on the basis of those beliefs. Furthermore there must be reasonable accommodation by employers to prevent direct discrimination. It is difficult to see how direct discrimination could be justified and we are not aware of any instances of positive discrimination.

Under equality legislation employers must have due regard to the need to eliminate discrimination, harassment and any other conduct that is prohibited under the Act, advance equality of opportunity and good relationships between persons who share a relevant protected characteristic such as religion and belief and persons who do not share it. This includes tackling prejudice and promoting understanding. The equality duty applies across the workplace and includes e.g. services, policy-making, employment, planning and procurement.

Employers should also prevent victimization and harassment within the workplace. This could be through colleagues or customers discriminating against staff for their religious views or beliefs.

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

Yes

9. Will the impact be:

- ☐ Mostly positive
- ☐ Partly positive
- ☐ Positive and negative
- ☐ Partly negative
- ☑ Mostly negative

9a. Please explain and give examples.

The public have the trust and confidence in pharmacists that they will act professionally and respect confidentiality. It is important that pharmacists are seen to act in the patients' interest in relation to safety and the provision of sound advice to minimise harm. It is important that pharmacists are seen to act according to a recognised ethical code and are not simply acting out of personal or commercial self interest in the delivery of goods.

Pfizer has taken a principled stand against the use of drugs in capital punishment and professional associations of healthcare workers have regarded involvement in capital punishment unethical. There is a justifiable concern that Pharmacists might be expected to participate in assisted suicide if ever it were legalised. (However, the Marris Bill which would have introduced assisted suicide was comprehensively defeated in September 2015 by 300 votes to 118). For those with conscientious objections to medically induced abortion it is important that the conscience clause is supported.

The current ethical standpoint of the GPhC supports the need for professionalism within Pharmacy for the benefit of patients and to avoid unnecessary harm. We agree with the original ethical standard that *"the care, well-being and safety of patients are at the heart of professional practice."* It is necessary to maintain the trust and confidence of the public and the standards of the profession. Nevertheless, divergence of ethical views is currently recognised and accommodated by the GPhC within our pluralist society. The law rightly prohibits discrimination, victimisation and harassment of those with ethical views supported by religious beliefs