national
secular
society

GMC CONSULTATION: PERSONAL BELIEFS AND MEDICAL PRACTICE

A JOINT RESPONSE FROM
THE NATIONAL SECULAR SOCIETY
AND
THE SECULAR MEDICAL FORUM

21 SEPTEMBER 2007

1. INTRODUCTION

The National Secular Society is the principal national organisation devoted to creating a secular society without religious privilege. The Society supports Human Rights and seeks to minimise prejudice, discrimination and disadvantage, particularly on the grounds of lack of belief. Since its foundation in 1866, it has worked for a wide range of reforms, covering such areas as freedom of expression, legal abortion, race and sex equality.

This secular approach should extend into health care. Although some patients may wish to talk about their religion or beliefs, doctors and other health care workers should be wholly guided by the patient's needs and requirements, keeping their own beliefs (or lack of them) to themselves at all times so that neither the patient's medical treatment nor the practitioner's behaviour towards them are affected in any way, tangible or otherwise.

In the interest of Human Rights and also of transparency within the Health Service, we tender the following comments.

2. APPOINTMENT PROCEDURES

The draft consultation states that doctors are not required to refer the patient directly to another doctor, but must ensure that patients have sufficient information to exercise their right to see another doctor (point 19). It states: *you must not leave the patient with nowhere to turn* (point 20).

The proposal leaves the onus to request onward referral on the patient. Several problems arise from this. The patient is in a vulnerable position and will often feel that they should defer to the authority of the doctor. Although many patients now are choosing to take control of their health care and to inform themselves, those from disadvantaged backgrounds or those disadvantaged by language barriers will still view the doctor's authority as conclusive. It is difficult to envisage the circumstances in which doctors could communicate conscientious objections to patients without also communicating personal judgement on the matter - for example, a refusal to consent to a termination of pregnancy without also transmitting disapproval of termination. In these or similar circumstances, a vulnerable or disadvantaged patient may feel that they cannot or should not request an onward referral.

There could also be pressure put on such vulnerable patients by doctors who try to discourage termination of pregnancy, for example. Although such occurrences would be rare, the proposal giving choice to the patient provides no protection to prevent this happening. We recommend that:

An automatic onward referral by the doctor would prevent any pressure, inadvertent or not, being placed on the patient. Paragraph 19 refers to the issue being discussed between the doctor and the patient to ensure that the patient has sufficient information to make the choice. Once the issue of the conscientious objection has arisen, it is not then appropriate for the doctor to discuss the situation with the patient. Such discussions could easily lead to pressure being put on the patient or to the doctor expressing beliefs to the patient in a way that causes distress contrary to Paragraph 17.

There could also be issues of loyalty to a doctor where there is a longstanding relationship that could discourage a patient from opting to request an onward referral. Automatic onward referrals by the doctor who exercises his or her right not to perform the treatment requested would provide protection to the patient. The benefits of an automatic onward referral outweigh the cost implications that might be associated with it.

If the automatic onward referral proposal is rejected then we recommend as an alternative that references to another doctor on conscience grounds should require the completion of a written form. This procedure would serve two purposes: firstly, it would protect the doctor in case of any future claims of insufficient advice and secondly, it would give the patient evidence should the doctor fail to follow the GMC guidelines. The form should be at least in duplicate, with one copy for the patient and another for retention by the referring doctor. All copies should be signed by both doctor and patient. In order to reduce the work-load of the GP, a standardized form could be produced with tick boxes.

3. MAKING INFORMATION AVAILABLE

There can often be a considerable delay between making an appointment and seeing a doctor. It is not acceptable after this delay for the patient to find that they cannot receive the required treatment because of the doctor's conscience. Nor is it acceptable in many circumstances for treatment to be further delayed while the doctor consults with employers (see 4 below).

Therefore, the NSS strongly recommends the provision of information proposed below.

Information about any treatments or procedures GPs are not prepared to undertake on the grounds of conscience should be made easily available to both current and potential patients.

This information should take three forms: information clearly visible on the practice website, leaflets available in surgery and notices on waiting room walls. It should include suggestions of alternative doctors within the practice or, where this is not appropriate, other practices – including phone numbers, directions and opening times. In rural areas, for example, where public transport is scarce or non-existent, patients should be informed of the easiest way to get to the nearest appropriate practice. The elderly, disabled or parents with small children may find it especially hard to get to another practice.

4. NEW STAFF

The draft consultation (point 21) states that: *If your post requires you to arrange treatment or carry out procedures to which you have a conscientious objection, you should explain your concerns to your employer or contracting body.*

Point 21 does not make it clear at what stage concerns would be discussed.

It should be unacceptable for doctors not to disclose such information until treatment stage, either to employers or to patients. In order to pre-empt this, we recommend that:

Doctors' intention to invoke conscience provisions should be made transparent to the patients no later than the time the appointment is made. If this notification is delayed until the circumstances triggering the invoking of conscience provisions, then treatment of a patient could be unacceptably delayed.

Because the subject of disclosure to employers raises issues of employment law, we have obtained informal legal advice. If the GMC pursues our recommendation on this point, as we hope, they will of course want to confirm our informal advice with more formal legal advice.

It is not envisaged that this requirement would fall foul of the Employment Equality (Religion or Belief) Regulations 2003. The imposition by the employer of a provision criterion or practice that required disclosure of treatments the employed doctor would not perform or prescribe would be applied to all doctors. It would be discriminatory contrary to the legislation only if it put the doctor at a disadvantage and cannot be shown to be a proportionate means of achieving a legitimate aim. It is likely that there would be no disadvantage to the doctors who do disclose conscientious objections so long as the employer was not able to treat them less favourably as a result of the disclosure. There is a clear legitimate aim of providing the best clinical treatment to patients.

5. CONSULTANTS

Given how long it can take to see a consultant, the NSS recommends that GPs should check before referring patients that the consultant has no moral or religious objection that may impinge on the treatment of the patients in both senses – the medical treatment and the consultant's behaviour towards them. Consultants should make themselves aware of any beliefs/values held by their support team of nurses and other professionals, foreseeing any situations in which these may become a problem for patients. We acknowledge this to be outside the scope of the consultation, but add that such situations could be made much more efficient if a database of consultants reserving the right to invoke such conscience clauses were available to those making referrals.

6. NURSES

Although nurses do not come under the regulation of the GMC, GP surgeries have practice nurses and the NSS is concerned that the proposed guidance should make reference to them. Practice nurses may offer advice and treatment in the areas of contraception and sexual health, for example. We recommend that:

It should be the responsibility of the practice doctors as a whole or the senior GP (perhaps in association with the practice manager) to ascertain whether nurses have any religious or moral objections to any form of treatment or advice. This information should not be made known to the public. Any other auxiliary health care workers in a practice should also come under this responsibility. If the reception staff taking the booking for nurse appointments for family planning, for example, they could make the appointment with the appropriate nurse without the patient needing to know about the moral objections of all the staff. Where appointments with nurses are made through the doctor it would be incumbent on the doctor to choose the appropriate nurse without discussing nurses' possible objections with patients.

Nurses and auxiliary health care workers employed in a practice could be required to disclose their conscientious objections to their employers for the purposes of ensuring that patient needs are met. There would be a duty on the employer to make sure that the employee was not treated less favourably as a result of those disclosures.

7. LONG-TERM DEVELOPMENTS

To promote transparency and protect Human Rights, the NSS would recommend:

A longer-term project to set up a register of all doctors in the UK and their conscientious objections. This should be available to the public both online and in written form. The Nursing and Midwifery Council should be encouraged to do the same.

As well as informing the patients, this would prevent doctors being put in a difficult situation.

8. INDIVIDUAL POINTS IN THE DRAFT DOCUMENT:

Point 1

This states that:

You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress.

We would recommend that:

Doctors be advised not to express political opinions, cultural or religious beliefs etc. unless (a) directly relevant to the clinical situation, (b) they have been expressly requested to do so by the patient and (c) the doctor is willing to do so (Point 8).Patients should be asked about their religion or belief only if it is directly relevant clinically and even then it should be made clear to them that they are under no obligation to answer.

Point 7

The final sentence states that: '*You must show respect for patients' beliefs and religious practices and take them into account when discussing treatment options'*. We propose the following alternative because of the ambiguity of the word 'respect': *The duty of the doctor should be to a) recommend the best treatment open to the patient, b) if the patient then raises belief issues, to be sensitive to those issues and explain the reasons for the best clinical option.*

We are concerned that reference should also be made to situations where guardians exercising their beliefs and religious practices when deciding about treatment options for those in their care could, in the opinion of the doctor, have an adverse effect on them. An example is resistance by Jehovah's Witnesses to blood transfusions for their children/those in their care. Clearly the court may have to become involved if the doctor's overriding duty of care to the child is being compromised. We recommend that:

The guidance should emphasise the duty of the doctor to request intervention from social services or another appropriate body where the beliefs of the parents or guardian are threatening to prevent the child receiving the appropriate clinical care.

Point 11 (Circumcision of male children)

The second sentence reads:

Others, including those who campaign against the practice of male circumcision, strongly believe that, because circumcision carries risks, it is wrong to perform the procedure on children who are not old enough to give informed consent, unless it is undertaken to address a specific clinical condition.

Objections to this procedure are varied and include those expressed later in life by those subjected to this procedure that they felt they had been violated. We are concerned that the proposed wording does not adequately communicate the strength of objections. Therefore, we recommend that:

The phrase *because circumcision carries risks* is expanded to read: *for a number of reasons including risk*. A less satisfactory improvement would be to delete the phrase altogether.

Point 18

A) The second sentence reads: *We do not wish to impose unnecessary restrictions on doctors, particularly in relation to expression of cultural preferences or religious and other convictions*.

We recommend the complete deletion of this sentence, which is superseded by our proposed rewording of Point 1.

Our reasoning is firstly because it seems to imply that doctors *may* express preferences and convictions, even where not relevant. We disagree with such expressions where not relevant, partly because they may be thought of as gratuitous by the patient and many may not feel confident enough to request the doctor to desist or that to do so might create difficulties. Secondly, it is not clear what criteria should be used to establish which restrictions are 'unnecessary'. If it is the intention of the sentence to convey that there is no wish to discriminate against doctors in relation to belief or culture, then an appropriate wording could be: *We do not wish to impose requirements on doctors in relation to their duties that would conflict with their religious beliefs or other convictions*. There is no entitlement under the Human Rights Act to manifest belief. The right of doctors to hold private beliefs and convictions that prevent them from carrying out certain treatments is distinct from a right to express or manifest those beliefs in the workplace.

B) The final sentence reads: *You must not discriminate against patients on the basis of your beliefs, by denying or delaying treatment for them because of their sexual orientation, gender or race*.

We believe that the listed grounds of discrimination do not go nearly far enough and propose instead the following:

You must not discriminate against patients, whether on the basis of your beliefs or otherwise, by denying or delaying treatment for them for a reason related to race, disability, ethnic or national origin, lifestyle, marital or parental status, religion or belief including absence of belief, sex, sexual orientation or socio-economic status

Point 25

This needs some clarification. It states that doctors may be *required… to set aside [their] personal and cultural preferences in order to provide effective patient care.*

This appears to contradict Point 18 and thus needs clarification. The NSS would like it stated in what way Point 25 would be implemented and monitored. For example, if a patient requested a female doctor to remove her veil and the doctor refused, what would happen next? In some surgeries, it is not possible to specify which doctor is seen – for example in walk-in clinics – so avoiding a veiled doctor may not be possible. It should also be made much clearer in what way 'preferences' differ from beliefs and moral values.

There is no right in law to obtain preferential treatment under a contract of employment due to cultural preferences. Examples such as veil-wearing will be caught by the provisions on discrimination on the grounds of religion. It must be a requirement that the best clinical care is always provided. So for example a Muslim doctor should set aside his/her religious views to dissuade a patient from fasting during Ramadan if regular meals were essential to that patient's health. As another example, patients with diabetes or pregnant patients who are particularly observant may choose to fast and should be warned of the health risks.

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