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A response to the General Pharmaceutical Council consultation on religion, personal values and beliefs

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About the National Secular Society

The National Secular Society works for the separation of religion and state and equal respect for everyone's human rights, so that no one is advantaged or disadvantaged because of their beliefs.

This response has been drafted in consultation with the Secular Medical Forum, a special expertise network of healthcare professionals within the NSS membership which provides expert advice to the Society on healthcare related issues.

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.

We propose that the wording of the examples under standard 1 – about 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 example]

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

Question 1.

Do you agree with the proposed changes?

Yes

Question 1a.

Please explain your reasons for this

We support the change to the new wording in Standard 1. The new wording places the onus of responsibility on pharmacy professionals to ensure that those using pharmacy services are not obstructed by the pharmacy professional's own personal views.

Whilst we recognise the right of pharmacy professionals to have conscientious objections to providing certain services, it is vital that the primary focus should always be on the person using pharmacy services. We support the accommodation of pharmacy professionals with a conscientious objection to providing a certain treatment wherever reasonable and possible. In order to do so, the professional should be honest and open about the self-imposed restrictions on their work at the outset in order to ensure that the employer can consider whether or not it is possible to accommodate those views and if so, how. If it is not possible to accommodate the strongly-held views of a pharmacy professional at all times then the pharmacy professional must make a decision

as to whether they wish to work in such an environment where the expression of their own views may be compromised. If they are not willing to accept that there may be occasions when they must place the patient's treatment needs above their own views, the management of the pharmacy responsible for ensuring that this Standard is maintained will have to explore with any such pharmacy professionals whether any alternatives can be found, e.g. through redeployment or alternative hours that eliminate any possibility of patients' treatment needs being compromised on conscience grounds.

For example, where two pharmacists are working in the same pharmacy, and one expresses a conscientious objection to providing a certain activity it might be acceptable to arrange for another suitably trained and willing pharmacist to perform those specific tasks. However contingency plans must be made for illness, travel delays or other unexpected events so that prescriptions such as those for EHC are always promptly dispensed and that those using pharmacy services are not obstructed. This is essential for person-centred care.

It should not be assumed that because a pharmacy professional has stated their objections that those objections can necessarily be accommodated. Where there is a conflict between the views and objections of a pharmacist and the provision of non-judgmental, safe, timely, patient-centred pharmacy services, the provision of services should always take precedence so as not to compromise patient care. It would be important to include in the guidelines robust material and examples making clear that accommodation is to be welcomed but employers are entitled – and indeed are required – to limit this for legitimate business reasons and needs. Material from external agencies such as EHRC and ACAS is likely to be helpful.

We welcome unreservedly the comment in the introduction and the further detail in section 3e about the attitudes and behaviours of pharmacy professionals being of prime importance. Particularly for those seeking advice or treatment on sensitive matters such as contraception, the body language and comments of a pharmacist who is not sympathetic to the pharmacy user may itself be a barrier to safe care. We endorse the changed requirement for pharmacists to ensure that they "safeguard and respect a person's dignity".

We support the decision of the GPhC to remove the passage exhorting pharmacy professionals to balance the competing views of pharmacy users with their own. Whilst superficially attractive as an idea, balance per se does not recognise the inherent power imbalance in the pharmacy-patient relationship nor the primary importance of the pharmacy user. Pharmacy users without specialist knowledge may not be aware of all the options so it is incumbent on pharmacy professionals to facilitate the informed decisions of pharmacy users that best reflect their own views rather than those of the pharmacy professional.

There is evidence that some pharmacy professionals with strong personal views, usually religiously-informed, have felt justified in making their own value judgement almost always in line with their own views. The patient might not even have been made aware of the full range of options. Whilst it may be understandable that some people who hold strong views on a subject are keen to influence the views and behaviours of others who might not share those views, the risk in the pharmacy setting is that pharmacy professionals have felt both justified and supported by their regulatory body in presenting to pharmacy users a personally-biased version of pharmacy services which reflected the pharmacy professional's own values and beliefs rather than professional opinion. In

such circumstances the values and beliefs of some pharmacy users, turned away by religious pharmacists, have been afforded less respect and their health potentially endangered. We support the explicit new recommendation in 3d to "be mindful of the difference between religion, personal values or beliefs, and a professional clinical judgement".

We are extremely concerned by the comments and justifications of some of those making a public stand against the latest consultation despite it putting patient care as paramount. The response to the 2016 GPhC consultation by the Christians in Pharmacy organisation exemplifies the need for the new wording. They state that 'they cannot engage in contentious practices'. Yet, some of the practices they describe as 'contentious' such as EHC, are legal, reasonable, and will have been considered to be in the patients' best interests by the registered medical practitioner who wrote the prescription following a proper medical assessment. They seem to prioritise the conscience of the pharmacists ahead of patient care. This is clearly at odds with the profession's commitment to person-centred care.

These comments demonstrate a significant lack of insight, particularly when such a group claims victimhood for pharmacists such as themselves without considering the needs, wishes and best interests of the people whose treatment they are obstructing. In this context the new guidance is evidently more robust and more patient-focussed. The proposed new guidance is also more in line with Article 18(3) of the ICCPR. "Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others." Failure to dispense a prescription on conscience grounds potentially engages almost all of these provisos and accords with the U.S. Supreme Court's position in *Stormans, Inc. v. Wiesman*.

Question 2.

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

No

Question 3.

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

The draft guidance covers a helpful range of situations and is to be commended for explaining in some detail certain potential areas of conflict and for giving a clear steer as to the spirit of the guidance. We would like to add some further points of clarification to be considered for inclusion in the final guidance to pharmacy professionals.

We have serious concerns about the significant adverse implications referral has for patient care and recommend more detailed clarification of the exceptional circumstances in which referral may be an acceptable option. In one case study of refusal to dispense emergency contraception we saw the patient was not offered a referral. This was in a Boots in an urban area.

A pharmacist who feels so strongly on religious/ethical grounds that they do not wish to dispense EHC for example may be more likely to try to justify why they are unable to refer a patient for the same treatment they have refused to provide it. It is clear that under the current regulations some pharmacy professionals do not make such referrals and actively seek to justify their refusal. The following quote from the 2016 Christians in Pharmacy consultation response illustrates the point: *"the strongly held moral convictions of the pharmacy practitioner may prevent them, in good conscience, from actively recommending another source of supply. This could probably be dealt with by allowing the concerned pharmacist to point out that other pharmacies/pharmacists would be willing to dispense without* ***themselves*** *making a direct referral."*

We consider both the failure of pharmacy professionals to treat or even refer a pharmacy user, and the suggestion, also in the above consultation response, that there should be an opt-in for pharmacists rather than an obligation to provide services, as deeply troubling from the perspective of the potential adverse implications for patient care. Not only are Christians in Pharmacy clearly unhappy with the existing arrangements that in our opinion fail to provide for adequate patient-centred care, they want the Standard to move further away from patient-centred care. We consider it both professionally and ethically unacceptable for a pharmacist to overrule on conscience grounds (as opposed to, for example, a potential mistake or drug interaction) the declared instructions of the prescriber whose responsibilities include making themselves aware of the patient's full circumstances in a way that the pharmacist might not be. Failure to dispense could include exposing the patient to increased risk of pregnancy, so-called "honour" violence, and in rare cases even death. This risk would be minimised by the seamless provision of services to pharmacy users who should not have to concern themselves with the personal convictions of their healthcare professionals.

We therefore recommend strengthening the recommendations in these explicit circumstances to give unambiguous advice to pharmacy professionals who do not feel able to provide a certain service because of their own personal beliefs. In these circumstances, pharmacy professionals must ensure

that by not providing the service themselves at the first point of contact they are not jeopardising the ability of the pharmacy user to receive the treatment in a timely fashion.

If appropriate arrangements are in place within the pharmacy, the pharmacist must then take active steps to make a direct referral and must ensure that there is a suitably qualified pharmacy professional able to provide the service within a reasonable time frame and that the pharmacy user is willing and able to access the alternative pharmacy professional. Unless these conditions are met onward referral is inappropriate. Pharmacists should be advised that they may face disciplinary proceedings should they fail to follow such safeguards.

We further recommend that whenever any referral takes place there should be a clearly documented audit trail. The discussion with the pharmacy user should be documented contemporaneously by the pharmacy professional and the outcome agreed and signed by both service user and pharmacy professional. This will offer support to pharmacy users whose care has been compromised and will offer defence to pharmacy professionals for whom reasonable accommodation has been arranged.

The regulations should as far as possible be written to regard external referrals (for EHC for example) on conscience grounds a prima facie breach of regulations, requiring a duplicate summary form to be given to the patient and a full report to the NHS and or GPhC prompting an automatic independent enquiry. The pharmacist should ascertain (and so record) that the pharmacy referred to is practically reachable by the patient in a reasonable timeframe, has the product in stock and is willing to dispense/sell it.

We recognise that stocking difficulties in pharmacies do arise. However, there is a significant risk that those with strongly held beliefs may be reluctant to order certain medicines such as EHC. The guidance should make it clear that deliberate stock outages are also a prima facie breach of regulations.

We understand that the GPhC has a role in regulating both pharmacy professionals and pharmacy premises and recommend that appropriate checks and balances are put in place to monitor adequate stock control and referral procedures.

The policing of such external referrals so as to minimise the adverse implications for patient care is extremely difficult and may be impractical. External referral poses significant risks (1) that the patient could be unable to obtain the required treatment for example, particularly in rural areas, on practical grounds e.g. financial or time availability, the risk of others finding out) and (2) the difficulty of policing such referrals made, often unwillingly.

We consider the US Supreme Court *Stormans Inc. v. Wiesman* came to the same conclusion by affirming conscience opt out for pharmacists but not by the pharmacy - i.e. internal referral only. Clearly it is up to pharmacies (and indeed pharmacists in the positions they choose to apply for) to organise themselves in such a way that no pharmacist need ever dispense prescriptions against their conscience, and this should normally be possible. Nevertheless, the pharmacy itself must take whatever steps are necessary to ensure that prescriptions are always promptly dispensed. We strongly recommend that GPhC adopt the position supported by the U.S. Supreme Court that

referral can only be within a pharmacy and that the pharmacy itself cannot refuse to dispense on conscience grounds.

We do however recognise that the ‘no external referrals/pharmacy must supply’ approach we feel is so much better for patient care may not always be practical for EHC sold over-the-counter. We hope that the GPhC enforces it as much as possible, for example when the pharmacists/pharmacies have appropriate training and contractual arrangements.

It was notable that our case study had been unable to obtain a GP appointment within the necessary time which is an increasingly common occurrence. We are also conscious of the Government's recently stated intention for pharmacists to take over some work from GPs. For both these reasons procedures and regulations for ‘over the counter’ sales (including ones to ensure that there is normally sufficient stock) need to be made more robust, with the aim to eliminate external referrals on conscience grounds and needless failures to supply for stock outages. This will presumably require collaboration with a number of bodies.

We were pleased to learn that that the GPhC has also been considering, as we have, that conscience issues need to be aired where those considering becoming pharmacists will see them; for example when recruiting, for students and those in training posts. We recommend that the onus of responsibility regarding conscience issues falling on the professional should be explicit in job applications and model contracts.

When the NSS was working with the EHRC in preparation for their report on *Religion or belief: is the law working?* The strongest calls for change were from orthodox religious groups for a much greater ’reasonable accommodation’ (as they described it) for religious conscience. The EHRC nevertheless concluded, as the NSS had also argued, that the law did not need to be changed.

We therefore suggest that this needs to become a major focus of implementation of stricter guidelines on conscience, for example in the guidelines and in preparatory practical work. Maybe this could initially be trialled with major chains of pharmacies and then rolled out to remaining pharmacies. We suggest that you ask them to incorporate it in their own mission statements, sales and employment procedures and contracts, remembering that existing contracts can be modified by sufficient notice of it being given to the employees. If no way can be found around sufficiently avoiding legal liability or exposure for a model clause, the intention of such a clause could be described. We suggest for example that while freedom of conscience will be afforded wherever possible, this does not extend to being complicit with a patient prescription not being dispensed or being refused on conscience grounds by the pharmacy, whether or not this is the stated reason for refusal, and that such failure or refusal to dispense constitutes a disciplinary and potentially dismissible offence. Doing it this way where, hopefully, all would sign up at an agreed date, should dispel concerns about mass migrations of pharmacists to chains that had not yet agreed to make such changes.

Question 4.

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

Yes

Question 5.

Will that impact be:

Mostly positive

Question 5a.

Please explain and give examples.

The advice from the GPhC that the balance has shifted in favour of the patient is much less ambiguous than the previous recommendation to balance the beliefs of pharmacy professionals with those of the patient. So where there is a conflict between the pharmacy professional's own beliefs and those of the pharmacy user, it is much clearer now that the patient's healthcare needs are the priority in all circumstances and that the provision of care to them should not be obstructed.

For example, if a patient arrives at a pharmacy with only one pharmacist on duty with a prescription for emergency hormonal contraception, there is now an explicit requirement that the pharmacy professional will dispense the medication. It is no longer acceptable for the pharmacist to tell the patient that they should look elsewhere as occasionally happens now much to the distress of the pharmacy user who has been turned away.

Considerable thought has been given within the guidance to the needs of pharmacy professionals with conscientious objection to providing certain services. As such it might be easier for them to discuss in advance with their employer any accommodating arrangements that might help them to work effectively without compromising either patient care or their own personal beliefs.

We do accept that there may be adverse consequences for pharmacists who refuse under any circumstances to dispense prescriptions for some products on grounds of conscience, particularly where there is unlikely to be cover from other pharmacist(s) who do not so refuse. We hope they can be deployed in ways that their skills can be utilised, but the legitimate needs of patients must come first; that is what they are employed to satisfy.

Question 6.

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

Yes

Question 7.

Will that impact be:

Mostly positive

Question 7a.

Please explain and give examples.

The proposed new guidance supports pharmacy employers in appointing pharmacy professionals who will provide a comprehensive service. It gives scope to accommodate conscientious objection

but supports employers who may decide that a pharmacy professional with strong conscientious objections, whose objections cannot reasonably be accommodated, might not be the right person for the job. Having these unambiguous standards will avoid pharmacies' patient-centred service delivery being compromised by staff unwilling to provide it.

Question 8.

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

Yes

Question 9.

Will that impact be:

Mostly positive

Question 9a.

Please explain and give examples.

The proposed approach and content of the standards and guidance will have a very positive effect on people using pharmacy services whose own views are now explicitly paramount. It has been very distressing, inconvenient and occasionally dangerous for some pharmacy users whose attempts to obtain reasonable treatment have been frustrated by the expression of the personal views and convictions of some pharmacy professionals usually with strong religious beliefs.

The current guidance should mean that a pharmacy user can expect that when he/she uses a pharmacy service they will receive the same treatment irrespective of the views and beliefs of the pharmacy professionals on duty or the pharmacy employers. A woman, for example, presenting to a pharmacy with a prescription for EHC, will now have a reasonable expectation that the prescription will be filled promptly in any pharmacy they choose to attend. If that doesn't happen for reasons of conscientious objection, then the pharmacy professional may face action from the GPhC for breaching the new guidance.

Question 10.

Do you have any other comments?

We commend the GPhC for taking such forward-thinking and robust steps to safeguard pharmacy users from the adverse consequences of the unrestricted expression of the personal beliefs of pharmacy professionals.