15 Morningside Road
Edinburgh EH10 4DP
SCOTLAND, UK

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Personal Beliefs and Medical Practice

Consultation response on behalf of the Scottish Council on Human Bioethics:

The **Scottish Council on Human Bioethics** (SCHB) is an independent, non-partisan, non-religious registered Scottish charity composed of doctors, lawyers, biomedical scientists, ethicists and other professionals from disciplines associated with medical ethics.
The principles to which the Scottish Council on Human Bioethics subscribe are set out in the ***United Nations Universal Declaration of Human Rights*** which was adopted and proclaimed by the UN General Assembly resolution 217A (III) on the 10th of December 1948.

The SCHB is very grateful to the General Medical Council for this opportunity to respond to the consultation on the ***Personal Beliefs and Medical Practice*****.** It welcomes the GMC's intention to promote public consultation, understanding and discussion on this topic.

Scottish Council on Human Bioethics Response

The document entitled *Personal Beliefs and Medical Practice* may be seen as very useful and constructive as a guidance document. However, a certain number of remarks were raised by members. These are as follows:

No Appropriate Definitions of Terms

The document does not adequately deal with the right to conscientious objection. No proper definition is given and there is confusion between this right and the patient's 'need to receive treatment'. For example in paragraph 4 would be the obvious place to explain about the right to conscientious objection. It seems to state that patients' 'rights' trump doctors beliefs and this cannot be seen as reasonable. Doctors are not free to hold beliefs if they may only do so provided patient's rights are not being infringed. There is confusion between these competing rights. Conscientious objection relates only to the doctor's own actions and not the actions or the intentions of the patient. It is concerning that para 4 goes on to state *'we expect doctors to be prepared to set aside their personal beliefs so that they can provide effective patient care*'. Surely something major is being taken away with that statement!

It is noted that there is no definition in paragraph 5 of what constitutes '*opting out of a procedure*' and '*refusal to treat*'. This seems to be the issue with the case of the Glasgow midwives, who by virtue of their seniority may be required to intervene in a 'procedure', which has been initiated by someone else, if there are complications which arise during the procedure. This action is being interpreted by their employers and legal authorities as a refusal to treat. Improved clarity on these terms would seem important.

Paragraph 5 does not define '*personal beliefs and value*'". Do these terms not include the belief in inherent human dignity on which all medicine is based and which is mentioned in the UN's Declaration of Human Rights? Is not the reason why society respects the autonomy of patients based on its *belief* that they have inherent human dignity? Do all physicians have certain beliefs? It is incorrect to indicate in paragraph 3 that '*personal beliefs and cultural practices are central to the lives of many doctors and patients*'. Actually, personal beliefs are central to the lives of *all* doctors and patients who believe in (1) human dignity, (2) the application of medicine and (3) the existence of the General Medical Council. This needs to be clarified and developed.

Paragraph 8 confuses the whole issue since the conscientious objection relates to the actions of the doctor not the patient.

Referrals by a doctor

It is important that doctors with conscientious objections, while stating their opinions frankly and sympathetically, should still be able refer their patients to another doctor, quickly and easily if that is their wish. This is to ensure that those doctors in the NHS with conscientious objections continue to be allowed to exercise those objections.

Best interests of the patient

A physician should never do something which would contravene what he or she believes are the best interests of the patient even if this individual insists on an intervention taking place such as gender reassignment. If this ethical principle (the physician putting the best interests of the patient first) is undermined, it would put many physicians in an impossible situation. It would force them to do something which they believe is clinically and/or ethically inappropriate.

Gender Reassignment

An illogical interpretation of the Equality Act specifically may exist in relation to gender reassignment. It is impossible to understand why it is not permissible for a medical practitioner to make arrangements for the individual to consult another practitioner for this specific procedure as they would with any other procedure which would fall within the very broad scope of the Equality Act. It seems this would principally be a point of law which needs to be addressed to ensure that those with a conscientious objection are not discriminated against, and their rights ignored, in relation to gender reassignment processes.

It seems illogical that current legislation allows a doctor to not be involved in abortion though he or she cannot refuse to be involved in gender reassignment cases. This is because the doctor cannot refuse to treat a certain kind of person. Why is it not acceptable for the doctor to refer the patient to a colleague as in the case of requests for abortion?

Prescribing the Contraceptive Pill

It is unreasonable that current legislation allows a doctor to not be involved in abortion though he or she cannot prescribe the contraceptive pill to unmarried women. This is because the doctor cannot refuse to treat a certain kind of person. Why is it not acceptable for the doctor to refer the patient to a colleague as in the case of requests for abortion? Why is a pregnant women seeking an abortion not a special type of person but an unmarried woman seeking the contraceptive pill is a special type of person the doctor cannot refuse to treat?

Abortion

Paragraph 7 has a footnote relating to abortion. Abortion is not legal in the UK as the GMC is no doubt aware. It is only decriminalised in certain situations.

Threatening Tone of Document

Paragraphs 2 & 6 almost read like threats.

Imbalance of the Document

The whole document keeps referring to patient distress and is very weighted towards patients.

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

Does this endnote include healthcare professionals who might want to refuse to prepare patients for an abortion? Preparing the patient is part of the procedure and therefore could come into the area of conscientious

objection. They could not refuse to provide any medical care which is necessary such as if the patient had a medical emergency while waiting for the abortion procedure.

Endnote 7: Children and young people

Endnote 7 is very concerning. It reads like a declaration that children have to be resilient to the views and beliefs of their parents and grandparents.

Generally, doctors should always respect the wishes of the parents of children up to 16 years unless those wishes would definitely result in harm to the child.

With regard to the treatment of children, it should include the prescription of contraception and the authorisation of abortion or gender reassignment as procedures which could be blocked by the wishes and beliefs of parents of children under 16 years of age.