Public consultation on Personal beliefs and medical practice guidance

Taking part in the consultation

Freedom of information

Your response to this consultation may be subject to disclosure under the Freedom of Information Act 2000, which allows public access to information we hold. This doesn't necessarily mean your response will be made available to the public, as there are exemptions relating to information given in confidence and information to which the UK General Data Protection Regulation applies.

Would you like your response to be treated as confidential?

No

Section 1 – structure and terminology

Question 1. To what extent do you agree or disagree with the following statement?

The updated guidance structure is accessible.

Agree

Question 2. To what extent do you agree or disagree with the following statement?

The updated draft guidance accurately reflects the range of personal beliefs and values that might influence the practice of doctors, PAs, and AAs and inform patients' decision making.

Agree

Question 3. Do you agree or disagree with this statement?

It would be helpful if there was a description of the relationship between personal beliefs and clinical opinion in the guidance.

Yes

Question 4. Is there anything else we should consider when defining the range of personal beliefs that can fall within the scope of this guidance?

(Character limit 4000)

There needs to be greater emphasis on the duty outlined in paragraph 87 (not to express beliefs in a way that could cause distress) and GMP paragraph 21 (ensuring any conscientious objection does not act as a barrier to a patient's access to appropriate care). These principles must be explicit within the main guidance and not left to the annex. It may be helpful to reiterate as the overarching principle that the care and welfare of the patient must always be the first concern regardless of any personal belief.

Question 5. Is there anything else we should consider in terms of the guidance structure and the terminology we use?

(Character limit 4000)

Our main asks are:
• Ensure abortion and reproductive healthcare are framed as being essential healthcare, common and where any delay causes additional distress and complications
• Recognise that patients are especially vulnerable and susceptible to shame and stigma, especially when faced with judgemental attitudes from a medical professional
• Whilst recognising the legal right of practitioners not to be involved in the procedure itself, they must always put the welfare of the patient first regardless of their beliefs
• If practitioners cannot offer care, they have a professional responsibility to ensure the woman suffers no detriment or harm:
o They must not cause more harm and distress by telling the women they have an objection (the statement in paragraph 21 is especially problematic here as explaining their objection will always make them feel judged)
o They must ensure there are no delays in care, having responsibility to find a colleague who will offer that care. This should be viewed no differently to where somebody presents where the practitioner lacks the competency to help – they have a responsibility to find somebody who does, and not simply refuse care

• Our members report that patients have been harmed as a direct consequence of care denial, and that it is not uncommon for women to experience additional distress, delays and judgemental attitudes which would be unacceptable in other areas of medicine. The guidance should ensure it is clear the needs of the patient must always come before a practitioner's personal beliefs.

There should be explicit mention that in UK law there is no concept of fetal personhood. Personhood (and therefore any legal or human rights) is only gained after birth following first breath. This grants critically important safeguards for both women (for example in being protected against forced operative delivery against their will) and clinicians (for example in recommending treatment in the interests of the woman). Those with conscientious objection may well have personal beliefs that disagrees with this, but it is the law and foundation for good medical practice.

Section 2 – personal beliefs of doctors, PAs, and AAs

Question 6. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
A. The updated draft guidance on doctors, PAs, and AAs being open with their employers, partners or colleagues where personal beliefs may affect their practice is clear.		X				
B. The updated draft guidance on doctors, PAs, and AAs being open with employers, partners or colleagues where personal beliefs may affect practice is helpful.		X				
C. The updated draft guidance on doctors, PAs, and AAs being open with employers, partners or colleagues where personal beliefs may affect practice is achievable in practice.		X				

Question 8. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don’t know
A. The updated draft guidance on how, when appropriate, doctors, PAs, and AAs should talk to patients about their beliefs is **clear**.					X	
B. The updated draft guidance on how, when appropriate, doctors, PAs, and AAs should talk to patients about their beliefs is **helpful**.					X	
C. The updated draft guidance on how, when appropriate, doctors, PAs, and AAs should talk to patients about their beliefs is **achievable in practice**				X		

Section 2 – personal beliefs of doctors, PAs, and AAs cont.

Question 9. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don’t know
A. The updated draft guidance on how doctors, PAs, and AAs should manage discussing conscientious objections with patients is **clear**.					X	
B. The updated draft guidance on how doctors, PAs, and AAs should manage discussing conscientious objections with patients is **helpful**.					X	
C. The updated draft guidance on how doctors, PAs, and AAs should manage discussing conscientious objections with patients is **achievable in practice**.					X	

Question 10. To what extent do you agree or disagree with the following statements?

	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**	**Don’t know**
A.The updated draft guidance on how doctors, PAs, and AAs should manage any conscientious objections they have that are not legal rights is clear.				X		
B.The updated draft guidance on how doctors, PAs, and AAs should manage any conscientious objections they have that are not legal rights is helpful.				X		
C.The updated draft guidance on how doctors, PAs, and AAs should manage any conscientious objections they have that are not legal rights is achievable in practice.				X		

Question 11. Is there anything else we should consider in relation to paragraphs 10–26 on the personal beliefs of doctors, PAs, and AAs?

(Character limit 4000)

We have concerns about the clarity and implementability of paragraphs 10-26 of the draft guidance. The guidance explains that medical professionals are legally entitled to exercise a conscientious objection and refrain from participating in termination of pregnancy and in vitro fertilisation. It then states the GMC's position that medical professionals are also able to exercise a conscientious objection in other circumstances.

Legally protected conscientious objection is already difficult to implement without causing distress, delayed care and discrimination [de Londras et al 2023, doi: 10.1016/j.healthpol.2023.104716]. Extending the right to conscientious objection "in other circumstances" will invariably place undue burden on employers, colleagues, and most of all patients whose medical care should not be subject to medical professionals' personal beliefs.

Conscientious objection is only coherent when the provider's moral objection relates to an act they are performing that they believe causes harm to a third party – specifically the destruction of what they consider a person. Any conscientious objection framework needs to be explicit about conflating personal religious observance with professional moral agency. The only permitted areas for conscientious objection in law are abortion and IVF.

We cannot think of any example of where exercising a conscientious objection would not "affect your relationship with the patient, or the treatment you provide or arrange." Medical careers and training are beyond the scope of this consultation, but we know from research evidence that most healthcare professionals shift their positions on conscientious objection following values clarification [Turner et al 2018 doi: 10.1186/s12978-018-0480-0]. Our position is that a medical professional has not put in the due diligence in examining their own conscientious objection until they have at least undergone some formal values clarification.

Our main concern with the guidance is:
- It does not have a clear position on how and what is allowed under conscientious objection that is not protected by law. It is our position that conscientious objection should only be permitted in the limited situations where there is legal protection because conscientious objection is a violation of principles of medical ethics (autonomy and non-maleficience) and of the human rights of the individual seeking care that is medically beneficial.

- In the two instances where conscientious objection is protected by law, we need clear regulation, clarity and safeguards to limit the well-documented, inevitable negative impact on patients and colleagues. The Annexe is useful in this regard (explicitly stating that the conscientious objection is restricted to direct delivery of the procedure and not administrative tasks including referral). However it should be made clear that even where a practitioner exercises lawful conscientious objection, they still have a duty of care to the patient and a professional responsibility to ensure they do not suffer any detriment as a result of their refusal to provide care.

Section 3 – personal beliefs of patients cont.

Question 17. Is there anything else we should consider in relation to paragraphs 47–53 on providing care where patients are children and young people?

(Character limit 4000)

It would be worth referencing the Gillick judgement and Fraser guidelines when young people present requiring reproductive healthcare, and stating explicitly that where a young person has competency, their requests for care should be respected. It would be helpful to also state explicitly that young people have a right to confidentiality (cross reference to GMC guidance on this would be helpful), and must be confident that any consultation and treatment will remain confidential with the only exceptions being where they consent to disclosure, or where it is required to prevent harm to themselves or others.

Section 4 – overall themes and comments

Question 19. To what extent do you agree or disagree with the following statement?

The guidance should acknowledge that a range of belief systems coexist and frame these neutrally.

Strongly disagree

Question 20. To what extent do you agree or disagree with the following statement?

The updated draft guidance frames personal beliefs neutrally.

Disagree

Question 21. Thinking about the proposed change in how explanatory examples are presented, which approach do you prefer?

Keep examples in the main text of the guidance

Question 22. Can you see any risks in removing examples from the main text and instead using them to develop supporting materials?

Yes

Question 23. If you said yes, please tell us about the risks.

(Character limit 4000)

In our experience those who practice belief-based care denial lack insight into the distress and harm they cause patients. They may even view their own behaviour as superior, or providing a positive role model. If examples of how their behaviour may affect vulnerable patients are not explicitly stated, those with more extreme views may fail to recognise the harm they cause.

Question 24. Can you suggest any scenarios where case studies or supporting materials would help explain how the principles in Personal beliefs and medical practice can be applied in practice?

(Character limit 4000)

We would like to highlight some examples of harm and distress our members have reported where women have been denied abortion care. Our experience is that practitioners responsible for belief-based care denial seem unaware of the consequences of their actions or the guilt and distress their actions cause, and are therefore not only causing harm to patients but also compromising their own professionalism. We believe this is usually owing to a lack of insight, and therefore hope that case studies would be a valuable tool to raise awareness and reduce the shame, stigma and harm our patients suffer.

1 – Woman admitted for surgical abortion as she feared her violent partner would discover abortion pills placing her at harm. Her procedure was cancelled on multiple occasions over 3 days owing to surgeons, anaesthetists and theatre staff expressing belief-based care denial. In desperation she requested an early medical abortion at home. Her partner discovered the pills and subjected her to a serious assault (resulting in a skull fracture).

2 – Woman admitted for a surgical abortion with severe hyperemesis and requiring oral anti-psychotic medication. Her procedure was cancelled on multiple occasions owing to surgeons, anaesthetists and theatre staff expressing belief-based care denial. She developed an acute psychiatric episode and developed deranged electrolytes as a direct result of remaining nil-by-mouth for days, with a significant loss of dignity and losing confidence in NHS care. Care was eventually provided by the abortion team having to themselves organise a rota change to ensure a surgeon without conscientious objection could manage her case.

3 – Woman in second trimester with severe epilepsy required a medical abortion. After two days she developed sepsis, but the on-call team denied a surgical procedure owing to conscientious objection.

4 – Woman having a community-based surgical abortion suffered a complication of uterine perforation. Request to admit for acute care and to complete the procedure was initially refused owing to conscientious objection, and subsequently the patient was discharged without treatment or follow-up as the clinician had a conscientious objection to abortion.

5 – Woman required an abortion owing to a scar pregnancy. She was refused admission owing to conscientious objection, and subsequently suffered a ruptured scar, massive haemorrhage and required an emergency hysterectomy.

It would be helpful also to state that abortion providers frequently encounter patients who are distressed by, and also lose confidence in, practitioners who express their personal beliefs to them even when these beliefs are expressed in good faith. We have multiple examples where care is delayed, and where management of complications has been problematic.

Section 4 – overall themes and comments cont.

Question 25. What impact, if any, do you think the draft updates to Personal beliefs and medical practice guidance could have on patients and the professionals we regulate who share protected characteristics under the Equality Act 2010 (the protected characteristics are race, disability, age, sex, gender reassignment, sexual orientation, religion and belief, pregnancy and maternity, and marriage and civil partnership)?

No impact

Question 26. If you think the draft guidance could be interpreted or applied in ways that lead to biased or unfair judgements, please explain how.

(Character limit 4000)

We are concerned that parts of the guidance may infer that practitioners should inform women that they object to abortion care. This will inevitably cause distress and in some, especially those who are vulnerable and feeling stigmatised, likely to cause shame. It may also result in a loss of trust in the NHS and medical profession. Paragraph 21 is particularly problematic, and we believe it is harmful to state that "you should be prepared to explain this is due to a conscientious objection you have. You may wish to mention the reason for your objection…". However sensitively this is done, it will inevitably cause distress and the woman will feel judged. Practitioners should follow other advice within the guidance (e.g. para 10 – "don't treat patients unfairly or cause them distress", 22 – "you must not obstruct patients from accessing services", annex citing GMP paras 19, 21 and 87) which are far clearer and more appropriate. It also must be explicit that whatever a practitioner's views, they must not impede access to care (i.e. the responsibility is on them to ensure care is seamless, to organise any swaps etc., and that the patient should not be made aware of this).

The guidance does not mention the impact of care denial on the staff who are advocating for the patient. Our members have reported considerable distress when they have to fight for their patient to access care, or worse witness them come to harm. Abortion services have historically been stigmatised, and this behaviour reinforces that perception and isolation that staff working in them can feel.

Question 27. Is there Is there anything else we should consider in relation to the guidance?

(Character limit 4000)

We would like it emphasised and made explicit that abortion care is essential healthcare that a third of women will have to access, but practitioners must recognise it remains stigmatised and those who are vulnerable are especially impacted by shame and any additional barriers to access care. Any delay will cause additional distress and the incidence of all complications significantly increases. The statutory right to conscientious objection only applies to direct involvement with the procedure, not to managing referral, advising about options, or managing the case beyond the procedure itself. Doctors are leaders within the NHS, and we find that other staff who have no statutory right to conscientious objection (e.g. theatre staff) not uncommonly prevent care where they see doctors denying care without consequence.

It would be helpful if it were made clear that practitioners must not cause shame or distress by refusing care or stating their beliefs. We would suggest that where a practitioner has deeply held beliefs, they manage this in the same way they would if they lacked competency as in any other clinical scenario – they take responsibility for ensuring her care continues seamlessly by organising whatever is necessary for another colleague to take over. They should not express their personal beliefs to the patient, and it should be explicit in the guidance that if they cause delay or distress to the patient that this could contravene Good Medical Practice. Although it does state in paragraph 17 that "you must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them", it needs to be highlighted that this always applies to the care of women needing an abortion who are especially vulnerable to feeling stigmatised and where judgemental attitudes can cause long term harm and loss of confidence in the NHS. Belief-based care denial must not prevent any practitioner from making the welfare of their patient their primary concern.

We would also like the GMC to consider including within the register a record of whether the practitioner has a conscientious objection so this is transparent and available for both patients and employers. It should also be mandatory for those exercising conscientious objection to discuss this at their annual appraisal, including how they managed any case to prevent harm to the patient and whether they have engaged in values training.

Section 5 – the consultation process

Question 28. How far do you agree or disagree with these statements?

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
A. The themes were well explained		X			
B. The questions were easy to complete		X			
C. I felt I was able to express my views		X			

Question 29. Please tell us here if you have any comments on any aspect of the consultation process

(Character limit 4000)

It would have been helpful to have conducted focussed stakeholder consultations prior to this consultation (preferably in the development phase), especially regarding abortion care given how common it is and frequently women suffer harm when conscientious objection causes delay and distress. Even though abortion care is likely the area most impacted by practitioners exercising conscientious objection, we are not aware of any consultation with abortion care experts or providers in the review or development of this guidance.

Q30. How did you hear about this consultation? Please only select one.

Word of mouth

Section 6 - Questions about you

We would be very grateful if you could give us some information about you to help us analyse the responses to this survey.

First name	Jonathan
Last name	Lord
Job title (if responding on behalf of an organisation)	Quality Lead
Organisation name (if responding on behalf of an organisation)	British Society of Abortion Care Providers (BSACP)
Email address	j.lord@exeter.ac.uk
Do you agree to be contacted by email for any further information?	Yes

Question 31. Are you responding as an individual or on behalf of an organisation?

Organisation

Question 43. Which of these categories best describes your organisation? Please select only one.

NHS / health and social care organisation

Question 44. In which country does your organisation operate? Please select only one.
UK wide