GMC CONSULTATION: PERSONAL BELIEFS AND MEDICAL PRACTICE
DRAFT GUIDANCE

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

Submitted by email: 11.6.12

Introduction

The Secular Medical Forum (SMF) comprises mainly doctors and other UK health care professionals working to safeguard patients from the harm caused by the imposition on them of other people’s personal religious views.

The National Secular Society (NSS) 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.

This joint consultation response expands on the joint response we submitted in February 2012 following the GMC request to the NSS for comments on the current (2008) guidance. For clarity, we enclose a copy of our February response which might helpfully be read in conjunction with this document.

Where we have responded to specific questions, we have done so in the order they appear in the GMC consultation document. For clarity, we have included the question and question number before our response. Recommendations are shown in bold.

Question 1: Do you think it is helpful to have guidance on this topic?

Answer: Yes

We commend the GMC for formulating guidance to ensure that doctors’ personal beliefs are not permitted to adversely affect patient care. Patients whose own personal beliefs differ from those of their doctor are most at risk. We strongly support the continued GMC focus on maintaining the care of the individual patient as the doctor’s main concern. We recognise that this remains the GMC’s intention although we are concerned that the draft guidance fails to achieve this end in several important respects.
Although many doctors will have been motivated to train and work as doctors by their personal beliefs, whether religious or not, there is no reason why the patients they treat should be affected by the beliefs of the doctor they happen to consult.

We consider that the inclusion in paragraph 1 (54.) of the phrase: ‘... or that are likely to cause them distress.’ is unhelpful and should be deleted. Whatever the doctor’s intentions, many patients are deeply distressed, harmed and/or feel exploited by the overt expression of doctors’ personal views and beliefs during a consultation or treatment. This often occurs despite the doctor intending to be helpful.

We urge the GMC to reconsider areas of the draft guidance where doctors’ beliefs or the beliefs of the relatives of non-consenting patients are given unjustified and inappropriate deference mainly by virtue of their being ‘religious’ or ‘cultural’ beliefs. In terms of equality impact, this privilege has the potential to cause disproportionate disadvantage and harm to vulnerable patients and to children whose own later personal views and beliefs are not yet known. Decisions taken on behalf of children before they are able to give informed consent or dissent to procedures (such as circumcision) of dubious or no therapeutic value have the effect, albeit years later, of violating irreparably the full, reasonable, legal expression of adults’ own beliefs.

We recommend that the GMC states unequivocally that doctors must not participate in non-therapeutic procedures on the normal bodies of children too young to give informed consent or dissent. This is particularly important for surgical procedures where there is always a risk of harm and where reversal may later be impossible.

Paragraph 4 of the draft guidance refers to the Human Rights Act 1998 (the Act). The Act distinguishes between the absolute right to hold a belief (Article 9 of the ECHR) versus the qualified right to express that belief. Much of our response revolves around this important distinction. We are concerned that the draft guidance fails to strike the right balance intended by the Act. Patients and members of the public must not be denied the reasonable expression of their own personal beliefs by a doctor wishing to express his or her own personal beliefs or by a doctor agreeing to treat a non-competent patient according to the beliefs of a relative or friend of that patient where the patient’s own beliefs are not known and the treatment is not urgent.

For example, women must not be obstructed from receiving good quality, evidence-based, professional sexual health advice and treatment irrespective of the beliefs of the doctor she consults. Doctors who have chosen to work treating patients who are nearing the end of their life should respect and act on all reasonable, legal patient requests for treatment or non-treatment. **We recommend that doctors who have chosen to work in these areas should not be allowed to divest themselves of their professional responsibilities and to refuse, on the grounds of their own beliefs, to provide care or treatment that most**
doctors would regard as best practice or that is in accordance with the reasonable wishes of a competent patient.

Non-therapeutic surgery should never be undertaken on a child’s body whatever the beliefs of the doctor or of the child’s guardians. By definition from a medical perspective, non-therapeutic surgery can always wait until the child is no longer a child and is able to give proper informed consent or dissent. Without this safeguard, the very concept of safeguarding children is debased and undermined. Allowing irreversible treatment to be undertaken on children for no therapeutic reason early enough that the child’s views could not possibly be taken into account subverts the principles underlying the Act. This would ordinarily be seen as a serious safeguarding issue were it not for inappropriate deference to religious or cultural considerations. We urge the GMC to afford proper protection to children whatever the chosen beliefs or cultural values the child’s parents may have. We agree that this should always be done sensitively and with respect for the child and his/her parents. The robust focus must remain on child safeguarding in a similar manner to all child safeguarding work.

We liken this to a doctor who, having anaesthetised his patient so that they could not possibly give consent, proceeds to perform surgery on the non-consenting patient, surgery to which the patient has not given informed consent and for which there is no pressing medical need; such action is an assault, not a medical treatment.

Informal legal advice that we have obtained suggests that doctors, and potentially the officers of the GMC for failing to prohibit such action, may be liable to future legal action by adults whose bodies were operated on for no therapeutic reason whilst they were still children. We recommend that the GMC seek its own legal advice in the context of the implementation of the Human Rights Act 1998.

The current draft guidance inverts the principles underlying the Act by allowing doctors both to refuse to treat competent adults and to impose treatment on not-yet-consenting children by virtue of the doctor’s own personal beliefs and at the expense of the patients’ own reasonable, legal choices. In the context of the GMC’s primary dictum of making the care of the patient the doctor’s first concern, we urge the GMC in the strongest possible terms to redress this imbalance. The current imbalance, rehearsed in the draft guidance, adversely affects those nearing the end of their life, children, adults of no belief or of a different belief to the one held by their parents, and women of reproductive age whose doctor has chosen to work in a field of practice where his or her own beliefs are in conflict with good medical practice.
Currently we allow doctors to object to treatments or procedures on the grounds of conscience, even if the right to conscientiously object is not supported by legislation.

Question 2 Do you think this is a reasonable position for us to maintain?

Answer: No

Where the law specifically allows doctors to exercise a conscientious objection, such as in terms of providing abortion services, we support GMC guidance which accurately reflects the legal position whilst preserving patients’ rights to good quality non-discriminatory health care. However, where there is no specific legislation, the GMC must place the care of the patient above a doctor’s own personal beliefs.

The onus should always remain on the doctor to ensure that patients receive the reasonable professional care to which they are entitled, unimpeded by the doctor’s own personal opinion. The pre-advertising of doctors’ own personal views, beliefs or ‘objections’ would fall a long way short of being sufficient grounds to permit such an exercise of ‘conscience’. Furthermore, pre-advertisement would equally place an unreasonable burden on patients who do not always have the luxury to choose when they need to consult a doctor. For example, a young woman seeking emergency contraception should not have to research in advance whether or not her doctor ‘objects’ to prescribing emergency contraception. Similarly, the description of an NHS GP practice as ‘Christian’ with the expectation that patients will opt-out of their doctor’s Christianity if they want to, is impractical and disadvantageous to many, including minority non-Christian groups who may wish to register with the practice but may feel debarred from doing so, inhibited from expressing their own beliefs or unwilling to even risk ‘offending’ their doctor by opting out of Christianity.

We recommend that the GMC gives unequivocal advice that doctors only be allowed to refuse to participate in those procedures specified in legislation and even then, only when the care of the patient is not compromised.

Unless specified in law, a doctor’s refusal to provide a certain treatment is better termed ‘personal refusal’ or ‘personal objection’. The phrase ‘conscientious objection’ originated in situations of military conscription; using this term confuses the objection of conscripted soldiers to killing other people with the refusal of a doctor, who has freely chosen his/her profession, to provide his/her patient with reasonable medical care to which they are legally entitled.

We recommend that the GMC reminds doctors that, unless exempted by legislation, they must always place their duty to their patients over their own personal beliefs. Doctors have chosen their profession as adults with formed opinions and personal beliefs; patients do not choose to become unwell and are seeking the medical care to which they are
entitled. If a doctor feels that their particular beliefs conflict with a patient’s legal entitlement to care then the burden of belief should be shouldered by the doctor, not by the patient.

Many doctors do successfully manage to set aside their own beliefs where necessary in the interests of providing good quality medical care in accordance with their patients’ wishes. In practice, a doctor who is unwilling to do so, should responsibly choose to work in a field of medicine where his or her own views are not going to come into conflict with the work they have chosen to do. **We recommend that the GMC advise doctors who may be unwilling to compromise their personal beliefs, whether religious or not, that they have a professional responsibility to choose a field of practice which will not bring their personal beliefs into conflict with reasonable, legal patient care.**

We welcome the distinction in paragraph 5 of the draft guidance between refusing to provide a procedure versus refusing to treat a particular patient, or group of patients. Where the law allows for a specific exemption, then a doctor can only exempt him/herself from providing the procedure in totality rather than judging which patients he/she will treat and which will be denied.

**The draft guidance on ‘conscientious objection’ creates significant confusion in two main respects:**
Firstly, by failing to limit the areas in which a doctor may reasonably ‘object’ or ‘refuse’ to provide a therapeutic procedure over and above those specified by legislation, such as abortion. This leads to a mushrooming of doctors’ objections to an increasing variety of therapeutic procedures at the expense of good patient care.

Secondly, by failing to clarify the lengths to which a doctor need go in responding to patient requests for unorthodox, unproven or non-therapeutic treatments, whether mainstream or not.

For example, the draft guidance implies that a doctor who (sensitively and with respect for the patient) ‘refuses’ to accede to a patient’s request to be referred to a spiritual healer, a chiropractor or a homoeopath should invoke the GMC’s conscientious objection guidance. This would place an unreasonable burden on those doctors who wish to practice good quality, evidence-based patient-centred care. Such doctors should be empowered to refuse to provide or refer for non-therapeutic or unproven treatments so long as they remain professionally accountable in terms of current best medical practice.

If it is not the GMC’s intention that doctors invoke GMC conscientious objection guidance in the face of such varied requests for unorthodox, unproven or non-therapeutic treatments, we recommend that the GMC issues explicit guidance to doctors to that effect. Furthermore, we recommend that the GMC changes that section of the current guidance (Endnote 3) which advises doctors to follow the GMC’s conscientious objection
guidance if refusing to refer a male child for non-therapeutic genital surgery as this would be wholly inconsistent with the above.

We recommend that the GMC emphasise the important difference between a competent patient’s choice not to follow best medical practice, which must be respected, and a competent patient’s wish to receive non-therapeutic or unproven treatments from their doctor. The latter does not necessarily need to be granted and may have implications in terms of a doctor’s responsibility to refer responsibly. This difference is not adequately dealt with in the draft guidance which makes no clear distinctions between therapeutic procedures and non-therapeutic or unproven treatments.

We also found unhelpful and confusing the guidance in Endnote 3: Circumcision of male children for religious or cultural reasons. A doctor who is placing the care of the patient as his first concern should refuse to provide, or refer for, an irreversible, non-therapeutic surgical procedure on a person who is not able to give consent. This is the case irrespective of the beliefs of the child’s parents - although parental views should always be sought and considered.

In this situation, the doctor, faced with a request for non-therapeutic interference with a child’s body, should be advised to consider invoking safeguarding procedures rather than being advised to invoke ‘conscientious objection’. In this context, the term ‘conscientious objection’ implies that it is the doctor who is acting outside best medical practice rather than being asked to collude with others in providing a procedure (routine neonatal circumcision) which is nowhere in the world considered best medical practice and is increasingly recognised as having significant side effects and ‘a violation of a boy’s rights to autonomy and physical integrity’.

We recommend that paragraphs 7-11 of the draft guidance be fully rewritten to reflect these important distinctions.

At paragraph 5, we explain that gender reassignment is only sought by a particular group of patients and cannot therefore be subject to a conscientious objection.

Question 3 Is the Guidance on Gender Reassignment Clear?

1 The Non-therapeutic circumcision of male minors, KNMG, 2010

(Combined statement of the Royal Dutch Medical Association, the Netherlands Society of GPs, the Netherlands Society of Youth Healthcare Physicians, the Netherlands Association of Paediatric Surgeons, the Netherlands Association of Plastic Surgeons, the Netherlands Association of Paediatric Medicine, the Netherlands Urology Association & the Netherlands Surgeons Association issued 27 May 2010)
**Answer: No**

We support draft GMC guidance in terms of advising doctors that they must not refuse to provide gender reassignment treatment. However, limiting this guidance to gender reassignment is unhelpful for the reasons we set out in answer to question 2 above on ‘Conscientious Objection’.

In practice, the refusal by a doctor to provide a certain treatment to a patient is often premised on the religion or belief of the doctor. It is not reasonable for a competent patient’s choices to be limited solely because of the beliefs of their doctor where no relevant legislation exists. For example, some doctors refuse to continue to provide treatment to a dying patient who has made a competent request to refuse further life-prolonging treatment. Where this refusal is based on the doctor’s personal beliefs, perhaps believing in sanctity of life, and where it obstructs a patient’s reasonable, legal choices, then this contravenes competent patients’ rights to reasonable autonomy. Furthermore, where patients are denied reasonable therapeutic treatment or forced to find another doctor because the attending doctor’s own beliefs differ from the patients’ beliefs, this is contrary to GMC anti-discrimination policy.

These difficulties can be circumvented by following our recommendations in response to question 2 above and limiting conscientious objection only to those procedures specified in the relevant legislation.

**We recommend that GMC guidance states explicitly that all refusals by doctors to provide reasonable, legal therapeutic treatment options where premised on the doctor’s own religion or belief, and where not covered by legislation, are professionally unacceptable. Patients are entitled to unobstructed access to healthcare.**

**Question 4 Are there any references to supporting information we could include to make the guidance more helpful to doctors?**

**Answer: Yes**

In Endnote 3: Circumcision of male children for religious or cultural reasons, a useful reference would be to the detailed discussion and guidance issued in 2010 by the Royal Dutch Medical Association. See endnote (1)

**Question 5 Is the guidance clear?**

**Answer: No**
We commend many aspects of the draft GMC guidance, as detailed above. However, there are areas where the guidance is unclear or contradictory, particularly in relation to conscientious objection to non-therapeutic procedures.

**We recommend that the guidance makes clear the distinction between patients with the capacity to make their own decisions and those patients vulnerable to the imposition on them of other people’s beliefs.**

The guidance remains overly concerned with the expression of doctors’ own beliefs rather than maintaining the focus at all times on the care of the patients who rely on doctors for their professional expertise.

**We recommend that the GMC reminds doctors that discussion of a doctor’s personal beliefs is always inappropriate unless the discussion is initiated by the patient.** Where the patient does ask about a doctor’s personal beliefs, the doctor might use this as an opportunity to explore the patient’s own views and beliefs and must only divulge their own beliefs in exceptional circumstances. Doctors should be reminded that patients from a variety of cultural or religious backgrounds may hold diverse beliefs; doctors should not make assumptions about patients’ beliefs and should never seek to impose or impress their own views on patients or seek to change their patients’ beliefs.

Doctors must at all times be aware that they have voluntarily chosen their profession and must therefore accept that there are professional limits to the free expression of their personal beliefs.

**Question 6 Do you have any other comments on Personal beliefs and medical practice?**

**Answer: Yes**

The SMF and NSS are regularly contacted by patients who have been harmed by the imposition on them of somebody else’s religious belief. These harms range from relatively minor irritation at religious intrusion through offers of prayer which may cause distress to patients already upset and lacking the confidence to assert their unwillingness to participate, to denial of competent patients’ wishes at the end of their life. The harms include difficulties accessing emergency contraception and abortion services, discredited attempts to convert homosexuals to heterosexuality and the lifelong physical and emotional distress caused to many adults whose bodies were subjected to ‘religious’ or ‘cultural’ surgery to satisfy someone else’s religious or cultural beliefs.

The main feature of these patients is that they usually belong to a minority or disadvantaged group: women, children, the non-religious or homosexuals. Some of these groups, particularly young women or children brought up in religious households, often lack the skills or self-confidence to assert their concerns and have no advocacy group to
represent them. GMC guidance in this area must take into account the vulnerability of these groups of people to the uncompromising demands of religious or cultural imperatives - imperatives that have nothing to do with the vulnerable patients themselves and imperatives which may deny patients appropriate treatment and may cause additional harm. The draft guidance takes some steps to redress this power imbalance but continues to give undue deference to the adult religious views of people who are not ‘the patient’.

Further Comments on Endnote 3: Circumcision of male children for religious or cultural reasons

In choosing to offer specific advice in relation to circumcision of male children for religious or cultural reasons, the GMC appears to be recommending a relaxation of existing child safeguarding procedures which would otherwise apply to all children faced with non-therapeutic surgery. Non-therapeutic surgery is not health care. We recommend that the GMC focuses on the patient, in this case the male child who happens to have been born to parents who request non-therapeutic surgery on him. In addition to the comments here, please see our response to question 2.

In principle, we support the right to the reasonable expression of freely-chosen personal beliefs, including religious beliefs, so long as this does not harm other people. In practice, many religious practices such as religious circumcision, directly affect other people.

Religious or cultural excision of a child’s normal male prepuce is a procedure performed on a child to satisfy someone else’s religious or cultural beliefs. No medical organisation in the world recommends routine infant circumcision for health reasons, and many advise strongly against it. These include the Royal Dutch Medical Association referenced above, the Swedish Paediatric Association, the Australasian Association of Paediatric Surgeons and the South Africa Medical Association. There is evidence of meatal stenosis, panic attacks, bleeding, infection, scarring, sinus formation, later psychological difficulties, loss of sexual sensitivity, orgasm difficulties in men and their partners, keratinisation of the glans penis, amputation of the penis and death. The penis is one of the most personal and private parts of a person’s body. Parents should protect and guard all parts of their children’s bodies as part of their parental responsibilities of guardianship. Religious circumcision denies the man a choice by imposing a major change on his body whilst he is yet powerless to resist and for reasons that may have little or no relevance to him as an adult.

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Male children of Jewish or Muslim parents should be given equal protection as all other children already have, to grow up with their normal genitalia intact.

The only justification for allowing doctors to perform irreversible religious surgery on a child’s body would be the presumption that the child would not later object or may feel aggrieved that it was not performed in the first place. Yet good medical practice when treating people without the capacity to give consent advises doctors always to take the least restrictive option; in this case, it would be least restrictive to preserve the boy’s normal penis for him to make his own decision as an adult.

In the context of the presumed acceptance by the child of his religious or cultural place, it is of note that Endnote 4: Refusal of blood products by Jehovah’s Witnesses states: ‘You should not make assumptions about the decisions that a Jehovah’s Witness patient might make about treatment with blood or blood products’. Using this same principle we recommend that the GMC gives specific advice to doctors to allow children the time to grow up and form their own opinions about non-therapeutic, cosmetic or non-urgent surgery particularly with regard to the most private and erogenous parts of their own bodies. Many adult men born to religious parents no longer follow the religion, belief or culture of their parents. Their views, often non-religious, should be respected as much as those of adult Jehovah’s Witness patients. The current presumption in favour of religious views discriminates against the non-religious.

Where a patient is incapable of choosing to consent or dissent to a non-urgent procedure, but may later be in a position to do so, the guiding principles for doctors should be those in the GMC guidance on ‘treating patients without the capacity to give consent’. Use of these principles would mean that all action taken would be in the best interests of the patient (not necessarily the patient’s family), that the least restrictive option should be taken and with consideration as to whether the patient will later acquire the capacity to make a treatment decision for a decision that can wait. We are dismayed that the GMC draft guidance persists in denying children these excellent guiding principles in favour of the choices of religious adults to impose their non-healthcare-related beliefs on their children.

The advice to doctors who object to non-therapeutic circumcision to follow conscientious objection advice implies a responsibility on doctors to find a doctor who doesn’t so object. But as the operation is non-therapeutic and increasing numbers of doctors regard the operation as unacceptable, is the GMC therefore recommending that it is incumbent on doctors to refer the parents or guardians of infant boys to private circumcisers where there is no local NHS service available? Are doctors therefore duty-bound to research the surgery complication rates of these private circumcisers? And should the procedure be performed inexpertly and additional damage be caused over and above the inevitable loss of a normal prepuce, it is unclear where the limits of responsibility for the referring GP would then lie.
The invitation to a religious adviser to be present at the circumcision ‘to give advice on how the procedure should be performed to meet the requirements of their faith’ is ill-conceived. Are religious advisers to be invited to scrub up in operating theatres? Is this to be limited only to ritual male genital surgery? For most operations conducted in surgical theatres, laypersons are not permitted in theatre for a variety of safety reasons. We do not agree that it is reasonable to make an exception for religious advisers, particularly when there is no medical rationale for operating.

We commend the first sentence of: Endnote 7: Children and Young people

‘Children and young people do not necessarily share the religious or other beliefs of their parents.’ The paragraph that follows is incomplete, however. We agree that doctors must involve mature children in decisions. However, the perceived implication is that if one acts quickly enough before the child has gained sufficient maturity to contribute to the decision-making process then there is little need to consider the child’s views. In fact, just such a view is expressed in certain religious texts which recommend infant circumcision precisely because the child is powerless to resist at that stage and the parents have not yet formed a strong bond with their child which might constrain their enthusiasm for surgery on their child’s genitals.

We recommend that the GMC advises doctors not to participate in non-therapeutic procedures on people who are not in a position to consent or dissent. By definition as non-therapeutic procedures there is no pressing clinical reason to perform the procedure on a non-consenting person and every reason to wait.

In previous communication from the GMC, it has been suggested that, because ritual circumcision is not specifically illegal in the UK, the GMC therefore has no remit to take action to prevent it. Yet, there is precedent in all manner of situations where there is no specific law yet the GMC offers specific recommendations. It is not illegal for a doctor to express his/her own personal views or beliefs to a patient but the GMC rightly advises doctors in what circumstances that might be appropriate or inappropriate. It is not illegal for parents to smack their children so long as no mark is left, yet a doctor who witnesses smacking or repeated smacking and considers the child to be emotionally or physically harmed by this has a duty to invoke safeguarding procedures on behalf of the child. It is not illegal for a doctor to refuse to treat a patient for any condition (unless they are breaching the Act) yet the GMC issues guidance on when it is inappropriate for a doctor to refuse to treat a patient.

Worldwide medical and legal consensus is growing that non-therapeutic ritual penile surgery is harmful and violates boys’ human rights. We urge the GMC to alter its stance by stating clearly that non-therapeutic surgery on minors is unethical, contrary to GMC guidance and may breach their human rights. Children, many of whom will later bitterly regret what was done to them, are being let down by a regulatory system overly
concerned with respecting the adult beliefs of the child patient’s parents and with loudly-vocalised public opinion rather than with the patient himself.

**Religious clothing**

The primary consideration is whether a doctor’s religious clothing or adornment impedes the standard of care or hygiene. Where it does so, doctors should be advised that they must make the necessary modifications. Additionally, the wearing of clothes or adornments with prominent religious or political symbolism contradicts GMC advice not to express a doctor’s own personal or religious beliefs to his/her patient. The danger is not one of offence, though that might occur, but that the patient might feel inhibited from sharing information or seeking treatment for fear of offending the doctor or being judged by the doctor. **Patients should not be placed in the position of having to modify their health-seeking behaviour according to the religious or political affiliation of their doctor.**

Should the GMC implement the suggestions in this submission, then the GMC would ensure that patients could have full confidence in their doctor’s ability and willingness to provide professional care to all patients no matter what the beliefs of the patients or the doctors.