Personal beliefs and medical practice

A draft for consultation

1 In *Good Medical Practice*[*] we advise that:

13. …you must provide a good standard of clinical care. Good care will involve:

a adequately assessing the patient's conditions, taking account of their history (including the symptoms, and psychological, spiritual, religious, social and cultural factors)…

b promptly providing or arranging suitable advice, investigations or treatment where necessary

c referring a patient to another practitioner when this is in the patient's best interests

49. You must treat patients fairly and with respect whatever their life choices and beliefs.

52. You must explain to patients if you have a conscientious objection to a particular procedure while following the guidance in paragraph 54. You must tell them of their right to see another doctor and make sure they have enough information to exercise that right. If it is not practical for a patient to arrange to see another doctor, you must ensure that arrangements are made for another suitably qualified colleague to take over your role.

* *Good Medical Practice* 2012 draft for consultation (2011).

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

58. The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs and priorities and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition.

60. You must not unfairly discriminate against patients or colleagues by allowing your personal views* to affect your professional relationships or the treatment you provide or arrange…

2 This guidance gives more detail about how to comply with these principles. Serious or persistent failure to follow this guidance will put your registration at risk.

Personal beliefs and values in medical practice

3 We recognise that personal beliefs and cultural practices are central to the lives of many doctors and patients, and all doctors have personal values which affect their day to day practice. In some areas the law specifically entitles doctors to exercise a conscientious objection†, or allows or prohibits particular treatments or procedures. We don't wish to prevent doctors from practising in line with their beliefs and values, as long as they also follow the guidance in *Good Medical Practice*. Neither do we wish to prevent patients from receiving care which is consistent with, or meets the requirements of, their beliefs and values.

4 However, in many cases, there is no law that specifies patients' or doctors' rights in relation to individual procedures‡. In these cases doctors should be free to practise medicine in accordance with their beliefs, provided that in doing so they are not denying patients access to appropriate medical treatment or services, or causing distress to patients. In these circumstances we expect doctors to be prepared to set aside their personal beliefs so they can provide effective patient care in line with *Good Medical Practice*.

* This includes your views about a patient or colleague's age, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status.

† In England, Wales and Scotland the right to refuse to participate in terminations of pregnancy is protected by law under Section 4(1) of the Abortion Act 1967. The Abortion Act does not apply in Northern Ireland. The Human Fertilisation and Embryology Act 1990 prevents any duty being placed on an individual to participate in any activity governed by the Act.

‡ Human Rights Act 1998 - Article 9 of the ECHR relates to the right to freedom of thought, conscience and religion. It provides an absolute right as far as holding a belief is concerned, but the right to act on one's beliefs or oblige others to comply with them is subject to qualification and cannot be used to support an action that infringes the rights and freedoms of others.

5 You may choose to opt out of providing a particular procedure because of your personal beliefs and values.* But you must not refuse to treat a particular patient, or group of patients because of your personal beliefs or views about them†. And you must not refuse to treat the health consequences of lifestyle choices to which you object because of your beliefs.

6 Employing and contracting bodies are entitled to require doctors to fulfil contractual requirements (except in relation to activities covered by legislation), which may restrict doctors' freedom to work in accordance with their conscience. This is a matter between doctors and their employing or contracting bodies.

How could doctors' personal beliefs affect patient care?

Conscientious objection

7 If you have a conscientious objection to a treatment or procedure that is not prohibited in the country where you work‡, you must do your best to make sure that patients who may consult you about it are aware of your objection in advance. You can do this by:

- **a** making sure that printed material about your practice and the services you provide makes clear if there are any services you will not provide because of a conscientious objection
- **b** being open with employers about your conscientious objection and exploring with them how to resolve the situation without compromising patient care and without overburdening colleagues.

8 If a patient wants or needs§ to know about a procedure you have a conscientious objection to then you must:

- **a** tell the patient that you do not provide the particular treatment or procedure, being careful not to cause distress – you may wish to mention the reason for your objection but you must be careful not to imply any judgement of the patient
- **b** tell the patient that they have a right to discuss their condition and the options for treatment (including the option that you object to) with another practitioner who does not hold the same objection as you and can advise them about the treatment or procedure you object to
- **c** make sure that the patient has enough information to arrange to see another doctor who does not hold the same objection as you.

9 If it's not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made – without delay – for another suitably qualified colleague to advise, treat or refer the patient. You must bear in mind the patients' vulnerability and the urgency

* The exception to this is gender reassignment since this procedure is only sought by a particular group of patients (and cannot therefore be subject to a conscientious objection – see paragraph 5). This position is supported by the Equality Act 2010 which prohibits discrimination on the grounds of gender reassignment.

† The Equality Act 2010 prohibits discrimination on the grounds of nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

‡ The Abortion Act 1967 does not apply in Northern Ireland.

§ Eg, the patient may not be aware of a procedure or treatment that another doctor, who does not hold your conscientious objection, may judge to be in their best interests. In these circumstances you must tell the patient that the treatment is widely available but that you have a conscientious objection to it and follow the guidance in paragraphs 8-11.

of the situation, and you must act promptly to make sure patients are not denied appropriate treatment or services. If the patient has a disability you should make reasonable adjustments* to your practice to allow them to receive care to meet their needs.

10 You will not necessarily need to end the discussion with your patient. However, if you or the patient feel that your conscientious objection prevents you from objectively assessing their best interests, you should suggest again that the patient seeks advice and treatment elsewhere.

11 You must not obstruct patients from accessing services or leave them with nowhere to turn. Whatever your personal beliefs about the procedure in question, you must be respectful of the patient's dignity and views.

Talking to patients about personal beliefs

12 In assessing a patient's conditions, it may be appropriate to ask them about their personal beliefs. However you must not put pressure on patients to discuss or justify their beliefs, or the absence of them.

13 During a patient consultation, you may talk about your own personal beliefs only if a patient asks you directly about them or if you have reason to believe† the patient would welcome such a discussion. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them. You should keep the discussion relevant to the patient's care and treatment and, as with disclosing any personal information to a patient, you must be very careful not to breach the professional boundary‡ that exists between you, and must continue to exist if trust is to be maintained.

How could a patient's personal beliefs affect their healthcare?

14 Patients' personal beliefs may lead them to:

- ask for a procedure which you may not judge to be of overall benefit to the patient
- refuse treatment which you judge to be of overall benefit to the patient¶.

See the endnotes for some examples of situations where this occurs.

15 You must respect a patients' decision to refuse an investigation or treatment, even if you think their decision is wrong or irrational. You may advise the patient of your clinical opinion, but you must not put pressure on them to accept your advice. The following principles also apply.

a You must accept a competent patient's refusal of treatment.

b In assessing what is of overall benefit to the patient you must consider their cultural, religious or other beliefs and values.

c You must be careful that your words and actions do not imply judgement of the patient or their beliefs and values.

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* This is a requirement of The Equality Act 2010

† Eg the patient has a Bible or Quran with them or some other outward sign or symbol of their belief. However you must be careful not to make assumptions.

§ You must also follow our guidance on *Maintaining a professional boundary between you and your patient* (consultation draft April 2012).

¶ For further exploration of this point in relation to end of life care see *Treatment and care towards the end of life: good practice in decision making* (2010)

Endnote 1: End of life care

Our guidance *Treatment and care towards the end of life: good practice in decision making* says the following about conscientious objection.

79. You can withdraw from providing care if your religious, moral or other personal beliefs about providing life-prolonging treatment lead you to object to complying with:

    A patient's decision to refuse such treatment, or

    A decision that providing such treatment is not of overall benefit to a patient who lacks capacity to decide.

    However you must not do so without first ensuring that arrangements have been made for another doctor to take over your role. It is not acceptable to withdraw from a patient's care if this would leave the patient or colleagues with nowhere to turn.

On the issue of advance care planning, the guidance says the following:

54. Depending on the patient's circumstances, it may also be appropriate to create opportunities for them to talk about what they want to happen after they die. Some patients will want to discuss their wishes in relation to the handling of their body, and their beliefs or values about organ or tissue donation.

55. You must approach all such discussions sensitively. If you are unsure how best to do this or how to respond to any non-clinical issues raised by the patient, you should refer to relevant guidelines on good practice in advance care planning.* If the patient agrees, you should involve in the discussions other members of the healthcare team, people who are close to the patient, or an independent advocate.

And on care after death:

84 Death and bereavement affect different people in different ways, and an individual's response will be influenced by factors such as their beliefs, culture, religion and values.† You must show respect for and respond sensitively to the wishes and needs of the bereaved, taking into account what you know of the patient's wishes about what should happen after their death, including their views about sharing information.‡ You should be prepared to offer support and assistance to the bereaved, for example, by explaining where they can get information about, and help with, the administrative practicalities following a death; or by involving other members of the team, such as nursing, chaplaincy or bereavement care staff.§

* Examples of national guidance on how to approach advance care planning include: *Advance care planning: national guidelines* (2009) Royal College of Physicians of London; *Advance care planning: a guide for health and social care staff* (Aug 2008); *Ascertaining wishes: a good practice guide. Advance care planning for care homes for older people* is available from Counsel and Care. The BMA has published guidance covering this and other issues in end of life treatment and care in *Withholding and withdrawing life-prolonging medical treatment: guidance for decision making* (2007).

† *The Liverpool Care Pathway* is one source of advice on meeting the spiritual and other personal needs of patients and their carers in the last days of life and into bereavement. See also the *All Wales Care Pathway for the Last Days of Life.* Welsh Assembly Government, in Welsh Health Circular (2006) 030. Advice is also available from the Multi-faith Group for Healthcare Chaplaincy.

‡ Disclosure of information after a patient's death is covered at paragraphs 70-72 of our guidance on Confidentiality.

§ Help in supporting bereaved adults and children is available from a number of sources, including the Child Bereavement Charity; Cruse Bereavement Care and Cruse Scotland.

Endnote 2: Contraception

You may have a conscientious objection to providing contraception. However, you cannot be willing to provide married women with contraception but unwilling to prescribe it for unmarried women. This would be a breach of our guidance as you would be refusing to treat a particular group of patients (unmarried women) rather than refusing to provide a particular treatment (contraceptive medication). This would also be illegal under the Equality Act 2010 which prohibits discrimination on the grounds of marriage and civil partnership.

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

If you are asked to circumcise a male child, you must proceed on the basis of the child's best interests and with consent. An assessment of best interests will include the child and/or his parents'* cultural, religious or other beliefs and values.† You should get the child's consent if he is competent. If he is not, you should get consent from all those with parental responsibility. If you cannot get consent for the procedure, eg because the parents cannot agree and disputes cannot be resolved informally, you should:

- inform the child's parents that you cannot provide the service unless you have authorisation from the Court, and
- advise the child's parents to seek legal advice on applying to the Court.

If you are opposed to circumcision except where it is clinically indicated you must explain this to the child (if he can understand) and his parents and follow our advice on conscientious objection (paragraphs 8-11).

If you agree to circumcise a male child, you must:

- have the necessary skills and experience to perform the operation and use appropriate measures, including anaesthesia, to minimise pain and discomfort both during and after the procedure
- keep up to date with developments in the practice of male circumcision including when the procedure is, and is not, necessary for medical reasons
- explain objectively to the child (if he can understand) and his parents the benefits and risks of the procedure
- explain to the child and his parents that they may invite their 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
- ensure conditions are hygienic and provide appropriate aftercare including advice to parents on how to minimise pain and discomfort and maintain cleanliness.

* 'Parents' here means all those with parental responsibility for the child.

† You must also follow our guidance *0-18 years: guidance for all doctors* (2007) see paragraphs 34-35.

Endnote 4: Refusal of blood products by Jehovah's Witnesses

Many Jehovah's Witnesses have strong objections to the use of blood and blood products, and may refuse them*, even if there is a possibility that they may die as a result.

You should not make assumptions about the decisions that a Jehovah's Witness patient might make about treatment with blood or blood products. You should ask for and respect their views and answer their questions honestly and to the best of your ability.†

You may also wish to contact the hospital liaison committees established by the Watch Tower Society (the governing body of Jehovah's Witnesses) to support Jehovah's Witnesses faced with treatment decisions involving blood.‡ These committees can advise on current Society policy regarding the acceptability or otherwise of particular blood products. They also keep details of hospitals and doctors who are experienced in 'bloodless' medical procedures.

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

Where a patient who is awaiting§ or has undergone a termination of pregnancy needs medical care, you have no legal¶ or ethical right to refuse to provide it on grounds of a conscientious objection to the procedure. The same principle applies to the care of patients before or following any other procedure from which you have withdrawn because of your beliefs.

* Adult patients who have capacity to make decisions about their care have the right to refuse any medical treatment.

† You must also follow our guidance *0-18 years: guidance for all doctors* which deals with making decisions where the patient is a child or young person, including issues such as capacity to consent, parental responsibility and refusal of treatment.

‡ The Hospital Information Service runs a 24-hour telephone line (020 8906 2211) for those trying to contact their local Hospital Liaison Committee. If you intend to discuss an individual patient's case you should seek consent before contacting the committee.

§ See paragraphs 8-11 on conscientious objection. This does not include care which is necessary preparation for performing a termination

¶ The case of Janaway v Salford Health Authority All England Law Rep 1988 Dec 1;[1988] 3:1079-84 set a precedent and defined participation as 'actually taking part in treatment designed to terminate a pregnancy'.

General Medical Council | 07

Endnote 6: Completion of cremation forms

If you are the only doctor legally able to sign the Certificate of Medical Attendant (Form B)* you should not refuse to do so on the basis of your own personal or religious objection to cremation. Refusal to sign the form could necessitate a referral to the coroner and a post mortem, causing unnecessary delay and distress to the relatives of the deceased patient.

Endnote 7: Children and young people

Children and young people do not necessarily share the religious or other beliefs of their parents. When you provide care or advice to a child or young person you must make sure that you consider them as individuals, with their own views, beliefs and preferences. Where children and young people have sufficient maturity and understanding to make decisions for themselves, you must respect their right to confidentiality and their right to give or withhold consent.

For further advice on consent and confidentiality see our guidance *0-18 years: guidance for all doctors*.

If you have concerns that a child's physical or emotional well-being is being compromised by their parent's religious or cultural beliefs or practices, you should follow our guidance in *Protecting children and young people: the responsibilities of all doctors*.

* Doctors' responsibilities when completing cremation forms are governed by the Cremation Acts of 1902 and 1952, and the Cremation Regulations 1930 (as amended). The Certificate of Medical Attendant (Form B) must be signed by a doctor who attended the deceased before death and has seen and identified the deceased's body after death. It can be completed by the same doctor (and even at the same time) as the Medical Certificate of Cause of Death (MCCD).