BMA

Expressions of doctors' beliefs

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All patients have a right to receive high quality clinically-indicated care in a supportive and non-judgmental manner.

The BMA recognises that some doctors and medical students may have a conscientious objection to participating in some procedures that are nonetheless lawful. This guidance sets out the BMA's views on conscientious objection and the manifestation of religious and cultural belief for both doctors and medical students. The BMA does not seek unnecessarily to restrict doctors and medical students seeking to exercise a conscientious objection, or in other expressions of their belief.

We seek to balance doctors' freedom with the rights of patients to receive appropriate treatment in a suitably non-judgmental fashion. In the BMA's view however, a treating doctor's primary obligation is to his or her patient. Where conflicts arise between the interests of patients and a doctor's freedom to exercise a conscientious objection or to manifest belief, in the BMA's view they must be resolved in favour of patients.

Conscientious objection guidance for doctors and medical students

BMA view in summary

The BMA believes that:

doctors should have a right to conscientiously object to participation in abortion, fertility treatment and the withdrawal of life-sustaining treatment, where there is another doctor willing to take over the patient's care;

doctors should be able to request that arrangements are made to accommodate their conscientious objection to participating in other medical procedures, provided that patients are not disadvantaged. All requests should be considered on their merits;

doctors should not claim a conscientious objection to treating particular patients or groups of patients;

doctors should not share their private moral views with patients unless explicitly invited to do so;

doctors should ensure that any manifestation of their religious or cultural beliefs (such as clothing or other religious icons) do not impact negatively upon the therapeutic relationship.

Conscientious objection and medical practice

The right to freedom of thought

An explicit legal right to freedom of thought, conscience and religion is protected by Article 9 of the European Convention on Human Rights. The right is not absolute. It can be limited in circumstances where such limitations 'are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or the protection of the rights and freedoms of others.'

In a recent case for example the European Court of Human Rights upheld a domestic UK judgment stating that it was lawful for an employer to prevent a geriatric nurse from wearing a necklace, in her case a crucifix, because it was necessary and proportionate on health and safety grounds and in the interests of patients.

> Read more about the Case of Eweida and others v. The United Kingdom (15 January 2013)

Medicine and diversity

The BMA is committed to promoting diversity and tackling unjustifiable discrimination in medicine. We recognise that in complex societies like ours there is a plurality of beliefs, backgrounds and cultures. Some doctors and medical students may wish to claim a right to a conscientious objection in circumstances not supported by the BMA.

Although we do not seek unnecessarily to restrict doctors' freedoms to object, where the rights of patients to appropriate and timely treatment are at stake, we do believe that the interests of patients must take priority and doctors should act with restraint in the manifestation of personal beliefs.

Patients' rights to care

Where it is available and approved by NICE, patients are entitled to timely, clinically-indicated care or treatment that is provided in a supportive, sensitive and non-judgmental manner. The legal right to such care and treatment is enshrined in the NHS Constitution. Doctors seeking to exercise a conscientious objection must take care not to undermine this right. Doctors employed by the NHS are contracted to provide a public service delivering aspects of this care in accordance with their terms and conditions of service.

Medicine is a varied profession. Doctors who wish to exercise a conscientious objection to certain procedures will quite understandably seek to specialise in areas where they will not ordinarily be called upon to perform them. For medical students, some doctors in training, and for some generalists, such as GPs, it may not always be possible to avoid contact with such procedures. In these circumstances, in the BMA's view, conscientious objection should ordinarily be limited to those procedures where statute recognises their right (abortion and fertility treatment) and to withdrawing life-prolonging treatment from patients who lack capacity, where other doctors are in a position to take over the care.

We recognise that the latter is not a legally enforceable right, although it is offered some support by the Mental Capacity Act Code of Practice, but we would support a doctor making such a request. Although reasonable - and lawful - requests to exercise a conscientious objection in relation to other procedures should ordinarily be considered, the BMA does not believe doctors should have a 'right' to object in these circumstances.

> Find out more about the NHS Constitution

The GMC on personal beliefs

Paragraph 8 of Good Medical Practice states:

If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see another doctor.

You must be satisfied that the patient has sufficient information to enable them 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.

Supporting a 'limited right' to conscientious objection

The BMA recognises that medical opinion differs in relation to the proper scope of conscientious objection. Some commentators have argued that doctors should have no rights to conscientious objection, that "to be a doctor is to be willing and able to offer appropriate medical interventions that are legal, beneficial, desired by the patient, and a part of a just healthcare system", and that such an obligation should be enforced.

We do not support such a restricted position. Partly for the reason that the right to exercise a conscientious objection to participating in abortion and fertility treatment is already provided for in statute. In addition, the BMA would support a request

by a doctor seeking to exercise a conscientious objection to withdrawing life-sustaining treatment from a patient lacking capacity - ie the patient cannot make a choice herself - where another doctor is available and willing to take over care.

The BMA distinguishes these procedures for a number of reasons. The first is their moral seriousness. Sincerely held views about when morally valuable human life begins differ in our society. Some for example believe that full moral value begins at conception. For those who hold this view, abortion is a very grave intervention. Likewise, in certain clearly defined circumstances, the Human Fertilisation and Embryology Act permits the use of human embryos for treatment and research.

Another reason we distinguish these interventions is because they relate to specific acts, not to specific individuals or groups of individuals. It is to the act of terminating a pregnancy, or, in relation to withdrawing treatment, the 'letting die' that the doctor objects to. In our view this is very different to a doctor refusing to treat certain types or classes of patient. The objection may also arise on the basis of genuine moral disagreement as to whether the intervention provides an overall benefit.

Medical Ethics Today: The BMA's Handbook of Ethics and Law (Chapter 7) has more information on this topic in relation to abortion and fertility treatment

Where it comes to classes of people, there is usually no doubt that the intervention could be clinically beneficial: the objection arises from the perceived nature of the patient, not the intervention. Objecting in principle to the termination of a pregnancy is very different to objecting to providing fertility treatment to same sex couples. In our view the latter would always be unacceptable.

> Read the BMJ article 'Conscientious objection in medicine' - Julian Savulescu, Director (BMJ, 2006)

Conscientious objection and medical professionalism

Recent research published in the Journal of Medical Ethics suggests that many medical students would consider exercising conscientious objections to a broad range of interventions, extending, in some cases, to a refusal to treat patients of the opposite sex or those whose ill health derives from personal 'lifestyle' choices. This research is strengthened by the GMC's recent review of its guidance on personal beliefs which noted an increase in the number of enquiries it had received from doctors seeking to exercise a conscientious objection. This also confirms the BMA's experience.

As the GMC states, 'good doctors make the care of their patients their first concern.' Care for their patients will not always be a treating doctor's sole concern but it is their primary one.

Medical professionalism refers to that set of values and behaviours that underlie successful therapeutic relationships.

Medical professionalism refers to that set of values, behaviours and dispositions that underlie successful therapeutic relationships. Although professionalism is a complex concept, it is clear that effective doctors cultivate the ability to reflect on their practice. An important aspect of this is developing an awareness of those areas where the expression of personal values might have a negative impact on patients or the therapeutic relationship. Of course doctors will bring their own private values to their work, but it is vital that doctors exercise restraint where the expression of these values or beliefs might be detrimental to the interests of patients.

In addition to its inter-personal aspect, medicine and health in the UK are important public goods. The NHS is committed to the provision of health on the basis of need. Although we recognise that the concept of health 'need' is complex, the BMA fully supports this position. Pragmatically, were significant numbers of doctors to opt-out of providing certain treatments or treating certain types of patients, the NHS would struggle to function. Were doctors to opt out of treating classes of patient - those for example whose illnesses were thought to arise from their personal choices - the fundamental obligation to provide appropriate treatment in a supportive and non-judgmental manner could not be met. Doctors and their institutions could also be vulnerable to legal challenge for discrimination.

Discrimmination

The Equality Act 2010 provides protection for individuals against unfair discrimination on the basis of the following 'protected' characteristics:

- disability
- gender reassignment
- pregnancy and maternity (which includes breastfeeding)
- race
- religion and belief
- sex
- sexual orientation

'Unfair discrimination' is defined in two ways: as 'direct' and as 'indirect' discrimination. Direct discrimination is where an individual is disadvantaged as a result of a policy that specifically provides inferior treatment to someone on the basis of one or more of the protected characteristics. Indirect discrimination arises as the result of a policy that may not have been intended to disadvantage individuals with any of the protected characteristics, but may nonetheless have that effect. A ban on hats for example might indirectly discriminate against those whose religion requires them to wear them, such as Sikhs.

A refusal to treat patients because of their gender or sexual orientation would render both doctors and their institutions vulnerable to charges of direct discrimination.

'Disability' is defined as 'a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.' Failure to treat individuals because their ill health might be the result of lifestyle factors could be construed as both direct and indirect discrimination against people with disabilities.

Discussion with patients

As mentioned earlier, patients in the NHS are entitled to expect high quality, clinically-indicated care delivered in a supportive and non-judgmental manner. At times, doctors or other health professionals seeking to exercise a conscientious objection may need to discuss the matter with their patient, explaining, for example, their reasons for referral to another practitioner.

In these circumstances they should ensure that they discuss the matter as sensitively as possible, bearing in mind that the patient may be in a particularly vulnerable position. Sensitive handling should be designed to minimise any distress to the patient arising from a perceived judgment of the patient or the patient's values by the doctor or health professional.

› Read our guide about dealing with discrimination

Conscientious objection and medical students

In a 2006 position statement, the GMC's Education Committee addressed the question of whether students could omit parts of the medical curriculum and still graduate with a medical degree and practise as a doctor.

The statement emphasised the GMC's commitment to a diverse medical student population but stated that its primary responsibility was to ensure the safety of patients. It acknowledged the argument that because some doctors go into specialties which do not involve direct patient contact, or subsequently enter careers unrelated to medicine, it should be possible for them to acquire a medical degree without demonstrating all the core medical skills.

However, the Committee concluded:

> Medical students clearly have a right to freedom of expression and having a range of ethical and religious perspectives contributes to medical education and practice. However, these considerations cannot compromise the fundamental purpose of the medical course: to train doctors who have the core knowledge, skills, attitudes and behaviour that are necessary at graduation...
>
> Good Medical Practice already makes provision for doctors who object on moral grounds to providing particular treatments without prejudicing patient care. However, there is an important difference between performing particular treatments that many doctors would not, in any event, ever be expected to perform in the NHS and the core skills required of every medical practitioner at graduation.

General Medical Council (2006)
Core Education Outcomes: GMC Education Committee Position Statement. Para 10.

The Committee also set its guidance in the context of the practical requirements of pre-specialty medical training:

> Doctors who graduate in the United Kingdom enter a two year Foundation Programme which involves a range of clinical experience, much of it based in emergency departments and involving a wide range of unselected and acutely ill patients... it would not be possible for a doctor to practise in that environment while refusing to examine, for example, half of all patients on grounds of gender or the large number of people whose illness can be attributed to their lifestyle.
>
> Indeed, prejudicing treatment on the ground of patients' gender, or their responsibility for their condition, would run counter to the most basic principles of ethical medical practice.
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> **General Medical Council (2006)**
> Core Education Outcomes: GMC Education Committee Position Statement. Para 11.

Arguably the limits of conscientious objection for students are drawn more restrictively than for doctors, even though a student exercising such an objection will be unlikely to put patients directly in the way of harm.

A failure to achieve certain key competences may nevertheless result in potential future harm to patients or certain classes of patient.

The expression of doctors' personal moral or religious views

Although the BMA recognises the importance of frankness and openness with patients, this does not extend to doctors offering unsolicited opinions about their own moral views. Although all doctors have private moral views, they should not share them unless explicitly asked by patients to do so. In particular, doctors should avoid making pejorative or judgemental comments about patients' values or behaviour. If doctors believe their personal moral views are likely to affect their advice or treatment, the patient must be given the option of seeing a different doctor.

'Lifestyle' choices can have a significant impact on health. Patients should be offered factual information about how to safeguard their health but the fact that their actions may have contributed to their condition should not give rise to moralising or delaying treatment.

If doctors believe their personal moral views are likely to affect their advice or treatment, the patient must be given the option of seeing a different doctor.

In some cases, habits such as smoking, drug or alcohol addiction have clinical implications for the effectiveness of any proposed treatment. These should be discussed candidly, in a non-judgmental manner, as part of informing patients. Doctors must avoid language or actions that imply discrimination, including gratuitous comments about patients' lifestyles. NHS guidance makes clear that such behaviour in a healthcare setting could be construed as harassment.

In 2008, a nurse was suspended on the basis of failing to demonstrate a professional commitment to equality and diversity, after offering to pray for a patient, who reported the comment. She was re-instated but it was made clear that offering prayers is only acceptable when patients ask for them.

The issue was discussed at the BMA's 2009 annual meeting, which recognised that the NHS is committed to providing spiritual care but that the initiative for it must rest with the patient.

Clothing and other expressions of religious belief or culture

As indicated above, the Courts have held that a ban on the wearing of unsecured necklaces by health workers could be legitimate where it is necessary and proportionate on health and safety grounds: to prevent patients grabbing it for example or to help limit the spread of infection. This was the case even where individuals felt themselves to be under an obligation to manifest their religious or cultural beliefs in such a way.

Some doctors may seek to manifest religious or cultural beliefs or views through the wearing of clothes that may not have any direct health and safety implications but may nonetheless have an impact on the therapeutic relationship. Concerns have been expressed about the impact on the development of trust between doctors and patients where, for example, women doctors choose to wear the Niqab or Burqa during consultations.

Like the GMC, the BMA does not seek to tell doctors what to wear. As with other manifestations of religious belief or culture, the BMA anticipates that doctors will put the interests of their individual patients first and will adapt their manifestations of culture and belief accordingly.

The GMC on clothing and expressions of religious belief or culture

It is important that patients feel able to build relationships of trust and communicate freely with their doctors.

Some patients, for example, may find that a face veil worn by their doctor presents an obstacle to effective communication and the development of trust. You must be prepared to respond to a patient's individual needs and take steps to anticipate and overcome any perceived barrier to communication.

In some situations this may require you to set aside your personal and cultural preferences in order to provide effective patient care.

BMA policy

At its 2008 Annual Representatives Meeting the BMA passed a resolution stating that doctors should only have a right of conscientious objection to those procedures where such a right is recognised by statute (to participating in abortion and certain forms of fertility treatment) and to the withdrawal of life-sustaining treatment from a patient who lacks capacity, where another doctor is willing to take over the patient's care.

While only the former are legally recognised rights, the latter is given some support by the Mental Capacity Act's Code of Practice and the BMA would strongly support a request by a doctor to exercise a conscientious objection in the latter case, even though it is not a right directly protected by statute.

In addition, the BMA believes that there is no reason why reasonable and lawful requests by doctors to exercise a conscientious objection to other procedures should not be considered, providing individual patients are not disadvantaged and continuity of care for other patients can be maintained. In these circumstances, conscientious objection should not be seen as a 'right', but individual requests should be assessed on their merits.