

The current protection of conscientious objection in health care practice

Accommodating Conscience Research Network (ACoRN)

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Introduction

‘It is suggested that **there is a danger in allowing “opt-out” to be seen as an entitlement gradually through guidance, without the legitimacy and the boundaries of such an opt-out being subject to a thorough reconsideration** ... We need to step back and re-evaluate when and to what extent acting as a healthcare professional is compatible with the ability to opt out of a procedure on the basis of conscience, and what the boundaries should be. It is submitted that a fundamental reconsideration of whether this should be a right or a privilege, or indeed not recognised at all, is needed across the healthcare professions and indeed more broadly in the public policy arena. Not simply, in the areas such as assisted dying, but more broadly in relation to clinical procedures as a whole rather than **sanctioning incremental extension of ‘opt-out’ across health care**’. (JV McHale, ‘Conscientious objection and the nurse: A right or a privilege?’ (2009) 18 *British Journal of Nursing* 1262, 1263).

Statutes

Vaccination Act 1898 (repealed by the National Health Service Act 1946)

s 2 (1) No parent or other person shall be liable to any penalty ... if within four months from the birth of the child he satisfies two justices, or a stipendiary or metropolitan police magistrate, in petty sessions, that **he conscientiously believes that vaccination would be prejudicial to the health of the child**, and within seven days thereafter delivers to the vaccination officer for the district a certificate by such justices or magistrate of such conscientious objection.

Abortion Act 1967

s 4 (1) Subject to subsection (2) below, no one shall be under any duty, whether by contract or by any statutory or other legal requirement, **to participate in any treatment authorised by this Act** to which he has a conscientious objection.

Provided that in any legal proceedings the **burden of proof of conscientious objection shall rest on the person claiming to rely on it.**

Human Fertilisation and Embryology Act 1990

s 38 (1) No person who has a conscientious objection **to participating in any activity governed by this Act** shall be under any duty, however arising, to do so.

(2) In any legal proceedings the **burden of proof of conscientious objection shall rest on the person claiming to rely on it.**

Convention

European Convention on Human Rights – Human Rights Act 1998, Article 9

1. Everyone has the **right to freedom of thought, conscience and religion**; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, **to manifest his religion or belief, in worship, teaching, practice and observance.**
2. Freedom to manifest one's religion or beliefs shall be **subject only to such limitations as 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 for the protection of the rights and freedoms of others.

Article 8

1. Everyone has the **right to respect for his private and family life**, his home and his correspondence.
2. There shall be **no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society** in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, **for the protection of health or morals, or for the protection of the rights and freedoms of others.**

Examples of sanctioned incremental expansion of CO

Re B (Adult Refusal of Medical Treatment) [2002] EWHC 429 (Fam), *per* Dame Butler-Sloss P:

27. ... the right of the competent patient to request cessation of treatment must prevail over the natural desire of the medical and nursing profession to try to keep her alive.

100 viii. **If there is no disagreement about [the patient's] competence but the doctors are for any reason unable to carry out the wishes of the patient, their duty is to find other doctors who will do so.**

DCA, Mental Capacity Act 2005 *Code of Practice* (2007):

What if a healthcare professional has a conscientious objection to stopping or providing life-sustaining treatment?

9.61 Some healthcare professionals may disagree in principle with patients' rights to refuse life-sustaining treatment. The Act does not change the current legal situation. They do not have to do something that goes against their beliefs. But they must not simply abandon patients or cause their care to suffer.

The Regulators

(i) Nursing and Midwifery Council *The code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2015), updated 2018:*

4. Act in the best interests of people [using or needing nursing or midwifery services] at all times

To achieve this you must:

4.4 tell colleagues, your manager and the person receiving care if you have a **conscientious objection to a particular procedure** and arrange for a suitably qualified colleague to take over responsibility for that person's care.

You can only make a 'conscientious objection' in limited circumstances. For more information, please visit our website at www.nmc.org.uk/standards.

Specific guidance - 'Conscientious objection by nurses, midwives and nursing associates': <https://www.nmc.org.uk/standards/code/conscientious-objection-by-nurses-and-midwives/>

(ii) General Medical Council - *Good Medical Practice* (2013), updated 2019:

52 You must explain to patients if you have a **conscientious objection to a particular procedure**. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs ... (footnote to *Personal beliefs and medical practice* (2013)).

Specific guidance - *Personal beliefs and medical practice* (2013):

8. You may choose to opt out of providing a particular procedure because of your personal beliefs and values, as long as this does not result in direct or indirect discrimination against, or harassment, of a patient or groups of patients. This means that 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.#

* So, a doctor can decide not to provide or refer any patients for treatments that cause infertility but cannot refuse to provide a patient with medical services because they are undergoing gender reassignment (or have done so). # For example, this means that while you may decide not to provide contraception (including emergency contraception) services to any patient, you cannot be willing to prescribe it only for women who live in accordance with your beliefs (eg by prescribing for married women but not for unmarried women).

Irish Medical Council – *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (2016):

49.1 You may refuse to provide or to take part in the provision of lawful treatments or forms of care which conflict with your sincerely held ethical or moral values.

(iii) General Pharmaceutical Council, *Standards for pharmacy professionals* (2017):

Standard 1: Pharmacy professionals must provide person-centred care

There are a number of ways to meet this standard, and below are examples of the attitudes and behaviours expected.

...

- recognise their own values and beliefs but do not impose them on other people
- take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs

Specific guidance - *In practice: Guidance on religion, personal values and beliefs* (2017):

In some cases, a pharmacy professional's religion, personal values or beliefs may influence their day-to-day practice, particularly whether they **feel able to provide certain services**.

This might include, for example, services related to:

- contraception (routine or emergency)
- fertility medicines
- hormonal therapies
- mental health and wellbeing
- substance misuse
- sexual health

Pharmacy professionals have the right to practise in line with their religion, personal values or beliefs as long as they act in accordance with equalities and human rights law and **make sure that person-centred care is not compromised**. (p 7)

Professional bodies

British Medical Association, *Medical Ethics Today: The BMA's Handbook of Ethics and Law*, 3rd ed (2013):

the BMA argues that **doctors should only claim a conscientious exemption to the procedures where statute recognises their right** (abortion and fertility treatment) **and to withdrawing life-prolonging treatment from a patient who lacks capacity**. The BMA's policy is to support doctors' rights to conscientiously object to carrying out non-emergency procedures in these limited instances. (p. 33)

Specific guidance - 'Expression of doctors' beliefs' (2018):
<https://www.bma.org.uk/advice/employment/ethics/expressions-of-doctors-beliefs>:

... **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**.

BMA, 'Expression of doctors' beliefs' (2018):

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.**

Guidance on specific treatments

(i) Contraception

BMA, Medical Ethics Today: (2013):

Although, legally, the use of contraceptives that are capable of preventing implantation does not constitute an abortion, the BMA recognises that some doctors, believing life begins at fertilisation, may have an ethical objection to their use. Those who take this view may choose not to provide such services. In the BMA's view ... **doctors with a conscientious objection to providing contraceptive advice or treatment have an ethical duty to refer their patients to another practitioner or family planning service.**
(p 277)

Summary - contraception

- **Health professionals with a conscientious objection to some or all forms of contraception are not obliged to provide them**, but they have an ethical duty to refer their patients promptly to another practitioner. (p 277)

(ii) Withdrawing life-sustaining treatment

BMA, *Medical Ethics Today* (2013); ‘Expression of doctors’ beliefs’ (2018).

GMC, *Treatment and care toward the end of life: Good practice in decision making* (2010):

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) a patient’s decision to refuse such treatment, or

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

RCP and BMA, *Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent: Guidance for decision-making in England and Wales* (2018):

33. A health professional who is unable, for reasons of personal beliefs, to make or implement a best interests decision to withdraw, or to continue, CANH should recognise this as a potential conflict of interest and hand over this aspect of the patient’s care to a colleague. (p 10)

There is no statutory right for health professionals to claim a conscientious objection to participating in the withdrawal of CANH. (p 25)

(iii) Assisted dying

BMA, 'End-of-life decisions: Views of the BMA' (1997):

If the law were to change to permit doctors to end patients' lives on request, participation in **assisted suicide would be a matter for the individual doctor's conscience, subject to professional guidance issued by the regulatory body.**

Assisted Dying for the Terminally Ill Bill 2004-05:

Clause 7(2) If an attending physician whose patient makes a request to be assisted to die ... or to receive pain relief has a conscientious objection as provided in subsection (1), **he shall take appropriate steps to ensure that the patient is referred without delay** to an attending physician who does not have such a conscientious objection.

(3) If a consulting physician to whom a patient has been referred ... has a conscientious objection ..., he **shall take appropriate steps to ensure that the patient is referred without delay** to a consulting physician who does not have such a conscientious objection.

Assisted Dying Bill [HL] 2016-17:

A person shall **not be under any duty** (whether by contract or arising from any statutory or other legal requirement) **to participate in anything authorised by this Act to which that person has a conscientious objection.**

Royal Pharmaceutical Society, *Assisted Suicide Policy Statement* (2013):

It is a **pre-requisite that a conscience clause is incorporated into any legislation**. There **must be no obligation for any pharmacist to participate in any aspect of an assisted suicide or similar procedure if he or she feels this is against their personal beliefs**. The framework we are proposing allows pharmacists to ‘opt in’ by completing the necessary training, rather than ‘opting out’. It also avoids the need for anyone ethically opposed to assisted suicide to signpost to another pharmacist as this can also pose an ethical dilemma.

Dealing with CO in practice

(i) Common law

Referral

Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland) [2014] UKSC 68, [40], *per* Lady Hale:

‘Whatever the outcome of the objectors’ stance, it is a feature of conscience clauses generally within the health care profession that **the conscientious objector be under an obligation to refer the case to a professional who does not share that objection.** This is a necessary corollary of the professional’s duty of care towards the patient. Once she has assumed care of the patient, she needs a good reason for failing to provide that care. But **when conscientious objection is the reason, another health care professional should be found who does not share the objection.**’

Barr v Matthews (1999) 52 BMLR 217, 227 *per* Alliot J:

‘Once a termination of pregnancy is recognised as an option, **the doctor invoking the conscientious objection clause should refer the patient to a colleague at once.**’

(ii) Professional regulators

NMC, *The code* (2018)

More than referral?:

4.4 ... **arrange for a suitably qualified colleague to take over responsibility** for that person's care.

Tell others:

4.4 **tell colleagues, your manager and the person receiving care** if you have a conscientious objection to a particular procedure ...

GMC, *Personal beliefs and medical practice* (2013):

Tell others:

11 You should also be **open with employers, partners or colleagues** about your conscientious objection. You should **explore with them how you can practise in accordance with your beliefs without compromising patient care and without overburdening your colleagues.**

GMC, *Personal beliefs and medical practice* (2013):

10. If, having taken account of your legal and ethical obligations, you wish to exercise a conscientious objection to particular services or procedures, **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 making sure that any printed material about your practice and the services you provide explains if there are any services you will not normally provide because of a conscientious objection.

12. If you have a conscientious objection to treatment or procedure that may be clinically appropriate for the patient, you **must** do the following:

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 a 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**.

More than referral?:

GMC, *Personal beliefs and medical practice* (2013):

13. **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 patient's vulnerability and act promptly to make sure they are not denied appropriate treatment or services ... In emergencies, you must not refuse to provide treatment necessary to save the life of, or prevent serious deterioration in the health of, a person because the treatment conflicts with your personal belief.

Good Medical Practice (2013):

52 ... **If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.**

GMC guidance repeated by the MDU, 'Conscientious objection' (2018):
<https://www.themdu.com/guidance-and-advice/guides/conscientious-objection>

Irish Medical Council – *Guide to Professional Conduct and Ethics* (2016):

Tell others:

49.2 If you have a **conscientious objection to a treatment or form of care**, you should **inform patients, colleagues and your employer as early as possible**.

49.3 **When discussing these issues with patients**, you should be **sensitive and considerate so as to minimise any distress your decision may cause**. You should **make sure that patients' care is not interrupted and their access to care is not impeded**.

49.4 If you hold a conscientious objection to a treatment, you must:

- **inform the patient that they have a right to seek treatment from another doctor**; and
- **give the patient enough information to enable them to transfer to another doctor to get the treatment they want**.

More than referral?:

49.5 **If the patient is unable to arrange their own transfer of care**, you should **make these arrangements on their behalf**.

49.6 In an emergency, you must make your patient's care a priority and give necessary treatment.

GPhC - *In practice: Guidance on religion, personal values and beliefs* (2017):

It is important that pharmacy professionals work in partnership with their employers and colleagues to consider how they can practise in line with their religion, personal values and beliefs without compromising care. This includes **thinking in advance about the areas of their practice which may be affected and making the necessary arrangements**, so they do not find themselves in the position where a person's care could be compromised. (p 7)

Tell others:

Pharmacy professionals should also:

- **tell their employer, as soon as possible, if their religion, personal values or beliefs might prevent them from providing certain pharmacy services, and**
- **work in partnership with their employer to make sure adequate and appropriate arrangements are put in place.** (p 9)

GPhC - *In practice: Guidance on religion, personal values and beliefs* (2017):

Referral or more than referral?:

We want to be clear that **referral** to another health professional **may be an appropriate option**, and this **can include handover to another pharmacist at the same, or another, pharmacy or service provider**. (p 8)

A referral may not be appropriate in every situation: for example, if a service is not accessible or readily available elsewhere for the person, or if, due to the person's vulnerability, a referral would effectively obstruct timely access to the service. Again, **pharmacy professionals should use their professional judgement to decide what is appropriate in individual cases**, and keep a record of these decisions, including any discussions with the person asking for care. (p 8)

If a pharmacy professional is unwilling to provide a certain service, they should **take steps to make sure that the person asking for care is at the centre of their decision-making**, so they can access the service they need in a timely manner and without hindrance. (p 7)

(iii) Professional association

Tell patients:

BMA, *Medical Ethics Today* (2013):

Doctors who **oppose contraception or the termination of pregnancy** ... should **inform patients who want those services how they can access them from another doctor**. (p 32)

In the event of seeing a patient seeking advice on [abortion, fertility treatment or withdrawing life-prolonging treatment from a patient who lacks capacity], doctors should **immediately make clear if they have a conscientious objection and inform patients of their right to see another doctor**. They should **ensure that patients have sufficient information to exercise their right to receive advice elsewhere**. If patients want to transfer but **cannot readily make their own arrangements to see another doctor, the practitioner they have consulted must ensure that arrangements are made, without delay, for another doctor to take over their care**. This should be done in as seamless a way as possible so that the patient is not disadvantaged. (p 33)

Summary – maintain a balanced relationship

- Doctors should not mention their own moral views to patients unless explicitly asked.
- Doctors have rights to their own moral views and can opt out of some lawful procedures, if this would not endanger patients. (p 33)

Referral:

BMA, *Medical Ethics Today* (2013):

doctors with a conscientious objection to providing **contraceptive advice or treatment** have an **ethical duty to refer their patients to another practitioner or family planning service**. (p 277)

More than referral?:

BMA, 'Expression of doctors' beliefs' (2018):

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.**

BMA, *Withholding or Withdrawing Life-prolonging Medical Treatment* (2007):

16.2 People who have a conscientious objection to withholding or withdrawing life-prolonging treatment should, wherever possible, be permitted to hand over care of the patient to a colleague. Where members of the team have a conscientious objection to the withdrawal of life-prolonging treatment they should, wherever possible, be permitted to hand over their role in the care of such patients to colleagues.

GMC, Treatment and care toward the end of life: Good practice in decision making (2010):

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) a patient's decision to refuse such treatment, or
- (b) 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.**

Tell others and more than refer?:

RCP and BMA, *Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent: Guidance for decision-making in England and Wales* (2018):

Where health professionals have a conscientious objection to the withdrawal of CANH, they have a responsibility to recognise this as a potential conflict of interest when considering decisions about CANH; this should be declared prior to beginning discussions within the healthcare team or with those close to the patient. If individual clinicians could not sanction a best interests decision to withdraw CANH, they should hand over the care of the patient to a clinician who could. Where, however, a health professional does not disagree in principle with the withdrawal of CANH but believes, in a particular case, that it is not appropriate, this should lead to further discussion and, where appropriate, a further clinical opinion being sought. (p 27)

What steps can be taken to support widespread implementation of the guidance?

Putting in place a process whereby doctors with a conscientious objection can notify senior colleagues and managers, and a process for alternative arrangements to be made. (p 73)

Concluding thoughts

Conscientious Objection (Medical Activities) Bill [HL] 2017-19:

(1) **No medical practitioner with a conscientious objection to participating in -**

(a) the **withdrawal of life-sustaining treatment;**

(b) any **activity under the provisions of the Human Fertilisation and Embryology Act 1990;** or

(c) any **activity under the provisions of the Abortion Act 1967, including activity required to prepare for, support or perform termination of pregnancy,** shall be under any duty to so participate.

(2) For the purposes of subsection (1) - “medical practitioner” means any person appearing in the registers of –

(a) the General Medical Council,

(b) the Nursing and Midwifery Council,

(c) the Health and Care Professions Council, or

(d) the General Pharmaceutical Council;

“participating in an activity” includes any supervision, delegation, planning or supporting of staff in respect of that activity.

(3) An employer (A) must not discriminate against or victimise an employee of A's (B) who makes use of the protections set out in this section –

(a) as to B's terms of employment;

(b) in the way A affords access, or by not affording B access, to opportunities for promotion, transfer or training or for receiving any other benefit, facility or service;

(c) by dismissing B;

(d) by subjecting B to any other detriment.

(4) In any legal proceedings –

(a) the burden of proof of conscientious objection shall rest on the person claiming to rely on it;

(b) a statement on oath by a person to the effect that they have a conscientious objection shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon them under subsection (4)(a).

(5) Nothing in this Act shall be taken to diminish any protections and exclusions in section 4 of the Abortion Act 1967 (conscientious objection to participation in treatment) or section 38 of the Human Fertilisation and Embryology Act 1990 (conscientious objection).

‘there is a danger in allowing “opt-out” to be seen as an entitlement gradually through guidance, without the legitimacy and the boundaries of such an opt-out being subject to a thorough reconsideration’. (JV McHale, ‘Conscientious objection and the nurse: A right or a privilege?’ (2009) 18 *British Journal of Nursing* 1262, 1263).