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Submission to the General Medical Council of the United Kingdom

Re: Personal beliefs and medical practice:
A draft for consultation (18 April-13 June, 2012)

3 June, 2012

Introduction:

The Protection of Conscience Project is a non-profit, non-denominational initiative that advocates for freedom of conscience in health care. The Project does not take a position on the morality or desirability of controversial procedures or services.

This submission comments on the draft consultation document, "Personal beliefs and medical practice."[1] It presumes that the document pertains only to conscientious objection arising from moral or ethical objections to a treatment, not to situations in which physicians deem a treatment to be medically contra-indicated, even if they also object to it for reasons of conscience.

In order to avoid misunderstanding and to identify common ground, the submission opens in Part I by identifying and defining key terms, drawing attention, when appropriate, to differences in terminology used by the draft consultation document. This is followed by a summary of points of agreement in Part II, not without an occasional caveat to ensure that the summary is correctly understood.

Part III summarizes some points that, if clarified or appropriately qualified, might increase the scope of agreement. Points of disagreement are identified and discussed in Part IV.

The submission closes with recommendations (Part V) for modification of the guideline.

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Part I: Terminology

I.1 The consultation document states that "personal beliefs" include "political, religious and moral beliefs," but also refers to "personal views" and "personal values," terms that are not necessarily equivalent to "personal beliefs." Nonetheless, the draft document seems to use all of these interchangeably. In this submission, the terms "personal beliefs" and "beliefs" mean moral, ethical or religious beliefs.

I.2 For the sake of brevity, treatments that are the subject of conscientious objection are sometimes described here as "morally contested," and those who decline to provide morally contested treatments for ethical, moral or religious reasons are referred to as "objecting physician(s)."

I.3 The distinction between "treatment" and "care" is important in significant religious, moral and ethical traditions, but the distinction is not made in the draft consultation document. Hence, its references to "medical care" or "care" are ambiguous.

I.4 In this submission:

I) **"care"** means attention to and provision of basic human needs: food, water, shelter, hygiene, warmth, respect, affection, etc.;

ii) **"treatment"** means interventions, procedures or services provided through or sought from physicians and other health care providers.

I.5 Note the restricted sense of the term "treatment." The interventions, procedures or services are not described in this submission as *medical* because objecting physicians frequently deny that morally contested procedures are legitimate aspects of the practice of medicine. However, there is no dispute that morally contested treatments may be "provided through or sought from physicians and other health care providers." (See IV.24.)

Part II: Points of agreement

Notice

II.1 It is reasonable to expect physicians to do their best to notify patients and employers in advance of treatments to which they object for reasons of conscience. It is common ground that conflicts should be avoided, especially in circumstances of elevated tension, and that they often can be avoided by timely notification of patients and employers, erring on the side of sooner rather than later. This must not be understood to impose a duty to anticipate every conceivable situation in which such an objection might arise.

Post-procedural treatment or care

II.2 The Project agrees that it is normally unethical for a physician to refuse to provide treatment or care to a patient on the grounds that she has had an abortion or other morally contested treatment. Objecting physicians do not become morally complicit in the prior acts of patients simply by treating medical consequences that result from their conduct.[2] The fact that a patient's illness or injury is the result deliberate, negligent or even criminal conduct has never

been a reason to deny medical treatment.

Discussion of beliefs

II.3 It is agreed that disclosure by a physician of his beliefs is acceptable only when the disclosure is solicited by a patient, or when it is reasonable to believe that it would be welcomed by the patient. It is also agreed that such disclosure and discussion ought to be limited to what is relevant to the patient's care and treatment. This should not be interpreted so strictly as to prevent a dialogue that is responsive to the needs of the patient as a human person.[3] It cannot be interpreted to exclude disclosure of conscientious objection and conversation naturally arising from it, since disclosure is required by the General Medical Council (GMC).[4]

III. Points requiring clarification or qualification

"Unfair" discrimination

III.1 The draft document's reference to "unfair" discrimination implicitly acknowledges that not all kinds of discrimination are unfair. The draft itself discriminates between what is legal and illegal, for example. However, discrimination between what moral or immoral, ethical or unethical, requires the application of an ethical or moral standard. Only to the extent that there is agreement on the content of such a standard can all agree on what counts as "unfair" discrimination. Within the context of the draft document, it is not clear that there is agreement on the standard to be applied.

"Likely" to cause distress

III.2 It is agreed that physicians must be careful not to "cause distress" by an "inappropriate or insensitive expression" of their beliefs to patients. However, a patient may be distressed merely because a physician refuses to provide a service, no matter how carefully that refusal is conveyed. Moreover, disgruntled patients or activists may fabricate claims of distress in order to harass physicians through disciplinary proceedings. Thus, "distress" in a patient - whether proved as a fact or advanced as a claim - is not necessarily evidence of professional misconduct.

Implied judgement

III.3 The draft warns that physicians must not "imply any judgement" of patients when disclosing conscientious objections. However, a physician cannot make such an objection without first forming the judgement that the treatment is immoral. It is reasonable to believe that the communication of the objection, which the GMC requires,[5] will cause patients to infer (correctly) the beliefs of the physician concerning the treatment. Patients may thus "feel judged" by the physician, even if the physician's judgement pertains to the morality of the procedure rather than the personal culpability of the patient. It would be unjust to require physicians to disclose conscientious objections to patients and then discipline them because a patient resents their beliefs.

Irrelevance of lifestyle

III.4 Many conditions treated by physicians are the result of patient choices about diet and exercise, the use of alcohol, tobacco and illicit drugs and other risk-taking behaviours: sometimes, even, of criminal misconduct. Thus, the Project agrees that physicians "must not refuse to treat the *health consequences* of lifestyle choices" with which they disagree or to which they object. (Emphasis added. See II.2.) However, this must not be understood to imply that objecting physicians are obliged to provide morally contested treatments. For example: in some circumstances, pregnancy and infertility may be considered to be "health consequences" of lifestyle choices. It does not follow that objecting physicians must treat pregnancy and infertility by abortion and artificial reproduction.

Non-obstruction

III.5 Objecting physicians act to preserve their own integrity, not to control the conduct of patients. Thus, it is agreed that physicians who refuse to provide a treatment for reasons of conscience are not entitled to actively prevent patients from obtaining the treatment elsewhere. However, physicians may also refuse to delegate or refer for a morally contested treatment in order to preserve their personal integrity. That must be distinguished from 'obstruction.' (See III.7.)

Pre-procedural treatment

III.6 As noted above, post-procedural treatment or care does not, of itself, make objecting physicians morally complicit in the prior conduct of patients. There is also no reason to deny pre-procedural treatment or care that is unrelated to a morally contested treatment. However, physicians may refuse to services or procedures that are meant to facilitate such treatments in order to avoid morally unacceptable complicity in them. (See III.7.)

Disclosure of options

III.7 Objecting physicians are required to disclose the availability of treatments that they find objectionable, and to advise patients that they may seek the advice of physicians willing to provide them. However, the consultation document fails to recognize that physicians may be unwilling to provide such information or advice if they believe that doing so makes them complicit in a morally contested treatment, or if disclosure may be harmful to the patient. This point becomes especially important in jurisdictions where assisted suicide or euthanasia are legal, and a physician is concerned that disclosing such options may have a disproportionate impact on a vulnerable patient. The position of objecting physicians on this point is the same as that of the GMC on providing information that supports the sale of organs, or providing information or reports that could facilitate assisted suicide. (See IV.19.)

IV. Points of disagreement

Specious claims of discrimination

IV.1 The draft claims that physicians are obliged to provide or facilitate 'gender reassignment,' and that they cannot refuse contraceptives to unmarried women if they provide contraceptives to married women. The basis for both claims is that only "a particular group of patients" seek 'gender reassignment,' that "unmarried women" constitute another "particular group," and that conscientious objection is prohibited because objections in these cases are to "particular groups" of patients, not to morally contested treatments.

IV.2 The GMC admits that current British statutes regulating abortion and artificial reproduction prevent it from directly prohibiting conscientious objection to such procedures. Nonetheless, the GMC's legal reasoning seems to preclude conscientious objection to both. Only women - a "particular group of patients" - request abortion. Again, only women with multifetal pregnancies - another "particular group" - request selective reduction.[6] Only a "particular group" - those unable to conceive naturally - seek artificial reproduction.

IV.3 At the very least, the GMC's reasoning with respect to contraception leads to the conclusion that *selective* conscientious objection to abortion is not permitted. Women over 14 weeks pregnant - just like "unmarried women" - form a "particular group." It would seem, then, that the GMC considers physicians are guilty of unfair discrimination if they provide abortions only for women who are less than 14 weeks pregnant. Of course, the same could be said of physicians willing to provide abortions in the second trimester, but not in the third.[7]

IV.4 Similarly, it appears that at least *selective* conscientious objection to artificial reproduction will be forbidden. Applying the GMC's logic, a physician who provides or facilitates artificial reproductive services for infertile couples would be forced to provide the same services for everyone, including, for example, a man who has had sex change surgery who wishes to use sperm frozen before surgery to conceive a child, so that he can be both father and mother.[8] It is disingenuous to pretend that there is any moral or ethical consensus on many of the issues involved with artificial reproduction,[9] and unacceptable for the GMC to use its disciplinary powers to impose its moral views under the pretence that there is.

IV.5 If the GMC is concerned about access to abortion, contraception and artificial reproduction, the draft consultation document is likely to reduce access, not increase it. If physicians who provide earlier abortions are forbidden from 'discriminating' against women who are further along, those with moral qualms about later procedures may prudently refrain from developing the skills needed for them,[10] or give up abortion practice altogether. Similarly, physicians willing to provide artificial reproductive services or contraceptives in some circumstances but not in others may cease providing the services altogether in order to avoid being forced to cooperate in what they believe to be wrong.

IV.6 The conflict between the GMC position and the statutory protection of conscience provisions

pertaining to abortion and artificial reproduction complicate evaluation of the draft document. However, this complication does not arise in the case of other legal but morally contested treatments sought by "particular groups."

IV.7 Apotemnophiliacs, for example, request the amputation of healthy limbs. In 1999, the GMC and professional bodies approved single leg amputations on two apotemnophiliacs at the Falkirk & District Royal Infirmary in Scotland.[11] If one follows the reasoning of the draft consultation document, all physicians must be willing to provide or facilitate amputations of healthy limbs because refusal to do so would amount to discrimination against a "particular group of patients."

IV.8 Only severely disabled children are candidates for "Ashley's treatment" - surgical and pharmaceutical interventions to stunt their growth and development.[12] Again, the rationale offered by the document indicates that refusal to provide or facilitate such treatments 'discriminates' against this "particular group of patients,"so that conscientious objection should be prohibited in such circumstances.

IV.9 One could, of course, go further. Only males seek ritual male circumcision. Only conjoined twins are candidates for separative surgery.[13] Only self-mutilators are likely to ask that knives and other implements be provided as part of their care plans.[14] Only certain "particular groups" might seek prescription medication to help them conform to religious teachings about sex.[15] All of these are morally contested treatments, but, since they are sought by "particular groups of patients," it would seem that all must be provided or facilitated by physicians, since refusal to do so would be 'discriminatory.'

IV.10 This demonstrates the first problem with the GMC's reasoning. "Particular group" is so elastic a notion that it can be applied to innumerable sub-groups of patients or stretched to include all of them as a subset of the population: "those seeking the service of a physician." The term is useful for fabricating specious claims of illicit discrimination, but for this very reason it fails to provide an acceptable standard by which to evaluate the conduct of objecting physicians.

IV.11 Certainly, it would be improper for a physician to refuse to provide services or treatment to patients because of his race, ethnic origin, religious beliefs, etc. But conscientious objectors are concerned to avoid moral complicity in wrongdoing, not with the sex, marital status or "group status" of the patient. Objections, if they arise, are to abortion, even though only women can have abortions: to premarital sex, even though only unmarried persons can have premarital sex: to the amputation of healthy body parts, even though only apotemnophiliacs request such surgery.

IV.12 Further, personal characteristics may be relevant to moral judgement. For example: a 20 year old man may not be faulted morally or legally for having sexual intercourse, and a friend may have no objection to making his apartment available for that purpose. However, the friend might well refuse the favour if the prospective bedmate were a nine year old girl rather than a nineteen year old woman, or if the would-be Lothario were cheating on his wife. Age and marital status may both be important factors in the friend's moral evaluation of the act and

his decision to avoid complicity in it, even though age and marital status are "personal characteristics."

IV.13 Objecting physicians should not be threatened with discipline for exercising this kind of rationally comprehensive moral reasoning. It is absurd and profoundly offensive to assert that physicians who refuse to be complicit in adultery, premarital sex, the mutilation or amputation of healthy body parts or the killing of human embryos or fetuses are acting like bigots.

Mandatory referral and delegation

IV.14 The draft insists that physicians who object to a treatment may decline to provide it themselves, but must provide the patient with "enough information" to arrange to see a non-objecting colleague who will provide it, and, if need be, assist the patient in making arrangements to have it provided by another physician.

IV.15 The reasoning of the draft consultation document is based on unstated faith-assumptions of the GMC about moral complicity and culpability. The Council appears to believe that someone who merely *arranges* for an act is absolved of moral responsibility, because only someone who actually *does* an act is morally responsible for it. Alternatively, the GMC may admit that some moral responsibility is incurred by referral or by otherwise facilitating a procedure, but that the degree of responsibility is sufficiently diminished in such cases that it is of no real significance.

IV.16 Many physicians are willing to refer for morally contested treatments because their evaluation of moral complicity is *consistent* with that of the GMC. The draft document fails to recognize that reasonable physicians who work from *different* moral premises reach different moral conclusions about moral complicity. Many people recognize the principle of vicarious moral responsibility, by which an accomplice or facilitator can be held responsible for acts done by someone else.

IV.17 The GMC can find the simplest illustration of this in provisions of criminal law concerning parties to offences and accessories after the fact, by which one may be convicted for indirect facilitation of criminal offences. The Medical Defence Union cautioned physicians about this in advice offered late last year.[16]

IV.18 The draft document fails to consider evidence taken in 2004 and 2005 by the British House of Lords Select Committee on Assisted Dying for the Terminally Ill, and the conclusions of the Committee concerning a bill to legalize euthanasia. The bill, in its original form, included a requirement that objecting physicians refer patients for euthanasia. Numerous submissions protested this provision because it made objecting physicians a moral party to the procedure,[17] and the Joint Committee on Human Rights concluded that the demand was probably a violation of the European Convention on Human Rights.[18] The bill's sponsor, Lord Joffe, promised to delete the provision in his next draft of the bill.[19]

IV.19 The GMC also appears to be unfamiliar with the moral reasoning of those concerned about the complicity of health care workers through even indirect participation in torture and

abusive interrogations. The World Medical Association (WMA) *Declaration of Tokyo* states that physicians are "ethically prohibited from conducting *any evaluation*, or *providing information or treatment*, that *may facilitate* the future or further conduct of torture."[20] (Emphasis added.) More recently, the WMA has emphasized that physicians "are prohibited from participating or *even being present*" during torture or other inhuman or degrading procedures.[21] *The Lancet*, among others, has asked, "How complicit are doctors in the abuse of detainees?"[22] and other journal articles have explored the answer with some anxiety.[23]

IV.20 Where capital punishment is legal, physicians may be expected by the state or others to participate in executions, especially those performed by means of lethal injection. The World Medical Association states that physicians must not "participate in capital punishment in any way, or during any step of the execution process," including planning and instruction.[24] The American Medical Association (AMA) forbids physician participation in executions, defining "participation" to include the same kind of actions that would be involved in referral or delegation.[25] The model provided by the AMA policy on physician involvement in execution and torture indicates that, in principle, it is not unreasonable for physicians to refuse to refer patients for procedures to which they object for reasons of conscience, on the grounds that referral would make them complicit in a wrongful act.

IV.21 The point here, of course, is not that capital punishment or torture are morally equivalent to morally contested treatments. The point is that, when professional associations are convinced that an act is seriously wrong - even if it is legal - one finds them willing to refuse all forms of direct and indirect participation in order to avoid moral complicity in the act. The GMC acted on this principle when it disciplined a physician who provided information about the sale of organs but did not actually engage in the practice.[26] It has also applied this principle in recent draft guidance on assisted suicide.[27] Conscientious objectors who refuse to refer or delegate for morally contested treatments act on the same principle, and it would be hypocritical if the GMC were to discipline them for doing so.

IV.22 Moreover, the principle that conscientious objectors ought to be forced to refer a patient would, logically, apply to *all* morally contested treatments. The GMC has already set a precedent by its approval of the amputation of healthy limbs (See IV.6), which is logically consistent with its support for sex-change surgery (See IV.1). Nonetheless, many physicians do not share the GMC's ethical evaluation of such surgery. Before compelling them to provide, refer or delegate for such procedures, the GMC should at least demonstrate the superiority of its own moral beliefs and justify why those who find them unsatisfactory should be made to conform to them, or be struck from the medical register.

IV.23 Referral is often erroneously explained as "striking a balance" between the interests of the physician and those of the patient. However, in cases of conscientious objection their interests cannot be balanced because they are not commensurable; they concern fundamentally different goods. A patient has an interest in obtaining a particular product or service, but the physician has an interest in maintaining his personal integrity. With sufficient imagination and political will one may find a way to accommodate the interests of both, but no 'balance' is achieved by subordinating one to the other.

Physicians must set aside personal beliefs

IV.24 It is the expectation of the General Medical Council that physicians will "set aside their personal beliefs" if those beliefs effectively deny patients "access to appropriate medical treatment or services" or cause "distress" to patients.

IV.25 Beliefs may be "personal," in the sense that one personally accepts them, but this does not make them parochial, insignificant or erroneous. Christian, Jewish and Muslim beliefs, for example, are shared by hundreds of millions of people. They "personally" adhere to their beliefs just as non-religious believers "personally" adhere to non-religious beliefs. In neither case does the fact of this "personal" commitment provide grounds to set beliefs aside. Thus, the reference to "personal" beliefs seems to have not other purpose than to belittle the beliefs of objecting physicians.

IV.26 The draft asserts almost at the outset that physicians may practise according to their beliefs only if they do not thereby deny patients "access to appropriate *medical* treatment or services," (emphasis added). The presumption that the contentious treatments are *medical* treatments may reflect the bias of the GMC. It is prejudicial because it effectively decides a key issue in advance. It is also unnecessary for the purposes of the draft, which does not subsequently describe contentious treatments as *medical*. (See I.5.)

IV.27 For the reasons stated in III.2, that a patient is "distressed" is not necessarily evidence of professional misconduct.

IV.28 The expectation that physicians will "set aside their personal beliefs" may reflect the view that, as professionals, physicians should be willing to subordinate their personal interest and comforts to those of their patients: that self-sacrifice is an important aspect of professionalism.[28] However, self-sacrifice has never been understood to include the sacrifice of one's integrity. To abandon one's moral or ethical convictions in order to provide services demanded by others is prostitution, not professionalism.[29]

IV.29 The GMC's expectation that physicians will "set aside their personal beliefs" actually requires more than that. One cannot simply "set aside" beliefs and operate in a moral vacuum. Thus, the draft document requires not only that physicians give up moral or ethical standards they believe to be true, but that they adopt standards approved by the GMC, even if they believe them to be false. What is expected is religious, moral or ethical *conversion*. The draft document signals the intention of the GMC to prosecute those who refuse to convert to the religious, moral or ethical systems it approves.

IV.30 Alternatively, the GMC may be content to allow physicians to believe what they wish, so long as they outwardly conform to its expectations by acting as if their beliefs do not exist. Rather than pursuing a policy of forced conversion, the GMC may simply be resurrecting the *Test Act* in modern professional dress: requiring physicians to agree to do what they believe to be gravely wrong as a condition for practising medicine in the United Kingdom.[30]

IV.31 In either case, it would be unfair to impose on physicians long-discredited policies of forced conversion and exclusion that would be plainly unacceptable to other professions and to the

people of the United Kingdom as a whole.

IV.32 It may be argued that freedom of conscience is not unlimited, and that the limits the GMC seeks to impose are reasonable. However, nothing in the draft document indicates that the GMC has actually considered the nature or importance of personal integrity and freedom of conscience, or that it has carefully investigated the issues relevant to establishing a rational and principled approach to limiting fundamental freedoms.

IV.33 Freedom of conscience can be exercised in two different but complementary ways; one may pursue an apparent good, or one may avoid an apparent evil. The decision to pursue an apparent good can be called the exercise of *perfective* freedom of conscience because it is potentially perfective of the human person. A decision to avoid an apparent evil can be described as an exercise of *preservative* freedom of conscience.

IV.34 The distinction between preservative and perfective freedom of conscience is critical. Preservative freedom of conscience is more fundamental than perfective freedom of conscience because the latter depends upon the preservation of moral character ensured by the former. By its nature, perfective freedom of conscience demands much more of society than preservative freedom of conscience.

IV.35 Limiting perfective freedom of conscience prevents people from doing the good that they wish to do, and may (if no alternatives are available) prevent them from perfecting themselves, fulfilling their personal aspirations or achieving some social goals. This may do them some wrong, but, if it does them some wrong, it does not necessarily do them an injury.

IV.36 In contrast, to force people to do something they believe to be wrong is always an assault on their personal dignity and essential humanity, even if they are objectively in error; it is always harmful to the individual, and it always has negative implications for society. It is a policy fundamentally opposed to civic friendship, which grounds and sustains political community and provides the strongest motive for justice. It is inconsistent with the best traditions and aspirations of liberal democracy, since it instills attitudes more suited to totalitarian regimes than to the demands of responsible freedom. By demanding the submission of intellect, will and conscience it reduces the person to a form of servitude that cannot be reconciled with principles of equality.[31]

V. Recommendations

Terminology

V.1 The guideline should

a) use consistent terminology by referring only to *beliefs*;

b) refrain from describing the beliefs of objecting physicians as *personal*, or from describing them in other irrelevant or prejudicial terms;

c) acknowledge and explain the distinction made by ethical and religious traditions between care and treatment;

d) describe morally contested treatments simply as treatments or services rather than medical treatments or services.

Notice

V.2 The guideline should clarify that the expectation that advance notice should be given of objections to morally contested procedures does not mean that physicians are expected to anticipate every conceivable situation in which such an objection might arise.

Discussion of beliefs

V.3 The guideline should

a) clarify that physicians will not be disciplined for reasonably complying with their obligation to disclose their objections and for conversation with a patient that naturally follows from the disclosure;

b) acknowledge that patient resentment of or anger at physician beliefs does not afford grounds for discipline;

c) acknowledge that the emotional reaction of a patient to the required disclosure of physician objections is not necessarily evidence of professional misconduct.

Unfair discrimination

V.4 The guideline should clarify what standards the GMC will apply when considering allegations that a physician has "unfairly" discriminated against a patient.

"Health consequences"

V.5 The guideline should clarify that the obligation to treat the health consequences of patient conduct does not imply an obligation to provide morally contested treatments.

Preservation of personal integrity

V.6 The guideline should distinguish between attempts to control patient conduct by obstruction of morally contested treatment and attempts to maintain personal integrity by refusing to facilitate such treatments by referral, delegation, or preparation.

Presentation of options

V.7 The guideline should acknowledge that physicians will not be disciplined simply for failing to provide information or advice that they believe will harm the patient or make them complicit in a morally contested treatment.

"Particular group"

V.8 The guideline should make clear that physicians

a) may decline to provide services or treatments that they believe make them complicit in wrongful acts, but

b) may not decline to provide services or treatments because of personal characteristics

of a patient unrelated to moral or ethical evaluation of the consequences of the services or treatments.

V.9 The guideline should not base ethical evaluation of physician conduct upon the alleged group status of a patient.

Referral and delegation

V.10 The guideline may recommend

a) that objecting physicians consider referral and delegation for morally contested treatments as a means of accommodating patient requests while maintaining their personal integrity, and

b) if referral or delegation is not acceptable, that objecting physicians be prepared to explain the moral or ethical reasoning for their judgement.

V.11 The guideline should not demand that objecting physicians refer patients or otherwise facilitated morally contested treatments.

"Personal integrity"

V.12 The guideline should be revised to eliminate any suggestion that

a) physicians should be forced to adopt beliefs that they find objectionable; or

b) physicians ought to do what they believe to be wrong.

Notes

1. General Medical Council, *Personal beliefs and medical practice: A draft for consultation* (18 April-13 June, 2012) (http://www.gmc-uk.org/Draft_explanatory_guidance___Personal_beliefs.pdf_48499491.pdf) Accessed 2012-05-17

2. The situation would be otherwise if the physician were to affirm the conduct of the patient, but this is not something one would expect an objecting physician to do, and simply providing post-procedural treatment or care does not necessarily imply such an affirmation.

3. The draft quotes a passage in *Good Medical Practice* that refers to "psychological, spiritual, religious, social and cultural factors" that are relevant to patient care and treatment.

4. *Good Medical Practice* 52.

5. *Good Medical Practice* 52.

6. MacNair, Trisha, "Selective Reduction in Pregnancy." *BBC Health*, June, 2008 (http://www.bbc.co.uk/health/physical_health/pregnancy/pregnancy_reduction.shtml) Accessed 2012-05-02. In 2002 at the Royal Victoria Infirmary in Newcastle it was suggested that a twin with a serious heart defect should be aborted in the 35th week of pregnancy. The suggestion was highly controversial and one physician threatened to commence legal action against the medical director of the hospital if the abortion proceeded. Rogers, L., "Doctors revolt over last-minute abortion of twin," *The Sunday Times*, 10 November, 2002. Also reported in *British Nursing News on Line*, 10 November, 2002 (Accessed 2006-06-13) GLADonline, 18 November, 2002. (http://purplyjoey.proboards.com/index.cgi?board=talk&action=display&thread=29) Accessed 2012-05-02

7. Most physicians in the United Kingdom do not provide abortions after 12 to 14 weeks gestation, and seem uninterested in developing the skills to do so. [Quinn, Ben and Boseley, Sarah, "Anti-abortion climate 'will deter new generation of doctors': British Pregnancy Advisory Service attacks politicisation of abortion and warns of impact on future healthcare." *The Guardian*, 1 April 2012 (http://www.guardian.co.uk/world/2012/apr/01/abortion-health) Accessed 2012-04-02.] The reluctance of Scots physicians to provide abortions after 15 weeks gestation has resulted in women travelling to England for the procedure. [Templeton, Sarah Kate, "Private firm plans Scottish abortion clinic." *The Sunday Herald*, 19 January, 2003. (http://www.highbeam.com/doc/1P2-9994164.html) Accessed 2012-06-03).] Abortion had been legal in Britain for over a generation when a third of junior doctors were reported to be conscientious objectors to the procedure. [Saunders, Peter, "Conscientious Objection to Abortion." *Triple Helix*, Winter, 2001. (http://www.consciencelaws.org/Examining-Conscience-Background/Abortion/BackAbortion36.html#001 Saunders 99)] The shortage of British physicians willing to provide abortions after 12 to 14 weeks is not an isolated phenomenon associated to domestic political issues.. On the

contrary: it appears to be part of a world-wide pattern: "French Doctors Rethinking Abortions in Face of New Law: At One Hospital, Physicians Quit en Masse." *Zenit,* 7 November, 2001. (http://www.zenit.org/article-2852?l=english) Accessed 2012-06-03; "Doctors under pressure as abortion demand goes up." Than Nien News, 15 March, 2010 (http://www.thanhniennews.com/2010/Pages/Doctors-under-pressure-as-abortion-demand-goes-up.aspx) Accessed 2010-05-21; "Quebec hopes to offer late-term abortions." *CBC News*, 10 September, 2004. (http://www.cbc.ca/news/canada/story/2004/09/10/abortions_lateterm040910.html) Accessed 2012-06-03; "Royal College calls for conscience decision on second trimester abortions." *Radio New Zealand*,11 March, 2006 (http://www.radionz.co.nz/news/bulletins/radionz/200603110838/2911d527) Accessed 2006-03-11; Ward, Harvey, *Are State Doctors in the Western Cape willing to implement the Choice of Termination of Pregnancy Act of 1996? An opinion survey conducted in the Western Cape in November 1997*. In fulfillment for the requirements of the FCOG (S.A.) part 2. (http://www.consciencelaws.org\Examining-Conscience-Background\Abortion\BackAbortion15.html); Marek, Marla J., "Nurses' Attitudes Toward Pregnancy Termination in the Labor and Delivery Setting." JOGNN, 33, 472-479; 2004.

8. Oldham, Jeanett, "'I want to be father and mother.'" *The Scotsman*, 10 December, 2001 (http://news.scotsman.com/index.cfm?id=1631152001) Accessed 2012-05-25

9. For example, there is substantial disagreement about the wisdom of providing artificial reproductive services for single people and same-sex couples. See Somerville, Margaret, "Dispossessed and forgotten: the new class of genetic orphans. *Mercatornet*, 18 September, 2007 (http://www.mercatornet.com/articles/view/dispossessed_and_forgotten_the_new_class_of_genetic_orphans) Accessed 2012-05-25; "Focus on Same Sex Marriage: The Case Against." *Mercatornet*, 28 July, 2011. (http://www.mercatornet.com/articles/view/the_case_against_same-sex_marriage) Accessed 2012-05-25

10. Assuming, of course, that the GMC will not require that anyone who provides abortions at all is obliged to acquire and maintain the skills necessary to provide third trimester abortions.

11. Ramsay, Sarah, "Controversy over UK surgeon who amputated healthy limbs". *The Lancet*, Volume 355, Number 9202, 05 February 2000. (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(00)82030-9/fulltext). Accessed 2012-06-03.

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14. Citing the precedent of 'harm reduction' by providing syringes to drug addicts, some members of the Royal College of Nursing have argued that patients who mutilate themselves by burning or cutting should be allowed to keep their 'tools' with them in hospital. They claim that this helps patients deal with mental trauma and actually reduces suicidal ideation. St. George's mental health hospital in Staffordshire provided cleaning equipment for blades and similar 'tools' in a pilot project, and has suggested that this should be included in a patient care plan. Triggle, Nick, "Nurses back supervised self-harm: Nurses want to be allowed to let patients who self-harm continue to do so in a safe environment in hospitals." *BBC News*, 25 April, 2006 (http://news.bbc.co.uk/2/hi/health/4942834.stm) Accessed 2012-05-02

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23. Miles, Steven H., "Abu Ghraib: its legacy for military medicine." *The Lancet*, Vol 364, August 21, 2004, p. 725-729; Lifton, Robert Jay, *Doctors and Torture*. N Engl J Med 351;5

24. World Medical Association, *WMA Resolution on Physician Participation in Capital Punishment* (October, 2008) (http://www.wma.net/en/30publications/10policies/c1/) Accessed 2012-05-22

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26. The Council found that the doctor had not participated in the organ trade, but that his conduct amounted to "encouragement of the trade in human organs from live donors". *BBC News*, "Organ trade GP suspended." 15 October, 2002 (http://news.bbc.co.uk/2/hi/health/2329447.stm) Accessed 2012-05-18

27. Among the kinds of conduct that may constitute illicit facilitation or cooperation in assisted suicide, the GMC includes: "encouraging a person to commit suicide, for example, by suggesting it (whether prompted or unprompted) as a 'treatment' option . . .providing practical assistance, for example, by helping a person who wishes to commit suicide to travel to the place where they will be assisted to do so . . . writing reports, knowing or having reason to suspect that the . . . reports would be used to enable the person to obtain encouragement or assistance in committing suicide. . .providing information or advice about other sources of information about assisted suicide, and what each method involves from a medical perspective . . ." General Medical Council, *Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide: a draft for consultation*.

(http://www.gmc-uk.org/Assisted_suicide_consultation_version_3_pub_0001.pdf_47681132.pdf
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28. "Professionalism," Professor R. Alta Charo suggests rhetorically, ought to include "the rather old-fashioned notion of putting others before oneself." Charo, R. Alta, *The Celestial Fire of Conscience- Refusing to Deliver Medical Care*. N Eng J Med 352:24, June 16, 2005. (http://content.nejm.org/cgi/content/full/352/24/2471) Accessed 2012-06-03.

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31. For an extended discussion of the distinction between perfective and preservative freedom of conscience, see Murphy, Sean *Notes toward an understanding of freedom of conscience*. (http://www.consciencelaws.org/issues-ethical/ethical134.html)