Conscientious Objection (Medical Activities) Bill [HL] HL Bill 14 of 2017–19

Summary

The Conscientious Objection (Medical Activities) Bill [HL] is a private member's bill introduced by Baroness O'Loan (Crossbench). The Bill received its first reading in the House of Lords on 28 June 2017, and is scheduled to have its second reading on 26 January 2018. In 2015, a private member's bill seeking to clarify the law on conscientious objection was introduced into the House of Lords by Baroness O'Loan, however it did not proceed beyond its first reading. The new Bill seeks to "clarify the extent to which a medical practitioner with a conscientious objection may refrain from participating in certain medical activities; and for connected purposes". Baroness O'Loan has described the purpose of the Bill as follows:

> Recent legal decisions and inquiries have shown that existing statutory safeguards for freedom of conscience in specific circumstances have been weakened, and that medical professionals with conscientious objections are currently experiencing discrimination due to their beliefs.
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> For example, in *Greater Glasgow Health Board* v *Doogan and Another* [2014] UKSC 68, the Supreme Court reversed a Scottish decision that the 'Conscience Clause' in the Abortion Act 1967 applied to midwives who have a conscientious objection to providing services ancillary to the act of abortion. Two Scottish midwives had argued that the protections within the Abortion Act extended to their own objections to any involvement in the process of care of the patient. The Court ruled that since 'participation' in abortion only constituted the direct performance of an abortion on a woman, the two midwives had no legal exemption from being required to give other material support in the context of an abortion being performed.
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> The Bill will address this issue. The purpose of this Bill, therefore is to secure for specified medical practitioners, whether doctor, midwife, nurse, pharmacist, or a relevant member of one of the professions allied to medicine, which are regulated by the Health and Care Professions Council, the right of conscientious objection to participation in certain medical activities, so that they will not be obliged to take part in the withdrawal of life-sustaining treatment, or in any activity authorised by the Human Fertilisation and Embryology Act 1990 or the Abortion Act 1967 (including activity required to prepare for, support or perform such activities).[1]

Clause 1(1) of the Bill seeks to exempt certain medical practitioners with a conscientious objection from participating in the withdrawal of life-sustaining treatment; any activity under the provisions of the Human Fertilisation and Embryology Act 1990 (relating to fertility treatment); and any activity under the provisions of the Abortion Act 1967, including activities required to prepare for, support or perform the termination of pregnancy. Clause 1(2) provides that the medical practitioners to which this exemption would apply would be those registered under certain regulatory bodies. These are: the General Medical Council, who regulate doctors; the Nursing and Midwifery Council, who regulate nurses; the General Pharmaceutical Council, who regulate pharmacists; and the Health and Care Professionals Council, who regulate a range of professions, including: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational

therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, social workers in England and speech and language therapists.

Clauses 1(3) and 1(4) relate to the legal aspects of the Bill. Clause 1(3) provides that employers must not discriminate or victimise—in terms of employment; in the way the employee is afforded access or not afforded access to promotion, training or benefits; by dismissing the employee; or by subjecting the employee to any other detriment—for making use of the exemption in the Bill. Clause 1(4) provides that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it, and, in such cases 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. The Bill would extend to England and Wales.

Existing Law and Guidance on Conscientious Objection

This section outlines the existing law and guidance in relation to conscientious objection for certain medical professionals and activities set out in the Bill. Such as doctors, nurses and pharmacists involved in the withdrawal of life-sustaining treatment and activities under the Human Fertilisation and Embryology Act 1990 and the Abortion Act 1967.[2] It also sets out the judicial attention the conscientious objection clause in the Abortion Act 1967 has received, which is what this Bill is seeking to address.

In general, doctors, nurses and pharmacy professionals owe a legal duty of care towards their patients under the common law. They are also bound to practice in accordance with standards set by their respective statutory regulatory bodies, namely the General Medical Council for doctors, the Nursing and Midwifery Council for nurses, and the General Pharmaceutical Council for pharmacy professionals.

Abortion and Fertility Treatment

Statutory exemptions for conscientious objection are currently in place for two of the medical activities the Bill aims to cover. The Abortion Act 1967 (1967 Act) provides a statutory exemption for individuals who have a conscientious objection to participating in abortion. Section 4(1) of the 1967 Act provides that:

> no person 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.[3]

This statutory exemption has received judicial attention from both the Appellate Committee of the House of Lords and the Supreme Court of the United Kingdom. In *R* v *Salford HA Ex p. Janaway* [1989] A.C. 537, a medical secretary refused to type up a general practitioner's letter to a consultant referring a patient with a view to a possible termination of pregnancy, and relied on the conscientious objection clause in section 4(1). The House of Lords dismissed her appeal on the basis that to 'participate in any treatment authorised by this Act' means taking part in treatment administered in a hospital or other approved place for the purpose of terminating a pregnancy, and that typing a letter referring a patient to a consultant with a view to a possible termination of pregnancy would not have been participating in treatment authorised by the Act, and therefore such a refusal was not protected by section 4(1).

Providing the lead judgment, Lord Keith of Kinkel commented on the wording of section 4:

> If Parliament had intended the result contended for by the applicant, it could have procured it very clearly and easily by referring to participation "in anything authorised by this Act" instead of "in any treatment [so] authorised". It is to be observed that section 4 appears to represent something of a compromise in relation to conscientious objection. One who believes all abortion to be morally wrong would conscientiously object even to such treatment as is mentioned in subsection (2), yet the subsection would not allow the objection to receive effect.[4]

More recently, the Supreme Court considered section 4(1) in *Greater Glasgow and Clyde Health Board* v *Doogan and Another* [2014] UKSC 68; [2015] A.C. 640. In *Doogan*, two Roman Catholic midwives working as coordinators (which involved booking in patients, allocating staff in the ward and supervising and supporting midwives assigned to patients) on the labour ward, where a small number of terminations took place, raised a grievance that their role as labour ward coordinators did not accommodate their conscientious objection. The hospital's view was that delegation, supervision and support did not constitute 'participating' with treatment and accordingly, rejected their grievance. After the Inner House of the Court of Session (in Scotland) found in favour of the midwives by construing section 4(1) broadly to incorporate the midwives' refusal within the scope of the section, the hospital appealed to the Supreme Court.[5]

The Supreme Court approached the case as one of statutory construction by considering what was meant by 'treatment' and 'participate' within the meaning of section 4(1). It noted that termination under the 1967 Act is a "process" and not just the actual ending of pregnancy, and therefore what is authorised by the Act is "the whole course of medical treatment bringing about the ending of the pregnancy".[6] The parties in the case—the midwives, Greater Glasgow and Clyde Health Board (the hospital employing the midwives) and the Royal College of Midwives (intervenors)—each argued their respective views which, according to Lady Hale of Richmond (with whom the other judges agreed), fell on a "spectrum of constructions" of section 4.[7]

At one end of the spectrum was the view of the Royal College of Midwives. They argued that the treatment authorised by the 1967 Act:

> is limited to the treatment which actually causes the termination, that is, the administration of the drugs which induce premature labour. It does not extend to the care of the woman during labour, or to the delivery of the foetus, placenta and membrane, or to anything that happens after that.[8]

The hospital argued that it "begins with the administration of the drugs and ends with the 'expulsion of the products of conception—foetus, placenta and membrane, from the womb'" and section 4(1) does not cover "making bookings or aftercare for patients who have undergone a termination" or "fetching the drug before it is administered" and as such 'participating' is limited to "direct participation in the treatment involved".[9] At the other end of the spectrum was the view of the two midwives who argued their right to object to any involvement with patients in connection with the termination of pregnancy to which they have a conscientious objection. Their objections extended to:

> receiving and dealing with the initial telephone call booking the patient into the labour ward, to the admission of the patient, to assigning the midwife to look after the patient, to the supervision of the staff looking after the patient, both before and after the procedure, as well as to the direct provision of any care for those patients, apart from that which they are required to perform under section 4(2).[10]

Lady Hale agreed with the hospital on treatment but added:

> [treatment] would also, in my view, include the medical and nursing care which is connected with

> the process of undergoing labour and giving birth: the monitoring of the progress of labour; the administration of pain relief; the giving of advice and support to the patient who is going through it all; the delivery of the foetus; which may require the assistance of forceps or an episiotomy; or in some cases an emergency Caesarian section; and the disposal of the foetus, placenta and membrane. In some cases, there may be specific aftercare which is required as a result of the process of giving birth, such as the repair of an episiotomy.
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> […]
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> These conclusions are supported by the exception in section 4(2), which provides that the right of conscientious objection does not affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman. One would expect this duty to cover any medical and nursing care during the process of termination and delivery which was necessary for those purposes.[11]

However, in relation to what is meant by 'participate' in the course of treatment, Lady Hale went on to explain that this was a "more difficult question".[12] She stated:

> On any view, it would not cover things done before the course of treatment began, such as making the booking before the first drug is administered. But a broad meaning might cover things done in connection with that treatment after it had begun, such as assigning staff to work with the patient, supervising and supporting such staff, and keeping a managerial eye on all the patients in the ward, including any undergoing a termination. A narrow meaning would restrict it to "actually taking part", that is actually performing the tasks involved in the course of treatment.
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> In my view, the narrow meaning is more likely to have been in the contemplation of Parliament when the Act was passed. The focus of section 4 is on the acts made lawful by section 1. It is unlikely that, in enacting the conscience clause, Parliament had in mind the host of ancillary, administrative and managerial tasks that might be associated with those acts. Parliament will not have had in mind the hospital managers who decide to offer an abortion service, the administrators who decide how best that service can be organised within the hospital (for example, by assigning some terminations to the labour ward, some to the Fetal Medicine Unit and some to the Gynaecology Ward), the caterers who provide the patients with food, and the cleaners who provide them with a safe and hygienic environment. Yet all may be said in some way to be facilitating the carrying out of the treatment involved. The managerial and supervisory tasks carried out by the labour ward coordinators are closer to these roles than they are to the role of providing the treatment which brings about the termination of the pregnancy. "Participate" in my view means taking part in a "hands-on" capacity.[13]

Accordingly, the Supreme Court unanimously allowed the hospital's appeal. It is suggested that this exemption applies not only to "doctors and paramedical professionals […] but anyone who participates in the termination of a pregnancy".[14] However, this exemption does not apply when participation by a healthcare professional is necessary "to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman".[15] Further, "taking advantage of this exemption does not relieve [a practitioner] of all duties towards the pregnant woman who has come for advice and assistance", and therefore a "practical solution for a practitioner with a conscientious objection is to make a standing arrangement with a colleague to accept referrals".[16]

Similarly, the Human Fertilisation and Embryology Act 1990 (1990 Act) provides an exemption for practitioners wishing to rely on their conscientious objection. It provides that "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".[17] Guidance is also provided by the Human Fertilisation and Embryology Authority in relation to conscientious objection.[18]

Withdrawal of Life-Sustaining Treatment

According to the General Medical Council, the "most challenging decisions" generally about withdrawing or not starting a treatment when it has the potential to prolong the patient's life include treatments such as antibiotics for life threatening infection, cardiopulmonary resuscitation (CPR), renal dialysis, 'artificial' nutrition and hydration and mechanical ventilation.[19] In England and Wales, the courts have regularly decided on cases concerning withholding and withdrawing treatment, and have ruled that prolonging life is not always in the 'best interests' of the patient where the patient lacks capacity to decide.[20] Where such circumstances arise, and a decision to withdraw life-sustaining treatment is taken or ruled by the courts, there is no statutory exemption that permits a healthcare professional with a conscientious objection not to participate in such course of action. The General Medical Council has, however, issued guidance on conscientious objection for when this concern arises in the withdrawal of life-sustaining treatment. The guidance, *Treatment and Care Towards the End of Life*, states that a doctor:

> Can withdraw from providing care if [his or her] religious, moral or other personal beliefs about providing life-prolonging treatment lead [him or her] to object to complying with (a) a patient's decision to refuse such treatment, or (b) decision that providing such treatment is not of overall benefit to a patient who lacks capacity to decide.
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> However, [the doctor] must not do so without first ensuring that arrangements have been made for another doctor to take over [his or her] role. It is not acceptable to withdraw from a patient's care if this would leave the patient or colleagues with nowhere to turn.[21]

Doctors are also provided with general guidance by the General Medical Council on what is expected of them during the course of practice. The guidance, *Good Medical Practice*, states in relation to conscientious objection, that a doctor:

> Must explain to patients if [he or she has] a conscientious objection to a particular procedure. [He or she] 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 [he or she] must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, [he or she] must make sure that arrangements are made for another suitably qualified colleague to take over [his or her] role.[22]

The General Medical Council has supplemented this with further guidance entitled *Personal Beliefs and Medical Practice*, which states that a doctor:

> May choose to opt out of providing a particular procedure because of [his or her] personal beliefs and values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients. This means [he or she] must not refuse to treat a particular patient or group of patients because of your personal beliefs or views about them. And [he or she] must not refuse to treat the health consequences of lifestyle choices to which [he or she] object[s] because of [his or her] beliefs.[23]

The Nursing and Midwifery Council has also included conscientious objection in the standards to which all nurses are bound. *The Code: Professional Standards of Practice and Behaviour of Nurses and Midwives*, states that nurses must:

> Tell colleagues, [their manager] and the person receiving [their] care if [they] have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care.[24]

However, in comparison to doctors, nurses may only lawfully raise this conscientious objection in two areas; those are the statutory exemptions of conscientious objection provided under the Abortion Act 1967 and the Human Fertilisation and Embryology Act 1990 Act, as described above.[25]

Pharmacy Professionals

In the *Standards for Pharmacy Professionals* set by the General Pharmaceutical Council, each standard is supplemented with examples of what "attitudes and behaviours are expected" from pharmacy professionals to meet each standard.[26] Standard one states that "pharmacy professionals must provide person-centred care".[27] Since May 2017, the guidance given of what is expected from professionals when their religion, personal values and beliefs interact with their work is to "recognise their own values and beliefs but do not impose them on other people" and to "take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs".[28] Situations where a pharmacy professional's religion, personal values and beliefs may influence his or her practice include the provision of services relating to contraception, fertility medicine, hormonal therapies, mental health and wellbeing, substance misuse and sexual health.[29] The General Pharmaceutical Council's guidance for pharmacy professionals, *In Practice: Guidance on Religion, Personal Values and Beliefs*, states:

> If a pharmacy professional is unwilling to provide a certain service, they should take steps to make sure 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. […] Pharmacy professionals should keep in mind the difference between religion, personal values or beliefs, and a professional clinical judgement.[30]

The guidance goes on to state that a referral to another health professional may or may not always be the most appropriate option, but that "pharmacy professionals should use their professional judgement to decide whether a referral is appropriate in each individual situation, and take responsibility for the outcome of the person's care".[31]

Employment Protection and Legal Proceedings

The Bill seeks to expressly legislate to ensure employers must not discriminate or victimise employees—in terms of employment; access to promotion, training or benefits; by dismissing the employee; or subjecting them to any other detriment—for making use of any exemption outlined in the Bill.

The law in England and Wales currently protects employees from various types of dismissal under the Employment Law Act 1996, and discrimination (direct or indirect), harassment and victimisation on the basis of an employee's religion or belief under the Equality Act 2010. Employees also have protection under the Human Rights Act 1998; for example, the right to freedom of thought, belief and religion and the right to freedom of protection from discrimination, as provided under Articles 9 and 14 of the European Convention on Human Rights respectively.

Whether a dismissal, and/or discrimination (direct or indirect), harassment or victimisation is based on an employee's conscientious objection, will depend on the individual circumstances of any particular case.

For example, in 2006, a registrar complained to the English courts of direct and indirect discrimination by her local authority employer due to them designating all registrars as civil partnership registrars, contrary to her conscientious objection to same-sex unions. Whilst the employment tribunal upheld her complaints, the Employment Appeal Tribunal and the Court of Appeal held that the authority's action was only indirect discrimination and proportionate to the means of promoting equality. Her appeal was also dismissed by the European Court of Human Rights in 2013, who found indirect discrimination had taken place, but that the authority's action was proportionate to achieving the legitimate aim of their commitment to equal opportunities which also required that none of its employees acted in a discriminatory manner.[32]

Clause 1(4) of the Bill seeks to impose a statutory requirement that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it, and, in such cases, 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 that burden of proof. Both the Human Fertilisation and Embryology Act 1990 and the Abortion Act 1967 also impose the burden of proof upon the person claiming to rely on conscientious objection under the terms of the Acts, and both provide that a statement on oath will be sufficient to discharge the burden of proof placed upon them.

General Reaction to Conscientious Objection

The British Medical Association has stated 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", and that they should have the right to request that arrangements be made to accommodate their beliefs "provided that patients are not disadvantaged". However, the British Medical Association states that doctors should not claim a conscientious objection to treating "particular patients or groups of patients" and should "not share their private moral views with patients unless explicitly invited to do so".[33] The Royal College of Nursing rely on the guidelines set out by the Nursing and Midwifery Council, as described above.[34]

In response to the 2015–16 Bill, secular doctors voiced their concerns that the Bill "would greatly expand the existing provision which allows for staff to opt-out of involvement in procedures such as the termination of a pregnancy".[35] The All Parliamentary Pro-life Group has argued that the conscientious objection provisions in the Abortion Act 1967 should be strengthened.[36]

In 2012, a survey of 733 medical students found that "nearly half of the students in [the] survey stated that they believed in the right of doctors to conscientiously object to any procedure" and that such a demand was "greater in Muslim medical students when compared with other groups of religious medical students".[37]

Update 16 March 2018

Following the publication of this briefing, the British Medical Association (BMA) published its parliamentary brief in response to this Bill on the 25 January 2018, and stated:

> The BMA supports doctors seeking to exercise a reasonable right to conscientious objection providing it does not lead to patient harm.
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> In light of this Bill's potentially grave impact on a patient's right to appropriate and timely care, by significantly extending the scope of conscientious objection without offering appropriate safeguards to patients, we cannot support it.[38]

[1] Text provided by Baroness O'Loan on request from the Library.
[2] Whilst the Bill also seeks to exempt those professionals regulated by the Health and Care Professionals Council—a body which covers a broad range of allied health care professionals—this Briefing focuses on doctors, nurses and pharmacy professionals only, as they are most likely to be involved in the activities that the Bill is designed to cover.
[3] Abortion Act 1967, s 4(1).
[4] *R v Salford HA Ex p. Janaway* [1989] A.C. 537, 570
[5] The Court of Session is Scotland's highest civil court, and is divided into the Outer House and the Inner House. The Outer House hears cases at first instance by a single judge. The Inner House is primarily the appeal court (with three or more judges) hearing civil appeals from both the Outer House and Sheriff Courts. The Extra Division is a division of the Inner House other than the First or Second Division. Appeals from the Inner House may go to the Supreme Court of the United Kingdom (see: Judiciary of Scotland, 'Court Structure', accessed 16 January 2018).
[6] *Greater Glasgow and Clyde Health Board v Doogan and Another* [2014] UKSC 68, paras 9–11 and 33.
[7] ibid, para 28.
[8] ibid, para 29.
[9] ibid, para 32.
[10] ibid, para 31.
[11] ibid, paras 34–5.
[12] ibid, para 37.
[13] ibid, paras 37–8.
[14] Christopher Johnson, *Medical Treatment: Decisions and the Law*, 2016, para 8.6.
[15] Abortion Act 1967, s 4(2).
[16] Christopher Johnson, *Medical Treatment: Decisions and the Law*, 2016, para 8.6.
[17] Human Fertilisation and Embryology Act 1990, s 38(1).
[18] Human Fertilisation and Embryology Authority, *Code of Practice*, 17 October 2017, paras 29.15–29.19.
[19] General Medical Council, *Treatment and Care Towards the End of Life*, 20 May 2010, para 3.
[20] See, for example: *Aintree University Hospitals NHS Foundation Trust (Respondent) v James (Appellant)* [2013] UKSC 67, para 35.
[21] General Medical Council, *Treatment and Care towards the End of Life*, 20 May 2010, para 79.
[22] General Medical Council, *Good Medical Practice*, 25 March 2013, para 52. See also: paras 54, 57 and 59.
[23] General Medical Council, *Personal Beliefs and Medical Practice*, 25 March 2013, paras 8–16.
[24] Nursing and Midwifery Council, *The Code: Professional Standards of Practice and Behaviour of Nurses and Midwives*, 2015, para 4.4.
[25] Nursing and Midwifery Council, 'Conscientious Objection by Nurses and Midwives', 2 April 2015.
[26] General Pharmaceutical Council, *Standards for Pharmacy Professionals*, May 2017, p 8.
[27] ibid.
[28] ibid.
[29] General Pharmaceutical Council, *In Practice: Guidance on Religion, Personal Values and Beliefs*, June 2017, pp 7–8.
[30] ibid.
[31] ibid.
[32] *Eweida and others v United Kingdom* [2013] ECHR 37, para 106. This case concerns the Employment Equality (Religion or Belief) Regulations 2003, which were subsequently codified into the Equality Act 2010.
[33] British Medical Association, 'Expressions of Beliefs', 30 June 2016.
[34] Royal College of Nursing, 'Refusal to Treat', accessed 17 January 2018.
[35] National Secular Society, 'Secular Medical Forum Warns that New Conscientious Objection Bill Threatens Provision of Patient Care', 18 June 2015.
[36] All Parliamentary Pro-life Group, *A Report into Freedom of Conscience in Abortion Provision*, July 2016.
[37] Sophie LM Strickland, 'Conscientious Objection in Medical Students: A Questionnaire Survey', *Journal of Medical Ethics*, 2012; no 38, pp 22–5.
[38] British Medical Association, 'Parliamentary Brief: Conscientious Objection (Medical Activities) Bill', 25 January 2018 (accessible via the search function on the BMA's website).