Our duty of care

Briefing notes for GMC consultation – personal beliefs and medical practice

gmc-uk.org/about/get-involved/consultations/personal-beliefs-and-medical-practice

General notes

1. **Deadline**: 11 June 2026, 11.59pm
2. **Eligibility:**
   a. All medical professionals may contribute to this consultation – it is not simply those who have religious beliefs or protected characteristics. If you have an ethical objection to participating in assisted suicide, then this would be a personal belief were it to be legalised as a health care treatment.
   b. Nurses, other health professionals, and members of the public can also respond.
3. The political **context** has changed since the existing guidance was published 13 years ago, and the new guidance should be read in the light of major recent attempts to change the law on assisted suicide at Westminster and Holyrood and the approval of new laws in the Isle of Man and Jersey. Such new laws *may* include specific conscientious objection provisions (as for abortion and IVF), but these may not be as comprehensive as health workers might wish, and they may be wholly absent (as was ultimately the case with the Scottish bill) in which case we would have to rely on this GMC document for guidance.
4. The document stipulates two particular contexts in which, regardless of a conscientious objection, **you must provide a contested treatment**. It is important to raise any concerns you have about these:
   - If you are contractually required by your employer (Clause 11)
   - If there is no reasonable alternative (Clause 23)
5. You can indicate that you wish your response to be treated as **"confidential".**
6. Dr Mary Neal (University of Strathclyde) recently gave a **helpful webinar** on the proposed changes for us; the video[1] and audio[2] are online, do please watch/listen and share.
7. If you haven't already, please sign the **ODOC Declaration**, a statement of resistance to doctor-assisted suicide based on wording used by the World Medical Association, which opposes assisted suicide and euthanasia.
   - ourdutyofcare.org.uk/declaration
8. *The Lancet* recently carried a **helpful letter** on conscientious objection and moral injury.[3]
9. There are 42 questions (the last dozen being straightforward "you" questions) and you can click through all of these to get a sense of them **without needing to answer each**:

[1] ourdutyofcare.org.uk/video/video-gmc-consultation-on-personal-beliefs/
[2] ourdutyofcare.org.uk/podcast-episode/gmc-consultation/?ts_post_id=5055&ts_track_num=1
[3] thelancet.com/journals/lancet/article/PIIS0140-6736(23)01910-4/fulltext

- 1-5: structure and terminology
- 6-11: on the personal beliefs of doctors, PAs, and AAs
- 12-18: relating to the personal beliefs of patients
- 19-26: overall themes, including equality, diversity and inclusion

10. **A copy of the consultation questions** is available as a download on our website.[1]

Specific Comments

Clause 11

> *"You may be required to fulfil contractual obligations that could limit your freedom to work in line with your beliefs. This may include conscientious objections."*

Comment: if you are contractually required to provide a contested treatment by your employer, there is no meaningful right to conscientious objection within this guidance (apart from the rare specific legal rights to object to direct provision of abortion or IVF procedures). Until now, assisting suicide will not have formed part of any area of medicine and you may feel that it would be fundamentally at odds with your practice, but if legalised, many aspects of health care – e.g. general hospital medical rotas, care of the elderly, general practice and specific palliative care roles – could see future contracts explicitly cover (and both current and future contracts interpreted as covering) assisting suicide. Does this guidance adequately protect those who do not support their specialty being reshaped to accommodate a new innovation?

➲ *Questions 6 and 11 of the GMC consultation*

Clause 12

> *"You should explore with your employer how you can practise in line with your beliefs while maintaining a good standard of care…"*

Comment: this is a value-laden statement, implying that those who do not wish to cooperate with the proposed treatment may fall below the expected standard of care. The converse may be true.

➲ *Questions 6 and 11 of the GMC consultation*

Clause 20

> *"There can be circumstances where your employer may require you to carry out a procedure or provide a form of treatment if doing so is part of your contractual obligations and you are not able to rely on a legal right to conscientiously object. You should be open with potential employers before you accept a job if you know part of your role could involve something you conscientiously object to."*

Comment: this again undermines the right to conscientiously object within healthcare in the UK, if it can simply be over-ridden by necessity by the employer. If required to make a statement about assisted suicide before taking most medical jobs, then this will create a two-tier system for doctors across the UK.

The recent Leadbeater Bill would only have provided legal protection for doctors who objected to very specific aspects of direct provision of assisted suicide, i.e. there would have been legal protection for those refusing to provide the functions of 'coordinating doctor', 'independent doctor' or to provide a specialist medical opinion as part of the assisted suicide assessment process. There would however have been many indirect aspects of care that would not have been protected in law, e.g. clerking in or providing day-to-day care for patients awaiting assisted suicide or providing emergency care for complications arising from a failed assisted suicide.

Jersey's recently-passed assisted suicide and euthanasia bill defines specific acts of 'participation' that professionals will have a legal right to refuse. It states that participation does not include 'providing an individual with a clinical service that is not directly related to assisted dying, such as providing medical or nursing care for cancer and providing management, supervisory, administrative or other services relating to the general provision of assisted dying'.

➲ *Option to make free text comments in Question 11 of the GMC consultation*

Clause 21.2

> *"You must tell the patient during the consultation if you don't provide a particular treatment or procedure that might be clinically appropriate for them, being careful not to cause distress. You should be prepared to explain that this is due to a conscientious objection. You may wish to mention the reason for your objection, but you must do this sensitively and take care not to imply any judgement of the patient."*

This could be an almost impossible task for a clinician. It is extremely difficult to explain that you have a conscientious objection without implying any judgement. Even if none is intended, the patient might misunderstand this and complain that judgement occurred. This guidance implies that you are required to explain why you do not provide a treatment and is setting up the clinician to fail and be subsequently criticised for their actions. There should be no requirement to say the reason why you don't provide a treatment.

Conversely, how ought a clinician who knows they will not be willing to assist with suicide but who perceives a patient's motivations to be remediable proceed? Are they expected to either involve or absent themselves in a binary manner? Or does their duty of care allow (or indeed demand) that they explore the motivations, and perhaps signpost them to suicide prevention support alongside (or indeed instead of) suicide assistance if the motivations appear to stem not from the qualifying illness but rather from (e.g.) loneliness, housing instability, pre-existing suicidal ideation or abuse? Would such exploration be considered "judgement"?

➲ *Questions 9 and 11 of the GMC consultation*

Clause 21.3

> *"You must make sure that the patient has enough information to arrange to see another medical professional who does not have the same objection as you."*

Should it be required that doctors signpost patients to a service to which they have an ethical objection? Some will feel that to do this will make them complicit with the action to which they object.

> ➲ *Questions 9 and 11 of the GMC consultation*

Clause 21.4

> *"If a patient is likely to have difficulty accessing appropriate treatment elsewhere, you must make sure that arrangements are made for another suitably qualified colleague to advise, treat or refer the patient."*

Should this be the responsibility of the clinician? Rather, this should be the responsibility of the health board or e.g. hospice board. Bear in mind that the politicians behind the recently fallen bills at Westminster and Holyrood were adamant that there should be no institutional opt-outs under any new "assisted dying" law, so even if you were able to absent yourself individually, you could not necessarily work in an environment free from the practice even if it conflicted with the institutional ethos, and there remains a risk of moral injury to health care professionals and others who sit on the boards of (e.g.) hospices.

> ➲ *Questions 9 and 11 of the GMC consultation*

Clause 23

> *"You should consider the availability of alternative care providers for the patient. <u>If no reasonable alternative is available, you must discuss all options with the patient and provide treatment whatever your personal beliefs</u> – unless you are able to rely on a legal right to conscientiously object."*

This is the crux of the matter: it means there is no right to conscientious objection within the guidance if the clinician is required to provide it when there is no reasonable alternative. The responsibility should be on the health board to provide the reasonable alternative (notwithstanding earlier comments regarding the likely lack of institutional opt-outs and possibly resulting moral injury).

This will particularly affect those working in rural areas.

> ➲ *Option to make free text comments in Question 11 of the GMC consultation*