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16 December 2019

Abortion Consultation
Northern Ireland Office
Stormont House
Stormont Estate Belfast
BT4 3SH

To whom it may concern,

A new legal framework for abortion services in Northern Ireland: GMC comments

We welcome the opportunity to comment on the consultation: 'A new legal framework for abortion services in Northern Ireland'.

For reasons that we outline below, most of the questions in the consultation fall outside our regulatory remit and we have therefore restricted our comments to a small number of areas. In addition, we believe that it would be helpful to provide some background and context in relation to some of the issues raised by the consultation. For these reasons, as well as for ease of reading, we have chosen to respond to the consultation in the form of a letter, setting out:

- the role and remit of the GMC. In particular,
  - the role and status of our professional guidance
  - our education remit
- the scope of our response
- specific comments on the 'conscientious objection' proposals in the consultation

The GMC's role and remit

The General Medical Council (GMC) is an independent organisation, accountable to parliament; protecting patients and improving medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training
- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers
- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

Our mandate rests on the Medical Act 1983 which sets out:

- our statutory purpose
- governance of the GMC
- our functions in relation to the medical education, registration and revalidation of doctors; the giving of guidance to doctors on matters of professional conduct, performance and ethics; investigating and acting on concerns about a doctor's fitness to practise.

As a UK regulator we take account of the law in all jurisdictions when carrying out our functions. This includes the provision of ethical guidance, where our aim is to set out standards which are consistent across all four countries of the UK, while taking account of any differences in legal frameworks.

Our guidance defines what makes a good doctor by setting out the professional knowledge, skills, values and behaviours required of all doctors working in the UK. It provides doctors with a framework within which they must exercise their own professional judgement and they should be prepared to justify their decisions and actions. As such, our guidance is not a set of rules and it does not set out thresholds at which it is considered a doctor's fitness to practice is impaired.

We would, however, be concerned where a doctor's actions fell seriously or persistently below the standards we expect and we have a duty to take action in such cases. We would investigate and take action when we have a serious concern about a doctor's behaviour, health or performance and we think the doctor could harm patients or damage public confidence in the medical profession.

Good medical practice (GMP) is our core guidance. We expand on the fundamental principles of GMP in supplementary ethical guidance which sets out more detailed expectations in relation to areas such as consent, confidentiality and personal beliefs, as well as other issues in practice.

In terms of the GMC's regulatory role in medical education, primarily this is one of oversight. We do not produce or own curricula. We do however determine the outcome requirements for the skills knowledge and professional behaviours that we expect undergraduate medical students and doctors in postgraduate training to achieve.

While we do not have powers to approve curricula for undergraduate medical education, we have a regulatory role in approving curricula for postgraduate training in the 65 medical specialties in the UK. With their clinical knowledge and expertise, the medical royal colleges and faculties, include specialty specific content in postgraduate curricula. The following links illustrate where abortion is covered in education and training at specialty level:

- Obstetrics and Gynaecology – much content on abortion in both Core curriculum and Advanced curriculum

- Genitourinary medicine – Trainees much know how to: *'Explain the legal situation with regard to therapeutic abortion, indications and available methods in the UK'* and give: *'Initial counselling and referral of women seeking abortion, unless conscientious objector in which case refers to colleagues without prejudice'.*

- Community sexual and reproductive health – much content on abortion

- Paediatric Cardiology – Trainees must understand the importance of non-directive counselling regarding continuation or termination of pregnancy.

All graduate doctors are required to undertake a two-year Foundation Programme. This provides training to develop doctors with a range of essential interpersonal and clinical skills for managing acute and long-term conditions. The Academy of Medical Royal Colleges (AoMRC) develops the Foundation programme curriculum which sets out the requirements to develop doctors with a range of essential interpersonal and clinical skills. We approve this curriculum and the outcomes. However, we do not make requirements relating to the specific content of the Foundation programme curricula. Instead, we set out a process that the AoMRC should follow to ensure that appropriate consultation is undertaken and appropriate medical expertise is brought to bear in its development.

The scope of our comments

The GMC recognises the weight of opinion on both sides of the ethical debate on abortion, and the extreme sensitivities raised by this area of medical practice. The GMC has not taken a view on whether Northern Ireland abortion law should change as we see this to be the role of the relevant legislature to determine.

In addition, it is not within our remit to advise on particular service delivery models (short of them clearly being in conflict with patient safety); nor would we advise on clinical issues, including taking a view on which clinical factors (such as specific time limits) should set the parameters for a legal framework for abortion in Northern Ireland. We see these as matters of public policy for other bodies and interested parties to comment on.

For these reasons, our response is focused on areas that are relevant to:

- our professional standards on conscientious objection – and how proposals in the consultation interact with those standards
- how these standards apply in the context of education and training

Our professional standards on conscientious objection

We know that some doctors have strongly held views which mean they object to abortion. We don't wish to prevent doctors from practising in line with their beliefs and values as long as they act in accordance with the law and:

- do not treat patients unfairly
- do not deny patients access to appropriate medical treatments or services
- do not cause patients distress.

Our guidance on conscientious objection is contained in *Personal beliefs and medical practice* and applies across all four countries in the UK (see paragraphs 8-16 of that guidance). It aims to balance the rights and interests of doctors' and patients', including the right to freedom of thought, conscience and religion, and the entitlement to care and treatment to meet clinical needs of a patient. It supplements and expands on the principles set out in paragraphs 15, 48, 52, 54, 57 and 59 of our core guidance *Good Medical Practice (2013)*. It applies to any procedure a doctor might have a conscientious objection to, irrespective of whether there is any corresponding statutory right to object, and sets out that (barring any contractual obligations) a doctor can choose to opt out of a procedure they have a conscientious objection to as long as patient care is not compromised or obstructed.

Our guidance sets out the steps that need to be taken should a doctor wish to exercise a conscientious objection, to ensure that patients' access to care and treatment is not compromised or obstructed as a result. This includes, for example, ensuring that patients have the information they need to access treatment elsewhere. It also says that, in emergencies, doctors must provide treatment necessary to save the life of, or prevent serious deterioration in the health of, a person because the treatment conflicts with their personal beliefs. If any of these circumstances is likely to arise, we expect doctors to provide effective patient care, advice or support in line with *Good Medical Practice*, whatever their personal beliefs.

We welcome the proposed introduction of a statutory right to conscientiously object to participate in abortion. Our understanding is that one of the protections afforded by such a statutory right would be to remove any risk that a doctor (or other relevant healthcare professional) could be subject to contractual obligations to participate in abortions.

We also note that the consultation proposals on the scope of conscientious objection do not create any inconsistencies with our professional guidance in this area.

Conscientious objection in the context of education and training

Where a medical student holds a conscientious objection to abortion, we would encourage them to discuss this with their medical school. However, medical students at graduation must meet all the GMC's *Outcomes for Graduates* and can't be exempted from any of these outcomes.

Our view is that medicine is a career possible for people of all faiths and personal beliefs. There will be different demands placed on doctors depending on the career path they choose and we firmly believe doctors' faith or personal beliefs should not be a barrier in pursuing their preferred speciality. It is important that doctors understand what is expected of them in our guidance and what is expected of them if they want to work in a particular speciality. There is also an expectation that employers and medical schools will work with doctors to help them practice in line with their beliefs.

There are some helpful resources for students, trainee doctors and medical schools, to help consider how best to support and accommodate personal and religious beliefs. For example, as well as our guidance there are resources produced by the British Medical Association (BMA) and Equality and Human Rights Commission (EQHRC)

We hope these comments are helpful and we would be happy to explore or clarify any aspect of our response with you further. We would also welcome the opportunity to support relevant partners during the implementation stage, including the development of guidance on the new legislative framework.

Yours faithfully,

Professor Colin Melville,
Medical Director and Director, Education and Standards