Royal College of General Practitioners (RCGP) organisational response to the General Medical Council (GMC)'s Personal beliefs and medical practice consultation

June 2026

About RCGP

We are the professional membership body for GPs in the UK. Our purpose is to encourage, foster and maintain the highest possible standards in general medical practice. We support GPs through all stages of their career, from medical students considering general practice, through to training, qualified years and retirement.

GMC consultation: Personal beliefs and medical practice

About this consultation

GMC: "We're reviewing the *Personal beliefs and medical practice* (2013) guidance and want to hear your views on an updated draft of the guidance.

This guidance forms part of the more detailed guidance on the professional standards. It explains how doctors, physician associates (PAs) and anaesthesia associates (AAs) can provide good, safe care and meet professional standards, while taking into account both their own personal beliefs and the beliefs of their patients. It recognises that patients' beliefs and values can influence their priorities and decision making when it comes to their treatment and care – and provides guidance for the professionals we regulate on how to approach this.

The guidance focuses specifically on personal beliefs in professional practice. It doesn't cover beliefs expressed outside work, or how we consider concerns that may be raised with us about them.

We're now carrying out an in-depth review to make sure the guidance:

- reflects developments across the UK's healthcare systems and wider social changes
- remains relevant to a range of situations and operational environments.

We've developed the updated draft guidance through extensive research, engagement with stakeholders, and expert advice."

Consultation questions

[RCGP responses are in blue]

Section 1.

Question 1. To what extent do you agree or disagree with the following statement?

The updated guidance structure is accessible.

- Strongly agree
- Agree X
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

In the current guidance, we don't define what personal beliefs are but recognise they can be religious, political, philosophical and / or moral in nature and informed by cultural practices as well as social and spiritual factors. We don't set out the differences between personal beliefs and clinical opinions in the current guidance.

In the updated draft guidance, we say:

'We recognise that personal beliefs (including political, religious, philosophical and moral beliefs) and cultural practices can be central to the lives of many medical professionals and patients. Medical professionals have personal values that can inform their day-to-day practice, and patients' beliefs and values can influence their priorities and inform their decision making when it comes to their treatment and care.'

Question 2. To what extent do you agree or disagree with the following statement?

The updated draft guidance accurately reflects the range of personal beliefs and values that might influence the practice of doctors, PAs, and AAs and inform patients' decision making.

- Strongly agree
- Agree X
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

Question 3. Do you agree or disagree with this statement?

It would be helpful if there was a description of the relationship between personal beliefs and clinical opinion in the guidance.

- Yes X
- No
- Don't know

Question 4. Is there anything else we should consider when defining the range of personal beliefs that can fall within the scope of this guidance?

[Free-text]

We (the Royal College of General Practitioners) consider it important that the framing of the guidance reflects the fact that everyone has personal beliefs and values that affect how they interact with others. Doctors should not feel that this guidance only applies to those with strong religious, cultural or philosophical beliefs. Even if such beliefs and values are largely subconscious, the aim of the guidance must be to support doctors to bring these beliefs and values to conscious awareness to avoid their affecting interactions with colleagues and patients in a negative way.

Question 5. Is there anything else we should consider in terms of the guidance structure and the terminology we use?

[Free-text]

N/A

In the current guidance we say that doctors, PAs, and AAs should:

- be open with their employers, partners or colleagues if they do not want to participate in or provide a procedure or treatment because of their personal beliefs – this is known as a conscientious objection
- explore with employers, partners or colleagues how they can practise in accordance with their beliefs without compromising patient care and without overburdening colleagues.

In our research we identified that the professionals we regulate may need to talk to their employers, partners or colleagues about other instances where their personal beliefs could affect their practice. For example, a surgeon who dresses modestly as part of their faith may

need an adjustment to bare below the elbow (BBE) policies. Having open conversations about this is important to find out whether accommodations can be made in the circumstances while maintaining safe patient care.

In the updated draft guidance, we:

- are clearer that the duty to be open about how personal beliefs might affect the practice of the professionals we regulate extends beyond conscientious objections
- recognise there may be contractual requirements that could limit the freedoms of the professionals we regulate to practise in line with their beliefs. While contractual requirements are a matter for doctors, PAs, and AAs, and their respective employers, we thought it could be helpful to acknowledge this.

In the updated draft guidance we say:

'You may be required to fulfil contractual requirements that could limit your freedom to work in line with your beliefs. This may include conscientious objections, working patterns, as well as organisational policies on dress codes. These are matters between medical professionals and their employing or contracting bodies.'

'You should be open with employers, partners or colleagues about your beliefs where these may affect your practice. You should explore with your employer how you can practise in line with your beliefs while maintaining a good standard of care and reducing any impact on colleagues in your team. See paragraphs 18–26 for more information on conscientious objections.'

Question 6. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
A. The updated draft guidance on doctors, PAs, and AAs being open with their employers, partners or colleagues where personal beliefs may affect their practice is **clear**.		X				
B. The updated draft guidance on doctors, PAs, and AAs being open with employers,		X				

partners or colleagues where personal beliefs may affect practice is **helpful**.						
C. The updated draft guidance on doctors, PAs, and AAs being open with employers, partners or colleagues where personal beliefs may affect practice is achievable in **practice**.		X				

In *Good medical practice* we recognise the importance of treating colleagues with kindness, courtesy, and respect to develop and maintain effective teamworking and interpersonal relationships. There's also a focus on role modelling respectful, fair, supportive, and compassionate behaviours.

We recognise that for some of the professionals registered with us, their personal beliefs and values have a strong and positive influence on their approach to work. In our research we also heard that some doctors, PAs, and AAs had very positive views about the value that their colleagues' beliefs or values brought to their practice, even where they did not share these beliefs themselves.

However, we're aware that there can be challenges:

- when colleagues hold different, or conflicting personal beliefs
- where a doctor, PA or AA seeks to discuss their personal beliefs with colleagues to a degree that is unwelcome and may feel imposing
- where there's a concern about the beliefs of a professional registered with us negatively affecting, or being perceived to negatively affect, patient care.

In drafting, we've built on the principles in *Good medical practice* around working to create a workplace culture that's respectful, fair, supportive, and compassionate.

In the updated draft guidance, we say:

'*You have the right to work and train in an environment which is fair, free from discrimination, and where you're respected and valued as an individual.*'

'You must help to create a workplace culture that is respectful, fair, supportive and compassionate. As part of this, you should not:

- *impose your views, beliefs or values on others*
- *treat your colleagues poorly based on any assumptions you have about their beliefs or because you disagree with their views or beliefs.'*

'If you witness the behaviours described in paragraph 14, you should act, taking account of the specific circumstances (see paragraph 58 of Good medical practice for examples of actions that could be taken).'

'If you have a formal leadership or management role and you witness – or are made aware of – any of the behaviours described in paragraph 14, you must act (see paragraph 59 of Good medical practice). You must also follow our more detailed guidance on Leadership and management.'

Question 7. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
A. The updated draft guidance on doctors', PAs' and AAs' responsibilities in contributing to a respectful, fair, supportive and compassionate workplace is **clear**.		X				
B. The updated draft guidance on doctors', PAs' and AAs' responsibilities in contributing to a respectful, fair, supportive and compassionate workplace is **helpful**.		X				
C. The updated draft guidance on doctors', PAs' and AAs'		X				

responsibilities in contributing to a respectful, fair, supportive and compassionate workplace is **achievable in practice**.						

In the current *Personal beliefs and medical practice* guidance we say *'You may talk about your own personal beliefs only if a patient asks you directly about them, or indicates they would welcome such a discussion.'* However, our research highlighted that the factors that indicate someone would welcome a discussion aren't always clear.

In our research we also found that the personal beliefs of some of the professionals we regulate can be more visible without them telling patients. For example, through their clothing.

In the updated draft guidance, we removed the wording on patients indicating that they would welcome a discussion on a doctor's, PA's or AA's beliefs. We've also been clear that there can be a link between the professionals we regulate talking to patients about their personal beliefs and discussing any conscientious objections they have.

In the updated draft guidance, we say:

'During a consultation, you should keep the discussion relevant to the patient's care and treatment. See paragraphs 18–26 for more information on discussing conscientious objections. If a patient asks you about your personal beliefs, you must be careful not to breach the professional boundary that exists between you. See paragraphs 3 and 4 in Maintaining personal and professional boundaries for further information. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them (see paragraph 87 in Good medical practice).'

Question 8. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
A. The updated draft guidance on how, when appropriate, doctors, PAs, and AAs should talk to patients		X				

about their beliefs is **clear**.						
B. The updated draft guidance on how, when appropriate, doctors, PAs, and AAs should talk to patients about their beliefs is **helpful**.		X				
C. The updated draft guidance on how, when appropriate, doctors, PAs, and AAs should talk to patients about their beliefs is **achievable in practice.**		X				

Section 2.

When we updated *Good medical practice* in 2024, we amended the text around conscientious objection. We removed the requirement for doctors, PAs, and AAs to explain to a patient if they have a conscientious objection to a particular treatment, allowing the professionals we regulate to use their discretion when deciding whether to tell the patient the reason they are unable to provide care themselves. This change reflects feedback we had about the impact it can have on patients to be told about the personal beliefs of their doctor, PA, or AA.

We reworded the text on conscientious objection in the updated guidance draft to bring it in line with the changes in *Good medical practice*.

In the updated draft guidance, we say:

If, having taken account of your legal, ethical and contractual obligations, you wish to exercise a conscientious objection, you must prioritise patient safety. You must make sure the way you manage this doesn't act as a barrier to a patient accessing appropriate care to meet their needs. As part of this:

- *You must take steps to make patients who may consult with you aware of your objection in advance. You can do this by making sure that any printed material or online information you provide about your practice and the services explains if there are any services you will not normally provide because of a conscientious objection.*

- *You must tell the patient during consultation if you do not 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 this is due to a conscientious objection you have. 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. Whatever your personal beliefs about the procedure in question are, you must be respectful of the patient's dignity and views.*
- *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 so they can discuss all the options available to them. 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. You must bear in mind the patient's vulnerability and act promptly to make sure they are not denied appropriate treatment or services. If the patient has a disability, you should make reasonable adjustments to your practice to allow them to receive care to meet their needs. See paragraph 65 of Good medical practice for more information on continuity of care.'*

Question 9. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
A. The updated draft guidance on how doctors, PAs, and AAs should manage discussing conscientious objections with patients is **clear**.		X				
B. The updated draft guidance on how doctors, PAs, and AAs should manage discussing conscientious objections with patients is **helpful**.		X				
C. The updated draft guidance on how doctors, PAs, and AAs should manage discussing		X				

conscientious objections with patients is **achievable in practice**.						

Doctors, PAs, and AAs are legally entitled to exercise a conscientious objection to, and refrain from participating in, certain treatments or procedures – these are the termination of pregnancy and in vitro fertilisation (IVF). We recognise there can be other circumstances where a professional we regulate may wish to exercise a conscientious objection.

In the current guidance, we say that when doctors, PAs, and AAs have a conscientious objection, they must not obstruct patients from accessing services or leave them with nowhere to turn. And this applies to all types of conscientious objection.

In the updated draft guidance, we:

- added more information on factors that should be considered by doctors, PAs, and AA where they have a conscientious objection that isn't protected in law. This includes the availability of alternative care providers, which can be particularly important if the conscientious objection relates to treatment or procedures that are time sensitive
- made clear the expectation that if no reasonable alternatives are available and a doctor, PA, or AA does not have a legal entitlement to conscientiously object, they must discuss all options and provide treatment, whatever their personal beliefs.

In the updated draft guidance, we say:

'You must not obstruct patients from accessing services or leave them with nowhere to turn.'

'You must consider the availability of alternative care providers for the patient. If no reasonable alternative is available, you must discuss all options with the patient and provide treatment, whatever your personal beliefs – unless you are able to rely on a legal right to conscientiously object. If you are unsure whether, in the circumstances, you are legally entitled to conscientiously object, you should speak to your medical defence organisation or seek legal advice.'

'In emergencies, you must not refuse to provide treatment necessary to save the life of, or prevent serious deterioration in the health of, a person because the treatment conflicts with your personal beliefs.'

Question 10. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know

A. The updated draft guidance on how doctors, PAs, and AAs should manage any conscientious objections they have that are not legal rights is **clear**.			X			
B. The updated draft guidance on how doctors, PAs, and AAs should manage any conscientious objections they have that are not legal rights is **helpful**.			X			
C. The updated draft guidance on how doctors, PAs, and AAs should manage any conscientious objections they have that are not legal rights is **achievable in practice.**		X				

Question 11. Is there anything else we should consider in relation to paragraphs 10–26 on the personal beliefs of doctors, PAs, and AAs?

[Free-text]

We consider that there need to be examples provided in the supporting materials to this guidance in order to make the paragraphs concerning conscientious objection clearer.

We consider that the wording in the first bullet point of paragraph 21 could be worded more clearly. The first bullet point ('You must take steps to make patients who may consult with you aware of your objection in advance. You can do this by making sure that any printed material or online information that you provide about your practice explains if there are any services you will not normally provide because of a conscientious objection') could be interpreted to

mean that it is necessary for clinicians to explicitly state that they are not providing particular services due to conscientious objection.

In the Legal Advice Annex, it is not clear that conscientious objection is covered by the Northern Ireland legislation (p. 15). It would be helpful to state that Part 7 of the Abortion (Northern Ireland) (No. 2) Regulations 2020 contains the 'conscientious objection' clause that allows staff to opt out of directly participating in terminations, except in emergencies necessary to save a woman's life or prevent grave permanent injury.

We are also concerned that paragraph 11 could be interpreted in a way that gives insufficient weight to legitimate conscientious objection. While contractual requirements are an important consideration, the guidance should make it clear that employers and contracting organisations should, wherever possible, seek reasonable accommodations that enable medical professionals to practise in accordance with their sincerely held beliefs, provided that patient safety and access to care are not compromised.

This issue may become increasingly important in relation to future developments in healthcare and changes in the law that raise ethical or moral concerns for some practitioners. The guidance should therefore make it clear that conscientious objection should not be undermined through contractual arrangements alone, and that any limitations on its exercise should be justified, proportionate and necessary to ensure patient access to appropriate care.

This may be particularly relevant in general practice should assisted dying or other ethically contentious services become lawful in the future, where clarity regarding professional responsibilities and conscientious objection will be essential.

Section 3.

In the current *Personal beliefs and medical practice* guidance, we focus on what the professionals we regulate should do if patients' personal beliefs lead them to request a procedure for mainly religious, cultural or social reasons, or to refuse treatment.

In the updated draft guidance, we made changes to more clearly highlight the importance of:

- considering patients' personal beliefs within decision-making discussions – this mirrors the principles in *Decision making and consent* (2020)
- avoiding making assumptions about how patients' personal beliefs relate to their care based on generalisations about people who share their belief
- exploring what care would be most consistent with, or meet the requirements of, patients' personal beliefs and values – and offering this, where possible.

In the updated draft guidance, we say:

'Patients' personal beliefs can shape their priorities and may influence their concerns, preferences, and expectations about their treatment and care. All of which will affect their decision-making. As a result, they may:

- *wish to explore potential adjustments to accommodate their beliefs*
- *refuse treatments that you judge to serve their needs*
- *ask for treatments or procedures for mainly religious, cultural or social reasons.'*

'In assessing a patient's condition(s), symptoms and taking a history, you must take account of:

- *relevant psychological, spiritual, social, economic, and cultural factors,*
- *the patient's views, needs, and values*

so that you have the information necessary to support them to understand their options and decide what treatment or referral may be best for them as an individual (see Good medical practice paragraphs 7a–7b and 34 and Decision making and consent paragraphs 16 –20).'

'It may be appropriate to ask a patient about their personal beliefs when finding out what matters to them. You must not put pressure on a patient to discuss or justify their beliefs, or the absence of them. You should avoid making assumptions about how patients' personal beliefs relate to their care based on generalisations about people who share their belief. You must be careful that your words and actions do not imply judgement of the patient or their beliefs and values.'

'When discussing treatment options with a patient, you should consider what would be most consistent with, or meet the requirements of, their personal beliefs and values – and offer this, where possible. You should discuss benefits and harms of available treatment, including the option to decline treatment. You should accommodate a patient's wishes if they would like anyone else to be involved in discussions and/or help them make decisions (see paragraph 27 of Decision making and consent).'

Question 12. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
A. The updated draft guidance on considering patients' personal beliefs when providing care and exploring suitable treatment options is **clear**.		X				
B. The updated draft guidance on considering		X				

patients' personal beliefs when providing care and exploring suitable treatment options is **helpful**.						
C. The updated draft guidance on considering patients' personal beliefs when providing care and exploring suitable treatment options is **achievable in practice**.		X				

Question 13. Is there anything else we should consider in relation to paragraphs 32–33 on providing care in line with patients' personal beliefs?

[Free-text]

Given the increase in wide-ranging verbal and physical abuse directed at GPs and their staff in recent years, we believe the guidance should include a clear and explicit statement that abuse of any kind is unacceptable. Such a statement would provide important support to colleagues who have experienced this behaviour. While paragraph 33 states that 'You have the right to work and train in an environment which is fair and free from discrimination,' this does not fully acknowledge the harm caused by prejudiced behaviour on the part of patients.

We therefore recommend that the guidance includes wording that recognises the rise in discriminatory abuse, acknowledges the impact this behaviour can have on GPs and other members of staff, and affirms that doctors have a professional responsibility to support colleagues who are subjected to such treatment.

It would also be helpful for the GMC to include examples in supporting materials on what practices should do in situations in which helping a vulnerable patient means not protecting a member of staff. There are two equally important principles at play: access to healthcare and the safety of staff. This is particularly pertinent to rural practices (please see the example in the response to Question 24).

All doctors, PAs and AAs have the right to work and train in an environment free from discrimination. To strengthen the guidance, we introduced some new content on when a patient expresses beliefs, or makes requests based on their beliefs, that are abusive or discriminatory in nature.

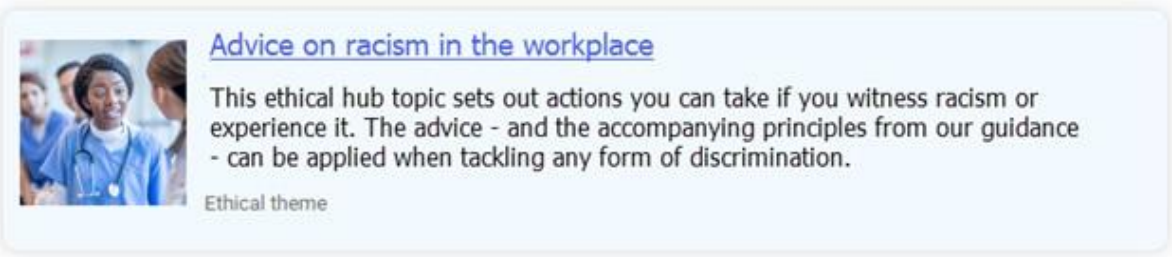
We want to be clear that supporting patients to receive care that is in line with their personal beliefs does not introduce an expectation that abusive or discriminatory behaviour should be tolerated.

To support doctors, PAs, and AAs who are facing these behaviours, we proposed signposting the professionals we regulate to their local policies.

We also plan to include a reference and link to our advice on racism in the workplace ethical hub page beneath this paragraph as shown below.

In the updated draft guidance we say:

'A situation could arise where a patient expresses a view, or makes a request based on their beliefs, that is abusive or discriminatory in nature towards you. You have the right to work and train in an environment which is fair and free from discrimination. Your organisation will have policies on what measures should be taken in response to abusive and unacceptable behaviour.'



Question 14. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
A. The updated draft guidance on how doctors, PAs, and AAs should respond when a patient expresses abusive or discriminatory views based on their beliefs, or makes a request				X		

based on these views, is **clear**.						
B. The updated draft guidance on how doctors, PAs, and AAs should respond when a patient expresses abusive or discriminatory views based on their beliefs, or makes a request based on these views, is **helpful**.			X			
C. The updated draft guidance on how doctors, PAs, and AAs should respond when a patient expresses abusive or discriminatory views based on their beliefs, or makes a request based on these views, is **achievable in practice**.			X			

In the current guidance, we say that some legislation prohibits particular treatments or procedures. In the legal annex, we note the duty on doctors in England and Wales to report known cases of female genital mutilation (FGM) in girls and young women aged under 18 to the police.

In the updated draft guidance, we updated the legal annex to include information on virginity testing and hymenoplasty (reconstruction of the hymen) in line with the Health and Care Act 2022.

We wanted to draw a clearer link in the guidance between requests for treatments and procedures that are against the law and safeguarding procedures. We proposed the following changes to clarify our expectations of the professionals we regulate if patients request procedures that are against the law.

In the updated draft guidance, we say:

'The right to hold a belief is protected in law but expressing and acting on beliefs can be restricted where this is justified […] Some treatments and procedures that may relate to personal beliefs or cultural practices are prohibited by law.'

'If a patient requests a procedure or treatment that's against the law, you must explain this to them and follow any safeguarding procedures that are relevant. See the legal annex for more information and Raising and acting on concerns about patient safety and Protecting children and young people for further guidance.'

Question 15. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
A. The updated draft guidance on how doctors, PAs, and AAs should manage patient requests for procedures or treatments that are against the law is **clear**.			X			
B. The updated draft guidance on how doctors, PAs, and AAs should manage patient requests for procedures or treatments that are against the law is **helpful.**			X			
C. The updated draft guidance on how doctors, PAs, and AAs should manage patient requests for procedures or treatments that are against the law is **achievable in practice**.			X			

Where a patient is a child, decisions around care and treatment can be more complex. In the current guidance, the content on what to do if the patient is a child or young person is woven throughout the guidance, including where there are disagreements about a child or young person's care.

In our research we found that doctors, PAs, AAs, and others don't always have a consistent understanding of parental responsibility.

In the updated draft guidance, we brought together the different points on care involving children and young people into one section to give greater clarity to the professionals we regulate. As part of this, we:

- made clear the expectation for children and young people to be involved in discussions about their care in a way appropriate to their age and maturity
- moved the content about parental responsibility and consent from the endnotes into the main body of the guidance, and signposted to *0–18 years* (2007) guidance where information on parental consent is set out in detail
- included the content from the current guidance on what the professionals we regulate should do if there are disagreements about a child or young person's care.

In the updated draft guidance, we say:

'If the patient is a child or young person, you should read the following section alongside the rest of the guidance.'

'You should assess the child or young person's best interests and involve them in their care a way that's appropriate for their age and maturity. This includes obtaining their consent for any care being provided if they have the maturity and understanding to give it. For guidance on assessing best interests, communicating with children and young people and capacity to consent, see 0–18 years paragraphs 12–29.'

'Where care is being provided for mainly religious, cultural or social reasons, you should also get consent from all those with parental responsibility. Similarly, all those with parental responsibility should be involved in decisions about refusing treatment which is essential to preserve life or prevent serious deterioration in health. See 0–18 years paragraphs 22–29, 34–35 and appendix 'Parents and parental responsibility'.'

'You should record who has provided consent and been involved in discussions in the patient's medical record.'

Question 16. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
A. The updated draft guidance on providing care for children and young people, where the personal beliefs of the child or young person and their family may affect their preferences and decision-making, is **clear**.			X			
B. The updated draft guidance on providing care for children and young people, where the personal beliefs of the child or young person and their family may affect their preferences and decision-making, is **helpful**.			X			
C. The updated draft guidance on providing care for children and young people, where the personal beliefs of the child or young person and their family may affect their preferences and decision-making,			X			

is **achievable in practice**.						

Question 17. Is there anything else we should consider in relation to paragraphs 47–53 on providing care where patients are children and young people?

[Free-text]

We broadly agree that the updated guidance on how doctors, PAs, and AAs should manage patient requests for procedures or treatments that are against the law is clear, helpful and achievable in practice, and welcome the updating of the legal annex to include information on virginity testing and hymenoplasty (reconstruction of the hymen) in line with the Health and Care Act 2022.

However, we do not agree that the updated guidance is comprehensive, as it omits to recognise faith- or belief-based abuse and harmful practices. All doctors, PAs and AAs should be aware of these forms of abuse and harm.

The GMC should provide clearer guidance on recognising and responding to abuse and harmful practices, as well as practices for which there is a mandatory reporting duty, such as FGM and hymenoplasty. FGM and hymenoplasty are just two examples within a wider range of harmful practices.

The guidance should make it clear that the issue is not about challenging or judging people's faith or beliefs. However, where beliefs are used to justify abuse or harm, this must not be tolerated.

We also broadly agree that the updated draft guidance on providing care for children and young people, where the personal beliefs of the child or young person and their family may affect their preferences and decision-making, is clear, helpful and achievable in practice. However, we also consider the guidance to not be sufficiently comprehensive on this topic.

The guidance should include reference to the importance of following safeguarding procedures if there are any concerns about abusive behaviour influencing parental decisions, and include reference to obtaining safeguarding/senior/legal advice if decisions are being made by those with parental responsibility that are potentially harmful or abusive, or not in the best interests of the child.

Question 18. Is there anything else we should consider in relation to paragraphs 27–53 on patients' personal beliefs?

[Free-text]

N/A

Many different belief systems co-exist in the UK. We recognise that personal beliefs (including political, religious, philosophical, and moral beliefs) and cultural practices can be central to the lives of many doctors, PAs, AAs, and patients.

We know the professionals we regulate can have personal values that can inform their day-to-day practice. And we recognise that patients' beliefs and values can influence their priorities and decision making when it comes to their treatment and care.

While differences in beliefs can at times present challenges, we recognise that personal beliefs can be a great source of strength and purpose for some of the professionals we regulate and patients. In *Good medical practice* (2024) we highlight the importance of showing respect for, and sensitivity towards, others' life experience, cultures and beliefs.

However, in our research, we heard that some feel the current *Personal beliefs and medical practice* guidance implies that the norm is for doctors, PAs, AAs, and patients not to have personal beliefs. We heard that as a result, it can seem like the current guidance presents personal beliefs as a challenge that needs to be worked around. This was not our intention with the current guidance.

In our research and conversations with stakeholders, we heard that those we regulate would support a reframing of the guidance to present personal beliefs neutrally with a clearer acknowledgement that a range of belief systems coexist.

We also identified that the current guidance doesn't reflect that some beliefs are more visible than others, for example through forms of dress. As a result, when redrafting guidance, we considered the tone and how guidance accounts for instances where beliefs might be more apparent.

Question 19. To what extent do you agree or disagree with the following statement?

The guidance should acknowledge that a range of belief systems coexist and frame these neutrally.

- Strongly agree
- Agree X
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

Question 20. To what extent do you agree or disagree with the following statement?

The updated draft guidance frames personal beliefs neutrally.

- Strongly agree
- Agree X
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

The current guidance includes a number of explanatory examples on how the principles we set out relate to different aspects of care and personal beliefs. These include cremation, non-therapeutic male circumcision, the use of blood products, gender reassignment and treatments causing infertility, contraception, and the withdrawal of life prolonging treatment.

There can be merits to having explanatory examples as it can show the types of circumstances in which the principles apply. But it can also result in them being given greater weight and risk the guidance appearing narrower in focus. The other guidance doesn't include examples in the main text, though some have links to case studies or other learning materials within the guidance.

Below is an example of how we've linked to a case study in *Good medical practice*.

We want the *Personal beliefs and medical practice* guidance to be principles-led and applicable in a broad range of circumstances as it applies to all the professionals we regulate – regardless of role type, specialty or career stage. As such, we are considering moving the examples into supporting materials, including case studies. And we've written the new draft version without explanatory examples.

Question 21. Thinking about the proposed change in how explanatory examples are presented, which approach do you prefer?

- Remove examples from the main text and instead include them in supporting materials (for example, as case studies) X
- Keep examples in the main text of the guidance
- Don't know / No preference

Question 22. Can you see any risks in removing examples from the main text and instead using them to develop supporting materials?

- Yes X
- No
- Don't know

Question 23. If you said yes, please tell us about the risks.

[Free-text]

We consider it important for the guidance to be supported by a range of clear and explicit examples, but we do not believe these should be embedded within the main text. The guidance itself should focus on setting out overarching principles. This approach would give users of the guidance greater flexibility to apply the principles to new and emerging situations, rather than feeling constrained by the examples included in the text.

However, for this approach to be effective, the guidance should include clear signposting and links to the supporting materials. Without this, there is a risk that GPs and other users may not be aware of, or make use of, the accompanying examples and resources available.

Question 24. Can you suggest any scenarios where case studies or supporting materials would help explain how the principles in *Personal beliefs and medical practice* can be applied in practice?

[Free-text]

We would like to see case studies or examples in supporting materials relating to how doctors should manage any conscientious objections they have that are not legal rights.

We would also like to see case studies or supporting materials relating to situations in which there is a tension or incompatibility between caring for a vulnerable patient and protecting a member of staff. For example, if a vulnerable patient is racially abusive to a member of staff in

a rural practice, should the practice remove the patient from the practice, knowing that the patient will have to travel a long distance to another practice and therefore may not be able to access healthcare – or allow the patient to stay at the practice, in order to facilitate vital healthcare, and thereby not protect the member of staff?

Section 4.

We've considered the impact of the current guidance and the proposed changes on doctors, PAs, AAs, and patients with different protected characteristics. For example:

- we have taken steps to make sure that we understand developments in case law concerning what constitutes a protected belief under the Equality Act 2010 and Article 9 of the Human Rights Act (1998)
- we recognise that the rights of different groups and individuals need to be considered and balanced. For example in instances where a professional we regulate wishes to exercise a conscientious objection. We've considered this throughout our drafting
- in the current guidance, we say that doctors, PAs, and AAs should inform their employers about their conscientious objections. However, they may face barriers to following this in workplaces where personal beliefs are seen negatively. We introduced a new standard around creating supportive workplaces in response to this challenge
- patients' personal beliefs are nuanced. To support patient specific conversations around care decisions we introduced a duty around not making assumptions about how patients' personal beliefs relate to their care based on generalisations about people who share their belief
- we identified that there isn't a consistent understanding of parental responsibility and how this relates to consent when a patient is a child or young person, which may present a risk to children and young people. In drafting we considered how to make this clearer.

We'd like to understand whether changes to the draft guidance will positively or negatively impact the professionals we regulate or patients who share protected characteristics.

Question 25. What impact, if any, do you think the draft updates to *Personal beliefs and medical practice* guidance could have on patients and the professionals we regulate who share protected characteristics under the *Equality Act 2010* (the protected characteristics are race, disability, age, sex, gender reassignment, sexual orientation, religion and belief, pregnancy and maternity, and marriage and civil partnership)?

- Very positive

- Somewhat positive X
- No impact
- Somewhat negative
- Very negative
- Don't know

We recognise that when introducing changes to guidance, there is the potential for unintended consequences.

We want to understand if the new draft of *personal beliefs and medical practice* could be interpreted or applied in a way that leads to biased or unfair judgements about doctors, PAs, AAs, or patients with particular protected characteristics. We will use this information when further developing the guidance.

Question 26. If you think the draft guidance could be interpreted or applied in ways that lead to biased or unfair judgements, please explain how.

[Free-text]

We recognise that situations may arise where different protected characteristics, beliefs or rights come into tension with one another. The guidance should continue to emphasise the importance of mutual respect, professionalism and lawful expression of beliefs, while recognising that doctors, PAs, AAs and patients may hold differing views. It should also acknowledge the need to balance competing rights and protected characteristics in a fair, proportionate and patient-centred manner.

We'd like your views on the guidance overall and anything we haven't specifically asked about already. When answering this question, please bear in mind the criteria which the final guidance must meet:

- relevant to the practice of individual doctors, PAs, and AAs and not an action for employers, educators or government
- relevant to most – if not all – of the professionals we regulate, keeping in mind that not all our registrants work in patient-facing roles
- actionable in practice and capable of being demonstrated with evidence – eg through appraisal and revalidation
- necessary to protect patients, maintain standards or to uphold confidence in the doctors, PAs and AAs that we regulate.

In particular, you might want to tell us:

- if there's anything missing from the updated draft guidance
- if there's anything we should remove from the updated draft guidance
- if there could be any barriers or enablers for doctors, PAs, and AAs to apply the updated draft guidance [link to draft] to their practice that we should consider.

Question 27. Is there Is there anything else we should consider in relation to the guidance?

[Free-text]

We note that the guidance now applies to doctors and PAs and AAs. It will be important that the implementation of the guidance does not inadvertently create confusion for patients regarding professional roles, responsibilities and accountability.