



FPM response to General Medical Council consultation on personal beliefs and medical practice guidance

In March 2026, the General Medical Council opened a public consultation on proposed updates to their existing guidance on *Personal beliefs and medical practice*, which forms part of the professional standards.

Personal beliefs can take many forms. They may be religious, philosophical, moral or political, and can also be shaped by ethical views, as well as cultural, social, or spiritual factors.

The proposed guidance 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.

FPM submitted its response (below) on 1st June 2026.

Questions

**Question 1. To what extent do you agree or disagree with the following statement?
The updated guidance structure is accessible.**

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

**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The updated draft guidance accurately reflects the range of personal beliefs and values that might influence the practice of doctors, PAs, and AAs and inform patients' decision making.**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
- Neither agree nor disagree



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- 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
- 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?

When defining which personal beliefs fall within the scope of this guidance, it may be helpful to consider several further dimensions. First, beliefs are not limited to religion or morality; they can also include professional identity, cultural norms, political values, and deeply held ethical frameworks that shape how clinicians interpret their duties. The draft already notes that “personal beliefs (including political, religious, philosophical, and moral beliefs) and cultural practices can be central to the lives of many medical professionals”, but in practice these categories often overlap and evolve over time.

Would expand to include spiritual beliefs to encompass doctors/AAs/PAs and patients who do not identify themselves as following any specific religious doctrine, e.g those agnostic or otherwise but may hold values and beliefs that stem from a spiritual source. Would explicitly mention those with absence of religion or spiritual beliefs. Would suggest this might be an appropriate topic to raise in the "Requests for care for mainly religious, cultural, or social reasons".

The guidance may need to account for emerging belief-based conflicts arising from new technologies, reproductive options, gender identity, end-of-life choices, and AI-supported care. These areas generate novel ethical tensions that may not fit neatly into traditional conscientious objection categories.

It may be useful to clarify that beliefs can be sincerely held without being absolute. Some clinicians may experience situational or contextual moral discomfort rather than a fixed objection, and the guidance could help distinguish between conscientious objection, moral unease, and professional disagreement.

Finally, the scope should ensure that recognising beliefs does not inadvertently legitimise discriminatory attitudes or undermine equitable access to care.



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

Numbered or lettered section headings would improve the ability to navigate and reference the proposed guidance.

May consider ensuring the guidance uses consistent, plain language that clearly distinguishes between personal beliefs, conscientious objection, moral discomfort, and professional disagreement.

Structurally, grouping sections by practical scenarios rather than professional perspective could make the document easier to navigate.

It may also help to define key terms early, especially where legal, ethical, and cultural concepts intersect. Using terminology that avoids assumptions can support neutrality.

Finally, cross-referencing related GMC guidance more explicitly would help users understand how this document integrates with wider professional standards.

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

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.

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

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

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



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.

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

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

A. The updated draft guidance on doctors', PAs' and AAs' responsibilities in contributing to a respectful, fair, supportive and compassionate workplace is clear.

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

B. The updated draft guidance on doctors', PAs' and AAs' responsibilities in contributing to a respectful, fair, supportive and compassionate workplace is helpful.

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



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C. The updated draft guidance on doctors', PAs' and AAs' responsibilities in contributing to a respectful, fair, supportive and compassionate workplace is achievable in practice.

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

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

A. The updated draft guidance on how, when appropriate, doctors, PAs, and AAs should talk to patients about their beliefs is clear.

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

B. The updated draft guidance on how, when appropriate, doctors, PAs, and AAs should talk to patients about their beliefs is helpful.

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



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

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

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

A. The updated draft guidance on how doctors, PAs, and AAs should manage discussing conscientious objections with patients is clear.

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

B. The updated draft guidance on how doctors, PAs, and AAs should manage discussing conscientious objections with patients is helpful.

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



C. The updated draft guidance on how doctors, PAs, and AAs should manage discussing conscientious objections with patients is achievable in practice.

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

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

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.

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

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.

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



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.

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

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

Regarding para 21, it would be helpful to acknowledge that in some instances, an alternative colleague should not only be appropriately qualified, but should ideally be accessible to that patient: not just for those with disabilities, but within socioeconomic boundaries, geographies, etc

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

A. The updated draft guidance on considering patients' personal beliefs when providing care and exploring suitable treatment options is clear.

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

B. The updated draft guidance on considering patients' personal beliefs when providing care and exploring suitable treatment options is helpful.

- Strongly agree



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- Agree

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

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

- Strongly agree

- Agree

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

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

To clarify how clinicians should respond when patients' belief-based requests conflict with resource limits, safeguarding duties, or public-health obligations.

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

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 based on these views, is clear.

- Strongly agree

- Agree

- Neither agree nor disagree
- Disagree
- Strongly disagree



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- Don't know

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.

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

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.

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

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

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.

- Strongly agree
- Agree
- Neither agree nor disagree



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- Disagree
- Strongly disagree
- Don't know

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.

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

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.

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

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

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.

- Strongly agree
- Agree
- Neither agree nor disagree



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- Disagree
- Strongly disagree
- Don't know

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.

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

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, is achievable in practice.

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

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?

Clarify expectations when belief-based parental decisions conflict with safeguarding duties, ensuring timely escalation while still involving the child appropriately.



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

Clarify how clinicians should balance belief-related requests with safeguarding, capacity assessment, and equitable access, ensuring consistent documentation and timely escalation.

**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
- 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
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

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)
- 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
- No
- Don't know

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

Concerns that these examples will not be read or appropriately acknowledged. Particularly for those with neurodiversity, this may limit the accessibility of the document if they are required to jump between sections and interrupts the flow. Would suggest keeping the examples within the main text, but expanded reference case studies may be helpful as supportive materials.

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?

Cases on belief-based refusals, cultural procedure requests, safeguarding conflicts, and managing discriminatory statements would clarify practical application of the principles.

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



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.

The draft could be misapplied if “personal beliefs” are interpreted too broadly, allowing subjective discomfort to resemble conscientious objection. Ambiguity around discriminatory beliefs may also create inconsistent judgements. Without clearer distinctions between belief, bias, and prejudice, decisions about refusals, referrals, or behaviour could inadvertently disadvantage patients or unfairly scrutinise clinicians.

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

Although the document describes very well the protection for the patient in cases of beliefs impacting care, it does not elaborate much on protection for the doctor/AA/PA with such beliefs in practice. It may be useful to include wording that acknowledges that while it is an obligation of the doctor/AA/PA to declare such beliefs, in practice this may be a delicate or intimidating issue to raise. Perhaps there would be an obligation by an doctor/AA/PA "receiver" of such information to ensure that this information does not impact a beneficial working relationship or restrict patient care in any way that lies outside of these beliefs. Though this would fall under the category of a discrimination due to a protected characteristic, I think it would be beneficial to highlight that clinical working relationships should not be affected by such a disclosure.

Regarding ‘how, when appropriate, doctors, PAs, and AAs should talk to patients about their beliefs’, it would be beneficial to recognise that the sharing of these beliefs relating to care as stated in para 17 may in some cases put a clinician at risk. While the para states that the discussion should be relevant to the patient's care and treatment, inevitably situations will arise when a clinician may need to disclose a very personal detail (e.g. religious affiliations, moral directions, values). I think it may be helpful to identify what exactly a clinician is obligated to share vs what they do not need to share. For example, are they obliged to say "I cannot perform this procedure due to my personal beliefs so I will refer you to Dr Y" or are they simply able to state "I am not able to perform this procedure, but I will refer you to Dr Y"?

Regarding ‘how doctors, PAs, and AAs should manage discussing conscientious objections with patients is clear’, the guidance is clear on not delaying care when there is a belief that a patient contributed to their condition, that it may benefit to have explicit language that where there is a conscientious objection, the doctor/AA/PA must not delay the patient's ability to access care (e.g. by delaying appropriate referral or information dissemination) in time-sensitive cases such as termination of pregnancy where delay may hinder that patient's ability to undergo the procedure at all.

Regarding ‘how doctors, PAs, and AAs should manage any conscientious objections they have that are not legal rights is clear’, the guidance would benefit from language where there is conscientious objection to a procedure that is carried out for religious, cultural, or social reasons. If a Dr without religious beliefs refuses to perform an procedure that is a



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norm within certain cultures, would this classify as unlawfully discriminating against a group of patients that practice this cultural norm? While the "Requests for care for mainly religious, cultural, or social reasons" section states that "you are not obliged to provide care when you do not believe that the procedure serves the needs of the patient", this itself may be quite subjective and indeed subject to the beliefs of the doctor, and could be seen as per the language used as discriminating against a group of patients. The language in conscientious objection could be made clearer with regards to what constitutes "unlawfully discriminating against a patient or a group of patients".