Letter from Glasgow

SERVING OUR PATIENTS

Two issues caught my eye in recent weeks and both concern aspects of doing the best for our patients. The first was a study of medical students in the UK.[1] The survey by Dr Sophie Strickland of King George Hospital, Essex, reported that 45% of over 700 respondents in Cardiff, Leeds and London said doctors should have the right to object to any procedure for which they have a moral, cultural or religious disagreement. I found this somewhat dispiriting—if we all have the right to object on this basis what becomes of our responsibilities to do the best for our patients. I recognize that the views and beliefs of doctors cannot be swept under the carpet, but if doctors act only according to their conscience and stop providing medical care to which they object, where does that leave patients?

In the UK the General Medical Council (GMC) provides guidance to doctors on what the expectations are regarding their conduct. The GMC's publication *Good medical practice*[2] provides the framework of principles and values which doctors in the UK must adhere to and, it seems to me, are applicable more generally. These principles include that 'you must show respect for human life and you must:

- Make the care of your patient your first concern…
- Treat patients as individuals and respect their dignity…'

The GMC guidance also specifically mentions the situation when providing medical care conflicts with religious or moral beliefs of doctors. In these circumstances it makes clear that doctors must inform their patients and tell them they are entitled to see another doctor. In a global context, the World Medical Association's International Code of Medical Ethics[3] states: 'The health of my patient will be my first consideration…. I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.'

In individual cases of conflict for a doctor, it may be possible (although it may not be practical due to monetary, time or other constraints) to make alternative arrangements such as getting the patient to see another doctor or healthcare provider. Now call me sceptical but if you multiply the number of doctors who are conscientious objectors, it is possible to see whole services and areas of care such as abortions being denied to women, or sexual health services and drug misuse services being denied to men and women. Indeed some doctors would say this is already happening in some parts of the world such as the USA with women being denied access to abortion services. Abortion in many ways acts as one of the touchstones for ethical issues in medicine and I note that Pai and Pandya[4] in their excellent discussion paper shied away from including abortion in their revised Hippocratic Oath.

We doctors have an obligation to serve our patients (in the case of public health doctors our 'patient' is the population) to the best of our abilities. Let us hope that despite the views expressed in the UK medical students' survey that when they emerge as doctors they continue the tradition of serving their patients in an objective manner and to the best of their abilities.

The second issue that I read about was that homosexuality is a disease which must be eradicated—according, that is, to India's Minister of Health and Family Welfare.[5,6] The minister afterwards said that he had been misquoted. Perhaps he should read an excellent text by Nutley and her colleagues called *Using evidence—How research can inform public services*,[7] which, among other things, underlines the 'knowledge requirements for effective social policy'.

As a doctor I celebrate, and do not denigrate, the diversity of the people we serve. But it is not just the celebration of diversity—so important to the functioning of a mature democracy—that is important. At a practical level, at the public health level, to engage with communities and individuals, you do not ostracise them but instead work with them—within the parameters of human rights and ethics we uphold. That does not mean that you necessarily agree with patients' views or their actions but rather this approach demonstrates both humanity and pragmatism. Lest you think this just relates to the gay community think about other groups or patients that doctors work with, for example, people with drug or alcohol dependence, sex workers, or people who eat too much—and all these individuals and groups deserve our support to tackle the health problems they face. No matter what doctors' personal views are on these topics, it is incumbent on doctors not to forget the obligations they have to, and the needs of, the patients they serve.

Of course, being gay is different in that it is not an illness or disease, but they do face health problems and issues which health services and health professionals must deal with. In 1987, Randy Shilts first published the classic book on HIV called *And the band played on: Politics, people and the AIDS epidemic*.[8] In the book, Shilts describes his account of the first 5 years of the AIDS epidemic and says: 'Because of their efforts, the story of politics, people, and the AIDS epidemic is ultimately a tale of courage as well as cowardice, compassion as well as bigotry, inspiration as well as venality, and redemption as well as despair.' It appears that nearly a quarter of a century after that seminal publication, some have still to pay heed to that message. Randy Shilts died of AIDS in 1994 aged 42. As a gay man he used his skills as a journalist and his courage as an individual to shine a light on the developing AIDS epidemic so that people with HIV could get the healthcare they needed. It is important we overcome our own prejudices and views to serve our patients to the best of our abilities. Serving our patients—and it could be argued serving the electorate as a minister—demands nothing less.

REFERENCES

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