White Paper

Response to the General Pharmaceutical Council Consultation on Religion, Personal Values, and Beliefs

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Please Describe Your Organisation: Specialist Human Rights Campaign Group

Please provide a brief description of what your organisation does and its interest in this particular consultation: Right To Life campaigns for the human right to life of every human being to be recognised, respected, and protected in law and medical practice, from conception till natural death. The wider implications of this mission include contributing to the fostering of an ethic of human dignity in the medical and general culture of the United Kingdom and the British Isles. Our interest in this particular consultation comes from this secondary aspect of our work, as we have an interest in seeing the freedom of conscience of medical professionals safeguarded in regulatory guidance, especially those who have conscientious objections to the provision of chemicals that either cause a miscarriage (abortifacients), or which may prevent the implantation of the already conceived human being (potential contragestives).

* This section corresponds to the Consultation Response Form's 'Section B – Responding on behalf of an organisation'.

1. Do You Agree With The Proposed Changes To The Wording Of The Examples Under Standard 1 – About Religion, Personal Values, And Beliefs?

No.

1a. Please Explain Your Reasons For This.

The GPhC are proposing to change the language in new proposed Standards. These currently say[1]:

"People receive safe and effective care when pharmacy professionals:

(…)

• recognise their own values and beliefs but do not impose them on other people

• tell relevant health professionals, employers or others if their own values or beliefs prevent them from providing care, and refer people to other providers".

The new language would say[2]:

"People receive safe and effective care when pharmacy professionals:

(…)

[1] *Consultation on religion, personal values and beliefs*, General Pharmaceutical Council, December 2016, pg. 10.

[2] *Ibid.*, pg. 11.

• recognise their own values and beliefs but do not impose them on other people

• take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs".

This would also affect the Guidance on "religion, personal values and beliefs in practice", which makes clear that "[p]harmacy professionals are personally accountable for meeting the standards and must be able to justify the decisions they make"[3], and that the applications of the standards "might mean that they are unable to take up certain working roles"[4].

That amendation, from "tell relevant health professionals, employers or others if their own values or beliefs prevent them from providing care, and refer people to other providers", to "take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs", is as the GPhC notes, "a significant change from the present position"[5].

Currently, as the previous language suggests, if the conscience of a pharmacist prevents them from providing some form of pharmaceutical service, the GPhC requires them to inform the relevant fellow staff and authorities in their context, and refer those who want the service that they cannot provide to other providers. This duty to refer in-and-of-itself has ethical problems, since if you object to a practice, by pointing others in the direction of how they might receive it, you 'materially cooperate' in that practice. Current guidance however, at least broadly limits the involvement of a pharmacist in practices s/he regards as unethical, and allows them to practise pharmacy with a degree of conscientious freedom.

[3] *Ibid.*, pg. 14

[4] *Ibid.*, pg. 17.

[5] *Ibid.*, pg. 11.

To replace this duty of referral with a "responsibility for ensuring that person-centred care is not compromised" due to their beliefs, however, could be abused in such a way as to deny the right of the pharmacist not to formally cooperate in whatever services to which ethically object. Or else, to prevent pharmacists with such objections from taking certain working positions, thus hindering them in their ability to progress professionally.

Indeed, this seems precisely what is in mind. The GPhC state explicitly that this language would[6]:

> *"[C]hange the expectations placed on pharmacy professionals when their religion, personal values or beliefs might – in certain circumstances – impact on their ability to provide services. They will shift the balance in favour of the needs and rights of the person in their care".*

As a concrete example of how this would affect practice, the consultation specifically marks the expectation that "a referral to another service provider might not be the right option, or enough, to ensure that person-centred care is not compromised"[7].

So, what this would mean in practice is that it would potentially no longer "be... enough" for a pharmacist to set out the options to patients and refer them to other providers. Instead, pharmacists could be obliged by GPhC regulation to provide drugs that they considered unethical, either because they would be at least potentially harmful to their patient, or to others.

This would disproportionately affect those pharmacists who possess convictions against the killing of innocent human beings from conception till natural death, because a key example of those whom drugs might affect adversely would be unborn children.

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[6] *Ibid.*, pg. 11.

[7] *Ibid.*

If the language proposed by the GPhC were implemented into its new standards, this would effectively abolish the right of pharmacists to not provide drugs that cause a miscarriage (abortifacients) or that may prevent a child who has been conceived from implanting in her mother's womb (contragestives), thereby killing them. This includes so-called 'emergency contraceptives', such as 'levonelle' (levonorgestrel) – also known as the 'Morning After Pill' (MAP) – and 'ellaOne' (ulipristal acetate).

The 'emergency contraceptive' ellaOne is a potential contragestive, because like RU-486 (the 'abortion pill') it is an 'anti-progestin' (it blocks the hormone progesterone). The primary intended effect of blocking progesterone is to stop or delay the ovaries from releasing an egg, which would be a contraceptive action. Since however (as happens with RU-486) the blocking of progesterone retards the womb lining, this means that this carries the potential to be contragestive. Consequently, the U.S. Food and Drug Administration (FDA), which regulates all chemicals that act to prevent or to end pregnancy in America, states that[8]:

> *"[Ulipristal Acetate] works mainly by stopping or delaying the ovaries from releasing an egg. It may also work by changing the lining of the womb (uterus) that may affect attachment (implantation)".*

The same is true of levonorgestrel, the MAP. This does not block progesterone, but is a pill with a progestin hormone (a synthetic version of progesterone). How this may work is not clear, but according to the FDA[9]:

> *"[Levonorgestrel] works mainly by stopping the release of an egg from the ovary. It may also work by preventing fertilisation of an egg (the uniting of sperm with the egg) or by preventing attachment (implantation) to the womb (uterus)".*

[8] *Birth Control: Medicines To Help You*, Emergency Contraception (U.S. Food and Drug Administration): http://bit.ly/2m2kpau

[9] *Ibid.*

Pharmacists who conscientiously care about the right-to-life of the human being from conception onwards would be compromised by the proposed requirement to not let their ethical principles prevent the provision of unethical drugs.

There are three bases for objecting to such a consequence of the implementation of the proposed language:

1) It Violates the Principle of Freedom of Conscience in Law and Medical Practice

Freedom of conscience is important to all of us as individuals: no-one would want for our professional lives to be divorced entirely from our personal ethics. We all want and expect to be able to work in such a way that we think is morally integral. In fact, such an expectation is something we have by right. According to equality legislation[10] (which the proposed Guidance requires pharmacists themselves to respect), not only religious beliefs but philosophical beliefs are protected characteristics. Employees may be protected against direct and indirect belief discrimination, harassment and victimisation because of their belief.

This reflects the UK's broader human rights obligations. Article 9 of the European Convention on Human Rights states[11]:

"Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance" (emphasis added).

This right to 'manifest belief' does not stop when one leaves one's house or a place where one's beliefs are held in common with others, but rather extends to our

[10] Cf. Section 10 of the Equality Act 2010: http://bit.ly/2mGDonX

[11] Article 9, European Convention on Human Rights (pp. 10-11): http://bit.ly/2ljwHqW

whole (including professional) life. The European Court of Human Rights has upheld conscience rights on the basis of Article 9, such as in the case of *Bayatyan v. Armenia* (2011)[12], out of concern for a proper balance between the rights of the individual and the interests of society.

This is why the concept of 'reasonable accommodation' (though in its infancy of development in British case law) legally exists, and may be appealed to for the sake of maintaining freedom of religion or belief. According to this doctrine[13], employers should make reasonable accommodation of the beliefs of their employers within the workplace, just as they would for other protected characteristics possessed by those they employ, such as those with physical impairments.

When applied to medical practice, conscience protections are the political and legal norm for medical professionals when it comes to actions that involve the destruction of unborn human life. It is well known that section 4(1) of the Abortion Act 1967[14] states that:

> *"[N]o person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection".*

Similarly, section 38(1) in the Human Fertilisation and Embryology Act 1990[15] states that:

> *"No person who has a conscientious objection to participating in any activity governed by this Act shall be under any duty, however arising, to do so".*

[12] *Bayatyan v. Armenia* (2011): http://bit.ly/2l7PJ8q

[13] A fuller consideration and exposition cane be found in *Towards The Reasonable Accommodation of Religious Freedom*, Peter Smith, Denning Law Journal 26:281-297 (2014): http://bit.ly/2m2v19e

[14] Section 4(1), Abortion Act 1967: http://bit.ly/2m2BtNs

[15] Section 38(1), Human Fertilisation and Embryology Act 1990: http://bit.ly/2l80nvN

This latter provision protects everyone from being morally compromised through having to dispose of, or experiment upon, embryonic human beings.

In 2010, the Council of Europe's Parliamentary Assembly adopted Resolution 1763[16] affirming the right of conscientious objection for medical professionals. This Resolution states that:

> *"[N]o person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion".*

This is a non-binding resolution, but it reaffirms the normative understanding of freedom of conscience, and in an expansive rather than restricted sense.

This importance of conscience freedoms is reflected in the way in which other forms of guidance and the law itself treats conscience. The General Medical Council (GMC) for example, in its Guidance on *Personal Beliefs and Medical Practice*, establishes that[17]:

> *"You may choose to opt out of providing a particular procedure because of your personal beliefs and values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients".*

The way this is handled professionally is also given a clear prescription[18]:

> *"You should… be open with employers, partners or colleagues about your conscientious objection. You should explore with them how you can*

[16] *Resolution 1763: The right to conscientious objection in lawful medical care* (2010), Parliamentary Assembly of the Council of Europe: http://bit.ly/2m2vDMc

[17] *Personal Beliefs and Medical Practice*, General Medical Council, section 8: http://bit.ly/2lPpnH2

[18] *Ibid.*, section 11.

practise in accordance with your beliefs without compromising patient care and without overburdening colleagues".

So, for the GMC, conscience rights are clearly established, and it is indeed 'enough' that a doctor is simply open about their beliefs, and through open dialogue between them and their employers and colleagues allow reasonable accommodation to occur without adverse effects either on patients or on fellow medical professionals. If this is sufficient for wider medical practice, it can and should be so in the area of pharmacy.

More closely to pharmacy profession, there is a clear analogy between the conscientious objection of pharmacists to the provision of drugs that may or certainly do destroy the conceived human being in the womb, to those who would object to the provision of drugs that would cause the death of an older human being. Indeed, very often these will be the same people.

Given this, similar consideration should be given to their conscientious objection to contragestive or abortifacient drugs, as the Royal Pharmaceutical Society (RPS) has given to their objection to the provision of life-ending poisons. In their 2013 policy statement on assisted suicide[19], the RPS proposed that in any future legislation legalising that practice, there would be a clear conscience clause, stating:

"There must be no obligation for any pharmacist to participate in any aspect of an assisted suicide or similar procedure if he or she feels this is against their personal beliefs. The framework we are proposing allows pharmacists to 'opt in' by completing the necessary training, rather than 'opting out'. It also avoids the need for anyone ethically opposed to assisted suicide to signpost to another pharmacist as this can also pose an ethical dilemma".

[19] *Policy Statement: Assisted Suicide*, Royal Pharmaceutical Society (2013): http://bit.ly/2lS6b9S

Not only then, did the RPS propose a clear right of conscientious objection to complicity in assisting suicide, but it proposed a model by which pharmacists could be clearly protected from even more remote indirect material cooperation in that practice (such as a duty of referral) by being required to 'opt in' rather than having to 'opt out'.

It would be more consistent then, both with normative legal principle, and the wider (proposed or actual) medical regulatory practice of Royal Societies and equivalent medical bodies, for the GPhC to continue to allow pharmacists with conscientious objections to involvement in the provision of potentially contragestive or abortifacient drugs to work in their profession in a way that coheres with their philosophical belief in the right to life of all human beings. This entails not being prevented from doing so by the implications of the proposed change, and therefore further entails that this amendation to GPhC standards should be dropped.

2) It Ignores the Importance of Medical Conscience in True 'Person-Centred Care'

So far, conscience rights might be seen as properly restoring the rights of the individual in the balance with the interests of society. It is important to note however, that wider society itself also has an interest in maintaining conscience rights.

Whether as potential or actual patients, we all of us ordinarily and rightly expect and should want physicians who have independence and professional integrity. That includes the integrity to do what they believe to be in our best interests. This is why healthcare professionals according to long-standing practice and convention have neither a legal or ethical obligation to provide treatments if they do not believe that the procedures are of overall benefit to the patient (an important fact that is not at all made clear in the consultation).

Conscientiousness is important not just to medical professionals themselves then, but to all of us, and is precisely part of any truly "person-centred professionalism". A

medical professional who cares about her patients will do what she thinks is best for them, and will not cooperate in something she believes to be actively harmful.

Despite this, the consultation gives an opaque and unhelpfully-oriented conceptualisation of what 'person-centred care' constitutes. As mentioned before, 'person-centred care' is defined by the GPhC in the consultation (as in past consultations) as "when pharmacy professionals understand what is important to the individual and then adapt the care to meet their needs – making the care of the person their first priority"[20]. This sounds superficially common-sensical, yet it is ambiguous enough to cause a problem.

Read rightly, the definition points out that a pharmacist, like any medical professional, should certainly "understand" what is important to the individual for whom they are caring in providing them with treatment. Patients will have a crucial contribution to make in the decisions about their care, and their wishes (for example, in the refusal of care) should not be simply overridden on a professional's whim. They should be treated as individual subjects rather than material objects, as the point of the care is the welfare of a unique person. As a principle, this is an important corrective to some 'paternalistic' approaches to medicine in which the determination of the professional is the primary or even solely important factor.

The definition of 'person-centred care' given by the GPhC can be read in a perfectly reasonable way, then. Yet how the consultation reports it is being interpreted reveals a serious problem. We are told that respondents to the previous consultation argued that "pharmacy professionals should not be able to refuse services based on their religion, personal values or beliefs, as it would contradict the principle of person-centred care" (pg. 10). (One would assume that enough expressed such a sentiment to apparently warrant this new consultation.) This suggests that person-centred care is being understood not as care that is centred on the person's individual needs and best

[20] *Op. cit*, GPhC *Consultation on religion, personal values, and beliefs* (pg. 10).

interests – which would include conscientiously-active decisions by pharmacists – but care that is centred on the person's wants, to the exclusion of the conscience of the pharmacist.

This is completely inappropriate, dangerous, and shows the ambiguity in the GPhC definition. To require care to be adapted according to "what is important to the individual", does not necessarily cohere with "making the care of the person [the pharmacist's] first priority", because "adapting" care to "meet their needs" is not the same as adapting it according to their subjective wants. It might be that a patient wants something that is objectively – or even just in the judgement of the medical professional – bad for them, being contrary to their welfare. Or indeed, contrary to that of others, such as an unborn child. For a pharmacist to go along with something in such a scenario that they knew or believed was genuinely and seriously unethical, or against the patient's best interests, would be a dereliction of moral and professional duty. What Edmund Burke said of Members of Parliament[21], can be equally said of pharmacists and other providers of medical care:

> *"[A medical professional] owes you, not his industry only, but his judgement; and he betrays, instead of serving you, if he sacrifices it to your opinion".*

To orient care towards the wishes of the patient then, rather than (or even despite and in the teeth of) the doctor's understanding of their best interests, reflects a false understanding of what 'person-centred care' really ought to mean. The fact is that medical professionals exist precisely because we, as patients, want people who have the training and the duty of care to make careful and informed decisions regarding our health because we ourselves generally lack that expertise. For them to do this effectively, they need the freedom to make conscientious decisions when performing their role. To instead force pharmacists to give patients what they want simply because

[21] *Letter to the Sheriffs of Bristol*, Edmund Burke (1777): http://bit.ly/2m2F3XZ

they desire it would be the opposite extreme of paternalism, and move towards reducing pharmacists to simply being commercial dispensers of chemicals rather than providers of medicinal care.

The proposed change to the standards by the GPhC's consultation ignores all of this, and not only undermines the moral independence and professional integrity of pharmacists, but even punishes those who act on their best ethical judgement in individual situations. Such an amendation to the GPhC standards would not only discourage medical professionals from developing moral sensibility, but would discourage those with keener moral sensibilities from joining the medical professions in the first place, lest they be put in positions where conscientious action would be seen as unacceptable from the beginning, and subject to penalty if ever acted upon. To allow any medical professional to be censured for acting in their own best ethical judgement would contradict rather than better serve, the interests of individual patients and wider society.

3) It Goes Beyond the Proper Role of the GPhC, and Ignores Pragmatic Considerations

Very finally, this action by the GPhC does far beyond what ought to be their role, and would for reasons going beyond what we have already explored, run contrary to the interests of the profession they regulate. The purpose of the GPhC is to set standards that pharmacy professionals ought to meet in the performance of their professional duty. It is not to interfere with the service requirements of pharmacy bodies themselves, and in whether and how they respect and reasonably accommodate the conscientious objections of their employees. The details of these matters should be between pharmacy professionals, and the pharmacies who employ them, not be co-opted by the GPhC.

Not only would the proposed change to the draft standards constitute over-reach by the GPhC, there is no obvious basis for it to occur at all. No evidence exists of a

serious or widespread denial of access to drugs to people who need them due to the conscientious objections of pharmacists. GPhC meeting notes *on the very issue of reviewing Standard 3.4 on religious and moral beliefs* in April 2012[22], specifically state that no such data is collected, and mention that only 'a small number of complaints' relating to 'fitness to practice' are received annually. Even of these, the GPhC point to no significant sub-set of such complaints caused by freedom of conscience.

If there is no practical reason affecting the pharmacy profession directly to warrant introducing such a change (as opposed to those against it due to the effects on individual pharmacists, patients, and society more widely that have been enumerated already), there is at least one practical reason against it: that it would be counter-productive to the pharmacy profession by encouraging litigation.

The GPhC argue that these changes would "shift the balance in favour of the needs and rights of the person in [the pharmacists'] care"[23], and reflect the "relevant legal framework of human rights and equality law"[24]. Since however, and as has been pointed out, part of equality legislation is the principle of non-discrimination, which overriding the philosophical and religious conscience of minorities would clearly violate, this change would open up the potential for a legal challenge by an individual or organisation aggrieved by the consequences of such a decision.

The GPhC should consider whether making this change, given all the above, is really worth the time and expense that such litigation would cost for imposing a standard on an issue that can far better be dealt with on the ground level by individual pharmacists and pharmacies under current standards.

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[22] General Pharmaceutical Council Meeting, *Review of Standard 3.4 – religious or moral beliefs*, Interim update (April 2012), section 4.3: http://bit.ly/2lS5Ofq

[23] *Op. cit.*, GPhC *Consultation on religion, personal values, and beliefs*, pp. 6, 11.

[24] *Ibid.*, pg. 9.

4. Would Our Proposed Approach To The Standards And Guidance Have An Effect On Pharmacy Professionals?

Yes.

5. What Would That Effect Be?

Mostly negative.

5a. Please Explain And Give Examples.

As explained in our answer to question 1a, current proposed language for the new Standards states that in the situation where the conscience of a pharmacist prevents them from providing some form of pharmaceutical service, the GPhC requires simply them to inform the right fellow staff and authorities in their context, and refer those who want the service they cannot provide to other providers.

Currently, as the previous language suggests, if the conscience of a pharmacist prevents them from providing some form of pharmaceutical service, the GPhC requires them to inform the relevant fellow staff and authorities in their context, and refer those who want the service that they cannot provide to other providers. This duty to refer in-and-of-itself has ethical problems, since if you object to a practice, by pointing others in the direction of how they might receive it, you 'materially cooperate' in that practice. Current guidance however, at least broadly limits the involvement of a pharmacist in practices s/he regards as unethical, and allows them to practise pharmacy with a degree of conscientious freedom.

To replace this duty of referral with a "responsibility for ensuring that person-centred care is not compromised" due to their beliefs, however, could be abused in such a way as to deny the right of the pharmacist not to formally cooperate in

whatever services to which they ethically object. Or else, to prevent pharmacists with such objections from taking certain working positions, thus hindering them in their ability to progress professionally.

Indeed, this seems precisely what is in mind. The GPhC state explicitly that this language would[25]:

> *"[C]hange the expectations placed on pharmacy professionals when their religion, personal values or beliefs might – in certain circumstances – impact on their ability to provide services. They will shift the balance in favour of the needs and rights of the person in their care".*

As a concrete example of how this would affect practice, the consultation specifically marks the expectation that "a referral to another service provider might not be the right option, or enough, to ensure that person-centred care is not compromised"[26].

So, what this would mean in practice is that it would potentially no longer "be... enough" for a pharmacist to set out the options to patients and refer them to other providers. Instead, pharmacists could be obliged by GPhC regulation to provide drugs that they considered unethical, either because they would be at least potentially harmful to their patient, or to others.

This would disproportionately affect those pharmacists who possess convictions against the killing of innocent human beings from conception till natural death, because a key example of those whom drugs might affect adversely would be unborn children. As we point out, so-called 'emergency contraception' can be contragestive in its effects, causing the death of a conceived human being, whereas outright abortifacients cause a miscarriage leading to the same consequence.

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[25] *Ibid.*, pg. 11.

[26] *Ibid.*

As we also point out, such an approach would be contrary to the medico-legal and regulatory norms respecting the conscience rights of medical professionals, and those pharmacists who object on ethical grounds to the destruction of innocent human life would be unjustly discriminated against and unfairly lacking reasonable accommodation for their views. This would mean finding themselves having to choose between their career, and their principles, or at best a career severely limited in its potential for development.

6. Would Our Proposed Approach To The Standards And Guidance Have An Effect On Employers?

Yes.

7. What Would That Effect Be?

Mostly negative.

7a. Please Explain And Give Examples.

As explained in our answer to question 1a, it is in society's interests that we have medical professionals who are independent and conscientious. It would serve no employer for their working arrangements to be effectively co-opted by the GPhC in this area.

Since the new strictures within the proposed language would demotivate conscientious medical professionals, and discourage potential conscientious employees from entering into this area of medicine, this would be a practical harm to pharmacy employers. It is far more likely that individual employers would be better served by being allowed to deal with individuals, and individual situations, within the wider flexibility allowed by the language in current Standards.

8. Would Our Proposed Approach To The Standards And Guidance Have An Effect On People Using Pharmacy Services?

Yes.

9. What Would That Effect Be?

Mostly negative.

9a. Please Explain And Give Examples.

As explained in our answer to question 1a, it is in society's interests that we have medical professionals who are independent and conscientious. It would serve no user of pharmacy services to see fewer people enter the pharmacy profession who have a strong conscience.

Since the new strictures within the proposed language would demotivate conscientious medical professionals, and discourage potential conscientious pharmacists from entering into this area of medicine, this would be a practical harm to pharmacy users. By contrast, given that current Standards already allow for those with conscientious objections to organise with their colleagues and employers such that all care can be alternatively provided by others, it allows for the flexibility and reasonable accommodation so that no pharmacy user is unjustly affected.

10. Do You Have Any Other Comments?

Yes. Very clearly, the recommended change to draft standards by the GPhC is one based on no apparent practical need, and proceeds from an irrational and dangerous misinterpretation of the concept of 'person-centred care'.

If imposed, this language would contravene important medico-legal and professional norms and open up the GPhC to litigation. Further, and most importantly, it would not merely violate the individual rights of pharmacists, unjustly discriminating against those with philosophical and/or religious convictions against the destruction of human lives, but in doing so would discourage conscientious people from entering or remaining in the pharmacy profession. In doing so, it would undermine the broader interests of patients and society as a whole in its discouragement and penalisation of considered and ethical medical practice and practitioners.

Due to this, whilst the drafting of this new language was meant to create a greater balance towards the welfare of pharmacy users, it achieves instead only an unnecessary imbalance against conscientious pharmacists which in its broader effects serves the interests of no-one.

Instead of this, the GPhC has the option and obligation to abandon such wholly unnecessary, thoroughly counter-productive, and discriminatory language and instead amend its standards to allow for and encourage pharmacists in their commitment to professional ethical action that is open, honest, and in a thoughtful and constructive manner engages with their employers, their colleagues, and their clients. Examples of this are already seen in the GMC guidance and the RPS proposals mentioned earlier in this response.

It may be the case that, on occasion, patients are inconvenienced by a delay in their access to certain drugs. Based on current reason and evidence however, the

wider benefit to individual patients that the professionals on whom they rely will be able to follow their best ethical judgements outweigh any foreseeable or hypothetical costs.

Conscience is crucial to medicine. If the GPhC wants a pharmacy profession that truly serves the individual person and puts them in the centre of care, it should not only reasonably accommodate, but actively encourage those under its regulatory competence who act with conscientious prudence in the performance of the service they provide.