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Religious and cultural beliefs: the potential for patient safety to be compromised

Clayton Ó Néill

Introduction

Patient safety is the backbone to good healthcare provision. The World Health Organisation (WHO) describes patient safety as:

The simplest definition of patient safety is the prevention of errors and adverse effects to patients associated with health care. While health care has become more effective it has also become more complex, with greater use of new technologies, medicines and treatments. Health services treat older and sicker patients who often present with significant co-morbidities requiring more and more difficult decisions as to health care priorities. Increasing economic pressure on health systems often leads to overloaded health care environments.¹

Patient safety is, thus, associated with stopping errors and preventing negative effects to patients. It is important to recognise that keeping patients safe involves lots of jigsaw pieces—the actions of the doctors, the hospital protocols, and guidance from regulatory bodies. Patient safety is compromised by equipment shortage,² escalating number of patients who have to be treated, disruptive patients, building issues, fatigue, medication errors, documentation errors, diagnostic errors, difficulties with discharge practice, workplace safety, sepsis, superbugs and cyber insecurity.³ All doctors have a duty to act when they believe patients’ safety is at risk, or that patients’ care or dignity are being compromised.⁴ This chapter questions whether and to what degree the expression of religious or cultural beliefs of patients can act as a threat to patient safety. The focus will be primarily on the United Kingdom (UK), but some references will be made to other jurisdictions.

We live in a new era, an era where patients feel that they have a sense of entitlement, an era where governmental bodies are under a duty to safeguard human rights, but also an era characterised by the ever-growing compensation culture. Cases are being taken under the tort of negligence every day, costing the National Health Service (NHS) billions! There is limited evidence, however, of cases based upon the religious or cultural beliefs of patients being brought in tort. Instead, these issues have mostly raised human rights concerns and action has been taken under the Human Rights Act 1998. The courts have been reluctant to use the language of patient safety. Instead, they have focused on human rights arguments and notions such as capacity and consent, inter alia. However, it is important to recognise the relevance of duty of care/breach of duty in the tort of negligence as well as the concept of informed consent following the recent Supreme Court case of Montgomery v Lanarkshire Health Board.⁵ Obviously, there are consequences for hospital personnel in terms of patient safety. If they don’t act in accordance with the autonomy of capacitated patients, there could be tortious or regulatory implications. Healthcare professionals have a responsibility to ensure patient safety, but, yet, allow for the autonomy of decision making. A conflict can exist between these two variables.

A lot of the literature comes from the perspectives of the systems that are put in place at a medical level by medical personnel, policy makers, technology experts, aimed at reducing human or technological error and subsequent harm to patients. There has, however, been little attention given to the role of patients themselves in contributing to the safety of their healthcare provision. Patients have a role to play within patient safety: they need to follow the regime of medication properly, they need to alert medical professionals to complications, they must reflect upon the decisions that they make and the consequences of those decisions, wise or
unwise that they may be. Vincent and Coulter argue that most of the main reports dealing with patient safety pay insignificant attention to how patients contribute to their own safety, whether as individuals or collectively. They argue that patients are often looked upon in a passive manner, as victims of mistakes. They recognise that an additional burden of responsibility ought not to be placed on patients who are particularly vulnerable. They state that ‘[w]hen patients are seriously ill it may be even more important to take their views and wishes into account, either by involving them directly or by using family members as surrogate decision makers’.

They identify a range of instances where patients can contribute to their own safety through ‘provision of diagnostic information, participation in treatment decisions, choice of provider, the management and treatment of disease, and the monitoring of adverse events’.

For this to be successful, a culture needs to develop in which patients are supported in taking extra responsibility for their own care and safety. Additionally, in a subsequent article, they identify areas where patient input into their safety is productive. Obviously, patient safety can be reduced by many worthwhile endeavours, such as double-checking and error procedures. Nevertheless, the human factor is an essential element in tackling cultural changes in order to enhance patient safety. This chapter argues that by further raising awareness of religious/cultural beliefs as an ingredient, that this could improve and impact upon patient safety. Lee and Newberg explain that evidence exists whereby religion can have a positive influence on health. For example, religion can positively affect how patients cope with medical issues and can have a constructive impact upon lifestyle and disease morbidity. The chapter will consider the relationship between the manifestation of religious or cultural beliefs and patient safety in the context of a number of different scenarios that potentially impact upon that safety, namely, ritual male circumcision, female genital mutilation (FGM) and the refusal of blood transfusions for religious reasons.

When we think of patient safety, we can visualise the Swiss cheese model of Accident Causation. According to this model, the healthcare safety protocols can consist of many slices of cheese, which contain risks to patient safety. In every slice of cheese, different layers of defences against these risks are set out one behind each other. This means that a weakness in one defence should not allow for the development of any related risk because all of the other defences will come into play, so that one single point of weakness would not exist. These barriers act as defences against failure in medical procedures. The slices of cheese are, however, full of holes: some are large and some are small and they are situated in different parts of the cheese slices. These holes represent the weaknesses in the healthcare safety protocols and practices within the medical system. When the holes become aligned in such a way that a hazard can pass through the continuum of holes, then a failure or an error in the health system can occur, which can compromise patient safety. We can think of the expression of religious or cultural belief as being a variable which may or may not be represented as a hole in the cheese slice. How can we ensure that the expression of religious/cultural belief on the part of the patient does not lead to or become a factor in error in healthcare? In other words, the existence of holes in the cheese slices can add to the flavour and texture of the cheese—variety is a spice of life—so too, the entitlement to act in accordance with religious/cultural belief, even when such actions compromise individual safety, is a positive component of holistic healthcare provision, but should not become a determining factor in the causation of errors.

One way of mitigating such errors is the provision of comprehensive guidelines that provide guidance to healthcare professionals as to how to deal with the manifestation of religious or cultural belief in healthcare decision making.

Guidelines on religious/cultural beliefs, patient safety and healthcare
In order to have a better understanding of the relationship between patient safety and the right to express one’s religious or cultural beliefs, it is necessary to consider the relevant guidelines and protocols. The right of patients to manifest their beliefs in medical contexts is protected by medical guidelines. Broadly speaking, the General Medical Council (GMC) state that the beliefs of patients may cause them to ‘ask for a procedure for mainly religious, cultural or social reasons’ and subsequently refuse treatment that the doctor might regard as being beneficial. Additionally, the NHS has produced guidelines for staff to better understand the needs of patients with particular religious or cultural beliefs. Firstly, the NHS recognises the legal requirements in the context of laws concerning discrimination, harassment and victimisation, as governed under the Equality Act 2010, as well as the role of Article 9 of the European Convention on Human Rights: freedom of thought, conscience and religion. The NHS validates the growing diverse mix of religious beliefs in the UK. This is set out in their report, entitled *Religion or Belief A practical guide for the NHS*. In the context of palliative care, the NHS report states that healthcare professionals should be ‘aware that an individual’s level of compliance with their religious belief may well vary according to their perception of their illness, and that relatives and/or next of kin may have differing views on religion, practice and observance’. The report states that there is a need to raise awareness of religious stereotyping and that staff should be aware of different beliefs and practices of individuals. Therefore, in the context of the guidelines under which medical professionals work, there is cognisance taken of patients’ religious and/or cultural beliefs. Notwithstanding the existence of guidelines that support this, there are, however, instances where the manifestation of religious belief might be perceived to impact negatively upon patient safety. One such instance is ritual male circumcision and attention is now drawn to that area.

**Ritual Male Circumcision**

Traditionally Jewish and Muslim parents wish for their children to be circumcised. However, the NHS does not routinely offer circumcision for non-medical reasons. What is the response of the GMC to ritual male circumcision? In *Personal beliefs and medical practice*, they say that if a patient or parent wants (or wants their child) to be circumcised for religious or cultural reasons, the doctor should:

- discuss with them the benefits, risks and side effects of the procedure. You should usually provide procedures that patients request and that you assess to be of overall benefit to the patient. If the patient is a child, you should usually provide a procedure or treatment that you assess to be in their best interests. In all circumstances, you will also need the patient’s or parental consent.

Additionally, at paragraph 20, the GMC recognises the relevance of the *best interests* test, whereby assessing best interests also involves an assessment of the child’s and/or his parent’s religious or cultural beliefs. The guidelines state that doctors should get consent from the child if they have ‘maturity and understanding to give it’. If this is not possible, parental consent should be granted. If, however, consent is not granted, as a result, for example, of a parental dispute, the doctor should state that he/she cannot undertake the circumcision unless authorised by the court. (Note that, to date, in such circumstances, the courts have always stated that circumcision is against the child’s best interests and that they should wait until the child is *Gillick* competent before allowing for the circumcision).

In the United States (US), circumcision is extremely common and, overall, it is regarded by many doctors as being a ‘relatively safe with a low overall complication rate’. Most of the complications associated with circumcision are ‘minor and can be managed easily’. However,
Krill et al point out that, even though it is quite uncommon, ‘complications of circumcision do represent a significant percentage of cases seen by pediatric urologists’ and these often result in surgical correction that is extremely costly to the US health care system. They state that severe complications are relatively rare, but that, on occasion, it has resulted in death. They call for a ‘thorough and complete preoperative evaluation, focusing on bleeding history and birth history’ and argue that ‘[p]roper selection of patients based on age and anatomic considerations as well as proper sterile surgical technique are critical to prevent future circumcision-related adverse events’. Perera et al, in a US context state that complications are uncommon. They argued that:

Strong evidence suggests circumcision can prevent human immunodeficiency virus/acquired immune deficiency syndrome acquisition in sub-Saharan African men. These findings remain uncertain in men residing in other countries. The role of adult nontherapeutic male circumcision in preventing sexually transmitted infections, urinary tract infections, and penile cancer remains unclear. Current evidence fails to recommend widespread neonatal circumcision for these purposes.

The NHS, in their report, entitled Religion or Belief A practical guide for the NHS drew attention to what they call a best practice model where, following concern about serious genital harm to boys as a result unregistered practice, local parents were encouraged to send their babies to a clinic in Tower Hamlets, London. The original unregistered practice involved the circumcision of boys aged about seven. This model attempted to provide regulation of an unregulated practice and, so, optimise patient safety. In theory, this is a practical and laudable step. In practice, parents signalled their satisfaction with it and recommend it to others. However, at an ethical level, there are some concerns because the circumcision is carried out on a voiceless and vulnerable infant. Those who were involved in this small study indicated that they thought that it was best to circumcise the child at an early stage in order to reduce pain and enhance safety. It is difficult, however, to agree with the NHS that this well-intentioned action is best practice. While the physical safety of the infant may be less threatened due to the earlier circumcision, this practice is still injurious and any injury that is harmful compromises patient safety and should not be promoted by the NHS, particularly due to the lack of patient consent.

The NHS also gives an additional example of what they deem to be good practice, namely the development of a private male circumcision service in Bristol to cater for the growing Muslim community. The NHS report states that, due to the lack of affordable safe circumcision services, families paid unregulated practitioners to carry out the circumcision. The report recognises that, to date, several cases have existed where the circumcision has resulted in genital damage. Interestingly, in Bristol, feedback indicated that the Muslim community felt confused about the lack of safe circumcision services and this mistrust had a negative impact on how they responded to health improvement programmes and health-enhancing initiatives. Responding to this consultation, the Trust, in conjunction with the Department of Health’s Pacesetters programme, worked with the Islamic community in order to ‘develop an affordable, safe, private male circumcision service for parents who wish to have their child circumcised for social, cultural or religious reasons’. Once again, however, it is questionable if the NHS should concern itself with medical procedures that bring harm to the child.

If we revert to the Swiss cheese model, we can now see a number of holes pertaining to the expression of cultural or religious beliefs and patient safety. Here is the circumcision of an infant who has not given informed consent, who has not the capacity to give this consent, who has not formed his own religious convictions that add to his sense of self-identity and self-
definition. A procedure takes place that is irreversible and that can have, albeit in very limited instances, detrimental physical consequences. There is potential here for the alignment of these accident causative variables where lack of informed consent, lack of capacity, lack of maturity all have the potential to lead to a trajectory of potential tort. What is to stop the grown baby suing the hospital or the doctor for carrying out a procedure to which he did not consent and that resulted in harm to him? Some would argue that the harm that is created is negligible and that the importance of circumcision as a tribal marker to some religions, particularly Judaism, is stronger than concern for patient safety. The practice of Islam of waiting until the child is almost a teenager offers an improved pathway, in so far as this older child could be capable of consenting, thus providing the grounds for a more equitable paper trail. Some parents consider that that it is within the best interests of the child to be circumcised in accordance with parental wishes, in line with the traditional religious practices to which the parents are affiliated. However, a greater argument exists that circumcision causes physical harm and so comes under the mantle of patient safety. Circumcising a baby is an infringement of their bodily integrity and doctors should be discouraged from carrying out this procedure until the child is capable of consent. As it stands, this practice is allowable. However, when contention around ritual male circumcision has been taken to the courts, the decision has always been made that the carrying out of this procedure is not in the best interests of the baby/boy. If the courts determine, following legal contention, that circumcision is not within the best interests of this child until they are Gillick competent, it is difficult to argue that it can be justifiable under normal daily practice.

Female Genital Mutilation

A more invidious compromising of patient safety exists in the form of Female Genital Mutilation (FGM) and international compelling arguments have been made for its total banning, due to the significant harm that is meted out to a young girl. It is estimated that across thirty countries, over 200 million women or girls have been subject to FGM. The most prevalent countries include Indonesia, Egypt and Ethiopia. Additionally, approximately 44 million of those who survive are under the age of 15. The practice is forbidden in 42 countries, including 24 African countries. In countries such as Sierra Leone, 90% of women aged 15-49 have been subjected to FGM. It is estimated that the number of girls subjected to FGM in the US has tripled since 1990. The first prosecution took place in the US in 2017, despite legislation being enacted for 20 years. However, only 25 US states include laws that regard FGM as a crime. Jones et al state that uncertainty exists as to why FGM is still so persistent and there is recognition that the strategies to combat it have been, in many ways, ineffective. They say that even though FGM has been strongly condemned internationally, it can only be eliminated if ‘practitioners are presented with a safe alternative that preserves their culture and, at the same time, protects the health and well being of women’. They further argue that:

…interventions for preventing FGM should be non-directive, culture-specific and multi-faceted to be of practical relevance. Such interventions should not only motivate change, but should also help communities to establish practical means by which that change can occur. Potentially effective prevention interventions targeted at local practitioners of FGM, parents, at-risk adolescents, health and social workers, governments, religious authorities, the civil society, and communities are presented.

This practice is disallowed in English law under the Female Genital Mutilation Act 2003. The NHS endorses the WHO’s condemnation of FGM and recognises that where ‘cases of FGM are presented, they should be treated as a child protection matter’. However, a subterranean cultural practice exists where FGM is prevalent and increasing within some communities in the UK. It is having a calamitous effect on patient safety, but, notwithstanding the shared
knowledge in the medical and social community that this practice exists and is being carried out, there are almost no prosecutions of FGM practitioners brought to the courts. It appears that sometimes those concerned with fostering group community relations are reluctant to engage with the cultural mores associated with this practice. However, there is a very strong link between FGM and significant and tragic consequences for girls. More than many procedures, this has the potential to affect a huge worldwide population. If we take the idea that there is a responsibility on the part of the medical profession to ensure patient safety, then surely lack of action to facilitate prosecution is a derogation of that responsibility. The problem will not only be resolved at the medical level, however. The problem has to be resolved at societal, community, educational and cultural level and should be led by coherent and holistic policy and practice.

**Jehovah’s Witnesses who refuse blood transfusions**

What are the legal consequences of allowing for the manifestation of religious belief of a patient in the knowing certainty actions or non-actions arising from this will result in harm or death to the patient? This question has particular relevance when it comes to adult Jehovah’s Witnesses who refuse blood transfusions. A number of such cases have come before the courts. In the end, all of them, notwithstanding some nuances, have found in favour of the patient acting in accordance with their own will, as long as it was proven that there was no undue influence or duress and that the patient had capacity to refuse treatment. According to Lord Donaldson in *Re T*, ‘every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death’. In the context of children, a case in point was *Re E* where the Jehovah’s Witness child was not allowed to refuse the transfusion but once he reached the age of 18, his refusal was accepted and he subsequently dies. In *Re E* Nolan LJ used the best interests test and further stated that ‘[a]n individual who has attained the age of 18 is free to do with his life what he wishes, but it is the duty of the court to ensure so far as it can that children survive to attain that age’. This, of course, was a significant example an instance where the religious belief of the patient compromised his own safety.

Patient safety is only one variable in this equation. Allowing an adult patient who has capacity to refuse treatment is a strict tenet of medical practice and, indeed, English law. Conducting an unwanted blood transfusion on a capacitated adult patient would be an infringement of their autonomy and so patient safety has to be balanced with the issue of autonomy and consent. In incapacitated patients, who express religious beliefs, then the whole question of their best interests come into play. Thus, for the adult, capacity and consent are key factors. The situation is more complicated in the case of Jehovah’s Witness children. There have been instances where such children have refused blood transfusions and many judges have said that it goes against their best interests, even if they could be regarded as Gillick competent. Therefore, they have consistently refused permission for a child to refuse the blood transfusion. The judge, in these instances, is trying to ensure patient safety and that no harm befalls the child. But is patient safety the only show in town, the only broker, the only arbitrating factor? The courts have been criticised for their overly paternalistic attitudes and for denying the Gillick competent child or a 16-17-year-old who satisfies the capacity test the right to refuse the blood transfusion. The advantage of this ‘bright line’ rule is legal certainty. The judge is, however, as often happens, between a rock and a hard place: the rock being the compromising of the safety of a child and the place being disrespecting the deeply-held belief of the child who is competent. This dilemma is never going to be easily resolved, and it would be facile to suggest that an equitable resolution can be arrived at. It is suggested here that there is still a need to give some weighting to the religious beliefs of the child. The age of the child should not be the
sole determinant of capacity. Other variables exist which could help in determining the capacity to want to act in accordance with religious belief, such as maturity, depth of religious affiliation and the degree to which the expression of religious belief fulfils the innate and long-standing deeply held and unwavering beliefs of the child. Of course, these factors are notoriously difficult to quantify, but weight should be allocated to them in the interests of giving regard to the deeply-held wishes of the child.

The Royal College of Surgeons (RCS) recently produced guidelines in response to the Supreme Court case of *Montgomery* where consent was clarified, entitled *Consent: Supported Decision Making Guide to Good Practice*. These guidelines then indicate that doctors need to take reasonable steps to make sure that patients are informed of any material risks associated with treatment and that the patients should be told of any alternative treatments. The guidelines recognise that the principle in *Bolam* is still applicable. These guidelines clearly state that there is now a move away from a ‘paternalistic traditional model of consent’ towards one that puts the patient first. This means that surgeons need to change their attitudes when dealing with consent: ‘they are no longer the sole arbiter of determining what risks are material to their patients’. The RCS also explain that discussion needs to focus on the individual patient. Therefore, the practitioner needs to get to know the patient sufficiently in order to comprehend their values and views. This includes their beliefs or the fact that a surgeon may disagree with the patient’s decision. The difficulty that applies here is the degree to which, from a practical viewpoint, a surgeon can validity assess the depth, sincerity and gravity of an individual’s belief. The guidelines recognise that case law supports the rights of patients to refuse treatment, even if there are potentially fatal consequences. Surgeons ought to discuss potential implications of the patient’s decision as well as the risks/benefits associated. Nevertheless, ‘this should be aimed at helping the patient make an informed decision and should not influence the patient to take a course of action that is not in keeping with their wishes, even if this course of action has been proposed by the multidisciplinary team’. When it comes to emergencies, however, the surgeon must proceed without consent or limited information and act in the patient’s best interests.

The RCS subsequently, in 2016, introduced specific guidelines in relation to patients who refuse blood transfusions for religious reasons (e.g. Jehovah’s Witnesses), entitled *Caring for patients who refuse blood*. They recognise the fact that doctors are under a duty to safeguard ‘physical wellbeing of patients’ but also understand that this can conflict with the rights of patients to make healthcare decisions. According to the RCS:

> Surgeons are duty-bound to respect patients’ religious freedoms and can feel uncomfortable refusing to treat patients because of restrictions stemming from a religious belief for fear of accusation of discrimination... Surgeons have the right to choose not to treat patients if they feel that the restrictions placed on them by the refusal of blood products are contrary to their values as a doctor. If a surgeon is not prepared to treat a patient who refuses blood they must refer them to a doctor who is suitably qualified and prepared to take on the patient knowing the circumstances of this refusal of blood.

In emergency circumstances, where an immediate blood transfusion is required, the staff ought to act in accordance with the patient’s best interests and try to ‘communicate with them to keep them informed wherever possible’. This is in line with GMC guidance, whereby ‘[i]n an emergency, you can provide treatment that is immediately necessary to save life or prevent deterioration in health without consent’.53
What about a situation where the patient cannot give an informed decision? Should clinical judgement overrule the wishes of family members? Yes. However, the relatives are encouraged to provide evidence indicating that an advance decision exists. What about children? The RCS point to the fact children can make valid legal decisions if they have the required capacity (e.g. under the Family Law Reform Act 1969 or if *Gillick* competent). Even though the main responsibility of surgeons is to ensure that the well-being of children is ensured, ‘every effort must be made to respect the beliefs of the family and avoid the use of blood or blood products wherever possible’.

**Overall trends**

If we consider what makes up the cases of a medical accident, we see that there are usually variables at system level. If religion is not to be a variable within the continuum of accident causation, then at system level and individual level, some certainty needs to exist. The relative importance of religious practice to the individual and the degree to which religious belief is a central tenet of existence can vary from patient to patient, from religious adherent to religious adherent, leading to difficulties in achieving this degree of certainty. To maximise the potential for achieving a level of surety, regulations that protect religious expression and balance patient safety must be well used and be subject to inspection and interrogation. Protocols should be agreed with hospital boards, shared with medical professionals and patients and subject to high-level leadership. There is a need to empower patients to have a greater understanding of both their right to express their religious or cultural belief as it applies to their medical care and equip them with the full knowledge of the consequences of any actions or non-actions that they take. All of this leads to a need for greater cohesion between medical, legal and societal systems, where patient rights and patient safety are all part of an agreed agenda.

The holy grail of patient safety is a Camelot-like context where care, concern, consent and capacity are hallmarks of best practice. The road to Camelot, however, is a stony one and can be beset by litanies of error. When errors happen, they usually do so because human beings make mistakes and systems can compound these mistakes due, sometimes, to lack of appropriate checking devices and procedures. When religious belief is a journey-man on this pathway, then the stones can be rockier and the pathway more torturous. There are instances where the manifestation of religious belief does result in compromising patient safety. But patient autonomy is key. A healthcare system that only aligns patient safety within very confined medical parameters would be one that, ultimately, negates patient autonomy. The exercise of this personal autonomy means that we can be the architects of our own medical downfall. As long as we have capacity, we have the autonomy to make medical decisions that may not be all that sensible, that may not be all that favourably balanced in terms of our own safety, but our autonomy is part of our self-identity and the right to express religious or cultural belief is one that needs the protection of the law and the support of medical personnel. Following a particular religion is, of course, not always a purely autonomous pathway. In many cases, the religious adherent is following the mandatory doctrine of his or her faith, which may lead no room for opting out. Recognising the perceived conflict that can exist between the liberty of autonomous actions and the duties imposed on the individual who follows a particular religious belief, Calderwood Norton argues that ‘[a]n autonomy-based justification for religious freedom is not… inconsistent with recognizing that a religious way of life can carry with it particular duties’.

It is clear that there are differences in the way religious adherents view the duties, obligations and freedoms that their religious practice imposes upon them. This, in turn, gives rise for the need for an individualised approach to patients when they make decisions based upon religious beliefs and when these decisions may have an impact upon their safety.
What is the impact of religious/cultural belief on patient safety and what are the instances where such belief compromises this safety?

Patient safety is a worldwide/global issue and, indeed, religion and its manifestation is also apparent at every corner of the world. The question is ‘Where does patient safety and religious/cultural expression intersect’? Obviously, religious expression is a human right, which is protected by a number of international conventions, but, at practical level, this chapter has considered its real-life impact on patient safety, including the safety of children. Particular attention has been given to a number of scenarios where patient safety is potentially compromised by this religious or cultural expression: ritual male circumcision, female genital mutilation, and refusal of blood transfusions by Jehovah’s Witnesses.

If we accept that the patient is more than the sum of their parts, then it follows that their safety is more than the summation and inclusion of tangible and measurable nuts and bolts. Assuring the safety of the patient involves knowing something of the patient including, where relevant, their religious or cultural beliefs. There are generic variables associated with patient safety, but an individualistic approach is also required where the understanding of the makeup of an individual patient can result in a better understanding of her healthcare needs. Within the parameters of this individualism, the religious and cultural beliefs of the patient can be included. A number of medical guidelines and reports allude to the importance of recognising cultural and religious belief in terms of ensuring good patient care. At a practical level, procedures and protocols that set out what should be done when particular medical treatment is either requested or refused as a result of religious belief should be agreed. At a second level, culturally, there has to be a non-judgemental openness that accepts the medical decisions made by patients with capacity when these decisions are based upon what might appear to be unreasonable religious/cultural belief. Equally, this openness must also, however, apply to a readiness to seek to prosecute those who flout the laws/violate human rights and compromise patient safety in the most extreme manner, such as in the case of FGM. There should not be fear of recognising cultural or religious practices that oppose the human rights of patients, as in FGM. In less menacing cases, the law of tort should be seen to apply.

Patient safety has to extend beyond the error and harm definitions to now encompass something a little bit further reaching than that. This concentration on error and harm in the safeguarding of patients on the part of healthcare professionals fails to take into account sufficiently the role of capacitated patients in their own medical care. We can accept as valid the previously given WHO definition of patient safety as ‘prevention of errors and adverse effects to patients associated with health care’.56 There are situations where a patient’s own decisions based, as in this instance, for example, on religious/cultural belief, put them in the way of harm and this needs to be factored into these definitions. It is proposed here that an understanding of patient safety be extended to ‘prevention of errors and adverse effects to patients associated with health care and decisions taken by healthcare personnel and/or patients’. The addition of this latter statement could have meritorious consequences in tort in so far as it provides recognition of the fact that the patient is an equal partner and, in some cases, a primary partner in the medical treatment offered and consented to. This broader perspective of patient safety would offer a more holistic view of the patient that recognises patient values and belief systems. This links in with the way in which tort now, in a post-Montgomery era, puts the opinions/consent of the patient first and rejects medical paternalism. A dialogical process is required that would ensure that this broader interpretation of patient safety is captured, understood and acted upon. No medical procedures that recognise religious/cultural belief and that bring about harm and so compromise patient safety may be given to a patient who lacks capacity to make specific decisions about their treatment and/or has not consented to the specific course of treatment. By
recognising the role that patients play in the determination of their safety and by acting upon
decisions made by the patient, based, in this case, on religious/cultural beliefs, the opportunity
arises for a more open and shared dialogue between healthcare professionals and patients,
leading to an even greater understanding of medical treatment and its consequences. This,
surely, has the potential to lessen acrimony and contention and to reduce negligence claims
that can emanate from situations where such contention exists. The broadening of the definition
of patient safety comes from a philosophical base where value is given to the right of patients
to act in accordance with their beliefs.

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7 ibid.

8 ibid.

9 For example, reminding staff to wash their hands.


14 ibid. p 10.

15 ibid. p 28.

16 GMC (n 12) para 18.

17 ibid. para 20.

18 E.g. Re J [200] 1 FLR 571.


20 ibid.

21 ibid.


23 ibid. p 64.

24 NHS (n 13) p 28.


26 NHS (n 13) p 29.

27 ibid. p 29.

28 ibid. p 29.

29 ibid. p 29.

30 See Re J (n 18).

31 Gillick v West Norfolk and Wisbech AHA [1986] AC 112. Gillick competence is where a child under 16 can provide consent if he or she has ‘sufficient understand and intelligence to enable him or her to understand fully what is proposed’. See p 189 of the judgment. Note that the courts may override the wishes of a Gillick competent child or his/her parents, if the courts feel that it is not in the child’s best interests: Re W [1993] Fam 64.


34 NHS (n 13) p 29.


40 Re E [1993] 1 FLR 386.

41 Also see Re L [1998] 2 FLR 810.

42 Note that further complications exist in relation to those who have ‘borderline capacity’ and vulnerable patients. See Emma Cave, ‘Protecting patients from their bad decisions: rebalancing rights, relationships, and risk’ Medical Law Review, 1-27 (available on advance articles).

43 Gillick (n 31).

44 Royal College of Surgeons, Consent: Supported Decision Making - good practice guide. (Royal College of Surgeons, 2016).

45 Bolam v Friern Hospital Management Committee [1957] 2 All E.R: ‘A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art’.

46 Royal College of Surgeons, Consent: Supported Decision Making (n 39) p 3

47 ibid. p 3.

48 ibid. p 10.

49 Ibid. p 11.

50 ibid. p 11.

51 Royal College of Surgeons, Caring for patients who refuse blood A guide to good practice for the surgical management of Jehovah’s Witnesses and other patients who decline blood (Royal College of Surgeons, 2016).

52 Ibid. p 8.

53 GMC, Personal Beliefs and Medical Practice (n 12) para 27.


56 WHO (n 1)