BMA

The doctor-patient relationship toolkit

British Medical Association
bma.org.uk

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About this toolkit

The doctor-patient relationship is critical to good person-centred health care and questions about aspects of this relationship are a significant area of ethical enquiry for the British Medical Association (BMA). This toolkit sets out the legal requirements, and rules and principles that apply in situations relating to the doctor-patient relationship so that health professionals faced with questions or dilemmas can use this information as part of the process of ethical decision making.

The purpose of this toolkit is not to provide definitive answers for every situation but to identify the key factors that need to be considered when such decisions are made and to signpost other key documents. All sections refer to useful guidance from bodies such as the General Medical Council (GMC), BMA, and health departments, which should be used in conjunction with the guidance. In addition, the medical defence bodies and many of the royal colleges produce specific advice for their members.

The guidance in this toolkit reflects best practice but we also acknowledge that, in spite of their best efforts, doctors cannot always provide the level, and quality, of care they want to, because of the current state of the NHS and, in particular, the pressures on health professionals from staff shortages and lack of resources. GMC guidance sets out the principles of good practice and professional standards expected of all doctors registered in the UK. They provide a framework within which doctors must exercise their own professional judgement. All doctors must be aware of and follow the guidance and those who do not meet the standards set out by the GMC risk complaint and potentially regulatory action. Where GMC guidance requires steps to be taken that we believe may be very difficult to achieve in practice, we have highlighted actions doctors can take to minimise the risks to themselves. This generally involves them taking steps to try to follow the guidance, recording in the record where this is simply not possible, as well as – where appropriate – raising the issue with management. Where we are aware of specific difficulties doctors face, we have raised these with the GMC and will continue to do so.

The Toolkit is available on the BMA's website. Individual health professionals, Trusts, Health Boards and medical schools may download it and make copies. The BMA would welcome feedback on the usefulness of the toolkit. If you have any comments, please address them to:

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This is the first edition of the BMA's doctor-patient relationship toolkit. Information about significant developments since its publication may be obtained from the BMA's website or by contacting the BMA medical ethics and human rights department.

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The doctor-patient relationship

Modern medicine is complex and dynamic. Although highly specialised, technologically sophisticated and often delivered by multi-disciplinary teams, strong doctor-patient relationships are at the heart of good care. Good therapeutic relationships, whether face-to-face or remote, are characterised by partnerships between doctors and patients. Patients increasingly seek to play an active part in their care, to understand the options available to them and to make the best health-promoting choices available. Doctors seek to explore what matters to individual patients, to provide them with the best available information, to act as advocates when needed, and to help them make choices that maximise their wellbeing in ways they are comfortable with. Good doctor-patient relationships are characterised by mutual respect, open and honest communication, and respect for the privacy, dignity and choices of patients.

Key principles

Health professionals are among the most trusted and respected groups in society. Patients and the general public greatly appreciate what they do, in often challenging circumstances. The onus is principally on the health professional to make contact with patients work well (although patients also have some responsibilities – see section 10), and to speak out when there is a risk of harm. The following are basic principles underpinning the doctor-patient relationship.

- Although doctors and patients both have obligations to treat each other with honesty and respect, doctors have particular duties to patients rooted in their professional status.
- Doctors must make the care of patients their first concern.
- Good communication requires openness, honesty and an ability to listen from both parties.
- Good patient care is person-centred, taking into account the patient as a whole person.

Do doctors and patients have different obligations?

Yes. As professionals, doctors are subject to specific duties rooted in their professional roles. While doctors and patients should both be honest in their communication and respectful in their dealings with each other, doctors have specific, patient-focussed duties. These duties prioritise the interests of patients. Key patient-facing principles are set out by the General Medical Council (GMC) in its guidance *Good medical practice*. According to the GMC, doctors 'must':

- Make the care of their patient their first concern.
- Treat every patient politely and considerately.
- Respect patients' dignity and privacy.
- Listen to patients and respect their views.
- Give patients information in a way they can understand.
- Respect the right of patients to be fully involved in decisions about their care.
- Be honest and trustworthy.
- Respect and protect confidential information.
- Make sure that their personal beliefs do not prejudice their patients' care.

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What is patient-centred care?

Good medical care is patient-centred. This means that doctors take a 'whole person' approach to the care of their patients. Rather than focussing on specific needs or pathologies, a patient-centred approach addresses patients as individuals, sees them 'in-the-round', and pays particular attention to their individual values and circumstances, as well as their specific health and health-related needs. Patient-centred care prioritises the dignity of individual patients and is characterised by compassion and respect. It seeks to help people take control of their own health and care to enable them to live independent lives. Patient-centred care also involves doctors ensuring that care and treatment are co-ordinated as well as personalised. Patient-centred care involves doctors and patients working together to:

- Identify the patient's health needs;
- Understand what is important to the individual;
- Make informed decisions about the patient's care and treatment; and
- Support the patient to make healthcare decisions in line with their needs, values and priorities.

The duty of care

Do doctors have a legal as well as an ethical duty of care?

Yes. A duty of care is both an ethical, legal, and professional obligation to safeguard and promote the health and well-being of patients whilst they are in their care. This means acting in the best interests of patients, and not acting, or failing to act, in a way that causes harm. Health professionals must also ensure that they act within their abilities, and not seek to provide care that lies beyond their level of competence – unless it is an emergency, no other appropriately qualified health professional is available, and they have a reasonable belief that they can improve the outcome for the individual patient.

In a health service that is under immense pressure, with severe staff shortages, it is becoming increasingly common for doctors to be put in situations where they are required to act at the limits of their competence. If nobody else is available to provide urgent medical care, doctors must do the best they can in the circumstances, using the skills they have but should report such incidences to their managers, explaining the situation, that nobody else was available to provide care and what treatment was provided. Where these situations become part of everyday practice, rather than one-off incidences, potentially causing patient safety, dignity or comfort to be compromised, the matter should be raised urgently with senior management in secondary care or, in general practice, with appropriate organisations e.g. Care Quality Commission and local ICB (Integrated Care Board). The BMA has guidance for consultants working in a system under pressure (see key resources) which may also provide a helpful steer for other health professionals.

What is the legal duty of care?

The law imposes a duty of care on a health care professional in situations where it is 'reasonably foreseeable' that they might cause harm to patients through their actions or omissions. To discharge this legal duty, healthcare professionals must act in accordance with the broadly accepted standard of care. This is generally assessed as the standard to be expected of an 'ordinarily competent practitioner' performing that particular task or role. Failure to discharge the duty to this standard may be regarded as negligence. For a summary of the legal test of negligence see http://psychrights.org/Countries/UK/BolamTest2003.pdf. As above, where, due to systemic problems, it is not possible to provide safe and appropriate care, this should

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be reported to senior management in secondary care, or, in general practice, appropriate authorities e.g. Care Quality Commission and local ICB.

When does the duty of care begin?

A duty of care to individual patients can vary depending on the type and duration of the professional relationship with them. Some health professionals only see an individual once for a specific purpose, such as writing a report or assessing eligibility for a social benefit (see section 12 on non-typical relationships and dual obligations). Such encounters are generally transitory and, although they still involve some obligations to the person being examined, rarely involve an ongoing duty of care. When a therapeutic relationship exists, the situation is different; the duty of care can start even before a patient is seen. Legally, health professionals have a duty of care when they assume some responsibility for a patient, such as when a patient is added to a general practice list. In secondary care, it may be on admission to a ward, acceptance onto a caseload, or once registered at an accident and emergency department.

How long does the duty of care last?

The duty of care begins when a doctor or other health professional first engages with a patient and continues until one or other party ends the relationship. This can be when the patient moves from the area, is discharged after treatment, or transfers to another practitioner, for example because the relationship has broken down (see section 11 on the breakdown of the doctor-patient relationship). Some duties to the patient, mainly those related to confidentiality, extend beyond that person's death. The BMA's confidentiality toolkit provides more detail on this issue – see key resources.

Do doctors have a duty to try to contact patients who miss important appointments?

Questions are sometimes asked whether doctors have a duty to try to contact patients who fail to return following an initial consultation concerning a serious health matter, or who discharge themselves from hospital contrary to medical advice. Patients with the requisite capacity have a right to refuse treatment, including not returning for essential follow up or to receive the results of a test. Likewise, patients with the necessary capacity are entitled to decline any further treatment. Doctors should, however, make reasonable efforts to inform them as to the likely consequences of their decision. A balance needs to be struck between encouraging them to protect their health, where they appear willing to do so, and respecting their right to refuse (see section 3 for more information about situations where a doctor disagrees with a patient's decision).

Where patients simply do not turn up for essential treatment or follow up, doctors should make reasonable efforts to contact them, keeping in mind their duties of confidentiality. Hospitals should take responsibility for contacting patients who miss appointments, copying any correspondence to the patient's GP. There is not usually a duty on doctors to make further attempts to contact adults with capacity about non-attendance, although they may need to communicate with the patient, their parents or carers, or consider making a safeguarding referral, if they are aware that there is a child or vulnerable person involved and they have concerns about their safety and welfare.

If there are reasons why contacting a patient at home may be difficult, for example a young person seeking sexual health services or someone who is a victim of domestic violence, it may be helpful to have discussions in advance to ascertain how they wish to be contacted and note this on the medical record.

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Delegation and referral

What are the responsibilities for the delegation of care, and referral of patients?

Delegation involves asking other staff to carry out procedures or provide care on your behalf. When a health professional delegates specific tasks to someone less qualified, the professional arranging the delegation still retains responsibility for the patient's overall management and must ensure that tasks are delegated only to those who are competent to carry them out. In many cases hospital doctors ask GPs to monitor or prescribe as part of a patient's ongoing care; this is different to delegation and in most cases responsibility will either be transferred to the GP or it will be part of a shared care arrangement.

Referrals are usually made to someone with more specialised knowledge to carry out specific procedures, tests, or treatment that fall outside the sphere of competence, or of usual practice, of the referring professional. Referrals are usually made to another registered health professional. If this is not the case, the person making the referral should ensure that the professional to whom the patient is referred is accountable to a statutory regulatory body or that systems are in place to assure the safety and quality of care provided. It is sometimes assumed that once a referral takes place responsibility for the care of the patient by the referring health professional ends. However, paragraph 44 (b) of *Good medical practice* states 'check, where practical, that a named clinician or team has taken over responsibility when your role in providing a patient's care has ended. This may be particularly important for patients with impaired capacity or who are vulnerable for other reasons.'

The GMC's guidance on *Delegation and referral* at paragraph 9 states: 'the following applies whether you are delegating or referring:

a) You should explain to the patient that you plan to transfer part or all of their care and explain why.
b) You must pass on to the healthcare professional involved:
   – relevant information about the patient's condition and history
   – the purpose of transferring care and/or the investigation, care or treatment the patient needs.
c) You must make sure the patient is informed about who is responsible for their overall care and if the transfer is temporary or permanent. You should make sure the patient knows whom to contact if they have questions or concerns about their care.
d) You should check that the patient understands what information you will pass on and why.

If the patient objects to a disclosure of information about them that you consider essential to the safe provision of care, you should explain that you cannot refer them or arrange for their treatment without also disclosing that information.'

Key resources

BMA – Confidentiality toolkit
BMA – Guidance for consultants working in a system under pressure
GMC – Delegation and referral
GMC – Good Medical Practice
The Health Foundation – Person-Centred Care Made Simple

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Patient autonomy and choice

Listening to patients and respecting their autonomy is a key ethical principle. Many patients wish to be active participants in their own healthcare and to be involved in creating and managing their health strategy and use of services. In most cases this is straightforward, and appropriate treatment options can be aligned with the patient's preferences. However, ethical dilemmas can arise when a patient disagrees with the advice given by health professionals or requests alternative treatment and care.

Patient choice

Can patients choose where to receive care?

Some patients would like more say about where and who provides care, and they may have increased expectations due to, for example, the NHS Constitution in England, which emphasises their right to make choices about their NHS care and to receive information to support these choices. However, in practice these choices are limited. According to the NHS constitution, patients in England have the right to:

- Choose their GP surgery, unless there are reasonable grounds to refuse (for example, they live outside the area that the surgery covers or a GP's list is closed); and
- For their first appointment, choose which provider, and team within that provider, to be referred to from all those who have a contract to provide the service (this can include private providers of NHS services).

There are some exceptions that may limit patient choice, for example patients cannot choose when and what services to use in cases where speed of access to treatment is particularly important, such as emergency services, cancer services, mental health services, and maternity services. In addition, people held under mental health legislation, military personnel, and prisoners (including prisoners on temporary release) cannot choose where to receive treatment.

Patients registered with a GP in Wales do not have a statutory right to choose at which hospital they receive treatment. NHS Wales does not operate a patient choice system but looks to provide services close to a patient's home where possible. However, patients on the border who are registered with a GP in England are entitled to exercise patient choice as outlined above.

Similarly, patients in Scotland and Northern Ireland do not have a statutory right to choose which NHS service they use.

Can patients choose which health professional provides care?

For reasons of dignity, specific cultural traditions, or the intimate nature of the examination, some patients may request to see and be treated by a member of their own gender. Where it is feasible to do so, reasonable patient preferences should be respected, but there is no legal requirement for the NHS to provide a health professional of the same gender in any healthcare setting.

Similarly, there may be specific reasons why complying with a patient's request to see a doctor of the same ethnicity, culture, or religion may provide clinical benefit. Nevertheless, patients cannot insist on seeing health professionals from a specific racial, cultural, or religious background, and any such requests which are based purely on unlawful discrimination, with no clinical benefit, should be refused.

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NHS bodies have obligations to provide competent, appropriately trained professionals but must not use racist or discriminatory criteria in their employment or referral practices. The NHS will not support racial or any other form of unfair discrimination. Private patients have more choice and can usually see the specialist they prefer but, if their care is funded by their insurer, the latter may specify where treatment is provided and designate a specific health professional.

Can patients insist on having a particular form of treatment?

No, if patients request treatment that is not clinically indicated, doctors are not obliged to provide it. Rather, the doctor and patient discuss the available treatment options including the risks and benefits of each, taking account of the patients' views and preferences, to reach a decision about what form of treatment would be appropriate. Where a patient refuses all available options, and requests an alternative, the patient's requests should be discussed and the reasons for requesting it explored but, if the doctor still does not believe the treatment request is appropriate, there is no obligation on the doctor to provide it. Disagreements can often be resolved locally by involving an advocate or more senior colleague, for example, but where disagreement continues, it may be appropriate to inform the patient of their right to seek a second opinion.

It is important to be aware, however, that in the case of *Burke v GMC* in 2004, the Court of Appeal held that where a patient with capacity requests clinically-assisted nutrition and hydration (CANH), or does so in advance of losing capacity, this should be provided. The Court was careful to explain that this did not mean that patients had the right to demand particular treatment, but rather that a fundamental aspect of the duty of care is to take all reasonable steps to keep patients alive, where that is their known wish. The question of what is 'reasonable' needs to be considered in the context of each case.

Where a treatment is clinically indicated but is not commissioned, or not available for other reasons, the patient should be informed of this (see section 4)

Can patients insist on being prescribed the medication they prefer?

No. Health professionals are responsible for all prescribing decisions they make and for any consequent monitoring that is needed as a result of the prescription given. Furthermore, the decision of whether, or what, to prescribe is a clinical decision based on the presenting symptoms and history. The GMC's guidance *Good practice in prescribing and managing medicines and devices* (April 2021) at paragraph 20 states: 'You are responsible for the prescriptions that you sign. You must only prescribe medicine when you have adequate knowledge of your patient's health and you are satisfied that the medicine serves your patient's needs.'

It can sometimes be difficult to manage patient expectations that they will leave a consultation with a prescription (for example, for antibiotics or the continuation of a prescription that is no longer indicated). Some patients may arrive at a consultation requesting a particular drug they have seen reported in the media, but which may not be appropriate for their condition or circumstances. Such pressure must be resisted; it is not good practice to prescribe medication that is not clinically indicated to avoid confrontation or simply based on patient preference. Whilst a patient's views should be considered, they are only entitled to medication that health professionals believe is appropriate and available within the service. The reasons why such requests cannot be complied with should be explained sensitively to the patient, together with advice about other treatment options, including

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self-care and, if the medication requested is clinically indicated but not commissioned, the possibility of obtaining medication outside the NHS (see section 4). If after discussion, the patient is not satisfied with the outcome it may be appropriate to inform them of their right to seek a second opinion (see below).

Where a patient requests a named brand rather than a generic medication, doctors should explain that they have an ethical obligation to make the best use of the resources available to provide care for all patients. Unless there are specific, and reasonable, arguments for preferring a particular brand, such requests should be refused.

Do patients have the right to a second opinion?

The GMC's guidance *Good medical practice* at paragraph 16 (e) states that doctors 'must respect the patient's right to seek a second opinion'. This is not the same as saying that NHS patients have a legal *right* to a second NHS opinion. It is generally considered to be good practice, however, to comply with patient requests for second opinions unless there are good reasons to justify a refusal. If a health professional refers a patient for a second NHS opinion, the patient cannot insist on seeing a particular practitioner or provider. A patient who requests a second opinion within the private sector can continue to access other NHS services.

Where a health professional agrees to a patient's request for a second opinion, they should advise the patient that people who are referred for a second opinion are treated as a new patient referral. A second opinion with a different health professional may be at a different clinic or hospital which might involve additional travelling. If they have a serious medical condition requiring urgent treatment, they need to be advised whether any delay in starting treatment due to obtaining a second opinion could have an impact on treatment outcomes.

Refusal or rejection of medical advice

Can competent adults reject medical advice and treatment?

Yes. Competent adult patients are entitled to reject treatment options. Their reasons do not have to be sound or rational; indeed, they do not have to give any reasons at all. Where a competent adult refuses treatment, a health professional is bound to respect that refusal; if they do not, they may face disciplinary action by their regulatory body, plus possible civil action, and criminal proceedings in battery. The only exceptions are when compulsory treatment under mental health legislation is necessary or, in limited circumsances, on public health grounds. However, the health professional's duty of care remains despite the treatment refusal. Paragraph 57 of *Good medical practice* states 'You must not refuse or delay treatment because you feel that patients' actions have contributed to their condition'. This therefore requires a health professional to continue to provide other care and treatments that are within the limits of the patient's consent.

Can competent adult patients refuse hospital admission?

Yes. Adult patients with mental capacity cannot be hospitalised against their will unless they are sectioned under mental health legislation. In such circumstances it is important to explore the reasons for their refusal, to identify whether they are acting under pressure, and to ensure that their decision is not based on a misunderstanding or incorrect information and that they understand the implications of the decision. Sometimes patients will change their mind if they are provided with additional or more accurate information, support, and encouragement, but, if they continue to refuse, that must be respected.

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Adult patients with capacity may also discharge themselves from hospital prematurely, but if they do so, or refuse essential treatment, they may be asked to sign a declaration by the hospital confirming that they understand the implications of their decision.

Can adult patients who lack capacity refuse medical treatment?

Capacity is task and time specific and so a patient may be able to refuse consent to some treatments but not others, depending on the seriousness and implications of the decision. An assessment of capacity should be specific to the decision the adult is seeking to take. Undertaking such assessments is a core clinical skill and is the responsibility of the health professional proposing the treatment, although in some complex cases more specialist input may be required. If a patient is not deemed to have the capacity to refuse (or consent to) a particular treatment, the clinician in charge of the patient's care must decide whether that treatment would be in the patient's best interests (or, in Scotland, if the treatment would benefit the patient); any views they express should form part of that assessment.

The Mental Capacity Act 2005 in England and Wales, and the Adults with Incapacity (Scotland) Act 2000 set out the legal framework in respect of all decisions taken on behalf of people who permanently or temporarily lack capacity to make such decisions themselves, including decisions relating to medical treatment. In Northern Ireland, decision making is currently governed by the common law with the exception of the provision of care and treatment in circumstances amounting to a deprivation of liberty for which there are specific regulations. New legislation combining both mental health and mental capacity law in Northern Ireland has been passed but has not yet been fully implemented. Details of any changes will be posted on the BMA website at www.bma.org.uk.The BMA has separate guidance on the treatment of patients who lack capacity and on best interests decision making – see key resources.

Combining NHS and private care

Do patients have the right to combine NHS and private care?

Patients can combine NHS and private care and are increasingly doing so. Patients may, for example, opt for private investigations to obtain a diagnosis before returning to the NHS for any treatment required. On return to the NHS, patients are placed on the waiting list according to their clinical need but will gain an advantage by reaching the waiting list earlier than others with similar clinical needs. Some doctors are uncomfortable with this practice which they see as 'jumping the queue' to the disadvantage of those who are not able to pay for private assessments. Nevertheless, this is an option that is available to patients and doctors who receive requests from patients should answer honestly and in a non-judgmental way. Doctors should be cautious, however, about raising with patients the option of private assessments or treatment in order to be seen more quickly (see below).

The Department of Health has published guidance on NHS patients who wish to pay for additional private care. The guidance states:

- 'NHS organisations should not withdraw NHS care simply because a patient chooses to buy additional private care.
- Any additional private care must be delivered separately from NHS care.
- The NHS must never charge for NHS care (except where there is specific legislation in place to allow charges) and the NHS should never subsidise private care.

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– The NHS should continue to provide free of charge all care that the patient would have been entitled to had they not chosen to have additional private care.'

Difficulties can arise where patients are receiving care simultaneously from two or more providers; this could be where part of the care is provided by the NHS and the rest within the private sector. Communication between those providing care is essential for the wellbeing and safety of patients; this is to prevent different treatment and/or medications being provided inadvertently that interact in a way that could be harmful to the patient or reduce their effectiveness. Encouraging patients to be open about any other sources of treatment they are receiving, and demonstrating a willingness to liaise with other providers, can help to reduce these risks.

What information can be given to patients about private care?

Patients are increasingly choosing to have private invesigations or treatment rather than wait for a prolonged period of time to be seen within the NHS. If patients specifically ask for information about alternatives, including private care, health professionals can respond, but particular care is required about raising the issue of private practice with patients.

It is not appropriate for health professionals to use their NHS patient lists to initiate discussion about their private practice or suggest to patients who are on their NHS waiting list that they could treat them more quickly on a private basis. Health professionals should not raise the issue of their private practice obliquely, for example by handing the patient a business card containing the address of both the NHS hospital and the health professional's private consulting rooms, or by adding the private clinic address to NHS letterheads. NHS consultants must manage their private practice as set out in the relevant code of conduct for private practice, and in the terms and conditions of the consultant contract.

Some patients may have private medical insurance which would cover their care and it is not problematic for GPs to ask patients this question when making a referral, so that they can explore that option.

Can patients obtain private prescriptions?

Under the NHS contract, a GP is unable to supply a private prescription to an NHS patient, except under specific circumstances, for example, in connection with foreign travel (for more information see Part 5, Regulation 25 of the National Health Service (General Medical Services contracts) Regulations 2015). If a patient is advised to be treated with a combination of drugs, some of which are not routinely available as part of NHS commissioned treatment, the patient is entitled to access the NHS funded drugs and can attend a private clinician separately (in a separate episode of care) for those drugs which are not available on the NHS.

Can patients who have tests or investigations in the private sector obtain NHS prescriptions?

Sometimes patients who have investigations in the private sector ask their NHS GP to prescribe any medication recommended. Even if patients opt for private treatment, they are still entitled to NHS services. If the medication is something that GPs would normally be familar with, the GP considers it to be clinically necessary and they have sufficient information to be able to prescribe safely, they would be required to provide it, even if the assessment from which the need was originally identified was carried out in the private sector. GPs would not, however, be required to prescribe specialist drugs with

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which they are not familiar, or those requiring specialist ongoing monitoring. There is also no obligation to prescribe if the medication recommended is not considered by the GP to be clinically necessary, or if it is not funded within the NHS.

Key resources

BMA – Adults with Incapacity in Scotland and Northern Ireland
BMA – Best interests decision making for adults who lack capacity toolkit
BMA – Mental Capacity Act toolkit
Department of Health – Guidance on NHS patients who wish to pay for additional private care
GMC – Good Medical Practice
GMC – Good practice in prescribing and managing medicines and devices

4 Communication and honesty

Good communication and honesty between health professionals and patients are fundamental to good medical practice. Patients perceive that the communication skills of health professionals are as important as technical skills for determining whether high quality medical care has been provided. Accurate, open, and efficient communication between health professionals is also a key component of providing high quality care to patients.

Communicating with patients

Why is good communication important?

Good communication is about establishing positive inter-personal relationships, as well as exchanging information. A failure to appropriately communicate can not only result in conflict, and a breakdown in trust between the patient and the health professional, it is a significant factor leading to patient harm and complaints. In research carried out by the GMC, the four most common communication failures by doctors that led to patient harm were:

- A failure to provide patients with appropriate and timely information;
- A failure to keep colleagues informed/sharing an appropriate level of information;
- A failure to listen to the patient; and
- A failure to work in partnership or collaboratively with patient/family or carers.

What are the key factors for good communication with patients?

As highlighted by the 2013 campaign 'hello, my name is .....', very basic aspects of communication can sometimes be forgotten in the hectic and high-pressure environment of healthcare, yet these are crucial to establishing a trusting relationship between patients and those providing care. It is important for patients to know who each member of the team is and, importantly, what their role is. In modern medicine, a number of different professionals collaborate to provide care and treatment and patients need to know whether the person they are speaking to is a doctor, nurse, physiotherapist, or other member of the healthcare team.

All healthcare professionals directly involved in a patient's care should therefore introduce themselves to the patient, and ensure the patient is aware of:

- Who is responsible for their clinical care and treatment;
- The roles and responsibilities of the different members of the healthcare team;
- The communication about their care that takes place between members of the healthcare team; and
- What to do and who to contact in different situations, such as 'out of hours' or in an emergency.

The importance of hearing and understanding patient views is a vital part of the doctor-patient relationship. Clear communication is also a key element of the discussion that leads to treatment decisions being made and to ensuring that the patient has given valid consent to any treatments or interventions. Health professionals should try to understand patients' views without making assumptions about the importance they attach to different outcomes. Health professionals demonstrate effective and respectful communication with patients by:

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- Exploring the patient's understanding, thoughts, worries and expectations about the problem and taking the patient's input seriously;
- Being approachable and friendly, and sharing decision making;
- Showing genuine care, and being respectful;
- Using plain language, and minimising the use of medical jargon; and
- Being specific and checking patient understanding.

What do I need to do if my patient cannot speak English or needs information in a different format?

Good information and communication are essential to high-quality, patient-centred care and this means that additional steps are required to assist those who do not speak English or have disabilities which affect their ability to understand the information provided, for example those who need British Sign Language or information provided in Braille. If patients cannot understand the information provided, they cannot give valid consent. High quality, accessible interpretation and translation services should therefore be made available within the NHS, free of charge.

Specific rules apply in Wales where Welsh has official language status. Health Boards in Wales are subject to Welsh language standards in terms of the services they provide to patients. This includes the 'active offer' of services in Welsh. Primary care providers also have certain duties under the Welsh language standards (see key resources) including recording the language preference of patients, making bilingual literature available, and promoting staff training and awareness.

Language preferences or communication needs should be clearly recorded in the medical record and on referral letters, so that suitable arrangements can be put in place including booking an interpreter to be available for appointments where necessary. It should not be left to the patient to find, or bring along, an interpreter – this should be arranged by the healthcare establishment. Family members acting as interpreters should be strongly discouraged because of the risk of technical information not being translated accurately and because of the impact this has on confidentiality. NHS England advises that where clinical staff are bilingual, they should use their professional judgement to decide whether they can competently converse directly with the patient or should use an interpreter.

Information leaflets and other documents that are usually available free of charge to patients should be made available in other languages or formats on request.

Although the NHS provides interpreter facilities, we are aware that these are not always easy to access and are sometimes unable to accommodate requests. If, having contacted these services, a suitable interpreter is not available within the necessary timescale, a judgement will need to be made about whether the consultation should continue, depending on the nature and urgency of the clinical need, and how much the patient has been able to understand. If the consultation continues, the fact that an interpreter had been requested but was not available should be recorded in the medical record. If this is a common occurrence, indicating that the service provided is not meeting the need, this should be drawn to the attention of senior management who have a responsibility to ensure that staff are able to provide information in a way that is understood, in order for the patients' consent to be valid. In general practice, concerns about the ability of the NHS interpreter service to meet demand should be raised with those

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commissioning the service. Recording information about unsuccessful attempts to engage an interpreter on the medical record, and raising the issue formally, will help to protect doctors against any future complaints and, by highlighting deficiencies, can prompt improvements to services.

Can I withhold information that I think may be harmful or distressing to the patient?

No, relevant information about their condition, prognosis etc should not be withheld from patients, including at the request of a family member. In the past doctors sometimes tried to protect patients from bad news, or potentially distressing or difficult conversations, by limiting the amount of information provided about the severity of their condition or the options available. This is no longer acceptable. Patients now expect, and have a right, to receive honest and full information, together with the support they need to deal with the information and the anxiety or distress that may flow from it.

The doctors' role is to ensure that decision making is returned, as much as possible, to the patient rather than pre-empting their choices. Even if active treatment is unable to provide a cure, there may still be important goals the patient wants to achieve, or things they want to do or say, if they know they are approaching the end of their life. These discussions, particularly about end-of-life care or decisions about whether to attempt cardiopulmonary resuscitation, are not easy, but they are an essential part of providing medical care. It is important that all doctors have appropriate training in communication skills to equip them to have these conversations.

There may be very exceptional circumstances, when a doctor judges that providing information would cause the patient serious harm. In this context 'serious harm' means more than that the patient will be very upset or may decide to refuse treatment, and the GMC advises that where doctors are considering withholding information, they should seek legal advice.

In the context of patients seeking access to their medical records, it is well-established in law that, in rare cases, certain information should be withheld, including where the relevant health professional considers the information would cause serious harm to the individual or another person; information about this can be found in the BMA's guidance on access to health records (see key resources).

Can patients refuse to receive information?

Information cannot be forced on individuals who do not want to receive it but, for their consent to be valid, patients need to know some basic information about what is proposed; the amount and nature of information required will depend on the individual circumstances (more information can be found in our Seeking Consent Toolkit).

Patients with capacity should be encouraged to know information that is important to their health and about the treatment options available. If patients express a wish not to receive that information, the reasons for this should be sensitively explored. Some patients may wish to receive information slowly, over a period of time, and this should be facilitated.

Those who refuse information should be made aware that they can change their mind at any time. Where information is not provided or if only partial information is given – at the patient's request – this should be clearly recorded in the medical record in a form that is easily accessible to others providing care for the patient.

4

Communicating with colleagues

Should I share patient information with colleagues?

Sharing relevant information, in a timely fashion, with colleagues who are involved in the patient's care is an important part of a doctor's duty of care. Patients who receive good co-ordination and continuity of care have better health outcomes, higher satisfaction rates, and the healthcare they receive is more cost effective; communication within and between teams involved in the patient's care is an important component of this.

In its guidance *Leadership and management for all doctors* the GMC states at paragraphs 11- 13:

> '11 You must make sure that you communicate relevant information clearly to:
> a. colleagues in your team;
> b. colleagues in other services with which you work;
> c. patients and those close to them in a way that they can understand, including who to contact if they have questions or concerns. This is particularly important when patient care is shared between teams.
>
> 12 You should not assume that someone else in the team will pass on information needed for patient care. You should check if you are unclear about the responsibility for communicating information, including during handover, to members of the healthcare team, other services involved in providing care and patients and those close to them.
>
> 13 You should encourage team members to cooperate and communicate effectively with each other and other teams or colleagues with whom they work. If you identify problems arising from poor communication or unclear responsibilities within or between teams, you should take action to deal with them.'

Health professionals should assess each patient's needs, in terms of communication, co-ordination, and continuity of care, and consider how those needs will be met. This may involve if possible - the patient seeing the same healthcare professional throughout a single episode of care or ensuring good communication and continuity within a healthcare team. For patients who use a number of different services, for example, services in both primary and secondary care, or attend different clinics in a hospital, healthcare professionals should ensure effective communication and co-ordination to permit a smooth transition between services.

In some cases, patients ask doctors not to share information with other health professionals who are providing care; for example, a patient may ask a doctor in secondary care not to provide information to their GP, or vice-versa. If the patient is a competent adult, this request should usually be respected even if this leaves the patient (but no one else) at risk of harm (there may be cases where there is an overriding public interest in sharing information, but these cases will be very rare). It is important, however, to discuss with the patient the reasons behind the request (and to provide reassurance about confidentiality if that is the concern) and to ensure the patient has understood the implications of their decision. Where a refusal to share information would impact on the ability to provide safe and effective care, the patient should be informed of this and – where it is the case – they should be told that without certain information, the treatment may not be able to proceed.

4

Honesty, openness and truth-telling

Should I tell patients about potentially beneficial treatments that are not available on the NHS?

Yes, patients should be informed about the range of relevant treatment options, even if there is little or no possibility of a treatment being made available within the NHS. Doctors are often hesitant about mentioning treatment options that they believe their patient cannot afford and are concerned about adding to the patient's distress or encouraging them to get into debt to pay for treatment. It is not, however, appropriate for doctors to make assumptions about their patients' financial situation or to deny patients relevant information because they believe it is not in their interest to know. Without all relevant information, patients cannot make informed decisions.

Doctors should be as open as possible about potentially beneficial treatment options, whilst sensitively explaining why some options may not be available within the NHS. They should be careful not to imply that the patient should pay for private treatment and must not use this discussion to promote any private service they offer.

Do I need to tell the patient if I have made a mistake?

Yes, there is both a legal and ethical duty on doctors (and health and care organisations) to be honest about acknowledging mistakes in diagnosis or treatment. In *Good medical practice,* the GMC says that if a patient has suffered harm or distress, doctors should:

- Put matters right (if that is possible);
- Offer an apology; and
- Explain fully and promptly what has happened and the likely short-term and long-term effects.

If the patient lacks capacity to understand, or is a young child, this information should be provided to an appropriate person, which could be a family member or carer of an adult, or the parent of a child. The Health and Social Care (Quality and Engagement) (Wales) Act 2020 strengthens the existing duties on NHS bodies in Wales, introducing (from April 2023) an organisational duty of candour on providers of NHS services (see key resources).

Whilst it is important to take action promptly when a mistake has been made, thought should be given to the best way to approach this (seeking advice from defence bodies or legal advisors, where appropriate). Such discussions need to be sensitively and carefully handled, acknowledging the error and the likely impact of this on the patient. In some cases, patients will need extra support, or counselling, to help them come to terms with the situation.

If a clinician believes that a previous doctor has made a mistake, missed important signs of a serious condition or that tests results may have been misinterpreted, they have an obligation to take action to ensure the patient is informed and that appropriate steps are taken, where possible, to put matters right. It is important that lessons are learnt from mistakes and, where there is a pattern of error, that it is reported to prevent other patients from being harmed. Joint GMC and NMC (Nursing and Midwifery Council) guidance also highlights the duty on health professionals to be open and honest with their oganisations by reporting incidents and near-misses to encourage a learning culture.

4

Can I withhold or remove relevant information from third party reports at a patient's request?

No. Patients often ask doctors to write reports for non-medical matters such as in connection with employment, benefits, or to support applications for firearms licences (the BMA has separate guidance on the firearms licensing process – see key resources). There is no obligation on doctors to comply with such requests but if they agree to do so they must do so honestly and must only sign reports that they believe to be true. We occasionally receive enquiries from doctors who have been asked by their patient to withhold relevant information from a report – in order to make the report more favourable to them, for example. As with all other areas of their professional lives, doctors must be honest and trustworthy and should not therefore accede to such requests. The GMC, in *Good medical practice*, states:

> 'You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents
> You must make sure that any documents you write or sign are not false or misleading.
> a You must take reasonable steps to check the information is correct.
> b You must not deliberately leave out relevant information.'

The BMA advises that reports may be written with information omitted but in such cases it must be clearly marked to state that some information has been withheld at the request of the patient.

Key resources

BMA – Consent and refusal by adults with decision-making capacity. A toolkit for doctors
BMA – Guidance on access to health records
BMA – The NHS Wales Duty of Candour
BMA – The firearms licensing process
GMC – Decision making and consent
GMC – Disclosing information for employment, insurance and similar purposes
GMC – Good Medical Practice
GMC – Understanding communication failures involving doctors (2019)
GMC and Nursing and Midwifery Council – Openness and honesty when things go wrong. The professional duty of candour
NHS England – Guidance for commissioners. Interpreting and translation services in primary care (2018)
Public Health Scotland – Interpreting, communication support and translation. National policy (2020)

5

Maintaining professional boundaries

The doctor-patient relationship is built on trust and doctors have particular ethical and professional obligations to ensure that appropriate professional boundaries are maintained. Although this is often considered only in terms of sexual or close emotional relationships, there are other common scenarios where questions of professional boundaries arise. There will be occasions where doctors meet patients socially and a friendship develops or where they work together in external ventures, such as local charities, but care should always be taken to ensure that professional boundaries remain.

Personal relationships

Why is maintaining professional boundaries so important?

Although the nature of the relationship between doctors and their patients has changed over recent years, with greater emphasis on partnership and patient autonomy, it is still the case that the relationship is not an equal one. There is an inevitable power imbalance, doctors have access to sensitive personal health data about patients and some patients who are seeking medical care may be in a very vulnerable position. Whilst a friendship or relationship may not influence a doctor's actions or decisions in any way, there may be a perception that it has or might have done. Doctors can also be vulnerable to complaints if a personal, or other non-clinical, relationship (for example a business arrangement) with a patient breaks down.

GMC guidance (*Maintaining a professional boundary between you and your patient)* is clear that:

- 'You must not pursue a sexual or improper emotional relationship with a current patient.'
- 'If a patient pursues a sexual or improper emotional relationship with you, you should treat them politely and considerately and try to re-establish a professional boundary.'
- 'You must not use your professional relationship with a patient to pursue a relationship with someone close to them.'
- 'You must not end a professional relationship with a patient solely to pursue a personal relationship with them.'
- 'Personal relationships with former patients may also be inappropriate.'

What type of relationship might be considered 'improper'?

Any sexual relationship with a patient is very likely to be deemed 'improper' even if it is a consensual relationship that developed in a social setting. The GMC's guidance is clear that you must not pursue a sexual relationship and must politely reject any sexual advances from patients. This strict prohibition extends to relationships with someone close to a patient and, in some circumstances, to former patients (depending on the time that has elapsed and the nature of the professional relationship).

There are some situations that doctors face where, in seeking to provide support to patients and their families, they could inadvertently step beyond the professional boundary. There is a risk of emotional attachment developing, for example, when patients seek support at times of emotional difficulty, after a loss or bereavement for example, or where a patient's relatives are vulnerable during a patient's acute or terminal illness. These types of scenarios require particularly sensitive handling to avoid a situation

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of emotional dependence arising or of the relationship extending beyond that expected of a professional doctor-patient relationship. A similar type of dependence can also arise where a doctor offers to help a patient with non-medical matters (such as completing benefits claims) when they are struggling but which, over time, leads to an expectation of ongoing support, making it difficult to refuse and extending their role beyond the usual professional role of the doctor. An awareness of how these issues can develop, if not carefully managed, can help doctors take steps to avoid this situation arising.

Other types of relationships with patients may also be considered improper although much will depend on the individual circumstances. Doctors should be alert to this and consider whether friendships, or other types of non-clinical relationships, with patients could be perceived as in any way inappropriate.

What should I do if I start a relationship with someone I meet socially and then realise they are a patient?

Personal relationships can arise in good faith when doctors and patients meet in a purely social setting, but it is essential that doctors take steps to establish and maintain professional boundaries. If they subsequently discover that the person with whom they are developing a relationship is also on their patient list, they should immediately cease the relationship or take steps to avoid a professional relationship developing; for example by ensuring that, when seeking treatment, the patient is allocated to another doctor. This may be awkward, and appear presumptuous, particularly at the beginning of a relationship but is always advisable.

Can I accept 'friend' or 'follow' requests from patients on social media?

Like other people, many doctors are prolific on social media and use this as a source of information and for campaigning on issues they believe in, including to promote health messages to their patients. Care is needed, however, to ensure this does not blur the boundaries between doctors' private and professional lives in a way that leads to ethical challenges. The GMC expects the same standards to be adhered to when communicating with patients on social media as they would face-to-face or on the telephone. Material posted onto social media sites, intended for friends, can be accessible to others, including patients. This means that patients may gain personal information about their doctor and their social life that could have an impact on the doctor-patient relationship and breach professional boundaries.

Doctors are advised, where possible, to try to maintain a professional distance from patients on social media, using appropriate privacy settings to limit access to personal material. If social media sites are used as a personal space, it is inadvisable to accept 'friend' or 'follow' requests from patients. Where GPs are part of local social media groups, it is likely that some other members will be registered with their practice; doctors should therefore be mindful that information they post may be accessible to patients.

Can I enter a business arrangement or transaction with a patient?

There is nothing to prevent doctors from entering into a business arrangement with a patient, where that is completely separate from their clinical relationship, but such arrangements should be approached with caution. For example, thought should be given to how this might be viewed by the patient and others, whether it could be perceived as a conflict of interests and whether it could have any impact on the clinical relationship, including if the business relationship were to break down or become

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acrimonious. It may be advisable before entering into any such arrangement to discuss the situation with the individual and suggest that it might be best for them to transfer to another doctor. It would never be appropriate for a doctor to approach a patient about investing in their business enterprise or to seek help or support for their own endeavours. Any such approach could put patients under pressure to accept and be seen as the doctor inappropriately using their position to gain personal advantage. This extends to non-financial interests. For example, we have been asked in the past whether it is appropriate for doctors to ask patients to put up posters to support their candidacy in local elections, or to ask patients to sponsor them for a charitable event. In our view, making such requests would risk crossing the professional boundaries of the doctor-patient relationship.

Treating colleagues, friends and family

Can I employ someone who is a patient?

Staff who work in a GP practice should be encouraged to register as a patient elsewhere to ensure a clear professional boundary, but it would not be appropriate to refuse someone employment on the basis that they are currently a patient. There should be a discussion about some of the challenges of having an employee-employer relationship alongside a clinical one. This includes issues around confidentiality, the management of situations where a patient needs to take a lot of sick leave, and the challenge that could arise if disciplinary proceedings needed to be invoked. Current employees who are also patients should be encouraged to register with another practice but in some small communities this may not be possible, or the patient may wish to remain with their current practice, and they cannot be required to move. Where staff members are also patients, it is essential that medical records are only used for the provision of care and not for any employment matters, unless explicit consent is provided by the patient.

Specific information about providing care for medical colleagues can be found in section 9.

Can I treat family members and friends?

It is not good practice for doctors to treat their family members and friends and every year a number of doctors are reported to the GMC for doing so – some having been reported by pharmacists or other medical colleagues. Many of these cases are resolved quickly, where there is evidence that it was a one-off incident where there was no other option available for example, but in other cases doctors are the subject of lengthy investigations and end up having sanctions imposed.

The GMC's guidance in *Good medical practice* is clear that: 'wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.' The BMA therefore advises against prescribing for close friends and family members except in rare circumstances where there is no other reasonable option available; in an emergency, for example, or providing a one-off prescription for antibiotics for a chest infection where there is nobody else available to prescribe. If you decide to do so, the GMC requires that 'you must make a clear record at the same time or as soon as possible afterwards; the record should include your relationship to the patient, where relevant, and the reason it was necessary for you to prescribe.' Controlled drugs should only ever be provided outside an established clinical relationship where it is necessary to avoid serious harm and no other option is available.

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GPs should encourage family members and friends to register with a different practice and doctors in secondary care should declare the relationship and make arrangements for care to be undertaken by a different doctor. This separation of the professional and personal relationship is an important part of maintaining professional boundaries. It also protects confidentiality and ensures objectivity, avoiding the risk of emotion or pressure impacting (or being perceived to have an impact) on the doctor's clinical judgement.

Even if they are formally being seen by another doctor, family members or friends sometimes ask for 'informal' medical advice. It can seem difficult to refuse to help when requested in this way, but it is important that those requiring medical care are seen in a formal setting; informal 'consultations' can lead to significant health issues being missed or false reassurance being given. In addition, as only those with a legitimate, established clinical relationship can access an individual's medical record, doctors treating family or friends informally may be unaware of relevant information that could affect their prescribing decision. In an emergency situation, if it is necessary to consult the individual's medical record in order to provide safe and effective treatment to a friend or family members, this should be recorded on the medical record with a note about when and why the record was accessed.

Doctors also need to be careful about requests from family and friends to comment on their doctors' decisions or advice; without all of the information and test results, such comments would be made on partial evidence and could undermine the patient's trust in their doctor and the care they are receiving.

Gifts and bequests

Can I give a small gift to my patient?

Doctors sometimes ask if it would be acceptable to send flowers, or buy concert tickets, to cheer up a patient who is having a difficult time. Whilst the motivation for this is laudable, it is important to consider how this could be interpreted by the patient, or by others, and whether this is consistent with the professional nature of the relationship; for these reasons we generally advise against the giving of even very small gifts to patients.

Can I accept gifts from patients?

Occasionally, doctors are offered gifts by patients or their families who wish to thank them for the care they have provided. NHS staff in England can accept gifts up to the value of £50 (and these do not need to be declared). Any gifts to NHS staff in England with a value of more than £50 – including the cumulative worth of gifts over a 12-month period – must be refused by individuals (although they may be accepted into an organisation's charitable fund). Any offers of cash, or vouchers, irrespective of the value, must also be declined. Individual Trusts are likely to have their own policies and procedures for declaring gifts in accordance with the national guidance.

Although there is no national guidance on accepting gifts in Scotland, Wales and Northern Ireland, similar rules will apply (although the amounts and rules on declaring gifts may differ); these are likely to be set out in guidance within individual establishments and so doctors should ensure they are familiar with the rules that apply where they work.

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Any doctor who is offered a gift from a patient is responsible for ensuring that this is within the rules set out by their Trust or Health Board.

Most general practitioners are not NHS employees and are therefore permitted to accept gifts from patients but are required to keep a register of all gifts accepted that are worth more than £100. This applies to all GPs, including locums, across the UK.

When accepting any gifts from patients or their families, doctors must make clear that this will not in any way influence the care or treatment the patient will received. The GMC makes clear in *Good medical practice*, at para 80, that:

> *'You must not ask for or accept – from patients, colleagues or others – any inducement, gift or hospitality that may affect or be seen to affect the way you prescribe for, treat or refer patients or commission services for patients. You must not offer these inducements.'*

I have been left some money in a patient's will, can I accept it?

Sometimes, doctors are informed after a patient's death that money or possessions have been left to them in a patient's will. The rules set out above apply whether the patient was alive at the time the offer of the gift was received or afterwards. If it is not possible for a doctor to accept a bequest, it may be possible for the money or items to be donated through the NHS establishment's charitable fund or to a registered charity of the doctor's choice. Advice should be taken on the individual circumstances.

Key resources

BMA – Receiving gifts from patients (GPs)
BMA – Social media, ethics and professionalism
GMC – Identifying and tackling sexual misconduct – ethical topic – GMC
GMC – Maintaining a professional boundary between you and your patient
GMC – Social media use: ethical topic
NHS England – Managing conflicts of interests in the NHS
GMC – Good practice in prescribing and managing medicines and devices

6

Trust and mutual respect

Trust in both parties is essential to the doctor-patient relationship. This involves a mutual commitment to honesty, openness, and transparency. Trust is linked to good communication, the maintenance of strong professional boundaries, and respect for confidential information. It also involves mutual respect and a joint search for positive outcomes. This section looks at circumstances where trust may be perceived to be under pressure from one or other party to the relationship.

Video and audio recordings

What if a patient asks to record a consultation?

Patients sometimes ask to record consultations. Given the availability of smart phones and other recording devices, such requests are likely to become more frequent. Although such requests have been perceived as signalling a lack of trust, or an intention to pursue a complaint, many patients request recording as a form of note taking; particularly if the information is complex, they have cognitive difficulties, or they are distressed or otherwise unable to retain information easily.

In our view, doctors should ordinarily encourage patients to make open and contemporaneous recordings to assist them in decision making and self-care. Such recordings should, however, be made openly. As with patients, doctors have privacy rights. Covert recording of consultations, as well as any subsequent publication of the recording, or parts of it, in publicly-accessible media, without explicit agreement, is a breach of doctors' privacy rights and may open patients up to legal proceedings. Doctors should consider posting information about their policy on making recordings in their practice or health facility. The BMA has separate guidance about how to manage situations where patients post consultations on-line (see key resources).

Can I record patients covertly if I have welfare concerns?

The use of covert recording is sometimes suggested where, for example, there are concerns about the wellbeing of a child and grounds for suspecting that parents or carers are causing the child harm. The use of covert recording should only be considered where there are no other feasible means to obtain information essential to the investigation or prosecution of a serious crime, or to protect someone from serious harm.

In the UK, any covert recording by the NHS, or those employed by or contracted to the NHS, come under the *Regulation of Investigatory Powers Act 2000* or the *Regulation of Investigatory Powers (Scotland) Act 2000*. If you are considering using covert recordings you must therefore ensure that you comply with the relevant legislation. In addition, as the GMC states:

> *'Before you consider making covert recordings, you must discuss this with colleagues, your employing or contracting body, and relevant agencies, except where this would undermine the purpose of the recording, in which case you should seek independent advice. You must follow national or local guidance.'*

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Covert medication

Can I covertly medicate my patients?

Where a patient retains relevant decision-making capacity, covert medication is unacceptable. It would involve the deliberate deception of a competent patient and clearly breaches the ethical and legal requirement to seek informed consent from capacitous patients for any treatment. Where there are doubts as to a patient's capacity, a formal assessment should be undertaken. Patients must not be misled as to the purposes of any treatment or medication.

Cases may arise however where covert medication might be in the best interests of a patient who lacks the capacity to consent to it. Any such decision must be taken by the clinician in overall charge of the care of the patient lacking capacity, in consultation with the multi-disciplinary care team. Those close to the patient, including anyone with formal decision-making powers, must be involved in the decision. The reasons for administering the drugs covertly should be recorded in the patient's care plan and regularly reviewed. Consideration must always be given to whether there are options available that are more respectful of the individual's free choice.

Conflicts of interests

What should I do if I think I might have a conflict of interest?

Doctors are under an obligation to make decisions based upon their assessment of what is best for their patients. Personal factors, such as any possible financial or other advantage for the doctor, or those close to the doctor, must not factor in the decision making. Both the BMA and the GMC stress the importance of doctors identifying possible conflicts of interests. Where they cannot reasonably be avoided, doctors should be open and honest about such conflicts of interest. Similarly, doctors must be open and honest about their financial arrangements. Doctors must not accept any inducement, gift, or hospitality that may affect – or be seen to affect – the way they treat, prescribe or refer patients, or commission services for their patients.

The BMA has specific guidance on transparency and doctors with competing interests (see key resources).

Chaperones

When is it necessary to use a chaperone?

Doctors and patients can sometimes be reluctant to ask for a chaperone, for fear that it indicates a lack of trust in the other party. Both the BMA and the GMC, however, recommend that patients are offered a chaperone for intimate examinations wherever possible, irrespective of their gender.

The presence of a chaperone helps to protect and support patients and doctors. Incidences of inappropriate behaviour by doctors are very rare but, given the nature of intimate examinations, concerns and complaints can sometimes arise as a result of misunderstanding or poor communication. The fact of offering a chaperone highlights the sensitive nature of the clinical encounter, which should raise awareness that particular care is needed to ensure proper explanation, communication, respect, and dignity, and that valid consent has been provided for the examination to proceed. This can help to prevent complaints occurring. Where a chaperone is present, they are able to provide an independent account of events should any complaint be made. A note should be made in the medical record of the name of any chaperone provided.

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GMC guidance (see key resources) states that when an intimate examination is being carried out a chaperone should be offered wherever possible, and this person should usually be a health professional.

What individuals consider to be 'intimate' varies and should be considered from the patients' perspective. It is likely to include examinations of the breasts, genitalia, and rectum, but may include any situation where patients might feel uncomfortable about being alone with a doctor, such as when it is necessary to darken the room for a retinopathy or remove an item of clothing.

Doctors sometimes find themselves in situations where it is simply not possible to offer a chaperone. In these circumstances, a judgement will need to be made about whether the consultation should continue, depending on the urgency of the clinical need and the views of the patient about whether to proceed or reschedule the appointment. If the consultation continues, the fact that no suitable chaperone was available – and that the patient consented to continuing without a chaperone– should be recorded in the medical record. If this is a common occurrence, for example due to staffing levels within the establishment, this should be drawn to the attention of senior management who have a responsibility to ensure that staff are able to comply with the requirements of the regulator. In general practice, where this could be particularly difficult, careful planning will be required to ensure that this part of GMC guidance can be met. One option, where it is known that an intimate examination will, or is likely to, be required, would be for patients to be provided with information and asked to give advance notification, for example in an appointment letter, if they would like a chaperone provided, so that suitable arrangements can be made.

A relative or friend of the patient is not an impartial observer and so would not be a suitable chaperone, but doctors should be sympathetic to a reasonable request to have such a person present as well as a chaperone, or when no chaperone is available.

Occasionally there may be disagreements over the use of a chaperone. Where a doctor feels uncomfortable about going ahead without a chaperone, but the patient refuses, the GMC states:

> *You must explain clearly why you want a chaperone present. Ultimately the patient's clinical needs must take precedence. You may wish to consider referring the patient to a colleague who would be willing to examine them without a chaperone, as long as a delay would not adversely affect the patient's health.*

Where the consultation is postponed, or care is passed on to another doctor, the reasons for this should be stated in full in the medical record. This should include the assessment undertaken of the risk to the patient of any subsequent delay. All discussions with patients about chaperones should be carefully recorded in the patient's medical record, including, if the patient does not want a chaperone, the fact that the offer was made but the patient declined.

Urgently needed medical care should not be delayed because there is no chaperone available. The circumstances necessitating the decision to proceed should be recorded in the medical record.

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Key resources

BMA – Patients recording consultations
BMA – Transparency and doctors with competing interests
Care Quality Commission – Covert administration of medicines
GMC – Good Medical Practice
GMC – Making and using visual and audio recordings of patients
GMC – Making recordings covertly – ethical guidance
GMC – Intimate examinations and chaperones – ethical guidance summary

7

Conscientious objection and expressing personal beliefs

What is a conscientious objection?

Doctors are entitled to have their own personal beliefs and values in the same way as any other member of society. A conscientious objection is when a doctor does not wish to provide, or participate in, a legal and clinically appropriate treatment or procedure because it conflicts with their personal beliefs or values. A conscientious objection is based on sincerely held beliefs and moral concerns, not self-interest or discrimination. Doctors can therefore only claim a conscientious objection provided it is lawful, non-discriminatory, and does not cause patients harm or deny them access to appropriate medical treatment or services.

The BMA does not want to unnecessarily restrict doctors from seeking to exercise a conscientious objection or other expressions of their belief. We seek to balance doctors' freedom with the rights of patients to receive appropriate treatment in a non-judgmental fashion.

Rights and limits to conscientious objection

Is there a legal right to conscientious objection?

There are only two areas in the UK where there is a statutory right to claim a conscientious objection; these are abortion and fertility treatment.

- Abortion – Section 4(1) of the Abortion Act 1967 (Scotland, England, and Wales) and section 12 of the Abortion (Northern Ireland) (No. 2) Regulations 2020 provide that a health professional cannot be compelled to participate in the administration of a procedure which results in the termination of a pregnancy if they have a conscientious objection, except where it is necessary to save the life, prevent grave permanent injury to the physical, or mental health of a pregnant woman. There is no statutory right to conscientious objection in the case of emergency hormonal contraception as this is not an abortifacient.
- Fertility Treatment – Section 38 of the Human Fertilisation and Embryology Act 1990 provides that a health professional cannot be compelled to participate in any activity covered in that legislation (assisted reproduction and embryo research) if they have a conscientious objection.

Are there any limits to the statutory rights of conscientious objection?

The limits of conscientious objection in abortion were confirmed in the UK case of Janaway v Salford Area Health Authority (1988) UKHL 17 which held that the right is limited to a refusal to participate in the procedure(s) itself and not to pre- or post-treatment care, advice, or management. The position was further clarified in the case of Greater Glasgow v Doogan and Another (2014) UKSC 68 in which the Supreme Court held that conscientious objection does not extend to health professionals supporting, supervising, and delegating to staff participating in abortion. A summary of these cases is available at: https://pubmed.ncbi.nlm.nih.gov/11648387/ and Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (supremecourt.uk). Furthermore, in an emergency, health professionals must provide appropriate care and treatment despite any conscientious objection.

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Should doctors be able to exercise a right of conscientious objection outside the limited statutory rights of abortion and fertility treatment?

Yes, subject to the provisos below, the BMA believes doctors should have a right to conscientiously object to participation in other legal and clinically appropriate treatments. For example, contraception, non-therapeutic male infant circumcision (NTMC), and the withdrawal of life-sustaining treatment.

However, this right does not extend to refusing to treat a patient where this would give rise to direct or indirect discrimination, or harassment, under the Equality Act 2010 in England Wales and Scotland or parallel legislation in Northern Ireland i.e., on the grounds of patient's age, disability, marital status, pregnancy, race, religion or belief, sex, and sexual orientation. This means for example, that a doctor must not refuse to provide a patient with clinically appropriate medical services because the patient is proposing to undergo, is undergoing, or has undergone gender reassignment, or a refusal to treat patients of the opposite sex. It is the procedure itself that the conscientious objection refers to, not specific characteristics of the patient.

It should also be noted that doctors may be required to fulfil contractual requirements that may restrict their freedom to work in accordance with their personal beliefs. For example, where the treatment is a core service, such as contraception, and all the GPs in a practice have a conscientious objection to its provision, they must make alternative arrangements for their patients by sub-contracting this part of the service.

Responsibilities of those with a conscientious objections

What are the responsibilities of doctors who have a conscientious objection to a treatment or procedure that may be clinically appropriate for the patient?

Where a doctor will not provide or participate in a treatment or procedure based on a conscientious objection this can affect patient care. The BMA believes that they have an ethical obligation to minimise disruption to patient care and must not use a conscientious objection to intentionally impede patient access to care. Furthermore, in an emergency, doctors must provide appropriate care and treatment despite any conscientious objection.

The GMC advises that where a doctor has a conscientious objection to a legal and clinically appropriate procedure or treatment, patients should be made aware of this in advance of a consultation. In its guidance *Personal beliefs and medical practice*, the GMC states at paragraph 10 'If, having taken account of your legal and ethical obligations, you wish to exercise a conscientious objection to services or procedures, you must do your best to make sure that patients who may consult you about it are aware of your objection in advance. You can do this by making sure that any printed material about your practice and the services you provide explains if there are any services you will not normally provide because of a conscientious objection.'

In addition, the GMC in its guidance *Personal beliefs and medical* practice at paragraph 12 states 'Patients have a right to information about their condition and the options open to them. If you have a conscientious objection to a treatment or procedure that may be clinically appropriate for the patient, you must do the following.

a) Tell the patient that you do not provide the treatment or procedure, being careful not to cause distress. You may wish to mention the reason for your objection, but you must be careful not to imply any judgement

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of the patient.

b) Tell the patient that they have a right to discuss their condition and the options for treatment (including the option that you object to) with another practitioner who does not hold the same objection as you and can advise them about the treatment or procedure you object to.

c) Make sure that the patient has enough information to arrange to see another doctor who does not hold the same objection as you.'

If a patient wishes to be seen by another health professional, the doctor must ensure they have sufficient information to enable them to do so. If it is not practical for the patient to make the arrangements themselves, the doctor must arrange for another health professional to take over their care without delay. It is important to ensure that any inconvenience or distress to the patient is kept to a minimum.

Doctors should also inform their employer and colleagues about their conscientious objection so that they can practise in accordance with their beliefs without compromising patient care or over-burdening colleagues.

Can doctors exercise a right of conscientious objection to patient 'life-style' choices?

No. It is not appropriate for doctors to refuse to treat patients whose illnesses are thought to arise from their personal choices, for example, smoking, alcohol, and drugs. The GMC in its guidance *Good medical practice* states at paragraph 48 'You must treat patients fairly and with respect whatever their life choices and beliefs' and at paragraph 58 'You must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition.' Patients should be offered information about how to safeguard their health but the fact that their actions may have contributed to their condition should not give rise to moralising or delaying treatment.

Expressing personal beliefs

Can doctors express or discuss their personal beliefs with patients?

The GMC in its guidance *Personal beliefs and medical practice* states at paragraph 31 'You may talk about your own personal beliefs only if a patient asks you directly about them or indicates they would welcome such a discussion. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them.' In the case of Kuteh v Dartford and Gravesham NHS Trust [2019] EWCA Civ 818 the Court of Appeal upheld the dismissal of a nurse after she initiated conversations with patients about religion, assured her employer that she would stop, yet continued to do so, told patients they had a better chance of survival if they prayed, gave patients bibles, and asked a patient to sing a psalm with her. A summary of the case is available at: https://www.crosslandsolicitors.com/site/cases/Kuteh-v-Dartford-and-Gravesham-NHS-Trust-proselytising

Some doctors may seek to manifest religious or cultural beliefs or views through the wearing of religious symbols. Like the GMC, the BMA does not seek to tell doctors what to wear. However, the BMA anticipates that doctors will be sensitive to the impact that such symbols may have on their patients.

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Does the BMA have any further guidance on conscientious objection?

Yes, the BMA has information on conscientious objection in its guidance on abortion, non-therapeutic male circumcision (NTMC), the licensing of firearms, and clinically-assisted nutrition and hydration (CANH) – see key resources below.

Key resources

BMA – Clinically-assisted nutrition and hydration
BMA – Non-therapeutic male circumcision (NTMC) of children – practical guidance for doctors
BMA – The firearms licensing process
BMA – The law and ethics of abortion
Human Fertilisation and Embryology Authority – Code of Practice 9th Edition
GMC – Good Medical Practice
GMC – Personal beliefs and medical practice

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Care at a distance

The COVID-19 pandemic accelerated the mainstream adoption of remote consultations, monitoring, treatment, and prescribing, either by phone, video, online, or via apps. As technology advances and new, innovative models of care provision are introduced, providing care at a distance is likely to expand and develop further. When used appropriately, there are a range of benefits for patients, doctors, and service providers of remote access to treatment when compared with traditional face-to-face care. However, there can be additional risks to practising remotely and there will always be circumstances in which traditional, in-person care is either preferable or necessary. As with face-to-face consultation, a doctor's primary obligation is to make the care of their patients their first concern. If they have a reasonable belief that this cannot be done safely and effectively by remote means, they should make all reasonable efforts to see the patient in person.

High-level principles

What obligations do I have when providing care remotely?

All relevant legal, ethical and regulatory obligations apply equally to care provided virtually or remotely as they do to in-person care. This includes consent, confidentiality, data management, capacity, and prescribing. There may also be specific clinical guidelines that doctors should follow which relate to remote care in their area of practice.

UK healthcare regulators and medical bodies have outlined ten high-level principles that registered healthcare professionals, including doctors, should follow in remote consultations and prescribing.

They should:

1. "Make patient safety the first priority and raise concerns if the service or system they are working in does not have adequate patient safeguards including appropriate identity and verification checks.
2. Understand how to identify vulnerable patients and take appropriate steps to protect them.
3. Tell patients their name, role and (if online) professional registration details, establish a dialogue and make sure the patient understands how the remote consultation is going to work.
4. Explain that:
   a. They can only prescribe if it is safe to do so.
   b. It's not safe if they don't have sufficient information about the patient's health or if remote care is unsuitable to meet their needs.
   c. It may be unsafe if relevant information is not shared with other healthcare providers involved in their care.
   d. If they can't prescribe because it's unsafe, they will sign post to other services.
5. Obtain informed consent and follow relevant mental capacity law and codes of practice.
6. Undertake an adequate clinical assessment and access medical records or verify important information by examination or testing where necessary.
7. Give patients information about all the options available to them, including declining treatment, in a way they can understand.
8. Make appropriate arrangements for after care and, unless the patient objects, share all relevant information with colleagues and other health and social care providers involved in their care to support ongoing monitoring and treatment.

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9. Keep notes that fully explain and justify the decisions they make.
10. Stay up to date with relevant training, support and guidance for providing healthcare in a remote context."

Deciding between remote and face-to-face consultations

When is a remote consultation appropriate?

Different medical specialties use remote consultations in different ways and circumstances relevant to that specific area of practice. In general, they are most obviously suitable for straightforward requests for treatment from patients with capacity, where a physical examination is not necessary, and when there is access to the patient's notes. However, in all circumstances it will still be important to exercise judgement in determining whether it is appropriate for an individual patient. Relevant factors might include any safeguarding concerns, whether they can access the consultation privately, and how comfortable they are in using the technology. Doctors must also ensure that they are able to conduct the consultation safely and confidentially. The General Medical Council has a flowchart to help doctors decide when it may be safe and appropriate to treat patients remotely.

Can patients insist on a face-to-face consultation?

The GMC advises that, where there is the option of either a face-to-face or remote consultation, "when it is within your power, you should agree with the patient which mode of consultation is most suitable for them." While doctors have a responsibility to take account of the resources available to them, if a patient has reservations about a remote consultation or does not feel that it appropriately suits their needs, then this must be taken into consideration.

When might remote consultations and prescribing not be appropriate or additional caution might be required?

The GMC advises that a face-to-face consultation may be more appropriate when a doctor:

- Is unsure about a patient's capacity to consent to treatment
- Needs to physically examine the patient
- Is not the patient's usual doctor or GP and the patient has not given their consent for the sharing of information from the consultation with their regular prescriber
- Is concerned that the patient is not able to access the consultation safely and confidentially
- Is concerned the patient may be unable to make a free and voluntary decision, for example if they are under pressure from others.

Prescribing remotely

Can I prescribe remotely?

Yes. As with any prescription, health professionals take full legal and ethical responsibility for the decision and should only prescribe when they have sufficient knowledge and experience to be satisfied that it is appropriate for the patient's needs. Doctors should follow the GMC's guidance on *Good practice in prescribing and managing medicines and devices* at all times.

When prescribing controlled drugs remotely, the GMC advises that doctors must ensure that additional safeguards are in place, including robust patient identity checks, confirmation that the patient has given consent for their regular prescriber to be contacted about the prescription, and that all

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relevant information is shared with the patient's GP or primary care record. Patients must also be given the "names, roles, and contact details of key people who will be involved in their care, as well as advice about who they can contact if they have any questions or concerns." Injectable cosmetic products must not be prescribed via a remote consultation.

Can I prescribe to patients who are overseas?

Yes, although depending on the circumstances, doctors should approach such requests with caution and carefully assess the risks involved. The GMC outlines additional factors that doctors will need to consider, in addition to the principles outlined above; such as how the patient will be monitored, differences in a product's licensed name, indications and dosage, and the indemnity and registration requirements that may be necessary to both practise and prescribe in the countries involved. Doctors are also expected to follow "UK and overseas legal requirements as well as relevant guidance on import and export for safe delivery, including from the MHRA".

Key resources

GMC – Ethical hub: remote consultations.
GMC – Good practice in prescribing and managing medicines and devices.
GMC – Remote prescribing: high-level principles.

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Doctors' responsibilities

A doctor's fundamental professional duty to make the care of their patients their first concern intersects with responsibilities to ensure their own health and conduct, or that of their colleagues, does not risk patient safety or call into question their fitness to practise. This section addresses issues including doctors diagnosing or treating themselves, and their responsibilities where they have concerns about their colleague's health or performance.

Doctors' health and healthcare

What responsibilities do I have to ensure that my own health does not affect patient care or safety?

Doctors are routinely exposed to health risks in the course of their work, including exposure to infection and needle-stick injuries. Doctors have a responsibility to ensure that their health does not adversely affect the care of their patients. In *Good medical practice*, the GMC states that "If you know or suspect that you have a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must follow their advice about any changes to your practice they consider necessary. You must not rely on your own assessment of the risk to patients." It further advises that doctors should also be immunised against common serious communicable diseases unless contraindicated.

In addition to the risks of infection, long hours, workload pressures, dealing with organisational change, and coping with patients' anxieties can also take a toll on doctors' physical and mental health, leading to severe stress or burnout. There is also now increasing recognition of the extent of moral distress and moral injury within the medical profession, which can have a very significant impact on doctors' health and well-being (see the BMA's report on moral distress in key resources). It is essential that doctors are alert to signs that their own health may be suffering and seek help and advice at an early stage. It is not a sign of weakness, but of strength, to admit to needing physical or emotional support at such times. In addition to local support services, the BMA's well-being service is available for all doctors (see information in key resources).

Is it appropriate for doctors to self-diagnose or self-treat?

No. Whilst it may be tempting for busy doctors to self-diagnose or prescribe for themselves, rather than take time out to see their registered doctor, this is high-risk both from a regulatory and a personal well-being perspective. Particular concerns include the temptation to extend oneself beyond one's competence and the possibility of denial in the face of serious illness. Doctors who self-prescribe may also fail to adequately document the treatment which could affect their future care if their treating doctor is unaware of the prescription. Of particular concern are self-prescriptions for medication where there is a risk of dependency, such as opiates or benzodiazepines. However, self-prescribing of regular medication is also problematic, particularly if this becomes frequent or routine, as opposed to a one-off situation where it is not possible to see another doctor. The GMC advises that "wherever possible" doctors "must" avoid providing medical care to themselves. All doctors should be registered with a GP, outside their family or workplace, rather than treating themselves or informally asking a colleague to do so.

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There may be exceptional cases where, due to circumstances outside of a doctor's control, self-treatment may be required, however they should be able and prepared to justify this decision. Where a doctor does self-prescribe, the GMC states that they must make a clear record at the same time or as soon as possible afterwards including the reason the prescription was necessary and follow its advice on information and safe prescribing. The circumstances in which a doctor may prescribe controlled drugs for themselves are strictly restricted to when "no other person with the legal right to prescribe is available to assess and prescribe without a delay" and "emergency treatment is immediately necessary to avoid serious deterioration in health or serious harm."

What considerations are relevant to treating patients who are doctors?

Doctors providing care for other health professionals need to treat them as their patients, avoiding short cuts, informal 'corridor consultations', and unjustified assumptions. Doctor patients should be seen within formal consultations and offered proper explanations of what is involved in the investigation and management of their condition. They may already be well aware of such information, but should be allowed the opportunity to be the patient and be offered advice and support, if they want that, in the same way as other patients would be. The same principles apply when doctors are parents or carers of the patient.

Doctors who are patients are entitled to the same high standards of care and confidentiality. Unless the patient consents, or there is another lawful justification, health professionals must not share information with others not directly concerned with their treatment. Sick doctors, particularly those with mental health and addictive problems, are often reluctant to seek medical advice due to concerns about confidentiality. Generally, they should be reassured that their confidentiality will be as closely protected as that of any other patient.

Out-of-area referrals should be considered, where possible, in cases where sick doctors have particular worries about confidentiality or being treated by colleagues who are acquaintances. As with all other patients, however, doctors' rights to confidentiality are not absolute and action needs to be taken where their health poses a threat to other people. Wherever possible, this should be discussed by the treating doctor with the sick doctor prior to disclosure.

Concerns about colleagues

What should I do if I have concerns about the health of a colleague?

Where doctors have concerns that the health of their colleagues may be preventing them from practising safely, they have a duty to take action, in the interests both of patient care and of their colleague's health. Not to intervene risks patient safety and can lead to further deterioration in the doctor's health and performance. Colleagues, particularly junior staff, are sometimes reluctant to speak out due to loyalty or for fear of damaging their own careers. However, the GMC emphasises the duty of all doctors to prevent risks to patients, including those arising from the ill health of colleagues. Early recognition and treatment considerably increase the chances of successful rehabilitation for the sick doctor. In *Leadership and management for all doctors*, the GMC states that "You should be aware that poorly performing colleagues may have health problems and respond constructively where this is the case. You should encourage such colleagues to seek and follow professional advice and offer them appropriate help and support. You must not unfairly discriminate against colleagues because of an issue related to their health or a disability."

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What should I do if I have concerns about the conduct or performance of a colleague?

Where doctors have concerns about the performance of a colleague, they should ordinarily and wherever possible offer them support in the first instance. However there remains an overriding duty on doctors to promptly raise concerns where there exists a risk to patient care or safety. In *Good medical practice* the GMC states that "If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken." Doctors should also familiarise themselves with and follow the GMC's guidance on *Raising and acting on concerns about patient safety.*

Key resources

BMA – Your wellbeing (bma.org.uk)
BMA – Needlestick injuries and blood-borne viruses: testing adults who lack capacity
GMC – Good practice in prescribing and managing medicines and devices
GMC – Leadership and management for all doctors
GMC – Raising and acting on concerns about patient safety

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Patients' responsibilities

With the shift towards a partnership model of the doctor-patient relationship, came the notion that patients have certain responsibilities as well as rights, both in terms of maintaining their own health and when accessing healthcare. This notion of patient responsibilities is encapsulated in the NHS constitution in England, and The Charter of Patients' Rights and Responsibilities in Scotland, both of which set out what patients, the public, and staff are entitled to expect from the health service, but also what concomitant duties fall to those who use the NHS. Whilst doctors have the primary responsibility to make the doctor-patient relationship work, patients also need to play their part.

Patients' responsibilities

What responsibilities do patients have?

Under the NHS constitution certain responsibilities are assigned to patients, which are designed to ensure the smooth, fair, and effective running of the NHS; these are to:

- Take personal responsibility for their own, and their family's good health and wellbeing;
- Register with a GP practice;
- Treat NHS staff and other patients with respect;
- Recognise that violence, or the causing of nuisance or disturbance on NHS premises, could result in prosecution and recognise that abusive and violent behaviour could result in them being refused access to NHS services;
- Provide accurate information about their health and condition;
- Keep appointments or cancel within a reasonable time;
- Follow the course of treatment that has been agreed;
- Participate in important public health programmes, such as vaccination;
- Ensure those close to them are aware of their wishes about organ donation; and
- Give feedback, both positive and negative, about the experience and treatment and care received.

Although these expectations are not so clearly articulated in all parts of the UK, it is reasonable to assume that the same responsibilities should be assigned to all patients.

Engagement with their health and healthcare

How can I encourage more patients to be actively involved in maintaining their own health and wellbeing and in the development of our service?

The BMA is very keen to involve patients more in the development and use of healthcare services and our Patients Liaison Group has produced a toolkit to help GP practices to facilitate this (see key resources). Many of the suggestions can also be applied in secondary care.

How can I encourage patients to complete a course of treatment?

It can be frustrating when treatment goals are not achieved due to lack of compliance with an agreed treatment regime or because patients do not complete a course of medication. It is important, however, for doctors to be non-judgemental when discussing non-adherence and to encourage patients to be honest about their medicine taking.

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Everyone has the right to refuse treatment, but it is important that reliable, accurate information is provided about the implications of doing so. This includes explaining the purpose of the medication and treatment and, where relevant, the need to complete a full course of treatment for it to be effective.

Non-adherence is sometimes the result of confusion or misunderstanding, rather than a positive choice. Where they are available, written information sheets can help patients to understand their condition and medication and can serve as a useful reminder; information can often be forgotten particularly when given during a consultation which the patient may find stressful. Requests by patients to record the discussion, or to take notes, should be accepted as a way of helping the patient to comply with the agreed treatment regime (see section 6). Special attention should be given to those who need particular help such as older people with hearing difficulties or those for whom English is not their first language (see section 4).

It is important when discussing treatment options to take account of the patient's own preferences and concerns, and to modify the chosen approach if appropriate. A patient may prefer to take a less effective medication with fewer side-effects, for example, and taking these types of factors into account is likely to increase compliance with the treatment regime.

Can I refuse treatment to patients whose lifestyle choices, or failure to follow an agreed treatment regime, have contributed to their condition?

No. Asserting that patients have a responsibility to take steps to protect and maintain their own health and wellbeing does not mean that those who do not do so can be denied treatment. The GMC states clearly, in *Good medical practice* (para 57), that:

> 'You must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition.'

Patients who demonstrate violent, aggressive or racist behaviour

Can I refuse to treat patients who engage in violent, aggressive or racist behaviour?

Violent, aggressive, or racist behaviour towards healthcare staff is entirely unacceptable and health professionals have a right to be protected from such behaviour. Employers have a duty of care to protect their staff and to put mechanisms in place to quickly and effectively manage any such situation that arises. In some circumstances, this may involve withholding treatment but there are also other steps that can and should be taken. BMA guidance on how to deal with discrimination from patients gives examples of the type of action that can be taken (see key resources).

Whether treatment can be withheld from a patient who acts in a violent, aggressive, or racist manner will depend on the reasons for the behaviour and the urgency of the patient's need. Sometimes the behaviour is caused by a patient's medical condition, mental illness, or medication. Identifying whether there is an organic cause for their behaviour is essential, particularly when patients appear to be acting out of character.

Patients who are threatening or racially abuse should not be denied urgent treatment or necessary immediate care, if this can be provided safely, but once the emergency situation has subsided this should be raised with the

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patient who should be informed that such behaviour in future could result in treatment being withheld.

Where such behaviour does not arise as a result of underlying pathology, and treatment is not urgently required, we support a doctor's right to delay or refuse immediate treatment.

Patients who are violent can be immediately removed from a GP practice list and patients who meet the criteria can be provided with care in a secure environment via the special allocation service (see key resources). Some hospitals also have specific arrangements in place to treat patients who are known to be prone to violence.

Healthcare establishments should have a protocol for managing violent patients. This should be available to patients and should advise that information about violent patients may be shared with other health professionals in the area, if this is necessary to protect staff from harm. In these circumstances, disclosure of information without consent will usually be justified in the public interest.

Key resources

BMA – How to manage discrimination by patients and their guardians/relatives
BMA – Patient and public involvement. A toolkit for GPs
BMA – Removing violent patients and the special allocation scheme
Department of Health and Social Care – The NHS Constitution for England 2021
NHS Inform (Scotland) – The Charter of Patients Rights and Responsibilities

11 Breakdown of the doctor-patient relationship

Doctors have particular responsibilities to try to make the relationship with patients work and to have the care of their patients as their first concern. Nevertheless, circumstances can arise when the relationship breaks down to such an extent that the best thing for all involved is to end the professional relationship and to pass the care of the patient to another doctor.

Decisions to end the professional relationship with a patient should never be made in the heat of the moment but only after careful thought and consideration of alternative options. Many patients who are misusing services or behaving inappropriately can change their behaviour if it is brought to their attention and they are informed of the consequences. Doctors must retain a high level of professionalism even in the face of difficult or confrontational behaviour from the patient.

Can I end the professional relationship with patients who make excessive demands?

It is not acceptable to end a professional relationship because of the resource implication, or time commitment, of providing a patient with necessary and appropriate care or treatment. Updated guidance for GP practices, from NHS England (see key resources), however includes 'unnecessarily persistent or unrealistic service demands that cause disruption' amongst inappropriate and unacceptable behaviour by patients that could, in some circumstances, lead to a patient being removed from a practice list.

Can I end a professional relationship with a patient who makes a complaint about me?

The GMC's guidance *Ending your professional relationship with a patient,* is clear that:

> *'You should not end a professional relationship with a patient solely because of a complaint the patient has made about you or your team, or because of the resource implications of the patient's care or treatment.'*

Complaints raised through the appropriate mechanisms should be handled sensitively and objectively and can provide learning for both health professionals and patients. The fact that a patient has made a complaint is not of itself grounds for ending the professional relationship. Being the subject of a complaint can, however, have a significant emotional impact on doctors, particularly if complaints are unfounded, repeated, vexatious, or make personal attacks on them. In such circumstances the complaint may be indicative of a significant breakdown in the relationship, where mutual trust and confidence has been lost. In these cases the best option for all concerned may be to end the professional relationship. It would be the irretrievable breakdown of the relationship, not the complaint, that would be the reason for ending the relationship, and this should be made clear to the patient.

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Managing a breakdown in the doctor-patient relationship

What should I do if my relationship with a patient has broken down?

The GMC's guidance on *Ending your professional relationship with a patient,* states that before ending the relationship doctors should:

a) Warn the patient that you are considering ending the relationship;
b) Do what you can to restore the professional relationship;
c) Explore alternatives to ending the professional relationship; and
d) Discuss the situation with an experienced colleague or your employer or contracting body.

Doctors must also be 'satisfied that your reason for wanting to end the relationship is fair and does not discriminate against the patient.'

All discussions or communications with the patients should be carefully documented in the medical record. This should be factual and objective and should not include anything that could unfairly impact on the patient's future treatment or professional relationships.

What should I do if I want to remove a patient from my practice list?

In some circumstances, where the relationship has broken down with one GP, it may be possible for them to see other GPs in the practice as an alternative to removing them from the practice list. Removing patients from a practice list is rare, but where the relationship has irretrievably broken down, BMA guidance, *Removing patients from your practice list,* recommends the following action is taken.

1. Where practices intend to remove a patient because of the breakdown of the doctor-patient relationship, you should first consider discussing the problem with an independent party, eg LMC secretary.
2. Issue a warning to the patient, preferably in writing, giving the reasons for the possibility of removal. Warnings are valid for 12 months and a written record must be retained.
3. Send a written notice to the PCO or NHS England, giving the patient's name, address, date of birth and NHS number. (In Wales, the Local Health Board sould be notified; in Scotland, the Community Health Index – see key resources; and in Northern Ireland, the Health and Social Services Board.)

Do I need to find another doctor for the patient to see?

Doctors have a duty of care to their patients and cannot simply abandon them. In secondary care, arrangements need to be made for another doctor to take over the patient's care before responsibility can be relinquished, to ensure the patient's treatment is not jeopardised and they continue to have the advice and care they need. In primary care, patients can be transferred to another GP in the practice, if available, or apply directly to another practice in the area or contact the relevant organisation to be allocated to another practice (ICS in England, Local Health Board in Wales, Business Service Organisation in Northern Ireland, and Practitioner Services Team in Scotland).

Key resources

BMA – Removing patients from your practice list
GMC – Ending your professional relationship with a patient
NHS England – Primary Medical Care Policy and Guidance Manual (PGM) – updated May 2022
NHS Scotland – How to remove patients | National Services Scotland (nhs.scot)

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Non-typical relationships and dual obligations

What if I do not work in a 'typical' doctor-patient relationship?

Not all professional relationships in medicine are primarily therapeutic. Doctors can work in a range of roles where they owe duties to other parties. Doctors may, for example, act as impartial and independent examiners with accountability to commissioning organisations. These include doctors working as examiners for insurance companies or employed by the state to assess eligibility for health-related benefits. In these circumstances, a doctor's primary obligation is not to the wellbeing of the individual patient but to the employing or commissioning body.

Doctors working in these roles must clearly explain the nature of the relationship to their patients. They must be clear that any tests undertaken, or information gleaned from the examination, are not for the purposes of the patient's healthcare. Although not an ordinary therapeutic relationship, in our view doctors retain some obligations to patients in these circumstances. If, for example, they identify health information important to the patient, this should ordinarily be disclosed to them. How such a situation will be managed should be discussed with the patient and the commissioning agent prior to the examination.

Access to medical reports

Do patients have the right to see medical reports written about them?

The Access to Medical Reports Act 1988 and Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 give patients the right to see medical reports written about them for employment or insurance purposes, by a doctor whom they usually see in a 'normal' doctor-patient capacity. This includes reports written by the patient's GP or a specialist who has provided care. This right can be exercised either before or after the report is sent. Patients have the right to highlight any disagreement with matters of fact recorded in the report, and to append their disagreement to the report, or to withdraw their consent for the release of the information.

Medical reports written by independent medical examiners are excluded from this legislation, and there has previously been debate and contention about the extent to which occupational health physicians, for example, were subject to the legislation. All registered doctors, however, are obliged to follow GMC guidance (see key resources) which states that individuals must be offered the opportunity to see a report written about them for employment or insurance purposes before it is sent unless:

– they have already indicated they do not wish to see it
– disclosure would be likely to cause serious harm to the patient or anyone else, or
– disclosure would be likely to reveal information about another person who does not consent.

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Managing dual obligations

What happens where I have clear obligations both to patients and to a third party?

Some doctors, such as those working in detention settings or the armed forces, can have what are known as 'dual obligations' with significant duties both to patients and another party. Ethical obligations to patients are not diminished in these circumstances. Doctors cannot be obliged by contractual or other considerations to compromise their professional independence. They must make an unbiased assessment of the patient's health interests and act accordingly. Although there is not always tension here, there may be instances when their role will not be in the interests of the individual, and conflicts, real or perceived, may arise.

What are the guiding principles for health professionals with dual loyalties?

The conduct of health professionals with dual obligations should accord with the ethical standards of other practitioners. In addition to the basic duties on all health professionals, those with dual loyalties should:

- Remember their duty of care for individuals, even where health assessments take place for reasons other than the provision of treatment;
- Ensure that patients are informed of the nature and extent of any dual obligations and the impact they may have on their rights and interests;
- Provide care that is, at least, of a comparable standard to that provided in the community;
- Seek informed consent, even if the law does not require it to be obtained;
- Respect the rights of patients to have access to appropriate information about treatment options;
- Respect patient confidentiality and inform patients at the time they provide information if it will be used for purposes other than their care – they should also know what those purposes are likely to be and whether they can opt out;
- Respect patients' human rights and be sensitive to the ways in which they may be compromised;
- Maintain robust standards of professional and clinical independence;
- Identify where services or conditions are inadequate and may pose a threat to health and raise concerns as appropriate;
- Be sensitive to the needs of patients with vulnerabilities and guard against inappropriate forms of discrimination; and
- Be able to justify any departure from accepted ethical principles or guidelines.

Key resources

BMA – Access to Medical Reports
BMA – Ethical issues in forensic and secure environments
BMA – Ethics toolkit for armed forces doctors
GMC – Disclosing information for employment, insurance and similar purposes – ethical guidance – GMC

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