

# Report of Public Meetings Held During the Review of 'Good Medical Practice'

**May 2006**



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## Introduction

This report presents the discussions which took place as part of a series of public meetings hosted by the General Medical Council (GMC) to inform the review of its core ethical guidance to doctors *Good Medical Practice* (GMP).

### *Background*

As the regulator for the medical profession, the purpose of the GMC is to protect and promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. The law gives us four main functions under the *Medical Act*:

- Keeping up-to-date registers of qualified doctors.
- Fostering good medical practice.
- Promoting high standards of medical education.
- Dealing firmly and fairly with doctors whose fitness to practise is in doubt.

Under the *Medical Act* the GMC has the power to ‘provide, in such manner as the Council think fit, advice for members of the medical profession on medical ethics’. The Council has delegated this function to the Committee on Professional Standards and Ethics (Standards and Ethics Committee or ‘SEC’), which has established a process for developing and reviewing this guidance. Consultation is a key part of this process.

### *Good Medical Practice*

First published in 1995, GMP sets out what is expected of doctors in their professional lives. It applies to every doctor on the Medical Register regardless of specialty, grade and area of practice (e.g. NHS doctor or independent sector). The primary purpose of GMP is to inform doctors of their duties, but it also has a variety of other uses. In particular it:

- Informs the medical undergraduate curriculum.
- Provides the basis of Appraisal for NHS doctors.
- Provides the basis of planned GMC revalidation of all doctors.
- Provides the benchmark for considering doctors’ fitness to practise.

Importantly, although it is guidance for doctors, GMP also aims to set out in a clear and accessible way what members of the public can expect from their doctors.

## *Keeping GMP Up to Date and Fit for Purpose*

The SEC launched a fundamental review of the guidance in June 2004 and following a redrafting process, issued a revised draft of GMP for formal consultation in August 2005. The consultation aimed to seek the views of professionals and members of the public, including people we do not normally hear from in formal consultations to inform decisions about what the guidance should say.

In addition to the written consultation, which was the primary vehicle for seeking views, we also:

- Commissioned Picker Institute Europe to carry out research with members of the public and professional into the standards expected of doctors (the full report is available on the Good Medical Practice Review site).
- Held other meetings with individuals and organisations to find out their views on the draft and the review generally.
- Held five Public Meetings around the UK.

### *Public Meetings*

The following Public Meetings were held during the consultation process:

Manchester	14 October 2005 (daytime)
London	27 October 2005 (daytime)
Cardiff	21 November 2005 (evening)
Edinburgh	22 November 2005 (evening)
Belfast	23 November 2005 (evening)

We used a 'Question Time' format to enable discussion of some ethical issues arising during the redrafting process. To see whether the discussions changed people's minds, we asked the audience to vote on questions before and after the question and answer sessions.

Non-GMC panellists and facilitators were selected for each meeting to ensure a mix of doctors, patients or representatives from patient bodies, an expert in medical ethics and if possible, a well known person who had some experience of or interest in medicine/healthcare. Briefings were provided for all facilitators and panellists.

The audience at each event comprised a mixture of invited professional and non-professional stakeholders and members of the public responding to advertising in local and medical press, local radio and other relevant publications.

The discussions in this report explore the key themes which arose across all five meetings. They outline any changes that were made to scenarios between meetings and use quotes to illustrate the range of views expressed and any particular tensions or areas of consensus rather than a definitive account of each meeting (which can be found in the transcripts of the meetings). Individual quotes have been attributed

by indicating whether it was the view of a panellist/audience member and the location of the meeting.

We used a series of scenarios at each of the meetings to see what participants felt doctors in those situations should do. The issues chosen for scenarios and why they were chosen are set out below.

#### Scenario 1: Doctors' private lives

The revised guidance placed emphasis on behaviour which could 'undermine public confidence in the medical profession.' We wanted to know what our audiences thought were the standards to be expected of doctors in their private lives and whether there were situations where behaviour in private could or should be subject to disciplinary action by the regulator.

#### Scenario 2: Problem patients or problem doctors?

GMP contains guidance on when in rare circumstances it may be appropriate to end a professional relationship with a patient. We wanted to explore this issue to see whether the threshold set out in the guidance was reasonable.

#### Scenario 3: Patient choice versus clinical judgement

The final scenario took two different forms (patient requesting an abortion in one and cosmetic surgery in another) but essentially asked, can doctors can justifiably refuse to treat a patient if they do not believe the treatment is in the patient's best interests? As the guidance on access to medical care in GMP had been changed, again we wanted to test the level at which it was now pitched.

Further information on the process of the review including next steps and other ways in which we sought views is available on our website <http://www.gmc-uk.org>. Go to 'Guidance on Good Practice' and then 'Good Medical Practice Review'.

## Issue 1: Doctors' Private Lives

### *Scenario for discussion at Manchester*

Simon Jones is a well-respected and successful heart surgeon. His clinical work is excellent. His personal life, however, is somewhat chaotic.

Mr Lee complains to the GMC that Mr Jones has seduced his 16-year-old daughter, Lily, and has been abusive towards her. Mr Jones has set Lily up in a flat, unknown to his wife and their three teenage children. Lily – who has just begun studying for her A 'Levels – has stopped attending most of her classes at college so that she can be at the flat whenever Mr Jones wants to see her (usually in the middle of the day).

Lily has confided in her mother in the past about Mr Jones's penchant for hardcore pornography, which makes her uncomfortable – he uses the flat to store his videos and magazines. Lily has been making increasingly distressed phone calls to her parents, saying she thinks that Mr Jones is seeing other women (apart from his wife).

Recently Lily confronted Simon about the affairs and he pushed her to the floor and punched and kicked her, saying it was none of her business, and threatening to kill her if she interfered. Mr Jones had pushed Lily around a few times before but this was the first time he had actually struck her. The following morning he apologised profusely, saying he'd over-reacted. Lily said she was scared at the time but is sure Simon won't act in that way again and she wouldn't dream of pressing charges – she's in love with him and believes that given time he'll leave his wife for her.

Mr Lee hopes that by contacting the GMC they will be able to intervene, and the situation will become public so that Mrs Jones will find out about Lily and it will force things to a head.

### **Question for audience vote (before and after debate):**

'Does it matter how a doctor behaves in their private life, as long as they are clinically competent?'

*Amended scenario for discussion at remaining meetings*

Simon Jones, 48, is a successful heart surgeon with an excellent clinical reputation.

Dr Little, an anaesthetist and colleague of Mr Jones at the hospital, contacts the GMC with concerns about Mr Jones's behaviour. Mr Jones, who is married with two teenage children, has been bragging to colleagues about his regular affairs.

Mr Jones also makes no secret of his obsession with hardcore pornography, and has offered to lend Dr Little videos and magazines (Dr Little has declined).

At a recent staff social event, Mr Jones confided to Dr Little that he was currently seeing a 16-year-old girl, Lily, who he has set up in a flat near the hospital so she is available whenever he wants to see her. Dr Little is horrified to realise that he knows Lily, who goes to his daughter's school. He makes discreet enquiries with his daughter and finds that Lily has not been attending many of her A' Level classes for the last couple of months.

Dr Little tells the GMC that Mr Jones's private life is now the subject of regular hallway discussion – he is concerned about Mr Jones's conduct and potential damage to the reputation of their hospital.

**Question for audience vote (before and after debate):**

'Should the GMC be able to discipline doctors for actions in their private lives?'

## Issue 1: Doctors' Private Lives

This scenario involved an excellent heart surgeon with a chaotic private life and the question posed to stimulate debate was, 'Should the GMC be able to discipline doctors for actions in their private lives?' Unsurprisingly, there was disagreement about whether actions in 'private' should be an issue for the GMC. Although many different issues were raised at each meeting, it is possible to identify three overarching themes in relation to this scenario. These were:

- a. Public versus private.
- b. The doctor/patient relationship.
- c. The role of the GMC.

Following the first meeting in Manchester we used feedback about the effectiveness of the scenarios in generating discussion to make a number of small changes. This meant that for this scenario, although similar issues were raised, there were some differences in the discussion at Manchester which are reflected in the scenarios presented above. The main differences were the inclusion of an allegation of physical assault and a potential complaint from the girls' father which was changed to a potential complaint from a colleague for the remaining meetings.

### *Public versus private*

Some participants felt that the GMC should not take action in such a situation because doctors were 'only human' and therefore it was unreasonable to expect doctors to be 'morally excellent', as they were entitled to privacy the same as anyone else.

*'...bizarrely I found myself looking for arguments to defend this man because I think, on the premise that I accept and am sympathetic to human frailty.'*  
(Panellist, Edinburgh)

*'I think if to be a doctor you have to be perfect in your private life then I think we would have a serious shortage. That is not criticising doctors; that is saying that nobody is perfect.'* (Panellist, London)

Whilst some felt that a right to privacy itself was reason enough for the GMC not to become involved, others cited different reasons:

*'One of the things we have a need for is civil liberties. All of us have a need for those civil liberties to be protected. Your personal needs and your relationship with your doctor are fine for you but acted upon they may well prejudice the civil liberties of the entire society.'* (Panellist, Manchester)

However, it was accepted that the right to privacy was not absolute and that there were examples where concerns about private behaviour would outweigh this right. The main examples given were, illegal behaviour; where behaviour became public

due to a lack of discretion on the part of the doctor - and something that many readily agreed with - where the behaviour was likely to interfere with the doctor's duties.

*'... bragging about it in fact probably gives even more cause for concern, because that is really, given his professional duties, the duties of a doctor, and the public awareness of these issues, that seriously calls into question for me his judgement.'* (Panellist, Edinburgh)

*'... do you want a clinical director managing budgets who has been previously convicted of fraud?'* (Panellist, London)

However, there was disagreement about whether and to what extent concerns about behaviours outweighing privacy, applied in this particular scenario and therefore whether the GMC should become involved:

*'I think that in terms of this question if they are not breaking the law then the GMC should not have the right to investigate their behaviour.'*  
(Audience member, Cardiff)

*'If somebody breaks the law they should be dealt with by the law but the profession should only become concerned if the manner in which they broke the law impinges and can be shown to have impinged upon the treatment of their patients'* (Audience member, Belfast)

*'...there are certain professions where private conduct can interfere with public duties. Medicine is one and the police force might be another, for example, but the question there is whether the private conduct really is interfering in some way in the public domain. In this particular example it is not.'* (Panellist, London)

Many participants thought that the decision about whether to take action or not related directly to whether the behaviour was in 'private', or had become 'public', but recognised that this itself was often a blurred dividing line. Some participants therefore questioned whether it was the behaviour itself, or the fact that it had become public, which was of concern?

*'I think that is where the problem is because people's chaotic personal lives often do impinge on their professional lives, we just cannot prove it.'*  
(Panellist, Manchester)

In this scenario, as the behaviour was legal and did not appear to have an impact on the doctor's clinical work, some participants felt that the GMC's involvement would therefore inevitably be on moral grounds and felt uncomfortable with this:

*'As a society we agree that things that are legal are fine and things that are illegal are beyond that line. The problem with the GMC disciplining on morality is that we do not really have an agreement on what is moral.'*  
(Panellist, London)

*'Now, we all work alongside sleazy people, we all know people who beat their wives, or drink too much, or who have nasty habits, but if those things do not impact on a person's job, and this is maybe impossibly libertarian, but I think he deserves to just be regarded as not very nice and allowed to get on with his job.'* (Panellist, Edinburgh)

Others however, voiced the view that the behaviour mattered regardless of whether it had crossed the threshold of legality or did not affect clinical ability, because the person in question was a doctor.

*'The question is does it matter, not whether the GMC should do anything, not whether the police should do anything, not whether social services should do anything, does it matter? It matters to me.'* (Audience member, Manchester)

Underlying this debate was the issue of how participants framed the doctor/patient relationship.

### *The doctor/patient relationship*

The participants discussed whether or not the behaviour of doctors in private should be judged any differently from that of other citizens. It became clear that the terms in which participants saw the 'doctor-patient relationship' was fundamental in determining this. In particular, there was debate on how far a doctor differed in his or her responsibilities from other members of society because of occupying a privileged position in society and having access to patients. Some felt that where behaviour was legal but nevertheless morally reprehensible, there was a need for some action because of the wider issue of trust at the centre of the doctor-patient relationship.

There was also disagreement over whether this relationship always existed, regardless of the type of practice. Some participants felt that clinical competence was paramount, whereas others argued that even in the case of a surgeon, the doctor/patient relationship was wider than expecting clinical competence:

*'...the underlying question there is how is it affecting his relationship with his patients, because being a surgeon is not just about making great slashes with a scalpel; it is about the relationship you build up with your patients and the work you do with them.'* (Audience member, London)

*'However, if you ask me as a patient whether I would like this highly competent nasty piece of work to operate on me or a less competent but thoroughly decent individual, I want this competent person. I want good plumbers and I really do not care whether they swear a lot at home.'* (Panellist, Manchester)

*'He is not with an underage, he is with a 17 year old, but, at the same time, if I knew that he is like that I would not want to take my daughter to him. You see, it is a very, very sensitive issue when you are dealing with sick patients and you want to give your daughter, your life, everything, to a doctor.'* (Audience member, Belfast)

*'...there are some professions where they have an inequality of relationship and trust is an ingredient in those relationships...So I think it is bound on a body like the GMC to be more vigilant. It does not matter if my bank manager is behaving in this manner.'* (Panellist, Belfast)

There were also contrasting views on whether the specialty in question made a difference. Some felt it would matter if the doctor was a paediatrician or a gynaecologist due to the duty owed by doctors to young people or the inherent sexism involved in hard-core pornography, whereas others attributed this to nervousness about sex generally rather than concerns with the doctor's behaviour.

*'If he had actually been, for example, and I know this is not going to sound very liberal, but if he had been my gynaecologist, for example, I would not feel comfortable going to him to be treated.'* (Panellist, London)

*'I do not care what attitude towards women my doctor has as long as he treats me okay as his patient and that is the difference.'* (Panellist, Manchester)

*'With this case history, first of all we have the regular affairs. That would not be a concern to me because we do not know the state of the marriage and, at the same time, of course, men brag about these things and exaggerate them anyway so I would not be quite sure about the status of that information. Secondly, with regard to the pornography, that did concern me. Obviously, I am not a student of hard core pornography but this is suggestive of a preoccupation with violence, sadism, degradation of women, power, and domination.'* (Panellist, Belfast)

Even where participants felt that private behaviour was a cause for concern, views differed on what action, if any, should be taken and who should take it? In particular, this discussion called into examination the role of the GMC.

### *The role of the GMC*

Of those that felt that the behaviour in the scenario did justify action of some sort, there was disagreement about the appropriate place to raise concerns.

In Manchester due to the additional, alleged (but unreported), physical assault in the scenario, many participants were clear that potentially illegal behaviour should be reported to the police and not the GMC (at least in the first instance).

*'Basically this thing really is dead in the water... I cannot see this Mr Lee [girl's father] being able to do anything else about anything if he is not prepared to go to the police.'* (Audience member, Manchester)

However, some of the participants felt that even without a formal allegation and/or evidence, the GMC should do something, but others rejected this position, as this exchange at the Manchester meeting demonstrates:

*'FEMALE AUDIENCE SPEAKER: Do you not think that the GMC need to know if one of the doctors is doing physical violence?'*

*THE CHAIRMAN: Our Panel say no.*

*PANELLIST: The GMC does not have its own police force. The GMC do not have a PC Plod they can send out to ascertain whether it was true. It is a matter for the police and the GMC would have to say the police need to investigate this.'*

At the remaining meetings, where physical violence was not a feature of the scenario, some argued that a higher standard of behaviour was expected of doctors and that this was because of the doctor/patient relationship. It was felt in this case that the GMC was the right body to investigate, as the purpose of 'self-regulation' was to consider behaviour against a higher standard and investigation was not therefore dependent on illegality, nor restricted to initial consideration at a local level.

*'...there is this concept of professionalism and conduct that leads us to come into question here. Ultimately this is what the GMC will question and what needs to be questioned here this evening; not whether it is a case of breaking the law but whether it is morally wrong and breaks the professional conduct that is expected by society of doctors.'* (Audience member, Cardiff)

Not all participants who argued that legal behaviour could raise issues of trust felt that the GMC was the right place for referring such a case. Instead, where such behaviour had the potential to disrupt working relationships (for example where this bordered on sexual harassment in the form of offering access to hard-core pornography where unsolicited) or damage the reputation of the hospital, it was for the employer and local systems to deal with it rather than the GMC. Whether through regulation by peers, in the form of words from a 'critical friend', or a formal investigation undertaken by an employer/local disciplinary systems, local action was seen as preferable and appropriate compared with a referral to the GMC.

*'Technically, Dr Little has no legitimate interest in this case; however, the issues around the impact of the relationship within the team is, I think, quite important and in that context Dr Little's responsibilities here are, first of all, that of the critical friend... he should then legitimately raise his concerns with the Clinical Director, the line manager or the Chief Executive to express his concerns.'* (Panellist, Belfast)

However, some felt that a GMC referral might be the right outcome at the end of this process:

*'...the GMC should be able to discipline doctors if these actions break the law. When you come to consider morals, however, these vary with time and according to the population's views. This doctor has done nothing wrong. However, do his activities potentially interfere with his practice? Is there a risk? Is he seeing children within his hospital practice? What about his bragging? I think this is something that the Trust should initially deal with and, if necessary, a GMC referral should be made. It should not be automatic.'* (Audience member, Cardiff)

*'My great sympathy with the GMC...when it comes to the point about extending their remit we must try and sort these things out locally with negotiation and only when local procedures are really exhausted should there be any possibility of the GMC getting involved.'* (Panellist, Manchester)

### *Summary*

Whilst there were contrasting views on whether the GMC should discipline doctors for actions in their private lives, during the discussion, it became clear that there were also areas of consensus. These ranged from the entitlement to privacy to the position of trust and power occupied by doctors and the implications of this for expectations about their behaviour.

It was agreed, for example, that illegal behaviour, impact on practice and indiscretion (even where behaviour was legal) all had the potential to impact upon the trust patients placed in doctors. There were differences in opinion on whether and to what extent it was for the GMC or other bodies (police, employers, local systems) to take action.

## Voting Results for Scenario 1 (Doctors' Private Lives)

Question 1: Should the GMC be able to discipline doctors for actions in their private lives?

<b>Manchester</b> (Note: different question posed)			
Audience Size:	85		
Audience make up:	70%	Public (incl. school children)	
	25%	Organisational Representatives	
	5%	Doctors	
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	47%	14%	33%
End	58%	20%	22%
<b>London</b>			
Audience Size:	80		
Audience make up:	24%	Public	
	14%	Medical Body Representatives	
	14%	Patient Body Representatives	
	20%	Other Body Representatives	
	28%	Doctors	
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	42%	40%	18%
End	27%	63%	10%
<b>Cardiff</b>			
Audience Size:	85		
Audience make up:	49%	Health professionals	
	28%	Public	
	18%	Medical Students	
	5%	Politicians	
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	59%	25%	16%
End	66%	27%	7%
<b>Edinburgh</b>			
Audience Size:	75		
Audience make up:	35%	Doctors	
	30%	Public/Patient	
	35%	Stakeholders	
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	60%	20%	20%
End	65%	31%	5%

<b>Belfast</b>			
<i>Audience Size:</i>	91		
<i>Audience make up:</i>	60% doctors		
	20% public/patient		
	20% stakeholders		
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	58%	37%	6%
End	59%	38%	3%

## Issue 2: Problem Patients or Problem Doctors?

### *Scenario for discussion at Manchester meeting*

Mr Bailey is registered at Dr Redman's general practice surgery. He has a history of manic depression and frequently refuses to take his medication, and the practice staff have found him difficult to deal with at times. He also has a problem with alcohol misuse and sometimes when he attends the surgery, he has clearly been drinking. He has little social support beyond his contact with community mental health workers.

Mr Bailey persistently makes requests for home visits for matters which seem insignificant to the GPs in the practice (however urgent they seem to Mr Bailey at the time). Having attended on him a few times, the practice GPs are now very reluctant to visit Mr Bailey at home.

Mr Bailey has made several formal complaints to the Primary Care Trust about the GPs in the practice, stating that they will not visit him at home, even in an emergency, that they do not listen to him or take his concerns seriously and deliberately give him appointments at the end of surgery hours which can be difficult for him to make. None of these complaints have been upheld by the PCT.

Mr Bailey often becomes aggressive in the surgery reception if he is kept waiting for an appointment, and on the most recent occasion he was racially abusive and threatening to reception staff. One of the surgery receptionists has threatened to resign and one of the GPs now refuses to see Mr Bailey after a consultation during which his aggression was so intimidating, she felt in real danger of being physically attacked.

When Mr Bailey is well and compliant with his treatment, he is very apologetic about his aggressive behaviour and regrets all the trouble he has caused the practice staff. The GPs are considering removing Mr Bailey from the practice list. The surgery is in a remote rural area and the nearest alternative GP surgery is some 10 miles away.

### **Question for audience vote (before and after debate):**

'Would Dr Redman be justified in removing Mr Bailey from his practice list?'

*Amended scenario for discussion at remaining meetings*

Mr Bailey is registered at Dr Redman's general practice surgery. He has a long-term condition and attends his GP regularly, often with information about his condition and treatment he has found on the Internet. He has little social support.

The practice staff think Mr Bailey is a demanding and difficult patient and many of the receptionists are reluctant to deal with him. When they do, they are abrupt and rude. They only give him appointments at the end of surgery as the GPs think 'he takes up too much time'. This means that Mr Bailey usually has to wait a long time before seeing a GP. He often gets quite agitated and angry when he is kept waiting and can be verbally aggressive.

At his next consultation with Dr Redman, Mr Bailey shows Dr Redman information he has found on the Internet about a new drug which he would like to be prescribed but Dr Redman tells him that it is not appropriate for his condition. Mr Bailey is feeling frustrated and upset. He swears at Dr Redman, and tells him that he is fed up with the way he is treated at the practice. He says that if Dr Redman and his colleagues were 'better doctors' they would be able to help him, and that he is going to make a formal complaint about Dr Redman and the practice staff.

The GPs meet to discuss removing Mr Bailey from the practice list.

**Question for audience vote (before and after debate):**

'Would Dr Redman be justified in requesting Mr Bailey's removal from his practice list?'

## Issue 2: Problem Patients or Problem Doctors?

This scenario centred on a patient with a chronic condition who was considered difficult and demanding by a GP practice and who was kept waiting and treated rudely by practice staff, which sometimes caused him to be verbally aggressive. The question posed to stimulate debate was whether the GPs would be justified in removing the patient from their list in these circumstances.

The scenario presented at the first meeting in Manchester had a different emphasis: in that case the patient suffered from a mental illness, which made him violent and threatening at times. There was less focus in this discussion on the behaviour of the practice staff towards him, which may have accounted in part for the greater focus at the Manchester meeting on issues relating to treating violent patients compared with the other meetings.

However, despite these differences, the audiences at the various meetings all felt that the patient should be entitled to care, but there was disagreement as to whether the GP in the scenario necessarily had to provide it.

A number of overarching themes which emerged during the five discussions. The main themes were:

- a. Thresholds for ending relationships.
- b. Doctors' obligations and.
- c. The doctor-patient relationship.

### *Thresholds*

The discussions all started with a consideration of whether, in the scenario presented, the patient's behaviour was sufficiently 'bad' to warrant him being removed from the list or referred elsewhere for care. There was an overwhelming view at the last four seminars that the GP would not have been justified in requesting the patient's removal from the list. Even at the first seminar in Manchester when the scenario focused more on the potentially violent behaviour of the patient, a large number of respondents were still unsure if removal from the list was warranted.

It was felt by most participants that there was a necessarily high threshold for removing patients from a doctors' list. For many, this amounted to situations where the patient was physically violent or threatening; although for others, verbal aggression was sufficient for a doctor to remove a patient from their list.

*'The only reason I think the practice has an absolute right to remove a patient is when that patient has demonstrated violence towards staff, particularly physical violence but also verbal violence.'* (Panellist, Cardiff)

Risk to doctors caused by factors outside the patient's control were considered differently, for example, violence caused by mental illness seemed to require a greater level of understanding or tolerance from doctors. Similarly, infectious diseases were considered to impose a higher duty on the doctor to continue to treat the patient:

*'Most doctors will make exceptions for a patient who is aggressive because they have a mental illness, or an addiction problem, or a complicated illness and they will accept that as opposed to somebody who, by dint of their personality, is always aggressive and abusive.'* (Panellist, Manchester)

*'Obviously if a patient has an infectious disease, I just have to be very careful in how I behave and I have to behave appropriately, sensibly, efficiently and effectively. I think violence is completely different. It is a different order of magnitude.'* (Audience member, Cardiff)

It emerged that many doctors felt that they had to accept some level of aggression or anger from patients who were ill and often, understandably frustrated but what made the difference was when this impacted on their staff or other patients, it was unacceptable. This seemed to be related to the need to balance doctors' obligations to all of their patients and the duty to safeguard the health and safety of their staff, which is discussed further below in relation to the theme of doctors' obligations:

*'Patients curse at me and act aggressive towards me very often, sometimes because of their conditions, sometimes because that is their nature. I am threatened all the time. That is okay. I keep these patients on my list, that is not a problem. When they start affecting (a) my staff and (b) my patients and impede my ability to look after the other patients, that is a problem.'* (Audience member, Belfast)

Many felt that a violence threshold alone was not particularly helpful and that the issue was more the therapeutic nature of the doctor-patient relationship. Using this broader threshold of 'irretrievable breakdown' of the relationship, which is the term currently used in our guidance, the focus shifted from the right of the doctor and his staff to be protected from harm, to ensuring that the patient received the care that they needed. Many who felt that the GP was not justified in removing the patient from his list in the scenario still felt that it may be in the patient's best interests to be treated elsewhere as this exchange in Edinburgh highlights:

*'THE CHAIRMAN: Well, that was the other point I was going to make because they are going to have a honeymoon of a relationship after this, aren't they?*

*PANELLIST: That is the thing. This is why it is a difficult question; it is not so much in what circumstances you can remove someone, but how do you deal with that breakdown in relationship? Can you save it? Will both parties be willing to put that past behind them and be able to work together in the future? Would it be better for everyone if they mutually – but I think it needs to be mutual one in this particular case and not one party removing the other, but a mutual agreement to part ways.'*

This was also directly raised at the other meetings

*'This man does sound like he has maybe not had as good a deal as he should have but it also sounds as if the therapeutic relationship has broken down. He does not seem to trust the practice any more as well as them having difficulties with him. It is two-sided. If he cannot trust them and they are having difficulty dealing with him then perhaps it may be the best for both if he is passed on to another practice, because if he is continuing to feel short changed it will take a lot to build back that trust.'* (Audience member, Belfast)

At the Manchester meeting, some people did think he should be removed because of his racist abuse of the receptionists (this did not emerge at the other meetings due to the different scenario) but the focus was still on the care that the patient was entitled to receive:

*'Me, as a doctor – I would take him off the list just because knowing this element of ignorance, I could not guarantee that I would do my best for this patient and he should be referred to the appropriate place.'*  
(Audience member, Manchester)

#### *Doctors' obligations to their patients*

Doctors' obligations to patients were seen to include a range of things, including communicating properly and, to some extent, being responsible for the relationship with patients working, to ensure continuity of care.

There was a strong sense that the GPs and the practice staff in this scenario had handled this situation badly and that communication with the patient at a much earlier stage may have prevented the deterioration of the relationship and ensured that the patient received the holistic care that many felt the patient needed:

*'I think Mr Bailey has a problem practice and not the practice having a problem patient...Unfortunately it appears that he does have perhaps an unfortunate manner but really the practice should understand what is driving his unfortunate manner and there are ways of explaining to patients that if they are not rude to the receptionist staff then they will get a better deal.'*  
(Panellist, Cardiff)

*'I think there are too many instances where doctors are striking off patients without enough explanation and understanding...I think the doctors want to look at themselves and their communication levels with the patient if they are going to the ultimate sanction of striking this patient off their list.'*  
(Audience member, Cardiff)

However, some of the meetings also discussed the difficulties that the system created for doctors in meeting their obligations to their patients. This often included reference to the pressures of modern general practice which limited doctors' time with each patient and which may have exacerbated the frustration many patients feel:

*'...if we removed everyone from our list who were rude to our receptionists of shouted at the doctors we would have no patients left. Pressures in modern general practice are such that people do get short-tempered and frustrated a lot of the time.'* (Panellist, London)

During the discussions a tension arose between the right of the doctor to refuse to treat a patient or remove him from his or her GP list and their obligation to ensure continuity of care for the patient. While it was agreed that a patient should not be left without care, there was disagreement, even among doctors, about how to achieve this and who should be responsible for ensuring the patient got the care they needed:

*'Does this practice necessarily have to deal with this patient with this history and I think the answer to that is probably no, but it is only on condition that someone deals with this patient... You can play pass the parcel with the patient up to the point that you are the last person who could actually deal with this patient and then it seems to me that your obligations are different.'* (Panellist, Manchester)

*'...if he is removed from our list and he does not have an underlying problem, he is just abusive, he will just be going to somebody else's list next door who does not know him very well and we are just transferring the problem, so this is an issue that I think we should address in the practice.'* (Panellist, London)

The point at which a doctor's obligation towards a patient ceased and it effectively become someone else's responsibility was also tested in many of the discussions. Many referred to systems that were, or should be, in place to ensure violent patients were treated in a safe environment or mentally ill patients were referred to services which met their needs. One participant suggested that this clearly was not the doctor's responsibility:

*'Their (the doctor's) responsibility is to be clinically competent and provide good services. They should not have to deal with violent aggression, racial abuse. That is their management organisation's responsibility.'* (Audience member, Manchester)

But this argument was countered by one audience member who clearly felt that this was part of the job:

*'...I have been in NHS admin – hospital admin – for about 20 years. I do think that all disciplines of staff in hospitals (which is my experience) need to remember why we are all employed and that is to deliver good and safe care to patients. I know how hard pressed GP receptionists are but why did they not give this chap a nine o'clock appointment in the morning? He would not have needed to wait and he may have been a nicer patient to deal with. I think we do need to remember the needs of the patient, whoever we are...'* (Audience member, Cardiff)

## *Doctors' obligations as an employer/leader*

Others noted that doctors might have greater obligations towards patients and others because of their position:

*'I would hold the GPs accountable for the receptionist's behaviour – I would go that far – because I think as a doctor we have a duty of leadership which I think extends to the other staff as well.'* (Audience member, Cardiff)

However, this raised another, often difficult issue. It was recognised that, as an employer, doctors had a duty of care towards their staff which may sometimes conflict with their obligations to individual patients. It was felt that whatever the doctors' obligations to their patients, this had to be balanced against the other competing obligations:

*'I think the doctor should be prepared to be sworn at every now and again. People do get frustrated and they do swear at their professional advisers. That is normal behaviour in a way...I think one might be justified in removing him from the practice list if he went around upsetting other members of staff in the practice, particularly the receptionists, practice managers etc, and the other patients waiting in the waiting room because that is impacting upon their care.'* (Panellist, London)

*'...it reminded me that GPs are also employers...If the reception staff are being continually insulted then you have a duty as an employer to actually do something to rectify the situation...So although I think removing him (Mr Bailey) from the list is quite an extreme thing I think it is important that we do take steps to protect people who work for us.'* (Audience member, Cardiff)

These discussions highlighted the tension between doctors' obligations to patients, to staff and to his or her contracting body and how to balance these while ensuring patients received appropriate care and treatment. For many, it was about finding an appropriate way to prevent this affecting the doctor/patient relationship.

This also highlighted an interesting tension between the perceptions of the public and the profession about what happens in practice. Many doctors made the point that it was a very rare occurrence and not something that was undertaken lightly, whereas a number of personal experiences recounted by audience members suggested that it may be a real problem. The following quotes highlight this tension:

*'We actually did some research in this area some years ago and basically patients removed from a doctor's list accounted to one removal per practice of five thousand patients per year. When you consider the number of GP patient consultations, that is a relatively small number. Now for those people that were removed, that is a very significant event to happen to them. But the other thing I would say is that actually for GPs who have to remove a patient from the list this is not a thing that anybody gets any pleasure from.'*  
(Audience member, Belfast)

*'As a patient with a long-term condition and also representing a patient-run charity, in an ideal world it would nice if the practices would give a person another chance, but they can actually remove a patient just because they say that the relationship has broken down. I do not think, as far as we know, they have to actually justify it much more than that, so patients definitely have it weighted against them. There is still quite a paternalistic attitude from a lot of GPs unfortunately.'* (Audience member, Edinburgh)

Flowing from this discussion was the fundamental issue underpinning this scenario; the nature of the doctor/patient relationship and the idea of the relationship as a partnership.

### *Doctor-Patient Partnership*

There were a number of different ways in which the nature of the doctor/patient relationship was discussed. In essence though, the two main issues which emerged were trust and the doctor/patient relationship as a partnership.

The nature of the doctor-patient relationship underpinned a lot of the discussion around when patients could be removed from the list and in particular, the idea that, if it was not a case of actual physical or threatened physical violence, it should be a decision taken through discussion and, where possible, mutual agreement between the patient and the doctor. This was discussed earlier in relation to thresholds for ending a professional relationship with patients and the nature of the therapeutic relationship between doctors and patients. At the heart of this discussion was the importance which is placed on trust in the doctor-patient relationship. Many participants expressed the view that if patients have lost trust in their doctors, for whatever reason, it may undermine their care and they might be better served by being transferred to another doctor.

A lot of the disagreement at the various meetings centred on deeply held beliefs about the nature of the relationship; what partnership meant and whether there was any place in the modern doctor-patient relationship for paternalism:

*'I do take the point that Claire makes also that this very, very ticklish business about the degree to which medical practitioners should be paternalistic, should direct the patient's treatment in a way that they really do believe is in the patient's best interests... We live in an age now where we value autonomy and want the patient to participate as much as possible, but it is also precisely the same age in which medical technology has advanced so far and so fast that it is very difficult for patients to understand what the best treatment options are, so it is a ticklish one.'* (Panellist, London)

The discussion about the 'expert patient' brought this tension between autonomy and paternalism into starkest relief. This centred on the scenario where the patient was bringing information he had found on the Internet to the consultation and explored the impact this might have on changing the nature of the doctor-patient relationship or contribute to the forging of partnerships between doctors and their patients.

*'I think the patient clearly feels he is not included in making these decisions and I think what is important here is that although the doctor may not understand or believe that the information is right that the patient has got from the Internet, that they discuss with the patient the pros and cons of that information and why they believe it is not the appropriate course of action...[comment from Chair]... Yes, I can perfectly understand that continually having the same patients getting the information from the Internet can get frustrating, but I still think it is important to cooperate with the patient and to reach a decision together about the treatment whether you think the information is good or not.'* (Audience member, Cardiff)

*'In the broader context, I do want to pick up this question about patient/doctor partnership because it is inevitable that patients, whatever their condition, I think particularly true of people with longer term conditions, will pick up an awful lot of information.'* (Audience member, London)

Others however, disagreed quite strongly with the notion of partnership in these terms:

*'...I know quite a lot of people whose views on their own health are very elaborate and wrong/irrational...I am not suggesting that if you are not a long-term sufferer that you do not know something of the illness that you have but we have to be very careful of endorsing intuition as opposed to rational science.'* (Panellist, London)

Some saw both the difficulties and the potential benefits which this changing relationship could bring:

*'I do not have a problem with patients being informed. I have a problem with them being misinformed by the Internet...I do not think it necessarily means more difficult patients. I would hope it means that patients are more likely to be partners in their own care, which is useful for us.'* (Panellist, London)

Some participants felt that the term partnership implied an equal relationship which also imposed obligations on patients whereas others thought it was simply discussing issues with patients and involving them in decisions about their care:

*'I think they have obligations to be honest in what they tell the doctor, I think they have a duty to be courteous; I think they have a duty to be reliable in attending appointments and all the rest of it and the whole issue of aggression.'* (Panellist, Belfast)

*'There is an improvement...about not having the secret "we've struck you off for no reason anyone can understand" but there is a bit more than that and a duty to discuss with patients to treat them as a partner, even if they are really difficult people...It is simple to talk to someone.'*  
(Audience member, Manchester)

There was also a feeling among some participants, both doctors and patients, that it was when doctors were not open to the information that patients brought with them

from the Internet or who disregarded patients views or knowledge about their own chronic or long term conditions that problems could arise.

*‘The condition changes constantly, and they think, “Oh yes, we will use this” and it is like, “No, that particular treatment is not appropriate at that time”, and when you say this to the doctor in a nice way, you are not being nasty, it is like, “Wait a minute, I don’t think that is going to work”, you are accused of being a difficult patient.’ (Audience member, Edinburgh)*

It was also noted by one participant that the nature of partnership and patients’ obligations also reflected on the role and remit of the GMC:

*‘They certainly have obligations. They are much more difficult to control because they do not have professional bodies like the GMC to police patients which perhaps they should do – have a GMC for patients.’ (Panellist, Manchester)*

### Summary

In summary, there seems to be general agreement that the threshold for doctors being able to remove patients from their lists must be very high. However, aside from violence, the critical issue seemed to be where the trust had been lost between a doctor and a patient. In these circumstances, it was generally agreed that it is often better for patients to be treated elsewhere to ensure they got the best possible care.

It was generally felt that trust was central to the doctor-patient relationship and that involving patients in decisions about their care was central to good doctor-patient relationships. Whether this should be defined as a partnership and what partnership meant in this context was less clear and a wide range of views were expressed at the different meetings.

## Voting Results for Scenario 2 (Problem Patients or Problem Doctors?)

Question 1: 'Would Doctor Redman be justified in requesting Mr Bailey's removal from his practice list?'

<b>Manchester</b>			
<i>Audience Size:</i>	85		
<i>Audience make up:</i>	70% Public (incl. school children) 25% Organisational representatives 5% Doctors		
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	31%	31%	38%
End	47%	22%	31%
<b>London</b>			
<i>Audience Size:</i>	80		
<i>Audience make up:</i>	24% Public 14% Medical Body Representatives 14% Patient Body Representatives 20% Other Body Representatives 28% Doctors		
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	17%	77%	6%
End	9%	88%	3%
<b>Cardiff</b>			
<i>Audience Size:</i>	81		
<i>Audience make up:</i>	49% Health professionals 28% Public 18% Medical Students 5% Politicians		
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	25%	70%	5%
End	17%	80%	3%
<b>Edinburgh</b>			
<i>Audience Size:</i>	75		
<i>Audience make up:</i>	35% Doctors 35% Stakeholders 30% Public/Patient		
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	17%	66%	17%
End	8%	88%	3%

<b>Belfast</b>			
<i>Audience Size:</i>	91		
<i>Audience make up:</i>	60% doctors 20% public/patient 20% stakeholders		
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	9%	80%	11%
End	6%	81%	14%

### Issue 3: Patient Choice Versus Clinical Judgement

#### *Scenario for discussion at London meeting*

Sarah is 18 and lives in a small, rural community. Until recently she lived with her boyfriend, having moved out from home when she left school at 16. She has been unemployed since then, struggling to find work due to a lack of confidence caused by her dyslexia and bouts of depression.

Following the break up with her boyfriend, which led to an episode of depression, Sarah has recently gained a place on a training course for which she will receive some financial support, provided she attends all lessons and completes the course. She not only needs the course for the income, but to start afresh and regain her confidence.

Sarah (who has always had irregular periods) has been feeling a little unwell for the past few months, and has put on some weight, but assumed this was due to the stress of breaking up with her boyfriend. However, she finally visits her GP and is horrified to discover that she is 20 weeks pregnant. Going through with the pregnancy would inevitably mean losing this opportunity to train and make a new life for herself, and the thought of going through it alone terrifies her.

Dr Smith believes that abortion is wrong and refers Sarah to the local pregnancy advisory organisation for counselling; the organisation does not provide referrals for terminations. But Sarah remains distraught following the advice and decides that an abortion is the right decision. With no one else to turn to for help or support, she asks Dr Smith for a referral. Dr Smith is not prepared to make a referral herself as she feels this would make her complicit in the abortion, and she feels that asking her colleagues to do so would amount to the same thing.

#### **Question for audience vote (before and after debate):**

‘Should Dr Smith have the right to act on her conscience and refuse to make the referral?’

*Scenario for discussion at Manchester, Cardiff, Belfast and Edinburgh meetings*

Mark has been referred privately to cosmetic surgeon Miss Lateef by his GP. Mark, 33, has always been rather shy and skinny; working out at the gym has built muscle on much of his body, but he remains particularly unhappy with his legs and has decided to have implants in his calves and thighs.

There's a high risk of a complication from the surgery because of Mark's medical history. Miss Lateef has expressed unwillingness to undertake the surgery because of the nature of the risks to Mark which she feels are not outweighed by the benefits of the operation.

But Mark is insistent and genuinely believes his life will be improved by having the surgery. He was outraged that Miss Lateef would consider turning him down for treatment that he is requesting and paying for, with full awareness of the risks involved. He feels the decision is entirely his to make – he is fully informed about the risks and fully competent to make the decision about the operation. Mark has approached Miss Lateef because she is renowned for success with this particular operation, but he has made it clear that if Miss Lateef turns him away he will ask less experienced surgeons (with whom the risk of complications would increase) until somebody agrees to carry out the operation.

**Question for audience vote (before and after debate):**

'Should Miss Lateef perform this operation?'

### Issue 3: Patient Choice Versus Clinical Judgement

At the Manchester, Cardiff, Edinburgh and Belfast meetings, the audience and panellists discussed a scenario and voted on the question, 'Should a surgeon perform a cosmetic procedure because the patient requests it and can pay, even though the surgeon thinks the risks are too high?'

At the second meeting in London, this scenario was replaced with a scenario about a doctor's right to refuse to provide a treatment, or refer a patient to another doctor to provide a treatment, to which they have a conscientious objection.

While these scenarios were quite different, the themes that arose were similar as both discussions brought out the tension in the doctor-patient relationship when patient and doctors' views were different. The main themes which emerged were:

- a. Autonomy and accountability.
- b. Patients as customers or consumers.
- c. The patient as a whole person.

Underpinning all of these themes is the nature of the doctor-patient relationship as a partnership.

#### *Autonomy and accountability*

There was a clearly prevailing view that irrespective of patients' rights, doctors should not be compelled to provide treatment which they believed was not clinically appropriate for patients.

There were a number of reasons for this; primarily the importance of the doctor's personal autonomy in being able to hold his or her own beliefs. As one doctor speaking from the floor said.

*'You have the right not to indulge in what you believe to be wrong, but you neither have the right to force somebody against their beliefs up a certain road.'* (Audience member, Belfast)

Other reasons included the view that due to their medical knowledge and expertise, patients should be slow to abrogate doctors' clinical authority. Doctors also operated within an ethical framework and were therefore expected to 'first do no harm'.

*'...on an ethical level [providing the treatment] would be simply impermissible where it seems to me the health care profession comes to the view that it is not in the clinical best interests of the patient to receive that. That would be contrary to the first principle of medicine which is First Do No Harm.'* (Panellist, Belfast)

Working within an ethical framework also meant that doctors could be held accountable for their actions, and as one participant stated, this had implications for the doctors' ability to exercise his or her autonomy.

*'[Dr Lateef] is individually accountable. One of these things I hate about the 'no blame' culture is that you suggest that if something goes wrong we can blame the system or blame someone else. You are individually accountable for things that go wrong so therefore you have the right to decide what you are prepared to accept to do as an individual practitioner.'*  
(Panellist, Manchester)

The question of how patients make decisions, and whether they are in a position to be 'autonomous' was also raised. The difficulties of understanding both risk and the complexities of medical treatment were identified. However, a consensus emerged that patients should be allowed to choose between options which are clinically appropriate – they may wish to take more or less risk; this is something only they can decide (but they can't demand treatment which a doctor does not wish to provide).

*'In medicine and health care it is presented as a choice to the patient and I suppose it goes back to informed consent and does the patient ever have sufficient information to actually be a partner in that area of choice....'*  
(Panellist, Belfast)

With this, often came the proviso that it then becomes the patients' responsibility to bear the consequences, either in terms of clinical accountability or, where treatment was provided privately, the cost of providing treatment for complications etc.

*'He was not prepared to live with a tumour producing horrific symptoms and disability and causing a crippling death. He was not prepared to die of that. He was prepared to die of a heart attack during the anaesthetic. He said this to the hospital, to the surgeon and the anaesthetist, and he said I am prepared to give you this in writing. I will not hold you responsible if anything happens as a result of the surgery and anaesthetic. I want you to operate.'* (Audience member, Manchester)

The issues of cost, choice and responsibility were further discussed under the next theme.

#### *Patients as customers or consumers*

Generally, audiences rejected the idea of patient as customer. In some cases this idea was explicitly identified:

*'Patients are not customers and health is not a commodity.'* (Panellist, Belfast)

Although there was some dissent from this view in both Manchester and Edinburgh:

*'I think we have to accept that we live in a consumer world and that consumers get what they want, and if they do not get what they want from one*

*shop, they will go to the next shop.... I think that if doctors try and hold back that tide they are wasting their time, because ultimately the consumer will win, the consumer will find what they want.'* (Panellist, Edinburgh)

However, this was at odds with the view that doctors' autonomy was important. At the London meeting, it became clear that in that particular example although the doctor was entitled to autonomy (to hold their own beliefs and act, or not act upon them), it was argued that where the patient was vulnerable, and reliant on that doctor for help, there came a point where the patients' right to treatment would 'trump' the doctor's right to hold a conscientious objection.

*'The key thing in the relationship between the doctor and the patient, no matter what it is, is the duty of care owed by the doctor to the patient if there is a real need. There is no point in looking at the past and saying well you did something wrong, you made a wrong choice in the past that has got you here and you have got to live with it.'* (Panellist, London)

In the cosmetic surgery scenario, this issue was also raised as an argument against seeing patients as consumers. Participants thought that even in the case of cosmetic surgery where the patient was paying for services, the standards of care should be the same and that even where a doctor refuses to treat on the basis of clinical judgement there was still an ethical duty of care towards the patient.

*'Goodness knows what is going to happen to this young man and she does have a duty of care towards him even when she is not giving him the specific thing he is asking for. That does not stop a doctor's duty of care.'* (Panellist, Cardiff)

*'I would have voted that she should have performed the operation provided she does not think it will harm him, but it is a difficult one. I think she should just sit him down, talk to him seriously and give him a list of other highly reputable cosmetic surgeons, to make sure he does not go to the cowboys.'* (Panellist, Edinburgh)

However, some participants felt that this would not prevent patients from seeking out doctors who would be willing to provide the treatment they wanted; generally speaking a doctor could be found, either in the UK or abroad, and it was up to patients to determine whether they wished to take the risk of accepting care from any individual doctor.

*'I come down always on the side of the citizen's choice. It is their assessment as to whether the risks are reasonable and it would not therefore be wrongful for these services to be provided. I do not think, as I said in the previous cases, that any particular doctor could have an absolute obligation to provide services that their conscience tells them not to deliver, but the problem is not that because there is usually somebody else willing to provide them.'* (Panellist, Manchester)

A distinction was drawn between providing treatment which did not (was not likely to) cause harm overall, and treatments which would meet a clinical need. No-one spoke

in support of requiring doctors to provide treatment which was likely to be harmful with only nugatory benefits (although some speakers' contributions implied this in the Manchester debate). There was more diversity of view on the degree to which patients should be able to choose between options (e.g., caesareans, or timing of inducing labour), and about patients taking risks against medical advice.

*'It is the difficulty of differentiating between clinical needs and wants, and sometimes not all wants can be safe or appropriate wants, so sometimes the good doctor has to say 'No', and has to have the right to be able to say 'No, I think this would be positively unsafe' and should not be constrained [into] doing something that they believe, after gauging the evidence and weighing the facts, they think is positively harmful.'* (Audience member, Edinburgh)

Again, underlying this issue was how to define the doctor/patient relationship. One panellist expressed the following view.

*'As a GP, at the end of next year I have got to offer patients a choice of five hospitals for their routine surgery, including one in the independent sector whether they want to or not...Dr Foster are now producing...a real gamut of quite complex statistical information that probably is not accurate in the first place that we are now foisting on patients saying it is your choice and we are becoming a bit like financial advisers.'* (Panellist, Manchester)

#### *The patient as a whole person*

More generally, however, there was a view that doctors should treat patients as whole people, and not focus solely on the presenting complaint, which is arguably underpinned by the same view that medicine should not be provided on the same basis as many other consumer services.

*'I think it much more likely that this person needs a different and wider look at their problems, rather than referral to another surgeon.... It is terribly important that this person has another doctor to go back to – a general practitioner or someone in that position – who is in a position to look at their needs from a much broader standpoint.'* (Audience member, Cardiff)

*'I think the second thing this case proposes is my concern about super-specialisation and the ability in doctors to be able to see cases in the round. If people just looked at this simply as accepting or rejecting a request for surgery then I think they miss the point here.'* (Audience member, Cardiff)

*'The point I am making is that you need to deal with the human being. The human being says, "My thighs aren't right, they don't look right then therefore I need surgery." No, you need help.'* (Panellist, Manchester)

In the context of cosmetic surgery, several audience members suggested there was a need to consider counselling or psychiatric help for the patient, although one audience member did comment that providing the surgery would resolve the 'psychological' need of the patient.

*'...if the operation is a success and it could be like in my father's case it will cure his psychological problem. ' (Audience member, Manchester)*

### *Summary*

The scenario illustrated overwhelmingly that both patients and doctors wanted partnership in decision-making, with both sides having rights and freedoms. Where a line was to be drawn between the right to choose treatment, and the right to refuse to provide it was more difficult. However, overall, patients did not want to force doctors by 'blackmail' or other means, to act against their clinical judgment or conscience. Equally, doctors did not want to force patients into particular treatments or unnecessarily restrict their freedom to choose.

## Voting Results – Scenario 3 (Patient’s Choice V Doctors’ Clinical Judgement)

Question 3: Should a surgeon perform a cosmetic procedure because the patient requests it and can pay, even though the surgeon thinks the risks are too high?

<b>Manchester</b>			
<i>Audience Size:</i>	85		
<i>Audience make up:</i>	70% Public (incl. school children)		
	25% Organisational representatives		
	5% Doctors		
	<b>Yes</b>	<b>No</b>	<b>Abstain</b>
Start	38%	26%	35%
End	36%	25%	38%
<b>Belfast</b>			
<i>Audience Size:</i>	91		
<i>Audience make up:</i>	60% doctors		
	20% public/patient		
	20% organisational representatives		
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	0	70%	6%
End	0	57%	5%
<b>Cardiff</b>			
<i>Audience Size:</i>	85		
<i>Audience make up:</i>	49% Health professionals		
	28% Public		
	18% Medical Students		
	5% Politicians		
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	12%	81%	5%
End	4%	92%	4%
<b>Edinburgh</b>			
<i>Audience Size:</i>	75		
<i>Audience make up:</i>	35% Doctors		
	35% Stakeholders		
	30% Public/Patient		
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	2%	83%	15%
End	3%	87%	10%

<b>London</b>			
<i>Audience Size:</i>	80		
<i>Audience make up:</i>	24% Public		
	28% Doctors		
	14% Medical Body Representatives		
	14% Patient Body Representatives		
	20% Other Body Representatives		
A different question was asked: Should Dr Smith have the right to act on her conscience and refuse to make the referral?			
	<b>Yes</b>	<b>No</b>	<b>Not sure/Abstain</b>
Start	14%	84%	2%
End	13%	84%	3%

## Conclusions and Reflections

In considering the first scenario, the number of votes against the GMC taking action against the doctor for action in his private life increased compared to votes before the discussion. In some cases however, the increase was very small (1% in Belfast) and the number abstaining or not sure remained high. There were also small increases in 'yes' votes from audiences in Cardiff and Belfast. Issues raised in the discussions included whether doctors were different from ordinary citizens given their position of power and access to patients and if action was needed, who should take it (GMC, employer, police?).

In the second scenario, fewer participants felt that Dr Redman was justified in requesting a patient's removal from his practice list after discussion, except in Manchester where 'yes' votes increased by 16%. During the discussion it became clear participants felt that the threshold for doctors to remove patients from their lists must be a high one. Violence and a loss of trust between doctor and patient were two examples where it might be justified to do so and in the latter this was mainly so that the patient could be treated elsewhere rather than continue with a relationship which was not working.

Finally, asked whether Miss Lateef should carry out an operation she did not feel was in the patient's best interests, on the whole, votes from participants at the Manchester and Edinburgh meetings changed very little following the discussion. At Belfast, none of the participants felt that the doctor should have to provide the treatment and in Cardiff there was a shift with voters moving from 'yes' to 'no' following the discussion. During the discussion, it was felt that shared decision-making was desirable, with both sides having rights and freedoms. Where a line was drawn between the right to choose treatment and the right to refuse to provide it, it was more difficult; although overall, patients did not want to force doctors by 'blackmail' or other means to act against their clinical judgement. Interestingly only in Manchester was the audience in favour of Mark getting treatment. The Manchester audience comprised a greater proportion of members of the public than other audiences.

Whilst the discussions did vary to some extent according to location, as can be seen from the voting results, overall this report has shown that common themes arose across all the meetings. Key issues included the trust that patients place in doctors and the extent to which doctors should be expected to justify it and the nature of the doctor-patient relationship.

We have learnt a lot about what works well and what could be improved in hosting these meetings. We were fortunate to have excellent facilitators for the events, all of whom in their own way teased out the contentious issues. We also had a good mix of panellists who were only too keen to offer an opinion on the issues. On the part of the audience, despite some dissatisfaction with having to come down one way or the other with the voting, which in some cases led to changes to the scenarios and questions, they were nevertheless happy to air their views and on the whole, accepted that there were no easy answers.

It was heartening for us to see that many of the same issues and conclusions were raised at these meetings as during the redrafting process. A large number of participants submitted completed feedback forms at the end of the events and we will of course take these comments into account if hosting such meetings in the future. We have found the meetings valuable for testing the redrafted guidance and underlying issues. Not only have they provided an opportunity to see what a wide variety of people expected of their doctors in these situations, but also provided an opportunity to explain the GMC's role in issuing ethical guidance and wider role more generally.

In addition to the findings of these meetings, the consultation has produced an array of information on how the redrafted guidance has been understood. Information on the post-consultation process including analysis, redrafting and development of supplementary guidance for the launch of revised GMP in November 2006 can be found on the GMC website.

## Feedback from Participants

*'I want to applaud the GMC for doing this because in preparation for tonight's panel presentation I came to realise that ethics does change and readdress situations, reflects social mores and I think it is a very valuable way of reflecting regularly, all of the ethics that doctors should be held to and I want to encourage the GMC to see this as part of an ongoing process.'*

*(Panellist, Belfast)*

*'I thought the problems were complicated and had many different aspects.'*

*(Audience member, Manchester)*

*'I have appreciated this opportunity to communicate between patient/public and GMC because you are so remote from us. Hopefully this is a start of discussing serious issues.'* (Audience member, London)

*'This has been a fascinating discussion. I would just like to congratulate the GMC. The number of times I have been at events where people are trying to find response to a fairly – it is not a densely written book, but actually any book that has that daunting air of being specific for a profession and not really accessible to anyone else, but the idea of trying to get a few scenarios and talk it through, I am staggered actually at the end of it how many issues we have pulled apart during the discussions tonight, and I did not think at the start there was nearly as much to say. So I think congratulations all round on that.'* (Chair, Edinburgh)

*'Very informative and interesting evening as a medical student it is a fascinating opportunity to be part of discussions as applicable to "real life" as many students would benefit professionally from seeing this.'*

*(Audience member, Cardiff)*

*'Much of interest to take back to local patients participation group.'*

*(Audience member, Belfast)*