

TRUST IS THE TEMPLE OF MEDICINE

Revised Governing Edition: Bodily Autonomy, Doctor-Guided Choice, Drug Quality and Law Reform

A legal classification is not clinical evidence. Law should protect the conditions of safe choice; it should not decide, merely by naming a substance, that a doctor and an informed patient may never consider it.

Purpose of this revision

This edition clarifies the intended argument of the original UK evidence-based submission. The central issue is law and practice: neither stigma nor a blanket legal category should automatically exclude a potentially helpful treatment from an individual, evidence-informed conversation between a patient and a competent doctor.

The definitions of help and care, the evidence on listening and diagnostic humility, and the call for proportionate, correctable medicine are preserved. Where wording in the retained 26 August 2026 evidence paper conflicts with this revised statement—particularly its treatment of medicines law—this governing revision takes priority.

Status and boundaries

This is a public-interest law-and-practice reform proposal, not a statement of current UK law, a personal prescription, or a claim that every substance is safe or useful. Current UK medicines and controlled-drug laws remain in force unless changed through lawful democratic processes.

Prepared by Alex Anderson · The Green Tank · 27 August 2026

Open for evidence, criticism, testing and correction.

Help and care keep their meaning

PROPOSED DEFINITION — HELP

Help is proportionate support that bridges a temporary gap between what a person can presently bear or accomplish and what the present situation requires.

PROPOSED DEFINITION — CARE

Care is attentive observation of condition and progress, combined with proportionate support that is repeatedly adjusted toward recovery, stability, reduced suffering or restored capacity.

Care is therefore a continuing feedback loop: observe → understand → support → receive feedback → reassess → adjust. A treatment is not made caring merely by good intention. Its effects must be heard, measured and allowed to change the plan.

REVISED BODILY AUTONOMY AND MEDICAL CHOICE PRINCIPLE

A competent adult's body belongs to that person. No relevant evidence or potentially beneficial treatment should be dismissed because of stigma, legal classification or non-clinical bias. A doctor should assess the evidence, the person, the product, the likely benefits and harms, uncertainty, interactions and monitoring. The patient should make the informed decision among medically supportable options.

The intended outcome is not conformity. It is helping a person function better—physically and/or mentally—according to goals they have freely identified, while respecting the equal rights and safety of other people. Function may include less pain or distress, greater stability or mobility, clearer thought, safer daily living, restored capacity, or participation in relationships and society.

A patient's wish is essential evidence about goals and acceptable trade-offs, but it is not proof of benefit. A doctor's expertise is essential to interpretation and safe use, but it is not ownership of the patient's body. Ethical practice requires both forms of knowledge to meet.

Law should govern quality and safe conditions—not prohibit clinical thought

In this proposal, quality is not a narrow purity test. It includes verified identity, composition, strength, dose accuracy, contamination control, manufacturing standards, truthful labelling, storage, traceability and supply-chain integrity. Law may also establish universal safeguards for valid consent, professional competence, record-keeping, monitoring, reporting and protection from harm to others.

What law should not do is turn the name or legal schedule of a substance into a conclusive clinical judgment. A doctor should not be prevented or criminalised merely for considering, trying or using a substance with a willing, informed patient when there is a clinically reasoned possibility of benefit and the safeguards below can be met.

Question	Current UK position	Reform proposed here
Who decides whether a controlled substance may be considered?	Statute and regulations restrict possession, supply and prescribing; some routes exist only for authorised products, clinicians or circumstances.	The law sets safe conditions. A competent doctor and informed patient decide whether an individual, monitored trial is medically supportable.
What does legal control prove clinically?	It creates legal duties and prohibitions; it does not by itself prove that every medical use is ineffective.	Classification must never substitute for current evidence, individual assessment or transparent reasoning.
What should regulation concentrate on?	Licensing, manufacture, supply, prescribing and controlled-drug safeguards.	Verified quality, truthful information, safe supply, consent, competence, monitoring, reporting and protection of others.
May a doctor decline?	Doctors remain responsible for lawful, safe, evidence-informed prescribing.	Yes—where outside competence or where expected harm cannot be justified. Reasons should be explained; a fair second opinion or referral should be available where appropriate.

This proposal concerns consensual clinical care. It does not remove laws against coercion, deception, adulteration, unsafe commercial supply, impaired driving, non-consensual dosing, diversion, or conduct that creates a concrete and serious risk to other people.

A fair pathway for considering any substance

No substance is automatically medicine merely because someone wants it. The question is whether a particular use can become a responsible medical option for a particular person. The following pathway keeps the door open without abandoning evidence or care.

1 • Hear the aim	Record the patient's own physical and/or mental difficulties, desired function, previous experiences, constraints and acceptable trade-offs. Do not translate the person's goal into compliance with social convenience.
2 • Examine all relevant evidence	Consider clinical studies, mechanistic evidence, case evidence, patient observations, prior response, uncertainty and credible alternatives. Do not ignore favourable or adverse evidence because it is inconvenient to either party.
3 • Verify the product	Establish identity, composition, purity, strength, dose accuracy, contaminants, storage and provenance. If quality cannot be adequately known, the uncertainty itself may make a trial unsafe.
4 • Assess the individual	Review diagnosis or working hypotheses, capacity, physical and mental health, pregnancy where relevant, interactions, dependency risk, contraindications, support needs and risks to others.
5 • Decide together	The doctor explains expected benefit, material risks, uncertainty, alternatives and the option of no treatment. The patient chooses freely among medically supportable routes. Consent may be withdrawn.
6 • Use the minimum sufficient trial	Agree dose, duration, measurable goals, review interval, responsibilities, safeguards and stopping rules. Start with the least burdensome arrangement reasonably capable of testing benefit.
7 • Learn and correct	Record function, symptoms, adverse effects and the patient's account. Continue, adjust or stop according to evidence. Publish de-identified outcomes where lawful and useful so collective knowledge improves.

The patient has authority over their body. The doctor has responsibility for competent, honest clinical practice. Neither should be replaced by a blanket legal assumption about the substance's name.

Safeguards that preserve choice rather than erase it

Quality control is necessary, but quality alone cannot establish that a use is safe. Dose, route, interactions, setting, vulnerability, dependency potential, uncertainty and monitoring all matter. These are reasons for careful clinical judgment—not reasons to exclude the question before it is asked.

A trial should normally require

- a competent adult with decision-making capacity, or a lawful best-interests process where capacity is absent;
- a medically coherent aim connected to physical and/or mental health, functioning, stability, recovery or relief of suffering;
- verified product identity, composition and dose, with contamination and supply risks controlled;
- a clinician acting within competence, or supported by an appropriately competent specialist;
- honest discussion of evidence quality, material risks, uncertainty, alternatives and the option to stop;
- interaction checks and a plan for dependency, withdrawal or deterioration where relevant;
- measurable aims, review dates, adverse-event reporting and predetermined stopping rules; and
- proportionate protection of children, people without capacity, and anyone exposed to non-consensual risk.

Fair disagreement

Patient autonomy does not mean that a person can compel a particular clinician to prescribe or administer something the clinician cannot responsibly support. Professional judgment does not mean that a clinician may end the conversation with stigma, status or ‘the rule says no.’ A refusal should identify the clinical or competence reason, distinguish it from the legal barrier, acknowledge uncertainty, and provide access to review, a second opinion or an appropriate specialist route where reasonably available.

If the expected harms cannot be brought within a medically defensible range, a doctor may recommend against or decline the trial. The patient remains entitled to clear reasons, respectful treatment and lawful alternatives. Emergency, safeguarding and public-safety duties remain proportionate exceptions, not a general claim of ownership over another person’s body.

Do not ignore evidence. Do not exclude a potential treatment through bias. Do not confuse legal prohibition with a clinical conclusion. Do not confuse openness with an absence of safeguards.

What this revised submission asks the United Kingdom to do

- Create a lawful clinical-access route through which any substance may be considered on its evidence and individual circumstances, rather than excluded solely by legal category.
- Refocus substance-specific controls on verified identity, composition, manufacture, dose, labelling, traceability and secure supply, together with universal consent and safety duties.
- Protect clinicians from criminal or professional sanction merely for a documented, competent, good-faith trial agreed with an informed patient under an authorised monitoring framework.
- Require refusals to separate clinical reasons, competence limits, resource limits and legal barriers, so patients can understand and challenge the real decision.
- Create rapid independent review and specialist-referral routes where a legal restriction blocks an otherwise medically supportable option.
- Collect benefits, harms, withdrawals and patient-reported function in a transparent evidence register, with privacy protection and scheduled public review.
- Use pilots, sunset clauses and stopping rules so reform can be corrected when evidence changes or harm exceeds agreed thresholds.
- Preserve offences and protective intervention for coercion, adulteration, deception, non-consensual dosing, dangerous diversion and concrete harm to others.

Evidence and current-law anchors

Existing UK professional guidance already supports shared decision-making, informed consent, adequate clinical assessment, safe prescribing, explanation of reasonable options and carefully justified use of some unlicensed medicines. Existing law also contains medicines and controlled-drug frameworks. The reform proposed here goes further: it asks Parliament and regulators to ensure that substance identity alone cannot permanently close a medically reasoned route.

- [GMC — Decision making and consent](#)
- [GMC — Deciding if it is safe to prescribe](#)
- [GMC — Prescribing unlicensed medicines](#)
- [MHRA — Supply of unlicensed medicinal products \('specials'\)](#)
- [MHRA — Early Access to Medicines Scheme](#)
- [Human Medicines Regulations 2012](#)
- [Misuse of Drugs Regulations 2001](#)

Interpretive correction

The retained evidence paper's statements that it 'does not recommend abolishing medicines law,' 'does not require unlawful prescribing,' and supports 'proportionate, evidence-based and reviewable regulation' should now be read through this revision. The proposal does not abandon law: it changes law's proper task. Law should secure quality and the general conditions of safe, consensual practice; it should not impose a blanket, substance-name veto on an individual doctor-patient decision.

The following sixteen pages are the retained 26 August 2026 evidence base. This six-page governing revision supersedes conflicting interpretations while preserving the paper's research, definitions and wider proposals.

TRUST IS THE TEMPLE OF MEDICINE

An Evidence-Based UK Submission on Help, Care, Listening,
Avoidable Harm, Equity and Open Medical Development

FORMAL REQUEST FOR UK-WIDE REASSESSMENT

CENTRAL PROPOSITION

Medicine does not need to be incapable of error. It must remain capable of hearing, seeing, learning and correcting before avoidable harm becomes irreversible.

Public-interest submission

Prepared for consideration by UK health departments, NHS bodies, regulators, professional institutions, researchers, clinicians, patients and the public.

26 August 2026

Author / submitting party: _____

Status and scope of this submission

This document is an evidence-based policy and ethics submission, not clinical guidance for individual treatment. It combines empirical research, existing UK professional and legal standards, and clearly labelled normative proposals. It does not argue that patients are always diagnostically correct, that clinicians should disregard evidence or law, or that every medicine should be freely supplied without safeguards.

Healthcare is devolved across the United Kingdom. The General Medical Council regulates doctors across the UK, while service frameworks differ in England, Scotland, Wales and Northern Ireland. England's NHS Constitution is therefore cited as an English constitutional source, alongside Scottish, Welsh and Northern Irish standards where relevant. UK-wide implementation would require jurisdiction-specific legal and policy work.

THE SUBMISSION ASKS FOR REVIEW, NOT BLIND ADOPTION

Every proposal in this document should itself be open to evidence, criticism, testing and revision. A paper asking medicine to remain correctable must remain correctable itself.

Executive summary

This submission asks the United Kingdom to conduct an open, evidence-led reassessment of what the words help, care, medical necessity, proportionality, trust and equitable access mean in modern healthcare. It argues that existing UK standards already contain much of the required foundation: clinical need, patient partnership, evidence-based practice, equity, reduction of avoidable harm, public accountability, research and innovation. The central problem is not absence of principles, but inconsistent operationalisation.

The proposed model defines help as proportionate support that bridges a gap between present demand and present capacity. Care is the continuing feedback process: observe, support, receive information, reassess and adjust. The frequency of that feedback must depend on the situation. Where serious deterioration can occur quickly, care that looks again too late is not adequate merely because a review was eventually scheduled.

The evidence base demonstrates that communication failures, history-taking failures, premature diagnostic closure, cognitive bias and overconfidence can contribute to diagnostic error. Modern professional standards therefore correctly require clinicians to listen to patients, acknowledge uncertainty, discuss reasonable alternatives and support informed decisions. Patient experience is evidence, although it is not automatically the correct explanation of that evidence.

The submission also proposes a minimum-sufficient-intervention principle: where more than one clinically reasonable route exists, avoidable additional harm requires justification. This does not mean delaying lifesaving invasive treatment. It means asking whether the same necessary benefit can reasonably be obtained with less injury, burden, restriction or loss of agency.

Access to medicines and technology should likewise be assessed by clinical need, evidence, expected benefit and harm, safe-use requirements and fair resource allocation. Regulation has legitimate protective purposes, but restrictions should remain evidence-based, proportionate, reviewable and capable of exceptions or reform when individual clinical need and evidence justify reconsideration.

Finally, this submission asks that publicly constrained healthcare capacity place medicine before vanity: urgent and clinically indicated treatment should take priority over purely elective aesthetic enhancement when the two compete for scarce clinical resources. This principle must not be used to dismiss reconstructive treatment, treatment of disfigurement, functional restoration, or aesthetic procedures that have genuine clinical or psychological indications.

No person should receive greater clinical worth because of wealth, fame, title, office, social status, influence or self-perceived importance. Legitimate priority should arise from transparent clinical and public-health reasons - not privilege.

Ten requests for action

No.	Request	Purpose
1	Create a UK Open Review of Help and Care	Develop operational definitions and measurable standards with patients, clinicians, carers, ethicists, scientists and the public.
2	Treat patient feedback as clinical data	Require systems to receive, document and appropriately weight patient observations, especially when they contradict an existing assumption.
3	Make feedback frequency risk-responsive	Set reassessment intervals according to urgency, rate of change, uncertainty and consequence of missed deterioration.
4	Adopt minimum sufficient intervention	Prefer sufficiently effective lower-harm options where clinically reasonable; document why a more harmful route is required.
5	Audit treatment-access barriers	Review legal, financial, geographic, administrative and institutional barriers for necessity, proportionality, evidence and equality impact.

No.	Request	Purpose
6	Protect clinically justified medicine access	Maintain safety regulation while creating transparent, reviewable routes for exceptional or non-standard access when evidence and individual need justify it.
7	Put clinical need before status or vanity	When scarce public clinical capacity is contested, prioritise health need and meaningful benefit over purely elective aesthetic enhancement or social importance.
8	Use appropriate technology openly	Assess and deploy validated digital, diagnostic, monitoring, minimally invasive, assistive and AI-supported technologies transparently and equitably.
9	Publish reasons and outcomes	Create auditable public reporting on access, reassessment, avoidable harm, technology adoption, inequalities and patient-feedback closure.
10	Build correction into the system	Ensure second opinions, escalation, incident learning, record correction, review and policy challenge remain practically accessible.

1. The semantic problem: intent is not enough

Healthcare language can hide important distinctions. An intervention may be labelled help because the person providing it intends benefit. But intention alone cannot establish whether the action actually helped. A clinically useful definition must include need, proportionality, outcome, feedback and capacity to correct.

PROPOSED DEFINITION - HELP

Help is proportionate support that bridges a temporary gap between what a person can presently bear or accomplish and what the present situation requires.

Conceptually, if D represents present demand and C represents present capacity, the support gap can be illustrated as $G = \max(0, D - C)$. This is not a validated clinical equation. It is a relational model: the amount and form of help depend on the gap that actually exists, not on an abstract assumption about what a person should be able to tolerate.

PROPOSED DEFINITION - CARE

Care is attentive observation of condition and progress, combined with proportionate support that is repeatedly adjusted toward recovery, stability, reduced suffering or restored capacity.

Care is therefore not a single act. It is a feedback loop: observe -> understand -> support -> receive feedback -> reassess -> adjust. A system that acts but cannot adequately receive information from the person affected becomes progressively less able to distinguish help from interference.

2. Frequency and urgency are part of care

The existence of a follow-up appointment does not establish that follow-up is adequate. A meaningful care standard must ask whether important deterioration could occur before the next observation. The faster and more consequential the possible change, the shorter the safe feedback interval may need to be.

This submission proposes that feedback frequency be explicitly determined by four variables: urgency, rate of change, uncertainty, and consequence of missed deterioration. This is a systems principle, not a replacement for condition-specific clinical monitoring protocols.

- Stable, low-risk conditions may appropriately require infrequent review.
- Changing or uncertain conditions justify more frequent reassessment.
- High-consequence deterioration may require rapid or continuous monitoring.
- A patient reporting a material change is itself new information that may justify bringing reassessment forward.

3. Listening is an evidence-acquisition function

Patients possess continuous experiential information about their own bodies. Clinicians possess specialist knowledge of disease, diagnostics and treatment. Neither information source makes the other redundant. A patient may accurately report an observation while being wrong about its mechanism; a clinician may possess the better mechanistic model while missing a crucial change reported by the patient.

Research supports the clinical importance of information exchange. In the 1999 JAMA study by Marvel and colleagues, physicians redirected patients after a mean of 23.1 seconds; only 28% completed their opening statement. Patients who completed it required only around six additional seconds on average. [4]

Singh and colleagues examined 190 primary-care diagnostic errors and found breakdowns involving the patient-practitioner clinical encounter in 78.9% of cases; history-taking problems were among the identified process failures. [5] This does not prove that listening alone would prevent every error. It demonstrates that data acquisition and synthesis during the encounter are patient-safety issues.

4. Expertise must remain correctable

Training and experience are essential to medicine, but expertise does not remove human cognitive limitations. Graber and colleagues found cognitive factors contributing to 74% of 100 diagnostic-error cases they examined; premature closure was a prominent mechanism. [6] Berner and Graber subsequently reviewed overconfidence as a contributor to diagnostic error. [7]

A scientifically defensible formulation of the problem is therefore not that doctors are uniquely governed by ego. It is that authority, overconfidence, anchoring, premature closure, professional hierarchy and difficulty tolerating uncertainty can reduce the willingness to search for disconfirming evidence.

The ethical requirement is not: never be wrong. It is: never build or defend a system that prevents you from finding out that you may be wrong.

5. Epistemic injustice and patient credibility

A growing literature uses the term epistemic injustice for situations in which a person is unfairly disadvantaged as a knower. A 2024 systematic review by Cote identified recurring healthcare concerns including invalidation, failure to take testimony seriously, and insufficient recognition of patients as legitimate sources of knowledge. [8]

This submission does not propose replacing professional judgement with patient assertion. It proposes a narrower rule: relevant observations should not be discarded merely because they originate with the patient, and clinicians should distinguish disagreement with the patient's explanation from rejection of the patient's underlying observation.

6. Trust as a reciprocal medical obligation

The GMC states that patients must be able to trust medical professionals with their lives and health, and connects that trust with making patient care the first concern, listening to patients and working in partnership with them. [1] GMC Domain 2 requires clinicians to recognise patients' knowledge and experience of their health, acknowledge concerns, explain reasons for offered and non-offered options, discuss uncertainty, and provide information based on the best available evidence. [2]

Trust should therefore not be treated as obedience to medical authority. It is more defensibly understood as confidence that the system remains responsive: the patient can speak; the professional will listen; the professional can explain; new evidence can change the plan; deterioration can trigger reassessment; errors can be acknowledged and corrected.

7. Consent, reasonable alternatives and UK law

The Supreme Court decision in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 established that a doctor must take reasonable care to ensure that a patient is aware of material risks of recommended treatment and of reasonable alternative or variant treatments. [19] The later

McCulloch judgment clarified the role of professional judgement in deciding whether an alternative treatment is reasonable, while retaining the Montgomery duty regarding material risks and reasonable alternatives. [20]

This legal framework reinforces a central proposition of this submission: meaningful medical decision-making is not simply the transmission of an expert command. It requires dialogue about evidence, material risks, reasonable alternatives and what matters to the individual.

8. The minimum sufficient intervention principle

POLICY PROPOSAL

Where several clinically reasonable approaches could achieve the necessary outcome, prefer the route that achieves sufficient benefit with the least unnecessary harm, burden, restriction or irreversible loss - unless delay or lower intensity would itself create greater risk.

This is not an instruction to exhaust every conservative option before urgent or invasive treatment. Emergency surgery may itself be the least harmful available course. The principle is comparative: if a sufficiently effective lower-harm alternative is reasonably available for the individual, its existence is clinically and ethically relevant.

NHS England's Evidence-Based Interventions programme similarly aims to reduce unnecessary interventions and prevent avoidable harm, including where medical science has superseded older interventions with options that are less invasive or more effective. [17]

9. Medicine before vanity - carefully defined

When publicly funded clinical resources are scarce, priority should be based on transparent clinical need and expected health benefit rather than wealth, fame, title, political office, influence, social status or purely elective aesthetic preference. England's NHS Constitution already states that access to NHS services is based on clinical need, not ability to pay. [10] Wales states that people with the greatest health need should be cared for first and treatment should follow identified clinical priority. [12]

IMPORTANT SAFEGUARD

Aesthetic appearance can itself be clinically relevant. Reconstructive surgery, restoration after injury or disease, treatment of functional impairment, disfigurement-related distress, congenital conditions and appropriately assessed psychological harm must not be dismissed as vanity.

The NHS already distinguishes purely cosmetic surgery from reconstructive and clinically indicated procedures. Cosmetic surgery is not routinely provided by the NHS, while exceptions exist for health or substantial psychological reasons and reconstructive surgery is treated differently. [18] The

policy proposed here is therefore not hostility to appearance-related medicine. It is a priority rule when scarce healthcare capacity must be allocated.

Medicine before vanity means clinical need before purely elective aesthetic enhancement when the same scarce clinical resources are required for preventing suffering, disability, deterioration or death.

10. No clinical privilege by social importance

A person may be socially powerful, publicly important, wealthy, famous or institutionally influential. Those facts can create legitimate logistical considerations, such as security or continuity of public functions. They should not silently become measures of biological worth.

Clinical priority should arise from defensible criteria such as urgency, severity, likelihood of benefit, prognosis, safeguarding, infection control, public-health necessity and transparent resource-allocation rules. Status should not create a hidden clinical multiplier.

This is a direct application of the wider principle that society consists of the whole population. A health system serving only the most powerful particularly well while leaving avoidable suffering concentrated elsewhere demonstrates technical capability, but not equitable care.

11. Medicine access: regulation as protection, not an unexamined wall

This submission does not recommend abolishing medicines law. Regulation protects patients from contamination, counterfeiting, inappropriate dosing, interactions, toxicity, unsafe supply, ineffective products and other harms. The relevant policy question is whether each restriction has a clear protective purpose, remains proportionate to current evidence, and can be reviewed when circumstances change.

NICE medicines-optimisation guidance requires use of best available evidence together with clinical expertise and the person's values and preferences. [22] GMC guidance also recognises that unlicensed medicines may sometimes be necessary to meet an individual patient's particular clinical need, while placing responsibility on the prescriber for evidence, explanation, monitoring and follow-up. [21]

Because the rule says no is an administrative answer. Ethical medicine must also be able to explain what harm the rule prevents, whether that reason applies here, and what lawful route exists when the rule itself produces avoidable harm.

Where a clinician believes a treatment is clinically justified but an external barrier prevents access, professional responsibility may include explaining the barrier honestly, obtaining specialist advice, considering licensed and lawful alternatives, seeking exceptional access where available, supporting second opinion, documenting the problem and contributing evidence to policy reform. It does not require unlawful or unsafe prescribing.

12. Equity: capability must be shared

The proposition that medicine should be available to everyone rather than only to people born into advantage is already aligned with major UK policy commitments. England's NHS Constitution provides for a comprehensive service available to all and access based on clinical need rather than ability to pay. [10] Scotland's Patient Rights Charter requires safe, effective, person-centred care and non-discriminatory access while taking account of clinical judgement and fair resource use. [11] Wales' Health and Care Quality Standards explicitly require equitable care and state that quality should not vary because of location, personal characteristics or socioeconomic status. [12] Northern Ireland's current medicines strategy calls for equitable access to appropriate, safe and cost-effective medicines. [13]

NHS England's Core20PLUS5 programme specifically targets healthcare inequalities affecting the most deprived 20% and other populations experiencing poorer access, experience or outcomes. [16] WHO defines universal health coverage around access to needed quality services without financial hardship and continues to identify large global gaps in health-service and essential-medicine access. [14,15]

13. Open medical development using appropriate technology

A modern reassessment of medicine and care should use the widest appropriate technological capability available, while retaining safety, validation, privacy, human oversight and equal-access safeguards. Technology should not be adopted because it is fashionable, nor rejected because it is unfamiliar.

- digital and remote monitoring where it improves timely detection of deterioration;
- telemedicine and remote specialist access where distance is otherwise a barrier;
- patient-reported outcome and experience systems capable of rapid escalation;
- electronic records that make patient observations, uncertainty and reassessment plans visible across teams;
- AI-supported evidence synthesis, triage and decision support subject to validation, audit and accountable clinical oversight;
- clinical simulation and digital twins where validated for planning, training or risk reduction;
- non-invasive and minimally invasive diagnostic and therapeutic technologies where clinically appropriate;
- assistive and accessibility technologies so disability or communication difference does not remove a patient from the feedback loop;
- open, reproducible evidence review and publicly auditable implementation criteria;
- continuous evaluation for unequal performance across socioeconomic, geographic, disability and demographic groups.

Northern Ireland's Digital Strategy explicitly links digital transformation with personalised care, visibility of care pathways, precision medicine, user participation and reduction of digital inequalities. [13] Wales likewise places information, learning, improvement and research among the enablers of quality, and its People's Experience Framework treats experience as a continuous

feedback stream that should be visibly acted upon. [12,23] England's NHS Constitution explicitly commits to innovation, research and the use of research to improve current and future care. [10]

OPEN TECHNOLOGY PRINCIPLE

Every clinically plausible technology should be eligible for transparent assessment. Adoption should depend on evidence, safety, proportional benefit, cost-effectiveness and equity - not prestige, private purchasing power, institutional fashion or resistance to change.

14. Proposed UK Open Review of Help and Care

This submission requests a formal, time-bounded, publicly visible review jointly recognised across the UK, with devolved implementation. The review should not be owned solely by one profession or institution. Its legitimacy depends on combining professional expertise with lived experience and public accountability.

Suggested participants include patients and carers; clinicians from medicine, nursing, pharmacy and allied professions; emergency and critical-care specialists; primary care; public-health professionals; ethicists; statisticians; diagnostic-safety researchers; disability and communication-access specialists; health economists; legal experts; regulators; technology and AI safety specialists; and representatives of communities experiencing persistent access inequalities.

The process should publish evidence tables, conflicts of interest, dissenting opinions, modelling assumptions, meeting records, consultation responses and reasons for final decisions wherever lawful. Patient participation should be supported rather than tokenistic, including accessible formats, advocacy and payment for substantial public-participation work.

15. Proposed measurable standards

The following measures could turn ethical language into operational accountability. They are proposed for consultation and validation, not asserted as ready-made national performance indicators.

Measure	What it would test
Patient concern capture	Proportion of material patient concerns documented and linked to a clinical response or stated reason for no action.
Reassessment responsiveness	Time from a reported material change to clinically appropriate reassessment, stratified by urgency.
Feedback closure	Proportion of patient safety or experience reports receiving a visible response, outcome and learning action.

Measure	What it would test
Alternative-discussion rate	For selected high-impact interventions, proportion of records documenting material risks and reasonable alternatives.
Lower-harm option review	Where an invasive intervention is chosen, documentation of clinically reasonable lower-harm alternatives and reasons for choice.
Access inequality	Waiting time, treatment access and outcomes stratified by deprivation, geography, disability and other relevant equality measures.
Restriction review	Number and outcome of exceptional medicine/technology access requests, with reason categories and equality analysis.
Technology equity	Adoption and outcome differences for validated technologies across regions and socioeconomic groups.
Diagnostic correction	Rate and timeliness of diagnostic revision after new contradictory evidence or patient escalation.
Status neutrality audit	Independent testing for unjustified differences in clinical priority associated with wealth, fame, office or institutional influence.

16. A proposed decision test before consequential intervention

1. What meaningful health outcome are we trying to improve?
2. What evidence shows that this is the problem?
3. What evidence would make us reconsider the diagnosis or plan?
4. What has the patient observed, and have they had a reasonable opportunity to explain it?
5. How urgent is the situation and what is the cost of delay?
6. What are the expected benefits and harms of acting now?
7. What are the expected benefits and harms of waiting or doing nothing?
8. What reasonable alternatives exist?
9. Can a sufficiently effective result be obtained with less avoidable harm or restriction?
10. What uncertainty remains and has it been communicated honestly?
11. What matters most to this particular patient?
12. What follow-up or monitoring is required, and at what frequency?
13. What finding would trigger escalation, stopping or changing course?

14. If access to a treatment is blocked, what is the actual reason and protective purpose of the barrier?
15. If this decision proves wrong, have we created a realistic path to discover and correct it early?

17. Counterarguments and safeguards

A credible reform proposal must resist its own extremes.

- Patients can be mistaken. Listening requires appropriate evidential weight, not automatic agreement.
- Doctors can make reasonable errors without negligence or moral wrongdoing. Bad outcome does not equal bad doctor.
- In emergencies, delay can be more harmful than invasive action. Minimum sufficient intervention is not minimum intervention at any cost.
- Medicines regulation is necessary. The proposal is for proportionate, evidence-based and reviewable regulation, not unrestricted supply.
- Technology can amplify error, bias, surveillance and inequality. Open adoption requires validation, governance, privacy protection and human accountability.
- Resources are finite. Equity does not mean every person receives every intervention; it means allocation criteria should be transparent, clinically defensible and not covert proxies for wealth or status.
- Aesthetic or reconstructive interventions can have genuine health indications. The proposed priority rule applies only to purely elective enhancement when scarce medical resources are in direct competition with greater clinical need.

18. The social principle: medicine exists inside society

This submission uses civilisation as a relational concept rather than a description of wealth or technological sophistication. A society may possess extraordinary medical capability while distributing its benefits unequally. Capability answers what can be done; care answers how that capability is used and for whom.

Society is humanity in relationship - not merely the one or the few with enough wealth, status or influence to command the best available response.

The policy implication is concrete: when the United Kingdom possesses a safer, more effective or less burdensome medical capability, access to its assessment should not silently depend on social privilege. Where universal provision is not immediately possible, the reasons, prioritisation rules and route toward fairer access should be explicit and open to scrutiny.

19. Requested response from UK institutions

The submitting party respectfully requests that relevant UK institutions respond to the following questions:

1. Will you support an open, UK-wide reassessment of operational definitions of help and care, with devolved implementation?
2. Will you examine whether current systems reliably capture and respond to patient observations that challenge an existing diagnosis or treatment plan?
3. Will you consider a risk-responsive standard for the frequency of feedback and reassessment?
4. Will you examine formal adoption of a minimum-sufficient-intervention principle?
5. Will you audit medicine and technology access barriers for evidence, proportionality, equality impact and routes of exception or review?
6. Will you reaffirm that scarce public clinical resources are prioritised by clinical need rather than wealth, social status or purely elective vanity?
7. Will you establish transparent processes for evaluating and equitably deploying clinically appropriate emerging technology, including AI-supported systems?
8. Will you publish measurable indicators showing whether patient feedback is heard, acted upon and used to correct error?
9. Will you ensure that patients and carers participate as partners in the review rather than solely as consultees after decisions have been made?

20. Conclusion

The United Kingdom does not need to invent the moral foundation of medicine from nothing. Its existing professional standards, patient-rights frameworks, equality duties and health-system principles already emphasise trust, partnership, evidence, clinical need, safety, equity, learning and public accountability. The task is to make those principles operational enough that they still function when the patient is frightened, the diagnosis is uncertain, the institution is busy, the treatment is expensive, the technology is new, or the person asking for help has little social power.

Help should bridge an overwhelming gap. Care should watch the crossing at a frequency appropriate to the danger. Science should remain willing to discover that its current explanation is wrong. Intervention should impose no more avoidable harm than the necessary benefit requires. Regulation should protect rather than become an unexamined barrier. Technology should be assessed openly and, when justified, made available equitably. Publicly constrained medicine should place clinical need before purely elective vanity, and no human being should acquire greater clinical worth merely through status.

Trust should be the temple of medicine, but listening is its doorway.

The final request is therefore simple: do not demand that medicine be infallible. Demand that it remain able to hear, observe, learn, explain, reassess and correct. If evidence changes, let the treatment change. If technology can reduce harm, examine it. If a rule blocks appropriate care, explain and test the rule. If privilege distorts access, measure and correct the distortion. And if a person is calling for help, preserve a system capable of hearing them before the opportunity to help has passed.

Evidence map: what is established and what is proposed

Claim / concept	Status	Basis
Listening and partnership are professional duties	Established UK professional standard	GMC Good Medical Practice; NICE shared decision making.
Material risks and reasonable alternatives must be discussed	Established UK legal principle	Montgomery [2015] UKSC 11, with McCulloch [2023] clarification.
Communication/data-gathering failures can contribute to diagnostic error	Empirical evidence	Marvel 1999; Singh 2013; Graber 2005; NASEM 2015.
Cognitive bias, premature closure and overconfidence are diagnostic risks	Empirical evidence / diagnostic-safety literature	Graber 2005; Berner & Graber 2008.
Patients can be unfairly discounted as knowers	Developing empirical/ethical literature	Systematic review of epistemic justice in healthcare, 2024.
Access should follow clinical need rather than wealth/status	Existing policy principle plus proposed extension	NHS Constitution (England); Scottish and Welsh frameworks; NI medicines strategy.
Help = bridge between demand and capacity	Normative synthesis proposed here	Conceptual definition for consultation and testing.
Care = adaptive feedback process	Normative systems synthesis	Consistent with person-centred monitoring and learning frameworks; proposed as general operational definition.
Feedback frequency should be explicitly risk-responsive	Policy proposal	Systems inference from urgency, monitoring and deterioration principles; requires validation by specialty.
Minimum sufficient intervention	Policy proposal / ethical synthesis	Consistent with avoiding preventable harm and evidence-based intervention programmes.
Medicine before purely elective vanity when resources compete	Policy proposal grounded in clinical-need allocation	NHS clinical-need principles and existing distinction between cosmetic and reconstructive/clinically indicated care.
Open Technology Principle	Policy proposal	Consistent with UK commitments to innovation, digital health, research, equity and learning; requires technology-specific validation.

References and principal sources

URLs are included to make the submission readily auditable. Web sources were checked for this submission on 26 August 2026. Journal citations should be checked against the publisher record before formal academic publication.

- [1] General Medical Council. The duties of medical professionals registered with the GMC. Good medical practice 2024. <https://www.gmc-uk.org/professional-standards/the-professional-standards/good-medical-practice/the-duties-of-medical-professionals-registered-with-the-gmc>
- [2] General Medical Council. Good medical practice, Domain 2: Patients, partnership and communication. <https://www.gmc-uk.org/professional-standards/the-professional-standards/good-medical-practice/domain-2-patients-partnership-and-communication>
- [3] National Institute for Health and Care Excellence. Shared decision making. NICE guideline NG197. <https://www.nice.org.uk/guidance/ng197/chapter/Recommendations>
- [4] Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? JAMA. 1999;281(3):283-287. PMID: 9918487. <https://pubmed.ncbi.nlm.nih.gov/9918487/>
- [5] Singh H, Giardina TD, Meyer AND, Forjuoh SN, Reis MD, Thomas EJ. Types and origins of diagnostic errors in primary care settings. JAMA Internal Medicine. 2013;173(6):418-425. doi:10.1001/jamainternmed.2013.2777. <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1656540>
- [6] Graber ML, Franklin N, Gordon R. Diagnostic error in internal medicine. Archives of Internal Medicine. 2005;165(13):1493-1499. PMID: 16009864. <https://pubmed.ncbi.nlm.nih.gov/16009864/>
- [7] Berner ES, Graber ML. Overconfidence as a cause of diagnostic error in medicine. American Journal of Medicine. 2008;121(5 Suppl):S2-S23. PMID: 18440350. <https://pubmed.ncbi.nlm.nih.gov/18440350/>
- [8] Cote CI. A critical and systematic literature review of epistemic justice applied to healthcare: recommendations for a patient partnership approach. Medicine, Health Care and Philosophy. 2024. PMID: 38833134. <https://pubmed.ncbi.nlm.nih.gov/38833134/>
- [9] National Academies of Sciences, Engineering, and Medicine. Improving Diagnosis in Health Care. Washington, DC: National Academies Press; 2015. doi:10.17226/21794. <https://nap.nationalacademies.org/catalog/21794/improving-diagnosis-in-health-care>
- [10] Department of Health and Social Care. The NHS Constitution for England; and Handbook to the NHS Constitution. <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>
- [11] Scottish Government. Charter of Patient Rights and Responsibilities, revised June 2022. <https://www.gov.scot/publications/charter-patient-rights-responsibilities-revised-june-2022/>
- [12] NHS Wales Performance and Improvement. Health and Care Quality Standards. <https://performanceandimprovement.nhs.wales/health-and-care-quality-standards/>
- [13] Department of Health, Northern Ireland. Valuing Medicines: strategy for sustainable use of medicines; and HSC Digital Strategy. <https://www.health-ni.gov.uk/news/health-minister-launches-new-medicine-sustainability-strategy>

- [14] World Health Organization. Universal health coverage (UHC), fact sheet.
[https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))
- [15] World Health Organization. Essential medicines, fact sheet. <https://www.who.int/news-room/fact-sheets/detail/essential-medicines>
- [16] NHS England. Core20PLUS5 - an approach to reducing healthcare inequalities.
<https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>
- [17] NHS England / Academy of Medical Royal Colleges. Evidence-Based Interventions programme; NHS Payment Scheme summary of the programme. <https://www.england.nhs.uk/long-read/25-26-nhsps-nhs-provider-payment-mechanisms/>
- [18] NHS. Is cosmetic surgery available on the NHS?; NHS England clinical commissioning policy for aesthetic, plastic and reconstructive procedures (2026).
<https://www.nhs.uk/tests-and-treatments/cosmetic-procedures/advice/cosmetic-procedures-on-the-nhs/>
- [19] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11. UK Supreme Court.
<https://www.supremecourt.uk/cases/uksc-2013-0136>
- [20] *McCulloch and others v Forth Valley Health Board* [2023] UKSC 26. UK Supreme Court.
<https://www.supremecourt.uk/cases/uksc-2021-0149>
- [21] General Medical Council. Good practice in prescribing and managing medicines and devices: Prescribing unlicensed medicines. <https://www.gmc-uk.org/professional-standards/the-professional-standards/good-practice-in-prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines>
- [22] National Institute for Health and Care Excellence. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline NG5.
<https://www.nice.org.uk/guidance/ng5/chapter/Recommendations>
- [23] Welsh Government / NHS Wales. People's Experience Framework 2025.
<https://www.gov.wales/sites/default/files/publications/2025-04/peoples-experience-framework-2025.pdf>

Submission declaration

This document is presented as a request for examination and reform. Its normative propositions are deliberately distinguished from established evidence and law. It invites correction where evidence is stronger, weaker or different than stated. Its governing principle is the same one it asks of medicine: remain open to relevant evidence, preserve the ability to revise, and prefer demonstrable benefit over authority for its own sake.