

1. Legal Abilities and Duties of Doctors

What a UK doctor can lawfully do, and what an NHS doctor must do when treating an individual patient

Law and Policy in Medicine toolkit | Version 1.0 | 27 September 2026

Scope and status. This document focuses on NHS care in England, while also using UK-wide/Great Britain professional, medicines and employment-law sources where applicable. Health-service law differs in Scotland, Wales and Northern Ireland. This is a researched legal-information and assessment tool, not individual legal advice and not a substitute for urgent clinical care.

Core proposition. A doctor is not merely an administrator of NHS policy. A registered doctor must follow the law, work within competence, exercise clinical judgment, involve the patient, prescribe safely, and raise concerns when organisational systems or policies compromise patient safety or care. At the same time, a patient cannot compel a doctor to provide a treatment the doctor reasonably considers clinically inappropriate.

1. The legal and professional layers

Layer	Effect in practice
Primary legislation and regulations	Binding law. A local NHS policy cannot authorise conduct prohibited by statute or remove a statutory duty.
Case law	Binding legal principles according to court hierarchy; important for consent, clinical judgment and public-law challenges.
GMC professional standards	Not an Act of Parliament, but binding professional standards for registered doctors. Serious or persistent breach can affect registration.
NICE technology appraisals / specified recommendations	Can carry statutory NHS funding consequences where the Standing Rules require compliance.
NICE clinical guidelines	Important evidence-based guidance, but NICE states they do not override the clinician's responsibility to decide what is appropriate for the individual patient.
Local ICB/trust/practice policy	Operational rules. They must be lawful, rational, procedurally fair, equality-compliant and consistent with higher legal duties.

2. Lawful clinical abilities

- A doctor may assess, diagnose, investigate, treat, prescribe or arrange/referral for treatment within their competence and lawful prescribing authority. Good Medical Practice requires treatment decisions to be based on the individual assessment and the doctor's clinical judgment about likely effectiveness.

- A doctor may consider a treatment that is not the routine local option. NICE clinical guidance is normally taken fully into account, but it does not eliminate individual clinical judgment. If a clinician departs from a clinical guideline, the reasons should be clinically defensible and recorded.
- Licensed medicines may in appropriate circumstances be used outside their licence (“off-label”), and unlicensed medicines may sometimes be supplied for an individual patient’s special clinical needs under the Human Medicines Regulations 2012. GMC standards require sufficient evidence/experience, responsibility for prescribing, monitoring and follow-up. Additional legal restrictions can apply to particular medicines, controlled drugs and cannabis-based products.
- A doctor may refer to another clinician or specialist where the issue is beyond their competence, where specialist prescribing is legally required, or where specialist assessment is clinically appropriate.
- A doctor may refuse to prescribe or provide a requested treatment if, after proper consideration, they conclude it would not serve the patient’s clinical needs. GMC guidance requires the doctor to explore the request, explain the reasons for refusal and consider other options, including a second opinion.
- A doctor may raise, escalate and document concerns about unsafe organisational systems, policies or procedures. GMC guidance describes this as a duty where patient safety or care is being compromised.

3. Duties owed during assessment and treatment

Duty	Practical requirement
Follow law and relevant regulation	GMC Good Medical Practice expressly requires doctors to follow the law and relevant professional/regulatory requirements.
Adequate individual assessment	Take relevant history, symptoms, patient views, needs and values into account; examine/investigate where necessary.
Clinical competence	Work within competence; obtain advice, refer or transfer responsibility where necessary.
Evidence and effectiveness	Propose/provide effective treatment based on best available evidence and patient-specific assessment.
Consent and autonomy	Do not treat a capacitous adult without valid consent, subject to limited statutory exceptions. The patient may refuse offered treatment.
Information and reasonable alternatives	Explain material risks, benefits and reasonable alternatives sufficiently for informed decision-making.
Medication safety	Have adequate knowledge of the patient and be satisfied the medicine meets their needs; consider other treatment/medication and interactions.
Monitoring and review	Ongoing treatment decisions should be reviewed, especially if the condition, evidence, risks or patient preference changes.
Record keeping	Keep relevant clinical decisions and reasons clear and current, especially unusual prescribing or departure from common practice.

Raise safety concerns	Raise concerns where care is compromised by colleagues or organisational systems, policies or procedures.
Candour	Registered providers have statutory open-and-transparent duties, including specific duties after qualifying notifiable safety incidents.
Equality and reasonable adjustments	Service providers must not discriminate and must make reasonable adjustments where required by the Equality Act 2010.

4. What a patient request does - and does not - legally do

Patient control. A capacitous adult controls consent: they can accept or refuse what is offered. A request for a different treatment must be taken seriously and clinically considered, but it does not automatically create a duty to prescribe it.

- The doctor identifies treatment options that are clinically reasonable for the patient; the patient decides whether to accept an offered option. This structure is reflected in R (Burke) v GMC and later cases.
- Under Montgomery, clinicians must take reasonable care to make the patient aware of material risks of the recommended treatment and reasonable alternative or variant treatments. McCulloch clarifies that whether an alternative is a reasonable option involves professional clinical judgment supported by responsible medical opinion.
- If the patient proposes a treatment the clinician would not normally offer, GMC guidance requires exploration of the reasons, understanding and expected outcome before rejection.

5. When NHS policy appears to conflict with care

- A doctor should first identify whether the restriction is law, national commissioning rule, NICE technology-appraisal obligation, local formulary/policy, contract requirement or merely usual practice.
- If following a system or policy would compromise patient safety or care, GMC raising-concerns duties may be triggered.
- A doctor should not treat a local policy as legal authority to do something unlawful. Conversely, a doctor cannot simply ignore lawful prescribing restrictions, controlled-drug rules, commissioning law or a lack of competence.
- Where the issue is funding rather than clinical appropriateness, the clinician and patient can ask for the commissioning policy, reasons, exception/Individual Funding Request route, or a legally available referral/choice route.

6. Doctor-facing assessment questions

- ☐ What is the patient-specific clinical objective?
- ☐ What treatment options are clinically reasonable, including non-routine options?
- ☐ Is any proposed option prohibited/restricted by law, or only by policy/guidance?
- ☐ Does the option require a specialist, shared-care arrangement, controlled-drug authority or other governance?
- ☐ What evidence supports or argues against the option for this patient?
- ☐ What are the material risks of the proposed treatment, alternatives and no treatment?
- ☐ What monitoring, review and stopping criteria would make a trial safer?
- ☐ If I decline the requested option, have I recorded the clinical reason and explained alternatives/referral/second-opinion routes?

[] If organisational policy is compromising care or safety, have I raised the concern through an appropriate route?

Authorities and references

Primary legislation and official/regulatory sources are preferred. Links were checked for this version on 27 September 2026.

- [1] [Good Medical Practice - Domain 1 \(GMC\)](#) — Paras 3-7 include keeping up to date, following law, individual assessment and clinical judgment.
- [2] [Decision making and consent \(GMC\)](#) — Shared decision-making and consent standards.
- [3] [Handling patient requests for treatment \(GMC\)](#) — Paras 50-51: explore request, explain refusal and alternatives/second opinion.
- [4] [Raising and acting on concerns - Part 1 \(GMC\)](#) — Duty to raise concerns about systems, policies and procedures compromising safety or care.
- [5] [Prescribing unlicensed medicines \(GMC\)](#) — Evidence, responsibility, monitoring and follow-up requirements.
- [6] [Human Medicines Regulations 2012, reg. 167](#) — Supply to fulfil special patient needs.
- [7] [Human Medicines Regulations 2012, reg. 214](#) — Prescription-only medicines and appropriate practitioners.
- [8] [NICE Guidelines Manual - Introduction](#) — Clinical guidelines do not override individual professional judgment.
- [9] [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014, regs 9-12](#) — Person-centred care, consent and safe care.
- [10] [Equality Act 2010, ss 20 and 29](#) — Reasonable adjustments and service-provider non-discrimination.
- [11] [Montgomery v Lanarkshire Health Board \[2015\] UKSC 11](#) — Material risks and reasonable alternative/variant treatments.
- [12] [McCulloch v Forth Valley Health Board \[2023\] UKSC 26](#) — Clarifies the test for a reasonable alternative treatment.
- [13] [R \(Burke\) v GMC \[2005\] EWCA Civ 1003](#) — Clinical options are identified by professional judgment; patient cannot compel clinically inappropriate treatment.
- [14] [Employment Rights Act 1996, s 47B](#) — Protection from detriment for qualifying protected disclosures.