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VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: When are hospital doctors right to challenge patients' families?

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I've written before here about the importance of actively involving hospital inpatients' relatives—especially those who play vital and stressful roles as carers—and of ensuring timely and accessible conversations.[1] Inadequate or insensitive communication lies behind many complaints.[2 3]

But doctors responsible for large numbers of inpatients in overstretched hospitals have obligations to balance. Our primary obligation to the patient is enshrined in professional codes.[4] Then come obligations to all our patients, whether or not they have involved or questioning relatives. Time shouldn't be skewed disproportionately towards a few families at others' expense.

We must also weigh the needs of patients who are currently in beds against all those in the wider community or emergency department, who might need beds more acutely. All this can bring us into conflict with relatives.

Here are just some situations where I think we have a professional duty to negotiate solutions sensitively but sometimes to challenge directly. Acquiescing to keep the peace and avoid complaint is easier but sometimes irresponsible.

- When we must raise legitimate safeguarding concerns, even when the response is defensive.
- When refusal to accept important equipment or personal care for moving and handling patients or prevention of pressure sores puts the patient at serious risk of harm.
- When working on weekend or evening ward cover or in acute admission areas and we are constantly approached by families. These conversations are witnessed, so attracting other families, who sometimes hover closely and compromise other patients' confidentiality. If this happens when you are trying to get to a sick or dying patient or stay on top of a queue of admissions, saying "I can't stop now" is honest and necessary.
- When a patient's free decision to go home, even if this is risky, is being obstructed or subverted, sometimes behind the patient's back. Or when families expect a series of problems, some longstanding for weeks or months before admission, that should be dealt with outside an inpatient setting to be resolved before they will accept discharge, however long it takes. Keeping someone in an acute hospital bed for such reasons puts them at risk of harms and complications of hospitalisation. It also denies beds to other patients with more acute needs.
- When discussing limits of care or palliative approaches, and families push for interventions such as resuscitation, artificial nutrition and hydration, or antibiotics, we should avoid complicity if there would be little gain or a risk of worsening or prolonging patients' distress, however well intentioned the request.

Families shouldn't be blamed for our pressures at work or their desire for information, involvement, and reassurance. But nor should clinicians be blamed for sticking up for patients, thinking of the wider health system, and for sometimes pushing back.

1 Oliver D. David Oliver: welcoming carers on to the wards. *BMJ* 2015;356:h4959.pmid: 26385852.
2 Parliamentary and Health Service Ombudsman. Complaints about health organisations for the year 2014-15. www.ombudsman.org.uk/reports-and-consultations/reports/health/complaints-about-health-organisations-for-the-year-2014-15.
3 Parliamentary and Health Service Ombudsman. A report of investigations into unsafe discharge from hospital. www.ombudsman.org.uk/reports-and-consultations/reports/health/a-report-of-investigations-into-unsafe-discharge-from-hospital.
4 General Medical Council. Duties of a doctor. www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp.

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